Attachment B
Montana HELP Demonstration
Operations Protocol

I. Purpose

The Operations Protocol describes Montana's policies and procedures for implementing premiums and co-payments for HELP Plan participants.

II. Overview

HELP Plan participants enrolled through the Third Party Administrator (TPA) will be required to pay premiums and co-payments. Responsibility for paying premiums and co-payments will encourage HELP Plan participants to be more discerning health care purchasers, take personal responsibility for their health care decisions and develop health-conscious behaviors as consumers of health care services.

The following participants are excluded from the TPA and not subject to premiums: participants who (1) have been determined to be medically frail; (2) live in a region (which could include all or part of an Indian reservation) where the TPA was unable to contract with sufficient providers; (3) require continuity of coverage that is not available or could not be effectively delivered through the provider network offered by the TPA; and, (4) are otherwise exempted from premiums or cost sharing by federal law, and not within the scope of a waiver of that exemption, including participants with incomes at or below 50% of the federal poverty level (FPL). New adults who are excluded from the TPA or who have incomes at or below 50% of the FPL are not subject to premiums, but are subject to co-payments as set forth in the Cost Sharing State Plan Amendment (SPA).

Household cost sharing for all participants under the Demonstration will be consistent with Medicaid regulations, and premium and co-payments will be subject to an aggregate cap of 5% of household income. TPA participants will receive a credit toward their co-payment obligation in the amount of their total premiums, such that they shall not accrue out of pocket expenses for co-payments until accumulated co-payments exceed 2% of aggregate household income.

In accordance with the Special Terms and Conditions (STCs), Federal regulation, and State legislation, the State will exempt certain services from co-payments. Preventive services that are exempt from co-payments are recorded in Attachment C of the STCs.

III. Premiums

1. Overview

TPA participants will be charged premiums equal to 2% of their household income. The TPA will notify participants of their required monthly premium upon enrollment and that their cost sharing obligation of premiums and co-payments will not exceed 5% of their income, through a

monthly premium invoice and in the Participant Guide and, when applicable, through scripts used by the TPA's customer service representatives.

2. Payment

The TPA will administer and collect TPA participant premiums, providing multiple options for participants to remit payments. Participants can pay their premiums by check and money order. The TPA is currently developing an option for online payment of premiums via Automated Clearing House payments through the participant portal, which is scheduled to be implemented by the end of September 2016.

The TPA also has a process in place to accept third party contributions on behalf of participants. This includes ensuring that any amounts received are credited to the appropriate participant and the entity or individual who made the payment is tracked. State law does not limit which individuals or entities may contribute on the participant's behalf, and any third party's contribution will be applied directly to the participant's premium requirement; the contributions cannot be used to offset the State's share. Any individual or entity may initiate the process. In the event excess funds are received, funds will be returned to the appropriate remitter as required by relevant law and regulation.

There are no limits on the amounts third parties can contribute toward a beneficiary's premium obligation. Such third party contributions offset required beneficiary premium or copayment obligations only, and may not be used for any other purpose.

3. Consequences of Non-Payment

Consequences of non-payment of premiums vary depending on a participant's household income.

i. Participants with Incomes above 50% up to and including 100% FPL

Participants with income above 50% up to and including 100% of the FPL who fail to pay premiums will not be dis-enrolled from coverage. Unpaid premiums will be considered a collectible debt that may be collected or assessed by the State. Assessment occurs when the Department of Revenue sends a notice of debt to the participant and must occur no later than the end of each calendar quarter in which a person has collectible debt.

ii. Participants with Incomes above 100% up to and including 133% FPL

Participants with incomes above 100% and up to and including 133% FPL who fail to pay premiums will be dis-enrolled from coverage after appropriate notice and a 90 day grace period. All participants will receive monthly premium invoices via mail documenting their owed premiums; participants with premiums past due 90 days will receive a 90 day premium invoice via mail as well as a letter outlining circumstances under which they may avoid disenrollment.

Participants will also receive a letter from the Department of Revenue upon assessment of their debt. Individuals will have a right to appeal an adverse decision at any time.

Participants may re-enroll in coverage in the month that payment is made for the overdue premiums or in the month after the month that the Department of Revenue assesses overdue premium amounts (e.g., if the Department of Revenue assesses in March, the participant may re-enroll in April). Assessment occurs when the Department of Revenue sends a notice of debt to the participant and must occur no later than the end of each calendar quarter. For example, if a monthly premium is due on June 1st, the grace period clock runs for 90 days from July through September. If the premium remains unpaid the individual's coverage will be terminated on October 31st and the first day of non-coverage will be November 1st.

In order to re-enroll in the HELP Plan, the individual need not file a new application if they are within the 12 month continuous eligibility period; he or she must simply visit an enrollment office, call a toll-free number dedicated to re-activating enrollment, or go online to apply.mt.gov and opt back into the HELP Plan. In the month the individual successfully opts back in, eligibility is effective the first day of that same month.

4. **Assessment**
   When a participant has a premium payment that is over 90 days past due the debt will be transferred to the Department of Revenue to be assessed quarterly for tax offset. When the Department of Revenue has a tax refund, a notification will be sent to the participant to inform them that their tax return will be reduced by the assessed debt.

5. **Premium Examples**

Examples A and B illustrate how premiums will be applied to participants.

Example A: Participants with Incomes above 50%up to and including 100% FPL
A participant with no dependents has an annual income of $8,830, around 75% FPL. The participant's annual premium contribution is approximately $176 or $14 per month. Upon enrollment in the TPA, the participant is notified of their monthly premium and options for payment through a welcome package issued by the TPA, as well as a monthly invoice. If the participant fails to make monthly premium payments, the unpaid amount will be considered a collectible debt subject to assessment and collection by the Department of Revenue. The participant will not be dis-enrolled for failure to pay the monthly premium.
Example B: Participants with Incomes above 100% up to and including 133% FPL
A participant has an annual income of $25,000, around 125% FPL. The participant's annual premium contribution is $500 or approximately $41 per month. Upon enrollment in the TPA, the participant is notified of their monthly premium and options for payment through a welcome package issued by the TPA, as well as a monthly invoice. Participants are billed for premiums on approximately the 12th of each month, with a request to pay the premium by the 1st of the following month. If a participant enrolls after the cutoff for the current month's billing cycle, they will be billed for three months of premiums in the subsequent month.

Example B1:

- A participant enrolls on May 4th (before the billing cutoff) and is billed for their May and June premium on May 12th.
- If the participant does not pay by June 1st, the bill they receive in June will request payment for three months of premiums (May, June, and July).
- Should the participant not pay, the grace period will cover July, August, and September. The participant will be disenrolled in October with coverage lasting through October 31st. November 1st will be the first day of non-coverage, assuming the participant did not pay the first premium amount in full or any other premium amounts.

Example B2:

- A participant enrolls on May 15th (after the billing cutoff around the 10th of the month) and is billed on June 12th for both May, June and July premium payments.
- If the participant does not pay by July 1st, the bill they receive in July will request payment for four months of premiums (May, June, July, and August).
- Should the participant not pay, the grace period will last the months of August, September, and October, and the participant will be disenrolled in November with coverage lasting through November 30th. In this example, December 1st will be the first day of non-coverage, assuming the participant did not pay the first premium amount in full or any other premium amounts.

Premium payments are always credited toward a participant's oldest debt. If the participant fails to make monthly premium payments, and the premium becomes more than 90 days past due, and does not meet exemptions listed in SB405,[1] the participant will be dis-enrolled from the HELP Plan. In addition, the participant's outstanding premium balance will be transferred to the Department of Revenue for assessment and collection from their state income tax refund. The participant may re-enroll in the HELP Plan once they have remitted payment for unpaid premiums or after the Department of Revenue has assessed their debt. The Department of Revenue will assess participants' debt on a quarterly basis.

IV. Co-payments

1. Overview

Participants in the HELP Demonstration will be subject to maximum allowable cost sharing under federal regulations subject to an aggregate cap of 5% of household income. In addition, all TPA participants will receive a credit toward their co-payment obligations in the amount of the 2% of income in premiums they owe, such that they shall not accrue out of pocket expenses for co-payments until accumulated co-payments exceed 2% of aggregate quarterly household income. Certain health care services, preventive services, and drugs will be exempt from co-payments; these services and drugs are documented in the Preventive Services Protocol.

2. Co-payment Billing and Payment

[1] Montana Legislature, Senate Bill 405, http://leg.mt.gov/bills/2015/billpdf/SB0405.pdf.

Co-payment is assessed based on the date of payment. The State will utilize the following billing and payment process:

- Providers will not charge co-payments to participants at the point of service.
- Providers will submit claims to claims payment vendors (TPA, Pharmacy Benefit Manager, and MMIS) in compliance with International Classification of Diseases (ICD) coding guidelines.
- The claims payment vendors will review the claims, consulting the list of healthcare services, preventive services, and drugs to determine whether the claim is subject to a co-payment.
    - Preventive health care services including primary, secondary, and tertiary preventive services will be identified by diagnosis codes and/or procedure codes.
    - Pharmacy claims will be identified through drug classes. DPHHS will maintain the list of exempt preventive services and drug classes and review and update the list at least annually.
- The claims payment vendors will process claims, taking into consideration the 2% credit toward co-payment obligations and the 5% aggregate household cap to ensure participants are not inappropriately billed for co-payments.
- The claims payment vendors will send remittance advice to the provider with co-payment information.
- Providers will bill participants for applicable co-payments after receiving remittance advice from the claims payment vendors.
- If the participant has reached the 5% aggregate household cap, the provider will not bill the participant for the service.
- The TPA will include direction in the provider manual outlining the requirement to monitor uncollected co-pay amounts for HELP Plan participants. The TPA will send an annual survey to providers requesting a summary of uncollected co-payments from HELP Plan participants and their efforts to collect the co-payments.
- The enterprise data exchange should prevent overcharging of participants as well as the process described above in which participants are not charged at the point of service. However, if a participant is overcharged, the State will re-process the claim, notify the provider, and, if the provider has collected payment, the provider will reimburse the participant. If the participant's incurred co-payments exceed the 5% aggregate cap, the State will also send the participant a notice stating the participant may have been overcharged and instructing them to reach out to the provider to seek reimbursement.

Hospitals are required to comply with federal requirements to screen and provide services to individuals who require emergency care. The State presumes all visits to the emergency department are not subject to cost sharing, unless the provider provides a written attestation to the State that the provider meets the State's requirements for imposing co-payments for emergency department services. Co-payments for non-emergent use of the emergency department can only be charged if the hospital completes all of the below steps (per 42 CFR § 447.54(d).

1. Conducts an EMTALA-compliant medical screening examination that concludes the participant's condition is non-emergent;
2. Provides the participant with the name and location of an alternative non-emergency services provider;
3. Determines that the alternative provider can provide services at a lower cost sharing amount; and
4. Provides a referral to schedule treatment by the alternative provider.

In the event a visit is determined to be a non-emergency, before providing non-emergency services, the hospital will inform the individual that they may be subject to cost sharing and that the participant will receive a bill from the hospital once the co-pay amount is determined after adjudication of the claim. The State instructed hospitals of these requirements through written notice, posting the policy on the Medicaid website, incorporating the policy into the provider process, and establishing a hospital attestation process. Beneficiaries will not be charged a co-payment for non-emergency use of the ER unless the conditions detailed above and in compliance with 42 CFR § 447.54(d) are met. This policy is described in the HELP Plan Participant Guide.

3. Co-payment Examples

Examples C and D below illustrate how the co-payments will operate for participants with income above 50% up to and including 100% FPL, and participants with incomes above 100 up to and including 133% FPL.

Example C: Participants with Incomes above 50%up to and including 100% FPL

The participant is married without children (household size of two) with a household income of 75% FPL. The participant has a premium credit of approximately $239 or 2% of household income per year, or approximately $60 per quarter. During the participant's first quarter in the HELP Demonstration, the participant is billed for the following services:

- One preventive care visit (No co-payment) = $0
- One outpatient visit for a sinus infection ($4 co-payment) = $4
- One preferred prescription drug ($4 co-payment) = $4
- One outpatient physical therapy visit ($4 co-payment) = $4
- Two non-preferred prescription drugs ($8 co-payment per drug) = $16

Total co-payment: $28

The participant is not charged co-payment for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a co-payment; and (2) the participant's premium credit is being applied to the remaining co-payment, such that the provider is being paid in full for the service and does not have to collect a co-payment from the patient. The participant will not owe a co-payment.

Example D: Participants with Incomes above 100% up to and including 133% FPL

The participant is a single male with an annual income of $11,888, or 101% FPL, and has a premium credit of approximately $237 per year, or $59 per quarter. The participant has a maximum out of pocket cap of 5% of quarterly income, so will not be obligated to pay over $148 each quarter for all out of pocket expenses (or $59 in premiums plus $89 in co-payments). The participant is billed for the following services during the first quarter of enrollment:

- 1 preventive care visit (No co-payment) = $0
- 2 outpatient visits ($20 co-payment per visit, or 10% of the $200 payment the State makes for each outpatient service) = $40
- 6 preferred prescription drugs ($4 co-payment per drug) = $24
- 12 preferred non-prescription drugs ($8 co-payment per drug) = $96

Total co-payment: $160
Premium credit for the quarter applied to co-payment: $59
Maximum quarterly co-payments owed by participant: $89
Cost sharing waived (amount above 5% cost share max allowed by CMS): $12

The participant is not charged for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a co-payment; (2) the participant's premium credit is applied to the first $59 in co-payment, such that the provider is being paid in full for the service and does not have to collect a co-payment from the patient; and (3) the participant will owe his maximum quarterly co-payments totaling $90.

When the participant pays their premium, the payment is applied to the cap during the quarter for which the premium is due. In this example, if the participant is billed for $59 in premiums in March, the payment is applied to the first quarter.

V. Tracking of Premiums and Co-payments Against the 5% Aggregate Household Cap

On a quarterly basis, the State, working with its claims payment vendors (Xerox and Blue Cross Blue Shield of Montana) and through the enterprise data exchange detailed in Figure 1, will calculate the total incurred premiums and co-payments by each TPA participant to ensure that participants' total out-of-pocket payments do not exceed the aggregate 5% household cap. The State will track premiums and co-payments of all household members, including members who are not enrolled in the TPA, against the aggregate cap through data sharing across the TPA, MMIS, and Pharmacy Benefit Manager (PBM).

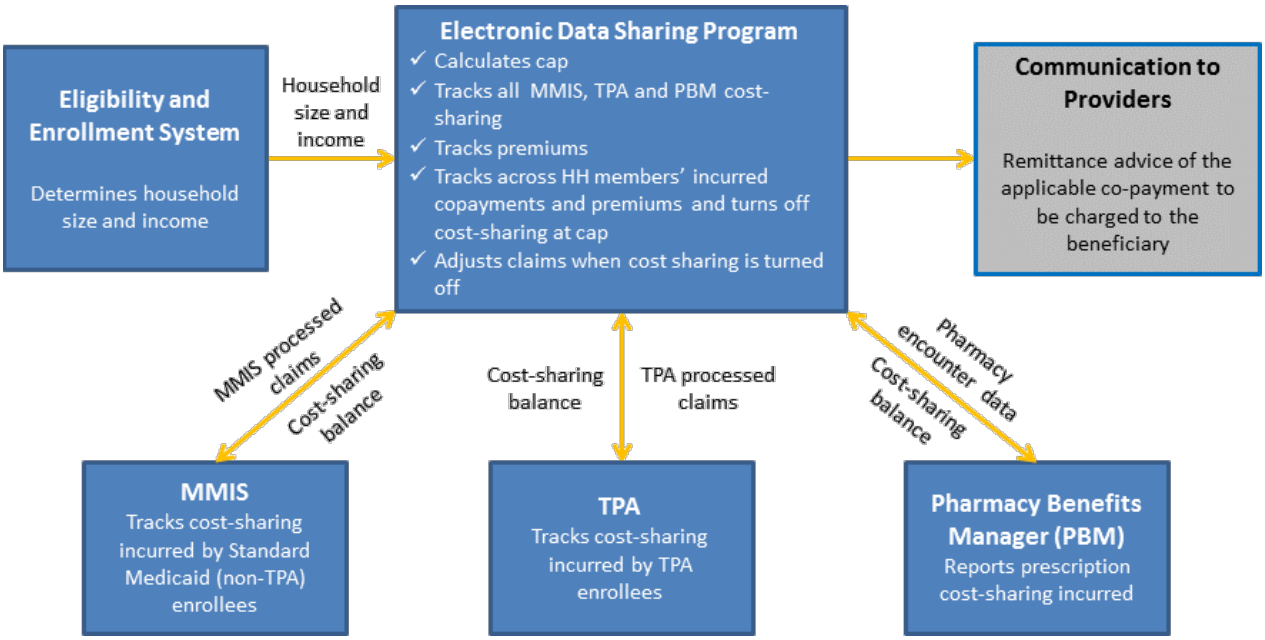
After each claim is received, a TPA participant will receive an Explanation of Benefits that summarizes service utilization as well as total amount of incurred premiums and co-payments obligation. The State is committed to ensuring the format and content of Explanation of Benefits are both responsive to the needs of the participant and support the purpose of the HELP Demonstration; any consumer feedback that is received on the Explanation of Benefits or notices

is carefully considered and used to inform revisions. Participants will have access to a Participant Help Line to assess whether they have reached their 5% aggregate household cap. The TPA is currently developing an enhancement to the participant portal which will display premiums, premium credit, and amount accumulated towards 5% maximum out of pocket expense.

If the State, through its electronic data sharing among the MMIS, TPA, and PBM, identifies a participant whose household has paid over the 5% aggregate limit, claims for which co-payments were inappropriately collected will be re-adjudicated and the provider will be required to refund the previously collected co-payment.

Providers will receive beneficiary co-payments based on the date of claims adjudication, until a participant reaches their 5% aggregate limit.

Figure 1. **Electronic Data Sharing Exchange**



If a participant would like a reassessment of his or her family's aggregate limit due to a change in circumstances or a termination of enrollment due to failure to pay a premium, the participant will be directed to contact the Office of Public Assistance (OPA) and follow their outlined request for review process. The premium amount shall be recalculated for the following month and the participant will be notified of the change in premium, if applicable.

If a participant disagrees with a decision on the aggregate limit or termination of enrollment for failure to pay premiums, the participant has the right to a fair hearing; a participant may request a fair hearing on the aggregate limit or premium amounts after their initial eligibility determination. To request a fair hearing the participant will be directed to call the Office of Fair Hearings or submit a form with their complaint. The fair hearing process is documented in ARM

37.5.307. Information regarding how to access a fair hearing is also documented in the Participant Guide and each Explanation of Benefits.

VI. Participant and Provider Engagement

1. Participant Education and Outreach

a. TPA-led education and outreach

The State will ensure through its contract with the TPA that the TPA has written policies regarding services exempt from co-payment and will work with the TPA to develop and disseminate information to participants, including through the Participant Guide, Welcome Letter, Welcome Brochure, and on the DPHHS HELP Plan website. Participants will be notified of the co-payment exemption policy and be provided with a list of co-payment exempted services within ten days of enrollment. The policy and list of exempted services will also be posted on the State and TPA's websites and will be available in hard copy upon a participant's request. The information provided to participants will comply with the Information and Communication Requirements detailed in the 1915(b)(4) Waiver STCs (Section 11), and will undergo revisions approved by DPHHS at least annually to ensure they are accurate and up to date. The TPA is required to comply with these requirements through its contract with DPHHS and DPHHS retains ultimate responsibility for approving materials and information provided to participants.

The TPA will be responsible for providing sufficient staffing and other administrative support to respond to participant questions regarding premiums and co-payments, and will be obligated to educate participants on these topics. TPA-led education must include information on how to interpret and use account statements; how to make payments on required premiums and co-payments; and the process for submitting questions and complaints about premiums and co-payments.

The TPA will regularly report to the State on the performance of its participant education and outreach activities. Should the State find the TPA's education and outreach activities to be ineffective, it will work with the TPA on a corrective action plan to meaningfully improve education and outreach performance.

In its Quarterly Reports to CMS, the State will describe actions the State and TPA have taken to inform participants about co-payment exempted services.

b. State-led education and outreach

The State is committed to working alongside the TPA to ensure eligible HELP Plan participants receive sufficient explanation of the Plan's policies, and the State will continue to serve as a resource for all Medicaid participants.

Upon Medicaid eligibility determination, HELP Plan participants will receive a notice from the DPHHS advising them of the following:

- Medicaid eligibility determination: The notice will include the basis of the participant's eligibility determination, effective date of eligibility, information on copayments and premiums, a review of covered services, information regarding procedures for reporting a change in circumstances, and website access to the participant guide and newsletters.
- Appeals: The notice will include information regarding the Medicaid appeals process as required under federal law.

In addition to TPA-led participant education and outreach activities, the State will ensure information regarding covered benefits and policies regarding premiums and co-payments are posted and accessible via the State's website as well as in hard copy upon participant request. Consistent with 42 CFR 447.57, the State makes available a public schedule describing current cost sharing requirements in a manner that ensures affected applicants, participants and providers have access to the information. The website will also include copies of participant materials such as the Welcome Brochure and Participant Guide, and provide contact information for dedicated Help Lines where participants may access assistance with eligibility and enrollment as well as medical, vision, dental, and prescription benefits. State staff will also be trained on the policies so that they may address or appropriately direct participant inquiries in a timely manner.

c. Copies of participant-facing materials

The following materials will undergo revisions approved by DPHHS at least annually to ensure they are accurate and up to date (any item not attached as an appendix is currently under revision):

i. **Welcome Letter** [Appendix A]
ii. **Participant Guide** [Appendix B]
iii. **Welcome Brochure** [Appendix C]

d. Copies of participant notices

The following materials will undergo revisions approved by DPHHS at least annually to ensure they are accurate and up to date:

i. **Notice of Eligibility Determination** [Appendix D]
ii. **Premium Invoice** [Appendix E]
iii. **Explanation of Benefits** [Appendices F and G]

2. Provider Education and Outreach

a. TPA-led provider education and outreach

The State will ensure through its contract with the TPA and review of TPA materials that the TPA has written provider education materials regarding co-payment exemptions. The State meets regularly with the TPA to understand how the TPA is conducting outreach to providers and works with the TPA to develop and disseminate information to providers. The TPA interacts

with providers through: the provider manual; review and approval of written notices and communications; provider trainings; and the TPA's quarterly provider newsletter.

b. State-led provider education and outreach

The State of Montana uses provider Medicaid Manuals to impart provider education. These can be found on the Montana Medicaid website, medicaidprovider.mt.gov. The State will also ensure its website includes important provider information and directs providers to the TPA for additional information and general provider services. The State has designated staff responsible for maintaining the website and relevant information for providers, and has a process in place whereby any changes to provider information are converted to the website in a timely manner.

The State will also partner with various professional associations to ensure education regarding the Montana HELP Plan is consistent with program policies and procedures, and that information about the HELP Plan is distributed through existing provider communication channels.

c. Copies of provider-facing materials

The TPA conducted several provider webinars during the first two months after HELP implementation, providers may access the education slides, which contain several slides specific to premiums and co-payments [Appendix H].

3. Participant Survey Approach and Design

The State of Montana will partner with the TPA to develop and administer a yearly survey of the following populations:

1. Participants enrolled in the TPA;
2. Participants who have been dis-enrolled from the TPA; and
3. Individuals who are eligible to enroll in the TPA.

Although survey questions may be slightly altered to ensure the best quality enrollee information is gathered, the preliminary survey can be found in Appendix I.

The survey size will be large enough to produce statistically significant results and will be designed to evaluate whether potential applicants and participants understand the program policies, premiums and associated consequences, and whether the premiums affect participants' decisions about whether to apply for the program.

VII. Grievances

The State and TPA will follow participant grievance and appeals processes described in the 1915(b)(4) and 1115 Waiver STCs and consistent with federal law. In its Quarterly Reports to CMS, the State will describe actions, complaints, grievances, and appeals filed during the quarter regarding service exemptions and co-payments as well as any actions being taken to address significant issues evidenced by patterns of complaints or appeals.

Participants are provided information on the grievance and appeals process in the Participant Guide, Explanation of Benefits, and any service denial communications. Participants may initiate an appeal at any time.

Montana HELP Demonstration

Operations Protocol

Appendix A

Welcome Letter

(2 pages)

Dear HELP Plan Participant:

Welcome to the Montana Health and Economic Livelihood Partnership (HELP) Plan! The Montana Department of Public Health and Human Services (DPHHS) and Blue Cross and Blue Shield of Montana (BCBSMT), have come together to offer health coverage to Medicaid-eligible Montanans. This Welcome Kit includes the following:

1. Welcome Brochure – tells you about the HELP Plan's covered benefits. Most benefits are managed at BCBSMT, but some benefits are managed at DPHHS.
2. Blue Access for Members [SM] (BAM) Flier – tells you how to go online and check claim status, see an Explanation of Benefits (EOB), verify eligibility, request identification (ID) cards or print a temporary ID card, and more.
3. HELP Plan Participant Guide – tells you about covered benefits and gives directions about how to use your HELP Plan benefit plan.

You will get your HELP Plan participant ID card in a different mailing.

The HELP Plan encourages you to stay healthy with covered preventive health benefits such as yearly physicals and a Health Assessment. The HELP Plan only pays for care you get from HELP Plan network providers.

We encourage you to pick a health care provider from the BCBSMT HELP Plan provider network as a primary care provider to manage your health care needs. This is the best way to use your benefits to get and stay healthy. A primary care provider can help coordinate your care between different types of providers, which will help you get the most from your HELP Plan benefit plan. A list of HELP Plan providers is at www.bcbsmt.com under 'Find a Doctor or Hospital.'

Since some benefits are managed at DPHHS, providers must accept Montana Medicaid for the following services in order for you to be covered by the Montana HELP Plan:

- Audiology
- Community Health Centers/Federally Qualified Health Centers (FQHCs)
- Dental
- Eyeglasses
- Hearing Aids
- Indian Health Services (IHS)/Tribal Health

- Pharmacy
- Rural Health Clinics (RHCs)
- Transportation

A list of Montana Medicaid providers is at
https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do

Go to HELPPlan.mt.gov to get a copy of the HELP Plan Evidence of Coverage (EOC). The EOC has more detailed information about HELP Plan coverage and benefits. Call **1-877-233-7055** to ask for a printed copy of the guide.

We look forward to serving your health care needs. Sincerely,

Blue Cross and Blue Shield of Montana
Montana HELP Plan

Claims Administrator * 560 North Park Avenue ***** PO Box 4309 ***** Helena, MT 59604-4309 ***** www.bcbsmt.com

This project is funded in whole or in part under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department.

Montana HELP Demonstration

Operations Protocol

Appendix B

Participant Guide

(36 pages)

BlueCross BlueShield of Montana

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

MONTANA HELP PLAN

PARTICIPANT GUIDE

www.bcbsmt.com/mthelpplan
HELPPlan.mt.gov

Update 10/01/2016

Thank you for choosing the Montana Health and Economic Livelihood Partnership (HELP) Plan as your health plan. This HELP Plan Participant Guide will help you learn more about the HELP Plan and how to use your HELP Plan benefits. The HELP Plan offers medical, behavioral health, dental, vision, prescription drug benefits, and much more. The HELP Plan works to keep you healthy, not just treat you when you are sick. When this HELP Plan Participant Guide is updated with covered services, copayment, or plan changes, it will be posted to **www.bcbsmt.com/mthelpplan** and **HELPPlan.mt.gov**.

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Montana HELP Plan

The HELP Plan is just one of many programs sponsored by the Montana Department of Public Health and Human Services (DPHHS) to provide health care coverage to Montanans. Most HELP Plan medical services are administered by Blue Cross and Blue Shield of Montana (BCBSMT). A small set of medical services will be administered by Xerox.

Services for the HELP Plan Processed by BCBSMT (must be a BCBSMT provider):

- Behavioral Health (Mental Health and Substance Use Disorder)
- Convalescent Home (excludes Custodial Care)
- Durable Medical Equipment/Supplies
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Emergency
- Hospital
- Lab and X-Ray (Medical)
- Medical Vision and Exams
- Mid-Level
- Physician
- Preventive
- Rehabilitative and Habilitative
- Surgical

Services for the HELP Plan Processed by Xerox (must be a Montana Medicaid provider):

- Audiology
- Dental
- Diabetes Prevention Program
- Eyeglasses
- Federally Qualified Health Center
- Hearing Aids
- Home Infusion
- Indian Health Services/Tribal Health
- Pharmacy
- Rural Health Clinic
- Transportation (Including ambulance)

Health Care Providers

The HELP Plan has many quality health care providers to serve you, from family doctors and dentists to physical therapists, behavioral health counselors, and most everything in between. When you are looking for care, check to see if a provider is a HELP Plan or Montana Medicaid in-network provider. The HELP Plan only pays for services if you use an in-network provider, unless you have preauthorization.

For Medical and Behavioral Health Care Providers

Before seeing a medical or behavioral health provider, ask the provider if he or she is enrolled as a HELP Plan or Montana Medicaid provider. You can access provider and HELP Plan information at **www.bcbsmt.com/mthelpplan**. If you don't have internet access, call BCBSMT Participant Services at **1-877-233-7055**.

Online Access to Claims

Register today with Blue Access for Members℠ at **www.bcbsmt.com/mthelpplan** to see medical and behavioral claim status, medical benefits and eligibility information. You can also submit questions to Participant Services online. Participant Services is available Monday through Saturday from 6 a.m. to 10 p.m. and Sunday from 9 a.m. to 6 p.m. Mountain Standard Time.

For medical or behavioral health benefit or claim questions, call BCBSMT Participant Services at **1-877-233-7055**.

For Other Health Care Services Providers

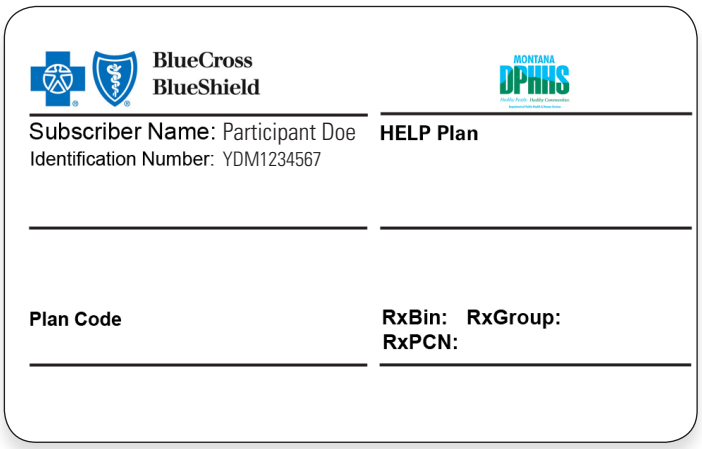
You can visit **HELPPlan.mt.gov** where you'll find information for Medicaid enrolled health providers for: dental, pharmacy, eyeglasses, Rural Health Clinics, Federally Qualified Health Centers, hearing aids/audiology, transportation, Indian Health Services (IHS)/Tribal Health, and Community Health Center Services. You can access Montana Medicaid information at **http://mtaccesstohealth.acs-shc.com/mt/general/providerlocator.do**. If you don't have internet access, call the Montana Healthcare Programs Help Line at **1-800-362-8312**.

For benefit or claim questions, call the Montana Healthcare Programs Help Line at **1-800-362-8312**.

Getting Started with the HELP Plan

Your HELP Plan Identification (ID) Card

BCBSMT will send you a HELP Plan ID card. Carry this card with you at all times and show it to your provider when you get care. This card is also used for buying prescription drugs. Call BCBSMT at **1-877-233-7055** if you do not receive a card in the mail within 4 weeks, or if you lose the card. You may also access Blue Access for Members at **www.bcbsmt.com/mthelpplan** to request an ID card or to print a temporary ID card.



Moving?

If you move, please let us know by calling the Montana Public Assistance Helpline at **1-888-706-1535**. Participants who move out of Montana are not eligible for the HELP Plan.

Coverage for Newborn Children

When a HELP Plan participant has a baby, the baby will automatically be enrolled in Montana Medicaid.

Your HELP Plan Rights

You have the right to:

- Expect quality medical care.
- Be treated politely and with respect by health care providers and their staff.
- Be told about your medical condition.
- Be told about the treatment your doctor advises before it happens.
- Refuse treatment.
- Be told of possible results before accepting or refusing treatment.
- Talk to your HELP Plan provider and expect your records and conversations are kept confidential.
- Choose your own HELP Plan provider.
- Make a complaint about the HELP Plan and receive an answer.
- Be informed how the HELP Plan works.
- Know what medical services are covered by the HELP Plan.
- Be informed of your copay responsibility for services received.
- Be informed of your premium responsibility and how it affects your copay amounts and out-of-pocket maximum.

Getting Started with the HELP Plan

Your HELP Plan Responsibilities

You and your HELP Plan health care provider are a team in protecting your health. Your job is to help your HELP Plan health care provider give you the best health care. So, keep the following in mind:

- Call ahead for an appointment when you need to see a HELP Plan provider. Providers often have busy schedules and cannot always see drop-in patients.
- Be on time for your appointments. Call your HELP Plan health care provider ahead of time if you are going to be late or can't keep your appointment.
- Tell your HELP Plan provider about your medical problems. Tell them the signs of trouble, pain, or changes you have noticed.
- Tell your provider about allergies and unusual health needs. Ask questions. Sometimes it helps to write a list of questions before you go to your appointment. Ask about risks, choices, and costs before treatment is given or drugs are prescribed.
- Fill all your prescriptions at the same pharmacy when possible. The pharmacist can answer questions about your prescriptions.
- Get complete directions about all medications, treatments, or tests. Write them down, or ask your provider to write them down.
- Pay your HELP Plan health care provider the copayment after the claim has been processed and you have been billed by the provider.
- Take time to decide about having a treatment before it happens. Be careful to review your treatment choices. Discuss your options with your HELP Plan health care provider. For many procedures, your HELP Plan provider will need time to get preauthorization.
- The HELP Plan does not cover some services. Please refer to the HELP Plan Services Chart in this guide for HELP Plan covered and non-covered services. You are responsible to pay for services that are experimental, investigational, unproven, not provided in the right setting, not medically necessary, or services that are not covered if you have signed an Advance Benefit Notice (ABN). If you don't see the service listed or you are not sure if a service is covered, call Participant Services at **1-877-233-7055**.
- HELP Plan providers may not bill you for services that are denied as not medically necessary, not provided in the right setting, experimental, unproven, investigational, and not covered unless you have signed an ABN (excludes ambulance).

HELP Plan Nondiscrimination Policy

The HELP Plan does not discriminate on the basis of race, color, national origin, age, disability or sexual orientation in admission or access to, or treatment or employment in, its programs and activities. The BCBSMT Section 504 ADA Coordinator can be reached at **(406) 437-5285**.

Premiums, Copayments, and Maximum Out-of-Pocket Costs

Premiums

As a participant of the HELP Plan you pay a monthly premium. Your premium helps cover the cost of your health insurance. The HELP Plan premium cannot exceed two (2%) of your yearly individual income. This total amount will be broken into monthly payments. BCBSMT will mail premium notices within the month prior to the due date. Premiums are due by the first of each month. Return the invoice stub and a check payment to the mailing address indicated on the invoice.

For participants at or below one hundred (100%) percent of the Federal Poverty Level (FPL), which equals approximately $990 per month for an individual, or $2,025 per month for a family of four, failure to pay premiums will not result in dis-enrollment. Unpaid premiums for all participants become a debt to the State and will be collected against future tax refunds. You can call Participant Services at **1-877-233-7055** to ask about your premium status.

Copayments

A copayment is a payment owed by you to your health care provider for health care services that you receive. You will be responsible to pay the provider after the claim has been processed. All participants will receive a credit toward copayments equal to the total owed premium amount for the quarter. Copayments will not be charged until the credit is met. You can call Participant Services at **1-877-233-7055** to ask about your copayment credit amount or other copayment questions.

If your income is at or above 100% of the FPL, and you have an outstanding copayment balance, a provider does not have to provide services for you again.

You may be charged for more than one copayment for a visit to your doctor. For example, your visit may result in the following copayments: x-rays, lab work, doctor visit, and for a facility fee (depending on the place of service). Contact Participant Services at **1-877-233-7055** if you have copayment questions.

Premium Credit Examples

Participants with Incomes 50 - 100% FPL

The participant is married without children (household size of two) with a household income of 75% FPL. The participant has a premium credit of approximately $239 or 2% of household income per year, or approximately $60 per quarter. During the participant's first quarter in the HELP Plan, the participant is billed for the following services:

- 1 preventive care visit (No copayment)
- 1 outpatient visit for a sinus infection ($4 copayment)
- 1 preferred prescription drug ($4 copayment)
- 1 outpatient physical therapy visit ($4 copayment)
- 2 non-preferred prescription drugs ($8 copayment per drug)

Total copayment: $28

The participant is not charged copayment for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a copayment; and (2) the participant's premium credit is being applied to the remaining copayment, such that the provider is being paid in full for the service and does not have to collect a copayment from the patient. The participant will not owe a copayment.

Participants with Incomes 101 - 138% FPL

The participant is a single male with an annual income of $11,888, or 101% FPL, and has a premium credit of $238 per year, or approximately $59 per quarter. The participant has a maximum out-of-pocket cap of 5% of quarterly income, so will not be obligated to pay over $149 each quarter for all out-of-pocket expenses (or $59 in premiums plus $90 in copayments). The participant is billed for the following services during the first quarter of enrollment:

- 1 preventive care visit (No copayment) = $0
- 2 outpatient visits ($20 copayment per visit, or 10% of the $200 payment the State makes for each outpatient service) = $40
- 6 preferred prescription drugs ($4 copayment per drug) = $24
- 12 preferred non-prescription drugs ($8 copayment per drug) = $96

Total copayment: $160
Premium credit for the quarter applied to copayment: $59
Maximum quarterly copayments owed by participant: $90
Cost sharing waived (amount above 5% cost share max allowed by CMS): $11

The participant is not charged for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a copayment; (2) the participant's premium credit is applied to the first $59 in copayment, such that the provider is being paid in full for the service and does not have to collect a copayment from the patient; and (3) the participant will owe his maximum quarterly copayments totaling $90.

The HELP Plan Services chart on the next few pages will let you know what the copayment cost is for services, if there is a copayment. A separate letter was sent to you when you enrolled that indicates what FPL level you are under, so you can look at your copayment column on the chart.

Copayment and Maximum Out-of-Pocket Costs

If your income is at or below 100% of the FPL, and you have an outstanding copayment balance, a provider does not have to provide services for you again.

Individuals Not Responsible For Copayment

- Pregnant women;
- Those age 20 and under;
- American Indians/Alaska Natives who are eligible for, currently receiving, or have ever received an item or service furnished by:
  - an Indian Health Service (IHS) provider;
  - a Tribal 638 provider;
  - an IHS Tribal or Urban Indian Health provider; or
  - through referral under contract health services.
- Terminally ill receiving hospice services;
- Receiving services under the Medicaid breast and cervical cancer treatment category;
- Institutionalized persons who are inpatients in a skilled nursing facility, intermediate care facility, or other medical institution if the person is required to spend for the cost of care all but his or her personal needs allowance

Services With No Copayment

- Preventive health screenings,
- Family planning,
- Eyeglasses,
- Transportation,
- Emergencies in the emergency room, and
- Medically necessary health screenings ordered by a health care provider.

Maximum Out-of-Pocket Costs

Payments toward premiums and copayments will be applied to your maximum out-of-pocket amount. The maximum out-of-pocket amount is 5% of the total household income. This is calculated on a quarterly basis. You can check with BCBSMT at any time to find out about your premiums, credit status, copayment, or expected cost of copayments.

Copayment and Maximum Out-of-Pocket Costs

Premium Rights and Obligations

Even if you cannot pay your premium, you may still be able to keep HELP Plan coverage. You will remain in the HELP Plan if:

A. Your income is under 100% of the FPL, which is approximately $990 a month for an individual, or $2,025 a month for a family of four; or

B. If your income is above 100% of the federal poverty level, you may lose your coverage if you fail to pay your premiums. You are still responsible for the payment of your premiums. The unpaid premium balance will be transferred to the State of Montana for collection from your state income tax refund.

Even if you cannot pay your premiums, you may still be able to keep HELP Plan coverage under certain circumstances including:

- You have been discharged from the United States military service within the previous 12 months;
- You are enrolled for credit in any Montana University System unit, a tribal college, or any other accredited college within Montana offering at least an associate degree;
- You see a primary care provider who is part of a patient-centered medical home;
- You are in a substance use treatment program; or
- You are in a DPHHS approved healthy behavior activity program administered by DPHHS or BCBSMT. The list of approved programs is located at HELPPlan.mt.gov or call **1-855-324-6259**.

If Montana DPHHS determines that you meet two or more of these conditions, you will continue to have access to the health care services covered by the HELP Plan. You will still be responsible for payment of your premiums.

If two of the following describe you, call **888-706-1535**:

• You have been discharged from the United States military service within the past 12 months; or	**To let us know you were in college or in the military go to apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance.**
• You are enrolled for credit in a Montana university, tribal college, or any other accredited college in Montana that offers at least a two-year degree; or	
• You are in an approved HELP Healthy Behavior Plan wellness program; or You are in a substance use treatment program; or You see a primary care provider who is part of a patient-centered medical home. You can find out by asking your doctor's office.	To find out more about the Healthy Behavior programs or to sign up please go to HELPPlan.mt.gov or call **BCBSMT Participant Services at 1-877-233-7055**. You can find out by asking your doctor's office. To let us know, go to **apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance**.

If you are disenrolled because you have unpaid (delinquent) premiums, you may reenroll in the HELP Plan after:

A. You have paid your unpaid premium balance in full; or

B. You have received notice from the State of Montana that your unpaid premium balance has been assessed against your future state income tax. This assessment occurs once per calendar quarter.

Participants that would like to reenroll should contact the Montana Public Assistance Help Line at **844-792-2460** or **apply.mt.gov**.

HELP Plan Services

This section tells if a service is covered by the HELP Plan. For details on these covered services, turn to the pages after the HELP Plan Services Chart. There may be other services that the HELP Plan will pay for that are not listed. Ask your HELP Plan provider if you're not sure if something is covered or requires preauthorization. HELP Plan Participant Services will also be able to help; call BCBSMT at **1-877-233-7055**.

Lifetime Maximum Benefit

There is no lifetime maximum benefit.

Preauthorization

Some HELP Plan services need to be approved before the HELP Plan will pay for them. Refer to the HELP Plan Services Chart to see if the services you need require preauthorization by your HELP Plan provider.

If you fail to get preauthorization for a service, you may be responsible to pay for that service if you signed an Advance Benefit Notification (ABN).

The description of the HELP Plan covered and non-covered services presented here is a guide and not a contract to provide medical care. Administrative Rules of Montana, Title 37, governs access and payment for HELP Plan services. The rules can be found at **mtrules.org**.

HELP Plan Services Chart – Services Must Be Medically Necessary.

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Acupressure	No	—	—	—
Acupuncture	No	—	—	—
Adaptive Equipment (reachers, appliances)	No	—	—	—
Ambulance (Emergency)	Yes	$0	$0	No. Call 1-800-292-7114 within 30 days.
Ambulance (Non-Emergency)	Yes	$0	$0	Call 1-800-292-7114 for authorization
Audiology Services (see Hearing Exams and Hearing Aids)	Yes	$4	10% of the Allowable Fee	No
Bio-Feedback	No	—	—	—
Birth Center Services	Yes	$0	$0	No
Birth Control	Yes	$0	$0	No
Cardiac Rehabilitation	Yes	$4	10% of the Allowable Fee	Yes
Case Management	Yes	$0	$0	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Chemical Dependency Treatment (CD facility inpatient)	Yes	$4	10% of the Allowable Fee	Yes
Chemical Dependency Treatment (CD facility outpatient)	Yes	$4	10% of the Allowable Fee	Yes, for some services
Chiropractic (for Adults through age 20. Must be ordered or referred by a HELP Plan provider)	No	—	—	—
Clinic Services	Yes	$4	10% of the Allowable Fee	No
Cochlear Implants	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Comfort and Convenience Items	No	—	—	—
Community Health Centers Services	Yes	$4	10% of the Allowable Fee	No
Comprehensive School and Community Treatment (CSCT)	No	—	—	—
Contact Lenses	No	—	—	—
Convalescent Home Subject to a 60-day limit	Yes	$0	$0	Yes
Corrective Lenses (see Eyeglasses)	—	—	—	—
Cosmetic Surgery	Only under rare circumstances	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Dental Anesthesia	Yes	$4	10% of the Allowable Fee	No
Dental Braces (orthodontia) through age 20 if medically necessary	Yes	—	—	Yes
Dental Implants	No	—	—	—
Dental Preventive/Diagnostic	Yes	$0	$0	No
Dental Treatment Subject to a $1,125 limit (excluding: preventive/diagnostic, dentures and anesthesia)	Yes	$4	10% of the Allowable Fee	No
Denturist	Yes	$4	10% of the Allowable Fee	No, check service limits
Developmental Disability Services	No	—	—	—
Diabetes Education	Yes	$0	$0	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Dialysis (outpatient and training for self-dialysis)	Yes	$4	10% of the Allowable Fee	No
Doctor Visits	Yes	$4	10% of the Allowable Fee	No
Drugs/Medications (over-the counter)	Yes	$4	$4	No
Drugs/Medications (require prescription - generic)	Yes	$0	$0	Yes, for some drugs
Drugs/Medications (require prescription - preferred brand name)	Yes	$4	$4	Yes, for some drugs
Drugs/Medications (require prescription - nonpreferred brand name)	Yes	$8	$8	Yes, for some drugs
Durable Medical Equipment (DME) and Medical Supplies	Yes	$4	10% of the Allowable Fee	Yes (for services over $2,500)
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), through age 20 if medically necessary	Yes	$0	$0	Yes, for some services
Emergency Room Services Emergency Services	Yes	$0	$0	No
Emergency Room Services Non-Emergency Services	Yes	$8	$8	No
Environmental Controls (air cleaners, heaters)	No	—	—	—
Exercise Programs or Equipment	No	—	—	—
Experimental Drugs or Treatments	No	—	—	—
Eye Exams	Yes	$4	10% of the Allowable Fee	No
Eyeglasses (frames and lenses)	Yes	$0	$0	Yes, for some features
Family Planning	Yes	$0	$0	No
Genetic Testing and/or Counseling	Yes	$4	10% of the Allowable Fee	Yes
Hearing Aids	Yes	$4	10% of the Allowable Fee	Yes
Hearing Exams	Yes	$4	10% of the Allowable Fee	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Home Health	Yes	$4	10% of the Allowable Fee	Yes
Home Infusion Therapy	Yes	$4	10% of the Allowable Fee	Yes
Homemaker	No	—	—	—
Homeotherapy	No	—	—	—
Hospice	Yes	$0	$0	Yes
Hospital (inpatient)	Yes	$75	10% of the Allowable Fee	Yes
Hospital (outpatient)	Yes	$4	10% of the Allowable Fee	No
Hot Tubs or Spas	No	—	—	—
Hypnotherapy	No	—	—	—
Inclusive Services	No	—	—	—
Indian Health Services/ Tribal Health Services	Yes	$0	$0	Yes, for some services
Infertility Treatment	No	—	—	—
Interpreter	Yes	$0	$0	No
Lab (laboratory services)	Yes	$4	10% of the Allowable Fee	No
Massage	No	—	—	—
Medical Marijuana	No	—	—	—
Medical Services Received Outside the U.S.A.	No	—	—	—
Medical Supplies and Equipment (see Durable Medical Equipment)	Yes	$4 provider	10% of the Allowable Fee	Yes (for services over $2,500)
Mental Illness Treatment (MI facility inpatient; hospital only)	Yes	$75	10% of the Allowable Fee	Yes
Mental Illness Treatment (MI facility outpatient)	Yes	$4	10% of the Allowable Fee	Yes, for some services
Naturopathic Physician Services	No	—	—	—
Neurofeedback	No	—	—	—
Nurse Advice Services	Yes	$0	$0	No
OB (obstetric) Services	Yes	$0	$0	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Occupational Therapy	Yes	$4	10% of the Allowable Fee	Yes
Orthodontia (dental braces) through age 20 if medically necessary	Yes	$0	$0	Yes
Orthotics	No	—	—	—
Out-of-State Services (only if emergency or not available in state)	No	—	—	—
Paternity Tests	No	—	—	—
Personal Assistant	No	—	—	—
Personal Transportation (Emergency)	Yes	$0	$0	Call Medicaid Transportation at 1-800-292-7114 for authorization.
Personal Transportation (Nonemergency)	Yes	$0	$0	Call Medicaid Transportation at 1-800-292-7114 for authorization.
Pharmacy (see Drugs)	—	—	—	—
Physical Therapy	Yes	$4	10% of the Allowable Fee	Yes
Pregnancy and Childbirth	Yes	$0	$0	No
Prescription Drugs (see Drugs)	—	—	—	—
Preventive Care Services	Yes	$0	$0	No
Private Duty Nursing (through age 20 if medically necessary, must be ordered or referred by a HELP Plan provider)	Yes	—	—	No
Professional Counselor	Yes	$4	10% of the Allowable Fee	No
Psychiatric	Yes	$4	10% of the Allowable Fee	No
Psychology Services	Yes	$4	10% of the Allowable Fee	No
Public Health Clinic Services	Yes	$4	10% of the Allowable Fee	No
Radial Keratotomy	No	—	—	—
Radiology (MRI, PET Scans, GI Radiology, CT Scans)	Yes	$4	10% of the Allowable Fee	Yes
Respiratory Therapy	Yes	$4	10% of the Allowable Fee	No
School-Based Services (through age 20 if medically necessary)	Yes	—	—	Yes

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Service Animals (including purchase, training and maintenance costs)	No	—	—	—
Shots (immunizations)	Yes	$0	$0	No
Social Work (see clinical)	Yes	$4	10% of the Allowable Fee	No
Speech Therapy	Yes	$4	10% of the Allowable Fee	Yes
Sterilization (excludes reversal of voluntary sterilization)	Yes	$0	$0	No
Stress Management	No	—	—	—
Surgery (inpatient)	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Surgery (outpatient)	Yes	$4	10% of the Allowable Fee	Yes, for some services
Telemedicine Services	Yes	$4	10% of the Allowable Fee	No
Telephone Service	No	—	—	—
Temporomandibular Joint Treatment (TMJ) Surgery	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Tobacco Cessation Counseling	Yes	$0	$0	No
Tobacco Cessation Drugs	Yes	$0	$0	No
Transplants	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Urgent Care	Yes	$4	10% of the Allowable Fee	No
Vitamins (requires prescription and includes prenatals for pregnant women)	Yes	$0	$0	Yes, for some vitamins
Weight Loss Clubs or Clinics	No	—	—	—
Weight Loss Surgery (gastric bypass, gastric banding or bariatric surgery, including all revisions)	No	—	—	—
Weight Scales	No	—	—	—
Wellness Programs	Yes	$0	$0	No
Whirlpools	No	—	—	—
X-Rays	Yes	$4	10% of the Allowable Fee	No

HELP Plan Services Described

This list includes examples of HELP Plan services. Not all services are listed and not all details about a service are shown. Ask your doctor or health care provider for more information. You can also call BCBSMT at **1-877-233-7055** for more information.

All covered treatments and services must be medically necessary. The participant receiving services must be enrolled at the time the service is delivered.

Ambulance Services

Emergency ambulance services are covered for emergency ground or air transports. Call **911** or your local emergency number for services. An emergency means a medical condition manifesting itself by sudden symptoms of enough severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individuals (or, for a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

Licensed ground and air ambulance services are covered to the nearest hospital equipped to provide necessary treatment when:

- The service is to treat a life-threatening illness or injury, or
- It is medically necessary – meaning other forms of getting to care would endanger the participant's health.

Ambulance services must be medically necessary. If you are not sure you should go to the emergency room, call your HELP Plan provider or Nurse Advice Line at **1-877-213-2568**. The call is free. Registered nurses are available 24 hours a day, 7 days a week to help you decide.

If you used your personal vehicle for emergency travel, you must call the Medicaid Transportation Center at **1-800-292-7114** within 30 days of the emergency in order to be considered for payment. Scheduled non-emergency use of an ambulance may be necessary in some cases, but you must receive preauthorization before travel takes place. Call the Medicaid Transportation Center at **1-800-292-7114**.

Audiology Services

(see Hearing Aids and Hearing Exams, pg. 21)

Birth Center Services

Birth center services are provided in a state-licensed health care place or hospital.

Birth Control

Pills, shots and most other types of birth control, and family planning supplies are covered. Birth control must be prescribed for you by a covered provider.

HELP Plan Services Described

Case Management

In the event of a high-cost medical problem, the HELP Plan may be able to recommend medically appropriate, cost-effective treatments for you and your provider to consider. A case manager will evaluate your condition with your HELP Plan provider. For additional information, call BCBSMT at **1-877-233-7055**.

Examples of illnesses where case management is valuable are:

- Severe diabetes,
- Cancer,
- Chronic illness (such as asthma, pneumonia, and lung problems),
- Acute injuries (such as head injuries),
- Heart problems,
- Multiple therapies (physical, speech or occupational therapies),
- Cystic fibrosis,
- Behavioral health conditions, and
- High-risk pregnancy.

Chemical Dependency Services

There are several different kinds of alcohol and drug treatment services:

- Non-hospital inpatient treatment – this service is 24 hours a day, 7 days a week, and patients live in the facility,
- Intensive non-hospital outpatient treatment,
- Hospital inpatient and outpatient treatment,
- Partial hospitalization, and
- Individual, group, or family counseling.

Preauthorization is required for inpatient services, residential treatment services, and intensive outpatient services. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Cochlear Implants

Cochlear implants and associated components require preauthorization. Call BCBSMT at **1-877-233-7055**.

Community Health Centers

The HELP Plan covers visits to Community Health Centers (CHC), Federally Qualified Health Clinics (FQHC), and Rural Health Centers (RHC).

If you have questions about CHC, FQHC, or RHC services, you may contact the Montana Healthcare Programs at **1-800-362-8312**.

HELP Plan Services Described

Convalescent Home Services

The HELP Plan covers services of a convalescent home as an alternative to inpatient hospital care. A convalescent home is an institution, or distinct part thereof, other than a hospital, which is licensed pursuance to state or local law. A convalescent home is:

1. A skilled nursing facility;
2. An extended care facility;
3. An extended care unit; or
4. A transitional care unit.

A convalescent home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured participants during the convalescent state of their illness or injuries and is not, other than incidentally, a rest home or home custodial care, or for the aged.

Convalescent home services are limited to 60 days per benefit period.

Convalescent home services must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Corrective Lenses

(see Eyeglasses, pg. 20)

Dental Services – HELP Plan Dental Treatment Services

A HELP Plan participant may receive up to $1,125 in dental treatment services per benefit year. The benefit year runs from July 1 through June 30. Each July 1st, HELP Plan participants become eligible for $1,125 of dental treatment services (treatment frequency limits apply). Services that are covered but do not count toward the $1,125 benefit period treatment limit, are preventive/diagnostic, anesthesia, and dentures.

You will have to pay for services that go over the $1,125 HELP Plan Dental Treatment limit. Any amount over the $1,125 limit is a private arrangement between you and your Medicaid dental provider.

Some dental services require Medicaid copayments. Make sure you know how much your services cost, and if you have reached your $1,125 dental treatment limit.

Most dental services are covered.

Some Dental Services That Are Not Covered:

- Dental Implants, and
- Cosmetic Dentistry.

NOTE

Surgical repair of the mouth and gums due to an accident or congenital defect may be covered under the medical benefits of your HELP Plan. Contact BCBSMT for more information at **1-877-233-7055**. Dental services needed for an accidental injury to healthy, natural teeth and gums are covered for up to 12 months from the date of the accident.

HELP Plan Services Described

Finding a HELP Plan Dentist

A list of Medicaid enrolled dentists is available at **HELPPlan.mt.gov** by clicking on the "Find a Health Care Provider" option.

Contact Medicaid enrolled dentists in your area to make an appointment and ask if they accept new HELP Plan patients. If your dentist is not currently a Medicaid enrolled dentist but would like to become one, the dentist may contact the Montana Healthcare Programs Help line at **1-800-362-8312**.

If you have questions about HELP Plan dental services, you may contact the Montana Healthcare Programs Help Line at **1-800-362-8312**.

Diabetes Education

The HELP Plan covers outpatient diabetes education services. Covered services include programs for self-management training and education as prescribed by a doctor. Diabetic supplies are covered under the section entitled 'Durable Medical Equipment and Medical Supplies'on page 19.

Dialysis

Dialysis is covered for participants who have chronic end-stage renal disease. Services covered at dialysis clinics include:

- Outpatient dialysis, and
- Training for self-dialysis.

Doctor Visits

Visits to your doctor's office are covered. When we use the term "doctor," we also mean physician assistants (PAs) and nurse practitioners (NPs), FQHCs, RHCs, IHS, tribal, and CHCs. Most services you get from a doctor are covered.

Examples of "doctor" services include:

- Treating high blood pressure,
- Office visits,
- Physicals (exams),
- Operations, and
- Shots (immunizations).

Drugs (Over-the-Counter)

The following over-the-counter drugs are covered if they are prescribed for you by your HELP Plan provider or Medicaid enrolled provider:

- Aspirin,
- Insulin,
- Laxatives, antacids, head lice treatment,
- Stomach products such as Zantac® and Prilosec OTC®,
- Allergy products such as Claritin®,
- Levonorgestrel,
- Ketotifin ophthalmic solution,
- Pyridoxine,
- Doxylamine,
- Nasacort AQ,
- Oxybutynin Transdermal, and
- Folic Acid.

HELP Plan Services Described

Drugs/Medications (Prescription)

Many prescription drugs are covered. Some prescription drugs may need preauthorization. To find out if a drug you need is covered or to find out if a drug needs preauthorization, talk to your pharmacist or the person who prescribed the drug.

The HELP Plan usually will pay for a 34-day supply of drugs. Participant may get a 90-day supply of some drugs for heart disease, high blood pressure, or birth control. Early refills may be authorized if the person who writes the prescription changes your dose. Early refills will not be granted for lost or stolen medication, or for vacation, or travel.

Prescription drugs are only covered if you go to a Montana Medicaid enrolled pharmacy. To find out if your pharmacy is enrolled, go to **HELPPlan.mt.gov**, and then click on the "Find a Health Care Provider" option.

Out-of-state pharmacy benefits will be paid only to Medicaid enrolled providers. Check the link to find out if your out-of-state provider is enrolled. Call the Montana Healthcare Programs at **1-800-362-8312** for more information.

Durable Medical Equipment (DME) and Medical Supplies

Medical supplies include things like wound dressings and diabetic needles, lancets, test strips, and devices for monitoring glucose.

DME must be ordered or referred by a HELP Plan provider. DME includes things like oxygen equipment, wheelchairs, prosthetic limbs, and orthotics. DME items must be the least costly option to treat the medical condition and used in your home, school, or work place. You will need preauthorization for DME items that cost $2,500 or more; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**. For answers to DME questions, ask your medical provider, your DME provider, or call BCBSMT at **1-877-233-7055**.

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

EPSDT services are comprehensive and preventive health care services for Participants through age 20 and include:

- Diagnostic and treatment services that are medically necessary,
- Comprehensive health and developmental history, physical exam, immunizations, lab tests and health education,
- Vision services, including diagnosis, treatment, and eyeglasses,
- Dental services, and
- Hearing services.

Emergency Room Services, Emergency Services

Emergency services are covered in the HELP Plan. An emergency is a medical condition manifesting itself by sudden symptoms of enough severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individuals (or, for a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

The HELP Plan pays for all medically necessary covered care that you get from HELP Plan providers. The HELP Plan covers emergency care and urgent care if you follow the rules below.

You should notify your primary care provider as soon as possible that you are receiving emergency care. You should arrange follow-up care with your primary care provider.

HELP Plan Services Described

Hospitals are required to comply with federal requirements to screen for and provide services to individuals who require emergency care. The State presumes all visits to the emergency department are not subject to cost sharing, unless the provider provides a written attestation to the State that the provider meets the State's requirements for imposing cost-sharing for emergency department services. Copayments for non-emergent use of the emergency department can only be charged if the hospital completes all of the below steps:

1. Conducts an EMTALA-compliant medical screening examination that concluded the participant's condition is non-emergent;
2. Provides the participant with the name and locations of an alternative non-emergency services provider;
3. Informs the participant of the amount of his or her cost-sharing obligation for non-emergency services provided in the emergency department;
4. Determines that the alternative provider can provide services at a lower cost sharing amount; and
5. Provides a referral to schedule treatment by the alternative provider.

In the event a visit is determined to be a non-emergency, the hospital may bill the participant for a copayment once the copayment amount is determined after adjudication of the claim. The State will instruct hospitals of these requirements, establish a hospital attestation process, and inform beneficiaries that they may only be charged a copayment for non-emergency use of the ER if these conditions are met.

Eye Exams

Eye exams and the fee to fit your eyeglasses are covered.

Optometric services for the medical treatment of diseases or injury to the eye by a licensed doctor or optometrist are covered.

To find an ophthalmologist or optometrist near you, refer to the HELP Plan Provider Directory on the website at **www.bcbsmt.com/mthelpplan**.

If you have questions, contact BCBSMT Participant Services at **1-877-233-7055**.

Eyeglasses

Eyeglasses are provided through a contract with Walman Optical Co. The HELP Plan will only pay for your eyeglasses if they are covered under the Walman contract. When ordering eyeglasses from the eyeglasses provider, make sure the provider carries eyeglasses covered under the Walman contract. If you choose to purchase frames or lenses that are not covered under the contract, it is your responsibility to pay for the purchase.

The HELP Plan pays for one pair of glasses every 365 days. However, if you have a medical condition that requires more frequent prescriptions, new lenses (but not new frames) may be covered more often.

All frames have a 24-month warranty to guard against defects. The warranty does not replace damaged frames other than manufacturer defects. You must return defective parts of the glasses for repair. Your HELP Plan provider may charge you a small handling fee for returning glasses for repair.

HELP Plan Services Described

The HELP Plan does not replace lost or stolen eyeglasses. The HELP Plan does not pay for contact lenses. If you have questions, contact the Montana Healthcare Programs at **1-800-362-8312**.

Family Planning Services

Most family planning services are covered, including, but not limited to:

- Physical exams, with breast exams,
- Pap test (to test for pre-cancerous conditions),
- Pregnancy tests,
- Birth control,
- Sexual health counseling (how to prevent or approach unintended pregnancy and sexually transmitted infections),
- Testing and treatment for sexually transmitted infections,
- Shots for German measles (to prevent pregnancy complications), and
- Shots for HPV.

You can receive most family planning services from your primary care provider or from other providers able to administer the services.

Hearing Aids

Hearing aids, hearing aid supplies, including batteries, and hearing aid repairs are covered when provided by a Medicaid enrolled provider. The Medicaid enrolled provider must request preauthorization for hearing aids. The HELP Plan participant must be enrolled on the date of the preauthorization request and on the date of service, including the date the hearing aid is provided to the HELP Plan participant. Hearing aid services must be ordered or referred by a HELP Plan provider.

For additional information on hearing aids, supplies and warranty, go to the Montana Healthcare Programs website at **HELPPlan.mt.gov**.

Cochlear implants and associated components require preauthorization. The HELP Plan provider must request preauthorization. Call BCBSMT at **1-877-233-7055**.

Hearing Exams

Hearing exams are covered and must be ordered or referred by a HELP Plan provider. For additional information on hearing exams, go to the Montana Healthcare Programs website at **HELPPlan.mt.gov**.

HELP Healthy Behavior Plan

BCBSMT has implemented a comprehensive health and wellness program for participants in the Montana Health and Economic Livelihood Partnership (HELP) Plan, with a focus on engaging participants and providers. This program is called the HELP Healthy Behavior Plan. The program has been designed to:

- Improve participant's knowledge of lifestyles that are healthy and promote wellness;
- Improve participant's understanding of chronic health conditions;
- Design programs to increase a participant's understanding of lifestyle behaviors that negatively impact their health;
- Ensure continuous health care;
- Provide easy access to health information;
- Provide participant resources to assist them in engaging in healthy lifestyle behaviors;
- Improve the participant-provider relationship;
- Improve health plan-provider communication; and

HELP Plan Services Described

- Engage existing provider and community health education programs in providing participant wellness information and in offering participant support for chronic conditions.

All participants will be offered information on health and wellness programs.

Programs offer Care Coordinator assistance on a plan of care involving diet, exercise, positive changes in lifestyle and goal setting. The goal is to encourage healthy changes and new habits that will lead to a healthier life.

Participants may call BCBSMT Participant Services **1-877-233-7055** and ask to be enrolled in one of the approved programs, or ask to speak with a Care Coordinator to learn more about this benefit. There are several DPHHS approved wellness programs available throughout the state of Montana. Descriptions of these programs are available on the BCBSMT participant portal, Blue Access for Members (BAM) at **http://bcbsmt.com/mthelpplan** and DPHHS' website at **http://dphhs.mt.gov/publichealth/chronicdisease/CommunityBasedPrograms**.

Wellness Programs in the Healthy Behavior Plan
Community Based Wellness Programs (DPHHS):
1. Montana Living Life Well Program;
2. Diabetes Self-Management Education;
3. Asthma Self-Management Education;
4. Arthritis Foundation Exercise program;
5. Walk with Ease program;
6. Diabetes Prevention Program; and
7. Montana Tobacco Quit Line.

BCBSMT Wellness Programs
The BCBSMT Wellness Programs are individualized programs designed to meet the needs of participants who may not be able to attend a community program, or prefer one-on-one interaction. Care coordinators are licensed medical professionals who provide this education and interaction over the phone.
1. Asthma Management Program;
2. Diabetes Prevention and Management'
3. Hypertension;
4. Tobacco/Smoking Cessation; and
5. Weight Loss and Healthy Lifestyles

Home Health Services

Home health services are provided by a licensed and certified agency. The services must be ordered by a HELP Plan provider. These services are covered but must be preauthorized. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Covered services include:
- Part-time care in your home from a skilled nurse,
- Home health aide care – services for a short, definite period of time to assist in the activities of daily living and care of the household to keep you in your home,
- Physical, occupational, or speech therapy,
- Non-routine medical supplies suitable for home use, and

HELP Plan Services Described

- Medical social worker services.

Home Infusion Therapy

Home infusion therapy must be ordered or referred by a HELP Plan provider. Some drug treatments must be given in your veins (intravenously). These treatments may be given in your home. Infusion therapy in your home is covered, along with the cost of the person who comes to your home to give you the drug treatments. For additional information on Home Infusion Therapy, go to the Montana Healthcare Programs website at **HELPPlan.mt.gov**.

Hospice

Hospice is end-of-life comfort care. Hospice manages all care related to the illness. Grief counseling is also available for the family. Hospice is provided by a licensed and certified agency. Hospice services are covered, but must be preauthorized. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Hospital Services

Services you get in a hospital, whether you stay in the hospital overnight or not, are covered. However, services must be ordered or referred by a HELP Plan provider. Some examples of services you might get in a hospital are:

- Emergency Room services,
- Medical or behavioral health services for which your HELP Plan provider admits you to the hospital,
- Physical therapy,
- Lab services,
- X-Rays,
- Cardiac rehabilitation,
- Pulmonary rehabilitation, and
- Surgery.

When you know ahead of time that you are going in the hospital, call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**. Hospital services must be preauthorized before you go. If you have an emergency and are admitted to the hospital, BCBSMT should be contacted within 24 hours or the next working day. If the hospital you are admitted to is a participating provider, it is the provider's responsibility to notify BCBSMT. If the hospital you are admitted to is not a participating provider, it is your responsibility to notify BCBSMT for preauthorization.

Indian Health Services (IHS) and Tribal Health Services

The HELP Plan partners with IHS, Tribally Operated Health Care Clinics, and Urban Indian Health Centers. These clinics provide medically necessary services for some enrolled participants. American Indian participants never have a copayment.

Interpreter Services

Interpreter services will be provided if you do not speak fluent English, are hearing impaired, or are otherwise in need. Interpreter services are covered if they are needed for you to get another covered service. You and your HELP Plan provider determine if an interpreter is required and your provider can arrange for a qualified interpreter to provide services. You may request a friend or family participant to be your interpreter. There is no cost to you for interpreter services.

Lab (Laboratory) Services

X-ray and lab services must be ordered or referred by a HELP Plan provider. Verify your HELP Plan provider is sending the

HELP Plan Services Described

X-Ray or lab work to another HELP Plan provider. Call BCBSMT at **1-877-233-7055**.

Medical Supplies and Equipment

(see Durable Medical Equipment, pg. 19)

Mental Illness Services

The HELP Plan covers these mental health services for all participants:

- Individual, group, and family counseling,
- Group therapy,
- Outpatient mental health assessments,
- Acute inpatient hospital services (preauthorization is required), and
- Psychological testing (preauthorization is required).

Preauthorization is required for inpatient services, residential treatment services, and intensive outpatient services. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Nurse Advice Line

Nurse Advice is a free telephone advice line you can call when you are sick, hurt or have a health question. Call **1-877-213-2568**. Nurses are there 24 hours a day, 7 days a week. Nurses at Nurse Advice can help you save time and money by guiding you to the right care at the right place and at the right time.

Nurse Advice can help you with problems like:

- Fever,
- Ear ache and headache,
- Flu and sore throat,
- Skin rash,
- Vomiting or upset stomach,
- Colds and coughing, or
- Back pain.

If you have just found out you have diabetes, heart disease, high cholesterol, or any other health issue, Nurse Advice may be able to give you some information and help answer your questions.

Don't call Nurse Advice when:

- You have a health concern you are sure is life threatening. In this case, call **911** or go directly to the emergency room.
- You've seen your doctor for a specific health problem and a follow-up appointment is needed. Call the office directly to schedule the appointment.
- You've seen your doctor for a specific health problem, and she refers you to a specialist. Call the specialist's office directly to set up an appointment.
- You need regular services such as transfusions or dialysis. Make this series of appointments directly with the doctor's office.

OB (Obstetric) Services

Prenatal visits, delivery, and checkups for the mother after she gives birth are covered. A baby's delivery must be in a

HELP Plan Services Described

licensed hospital or birth center to be covered.

Occupational Therapy
(see Therapies, pg. 26)

Out-of-State Services
You may need to get medical services outside of Montana.
- If you have an accident, crisis or something that cannot wait until you're back in Montana, seek help at a hospital. Call BCBSMT at **1-877-233-7055**; toll free, as soon as possible to see if a covered provider is close to you.
- All out-of-state hospital inpatient services need preauthorization before you get services unless you have an emergency. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.
- Other HELP Plan services require preauthorization as shown on the HELP Plan services chart in this HELP Plan Participant Guide.
- Services received outside the United States, including Canada or Mexico, are never covered.

Physical Therapy
(see Therapies, pg. 25)

Physician Services
(see Doctor Visits, pg. 18)

Pregnancy
(see OB, pg. 24)

Prescription Drugs
(see Drugs/Medications (Prescription), pg. 19)

Preventive Care Services
The HELP Plan covers preventive care services, and there are no out-of-pocket costs to you. Preventive care helps keep you healthy and includes:
- Regular checkups,
- Dental checkups,
- Eye exams,
- Mammograms, Pap tests, and other cancer screening, and
- Treatment for some chronic conditions.

Pulmonary Therapy
(see Therapies, pg. 25)

Respiratory Therapy
(see Therapies, pg. 25)

Social Work Services
Social work services are covered if provided by a licensed clinical social worker who is a HELP Plan provider. These services

HELP Plan Services Described

may be individual, group, or family therapy.

Specialty Care

Specialty care is any health care your primary care provider advises but cannot provide. Examples are X-Rays, therapy, or tests to spot a health issue. It is best if all of your health care services are managed by your primary care doctor. If you need specialty care, your primary care provider will refer you to a HELP Plan specialist. Referrals are not required for specialty care, including obstetrical and gynecological care, as long as you see a HELP Plan participating provider. However, treatment received from a provider who is not in the HELP Plan network will not be covered without preauthorization.

If specialty care is needed and a HELP Plan participating provider is not available in your area, contact BCBSMT at **1-877-233-7055**. We will give you information on how to obtain specialty care.

Speech Therapy

(see Therapies, pg. 25)

Supplies

(See Durable Medical Equipment (DME) and Medical Supplies, pg 19)

Surgery

Most medically necessary surgeries are covered, whether done in a hospital or surgery center. Some surgeries must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Telemedicine Services

Telemedicine services are covered when they are provided by HELP Plan providers. The services must be for covered benefits. Telemedicine services are provided through a secure electronic connection. The provider and the participant are not at the same site. There must be both an audio and video portion to the visit. Both the provider and participant must take part in the discussion.

Therapies

Covered therapies are:

- Occupational therapy (requires preauthorization),
- Physical therapy (requires preauthorization),
- Respiratory therapy,
- Speech therapy (requires preauthorization),
- Cardiac therapy, and
- Pulmonary therapy.

Occupational therapy, physical therapy, and speech therapy must be ordered or referred by a HELP Plan provider.

Coverage is provided for habilitative care services when the participant requires help to maintain, learn, or improve skills and functioning for daily living or to prevent deterioration. These services include, but are not limited to:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral health professional treatment.

HELP Plan Services Described

Applied behavior analysis for adults is excluded.

Habilitative care services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of inpatient or outpatient settings as prescribed by a physician or mid-level practitioner.

Coverage is provided for rehabilitative care services when the participant needs help to keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled. Rehabilitative services will include, but are not limited to:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral health professional treatment.

Applied behavior analysis for adults is excluded.

Rehabilitative care services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of inpatient or outpatient settings as prescribed by a physician or mid-level practitioner.

Therapy services must be preauthorized by your HELP Plan provider; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Tobacco Cessation

Tobacco cessation drugs and counseling are covered by the HELP Plan. You can also get help to stop smoking or chewing by calling the Montana Tobacco Quit Line at **1-800-QUIT-NOW** or **1-800-784-8669**.

Transplants

Organ and tissue transplants are covered. Transplant benefits include:

- Heart, heart/lung, single lung, double lung, liver, pancreas, kidney, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants.
- For organ and tissue transplants involving a living donor, transplant organ/tissue procurement, and transplant-related medical care for the living donor are covered.
- Transplants of a nonhuman organ or artificial organ implant are not covered.
- Donor searches are not covered.

For certain transplants, BCBSMT contracts with a number of Centers of Excellence that provide transplant services. BCBSMT highly recommends use of the Centers of Excellence because of the quality of the outcomes at these facilities. Participants being considered for a transplant procedure are encouraged to contact BCBSMT Participant Services to discuss the possible benefits of utilizing the Centers of Excellence.

Inpatient services must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

HELP Plan Services Described

Transportation

The HELP Plan may pay for you to get to your health care provider or other health care service, if the service is covered by the HELP Plan, and if you have no other way to get there. The following rules are used to decide if travel funds will be given:

- Preauthorization is required for each trip.
- You must use the least costly way to travel that still meets your needs.
- All transportation must be approved before you go, and if your appointment is changed, you must get your transportation approved again. The number to call for approval is **1-800-292-7114**.
- Travel funds can be provided for out-of-town or out-of-state if the service is not available near you. Advance payments will be on a case-by-case basis.
- You must be eligible for the HELP Plan on the date of the medical appointment.
- The mileage allowed per trip is based on the nearest provider who can provide the service, regardless of where the participant receives health care.

If you used a personal vehicle for emergency travel, you must call the Medicaid Transportation Center at **1-800-292-7114** within 30 days of the emergency in order to be considered for payment.

There are different rules for different kinds of transportation, such as taxicabs, buses, wheelchair-accessible vans, and non-emergency ambulances. Sometimes friends or family members can get paid for using their cars to take you to appointments. Be sure to call the Medicaid Transportation Center at **1-800-292-7114** before you arrange travel. You will be paid after you travel, if you have followed the above steps. The Medicaid Transportation Center will contact your doctor's office to make sure that you went to your appointment before paying.

Urgent Care

Some situations require prompt medical attention although they are not emergencies. In these situations, call your primary care provider and describe the situation. He or she will help direct your care. Examples include, but are not limited to:

- Sprains,
- Non-severe bleeding,
- Sore throats, or
- Ear aches.

Unless you get preauthorization, you must receive urgent care from HELP Plan providers. If you receive services from non-HELP Plan providers, you may have to pay for the services. You may also call the Nurse Advice Line at **1-877-213-2568**. Registered nurses are available 24 hours a day, 7 days a week. There is no charge for this call.

Vitamins

Vitamins are covered for certain conditions. For example, prenatal vitamins are covered during your pregnancy. You must have a prescription and you may need preauthorization; call the Montana Healthcare Programs at **1-800-362-8312**.

Wellness Programs

(See HELP Healthy Behavior Plan, page 21)

HELP Plan Eligibility and Key Contacts

Eligibility

For any issue related to your HELP Plan eligibility, you can contact the Montana Public Assistance Help Line at **1-888-706-1535** or **apply.mt.gov**.

For any issue or question related to medically frail eligibility, you can contact the Montana Public Assistance Help Line at **1-888-706-1535** or **apply.mt.gov**. Medically Frail means an individual has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

Key Contacts

For any issue or question related to services administered by DPHHS, you can contact the Montana Healthcare Programs toll-free phone number **1-800-362-8312**.

For any issue or question related to services administered by BCBSMT, you can contact the toll-free phone number **1-877-233-7055**. The hours are 8 a.m. to 8 p.m. Monday through Friday (Mountain Time). This toll-free number will receive incoming phone calls made from anywhere in the U.S.A.

Montana Relay Services

Telecommunications assistance for the hearing impaired.

1-800-833-8503 Voice, TTY
1-406-444-1335 Voice, TTY
relay@mt.gov

Interpreter Services

For forms and information on interpreter or translator services, call BCBSMT at **1-877-233-7055** or visit **http://medicaidprovider.mt.gov/forms#240933496-forms-a--c** for forms and additional instructions.

Denials and Appeals

Do You Disagree With a Service Decision?

If you disagree with a decision made about a service, there are few things you can do. Make sure to read this HELP Plan Participant guide to see if the service is covered by the HELP Plan. If you are not sure, you can talk with the contacts listed under the Key Contacts section of this guide. If you still do not agree, you can appeal.

For Benefits Administered by Blue Cross and Blue Shield of Montana (for example, medical, behavioral health, rehabilitation therapy. Please see page 3 of this Participant Guide for complete list.)

First Level Appeal

If you do not agree with a denial, or partial denial of a claim, you have 90 days from when you received the denial to appeal. To request an appeal, the request:

- Must detail your objections, and
- Must include any documents and information which you wish BCBSMT to consider in the appeal review.

A BCBSMT representative will let you know when your request for appeal is received. You will receive a written response within 45 days of receipt of your appeal.

Mail, call, or deliver your request for appeal to:

Blue Cross and Blue Shield of Montana
Appeals and Grievances Department
PO Box 27838
Albuquerque, NM 87125-9705
Phone: **1-877-232-5520**
Fax: **1-866-643-7069**

If you do not agree with the decision, you can make a second level appeal.

Second Level Appeal

The Office of Fair Hearing will handle your second level appeal. Within 90 days of receiving the first decision, if you do not agree with the decision, you may mail or fax your second level appeal request to:

Office of Fair Hearings
Department of Public Health and Human Services
PO Box 202953
Helena, MT 59620-2953
Fax: **1-406-444-3980**

Denials and Appeals

For Benefits Administered by Xerox (for example, pharmacy, dental, eyeglasses. Please see page 3 of this Participant Guide for complete list.)

Appeal Process

The Office of Fair Hearing will handle your appeal. Within 90 days of receiving the first decision, if you do not agree with the decision, you may mail or fax your appeal request to:

Office of Fair Hearings
Department of Public Health and Human Services
PO Box 202953
Helena, MT 59620-2953
Fax: **1-406-444-3980**

Other Resources To Help You

What If It Is a Discrimination Issue?

Participants enrolled in the HELP Plan have a right to:

- Equal access to services without regard to race, color, national origin, age, physical or behavioral disability, marital status, religion, creed, sex, sexual orientation, political belief, genetic information, veteran status, culture, social origin or condition, or ancestry,
- An interpreter or translator if needed, and
- Other help understanding benefits and services.

You can file a complaint if you believe you were discriminated against. If you need additional information regarding these protections, please contact:

Office of Civil Rights
US Department of Health and Human Services
1961 Stout Street, Room 1426
Denver, CO 80294
Phone: **1-303-844-2024**
DD: **1-303-844-3439**

If You Don't Want HELP Plan Coverage Any More

You have the right to ask to end HELP Plan coverage. To end the HELP Plan, call the Montana Public Assistance Help Line at **1-888-706-1535**.

Alternative Accessible Format

Persons with disabilities who need an alternative accessible format of this information, or who require some other reasonable accommodation in order to participate in the HELP Plan, should contact BCBSMT at **1-877-233-7055**.

Other Resources

For questions about your rights, this notice or for assistance, you can contact an assistance program or ombudsman.

Montana Office of the Commissioner of Securities and Insurance
840 Helena Ave
Helena, MT 59601
www.csi.mt.gov
Phone: **(800) 332-6148**

Other Useful Programs and Services

Organization or Service	Website	Phone Number
AIDS or Sexually Transmitted Diseases Questions	dphhs.mt.gov/publichealth/hivstd	1-(406) 444-3565
Behavioral Health Ombudsman	mhombudsman.mt.gov/default.mcpx	1-888-444-9669
Child Abuse and Neglect	dphhs.mt.gov/cfsd	1-866-820-5437
Child Support Customer Service	dphhs.mt.gov/csed	1-800-346-5437
Childhood Lead Poison Prevention Information	dphhs.mt.gov/publichealth/lead	1-(406) 444-0273
Children's Special Health Services	dphhs.mt.gov/publichealth/cshs	1-800-762-9891
Citizen's Advocate (Governor's Office)	citizensadvocate.mt.gov	1-800-332-2272
HELP Plan Transportation Approval	dphhs.mt.gov	1-800-292-7114
Legal Services	montanalawhelp.org	1-800-666-6899
Medicaid Fraud Line	dphhs.mt.gov/medicaid/fraudandabuse	1-800-201-6308
National Alliance on Mental Illness – Montana	namimt.org	1-(406) 443-7871
National Domestic Violence Hotline	thehotline.org	1-800-799-7233
Offices of Public Assistance (OPA)	dphs.mt.gov/hcsd/officeofpublicassistance	1-888-706-1535
Poison Control	dphhs.mt.gov/publichhealth/emsts/poison	1-800-222-1222
Social Security	socialsecurityofficelocations.com/state/MT.html	1-800-772-1213
Suicide Prevention	prevention.mt.gov/suicide	1-800-273-8255
Teen Dating Abuse Helpline	loveisrespect.org	1-866-331-9474
Tobacco Quit Line	dphhs.mt.gov/publichealth/mtupp/quitline	1-800-784-8669
WIC Nutrition Information	dphhs.mt.gov/wic/	1-800-433-4298

For questions about this guide, contact:

BCBSMT
560 North Park Avenue
Helena, MT 59602
1-877-233-7055

352488.0216

Montana HELP Demonstration

Operations Protocol

Appendix C

Welcome Brochure

(12 pages)

BlueCross BlueShield of Montana

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Montana HELP Plan

Welcome

Effective January 1, 2016

www.bcbsmt.com/mthelpplan or HELPPlan.mt.gov

Revised 10/1/2016

352210.0916

Contact Us

We are glad you chose the Montana Health and Economic Livelihood Partnership (HELP) Plan as your health plan! We want you to get the health care you need, when you need it. This HELP Plan brochure will help you get started. Keep it handy to answer some of your most common health plan questions.

IMPORTANT HELP PLAN PHONE NUMBERS

BCBSMT Participant Services.....**1-877-233-7055, TTY/TDD 711**

We are open:

Monday – Friday
8 a.m. to 8 p.m. MT
Voice mail is available 24 hours a day seven days a week.
Your call will be returned within one business day.

Alternate technologies (for example, voicemail) will be used on the weekends and federal holidays. The call is free.

24/7 Nurse Advice Line.....**1-877-213-2568, TTY/TDD 711**
Audiology.....**1-800-362-8312**
Behavioral Health Services.....**1-877-296-8206**
Dental.....**1-800-362-8312**
Eligibility Questions or Changes.....**1-888-706-1535, TTY/TDD 711**
Emergency Care.....**911**
Eyeglasses.....**1-800-362-8312**
Federally Qualified Health Centers (FQHCs).....**1-800-362-8312**
Fraud and Abuse.....**1-800-543-0867, TTY/TDD 711**
Grievances and Appeals.....**1-877-232-5520, TTY/TDD 711**
Hearing Aids.....**1-800-362-8312**
Indian Health Services (IHS)/Tribal Health.....**1-800-362-8312**
National Poison Control Center.....**1-800-222-1222**
Calls are routed to the office closest to you.
Pharmacy Services.....**1-800-362-8312**
Rural Health Clinics (RHCs).....**1-800-362-8312**
Transportation.....**1-800-292-7114**
Community Based Programs.....**dphhs.mt.gov/publichealth/chronicdisease/communitybasedprograms**
Web.....**www.bcbsmt.com/mthelpplan** or **HELPPlan.mt.gov**

CALL 911 IF YOU HAVE AN EMERGENCY.

PLEASE NOTE: For help to translate or understand this item, please call **1-877-233-7055** TTY/TDD **711**. You can get this document in Braille, or speak with someone by calling **1-877-233-7055**. The call is free.

The Importance of a Primary Care Provider (PCP)

YOUR PRIMARY CARE PROVIDER (PCP)

Your PCP is your main health care provider. You can see a BCBSMT in-network specialist without a referral from your PCP, but it is important that your PCP knows which doctors you see.

A PCP can be a:

- Family or general practitioner,
- Obstetrician/gynecologist (OB/GYN),
- Internist (Internal Medicine),
- Nurse Practitioner (NP) or Physician Assistant (PA), or
- A community health clinic such as a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

TO DO

It is recommended that you choose a PCP from the Montana HELP Plan Provider Network at **www.bcbsmt.com/mthelpplan.**

Look in the Provider Directory to:

- ☐ Choose a PCP for a pregnant participant under OB/GYN, Family Practice, Internal Medicine, or General Practice.
- ☐ Choose a PCP for adults in your family under Family Practice, Internal Medicine, or General Practice.

Note: Select FQHC/RHC through MT Medicaid Provider Finder.

You can call **Participant Services** at **1-877-233-7055** for help choosing a PCP. You can also ask Participant Services to mail you a Provider Directory. The website has an online directory and a tool called Provider Finder®.

Since some benefits are managed at DPHHS, you have to get care from providers who accept Montana Medicaid to be covered by the Montana HELP Plan. A list of Montana Medicaid providers is at the MT Medicaid Provider Finder at **https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do**.

MAKING AN APPOINTMENT

To make an appointment, please follow these steps:

- Call your PCP's office ahead of time.
- Tell the office that you are a HELP Plan participant and have your ID card handy.
- You may also contact your assigned Care Coordinator for assistance if you have one.

If you go to your PCP's office, or another provider's office without an appointment, the provider may not be able to see you. Please call your provider before you go to the office.

YOUR CARE COORDINATOR

As a HELP Plan participant, you can get care coordination support. A Health Assessment (HA) form will be in your HELP Plan Welcome Kit. If we have not received your completed HA within 60 days of joining the HELP Plan, we will call to complete your HA over the phone. This HA will be done at least once a year after that.

The HA helps us find the level of care coordination support you may need and could mean we provide you with a care coordinator. A care coordinator will work with you and others involved in your care, like your PCP, to help with your health care needs and make a care plan that helps you reach your health care goals.

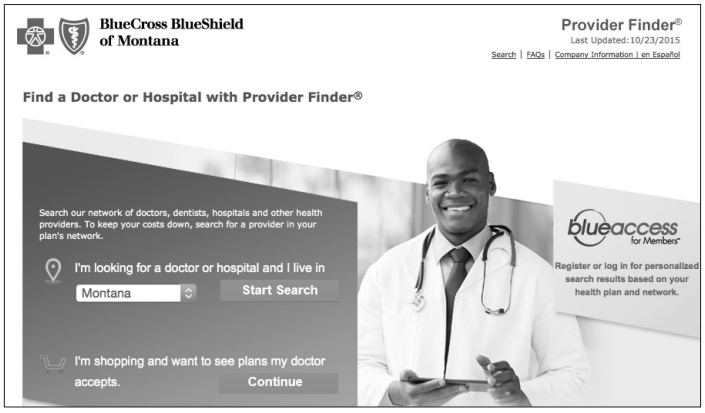
Care Coordinators also:

- Plan in-person visits or phone calls with you,
- Listen to your concerns,
- Help get you or your family the services you need, like transportation,
- Help set up care with doctors and other health care team members,
- Help you, your family and your caregiver better understand your health condition(s), medications, and treatments, and
- Refer you to managed wellness programs.

Provider Finder®

The Provider Finder lets you search for medical and behavioral health providers and hospitals in the Montana HELP Plan Network. Go online to use Provider Finder: **www.bcbsmt.com/mthelpplan** or **HELPPlan.mt.gov**.

- Search by name, city, state, or ZIP code; specialty, or service,
- Search for providers who are accepting new patients,
- Get a list of provider names, phone numbers, and addresses,
- Learn the providers' genders specialties, languages they speak, and
- Google Maps™ lets you see the provider's location and get directions.



Since some benefits are managed at DPHHS, you have to get care from providers who accept Montana Medicaid to be covered by the Montana HELP Plan. A list of Montana Medicaid providers is at the MT Medicaid Provider Finder at **https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do**.

Getting Medical Care

WHAT DO I DO IF I NEED TO SEE A DOCTOR RIGHT AWAY?

If waiting to be seen by a doctor would endanger your health or seriously harm you, call **911** or go to the nearest emergency room (ER).

1. Call your PCP's office. Ask if he or she can see you that day.
2. If you can't see your PCP right away, call the **24/7 Nurse Advice Line** at **1-877-213-2568**. You can talk to a registered nurse about your options.
3. If you still need to see a doctor, you can also go to an urgent care provider. Call **Participant Services** at **1-877-233-7055** if you need help finding a provider.

WHEN I SHOULD GO TO THE ER?

Go to the ER or call **911** if you or a covered family member has any of these symptoms:

- Chest pain,
- Shortness of breath or severe trouble breathing,
- Heavy bleeding,
- About to deliver a baby,
- Fainting or seizures,
- Intense or sudden pain,
- Sudden dizziness, weakness, or change in vision, speech, or mental state,
- Severe or persistent vomiting or diarrhea,
- Coughing or vomiting blood,
- Head, neck, or traumatic injury (such as a gunshot or stab wound),
- Major broken bones,
- Severe burns, or
- Poisoning or drug overdose.

If you go to the ER, be sure to bring:

- Your participant ID card, and
- Your PCP's name and phone number.

If you can, also bring:

- A list of any medicines you take, and
- A list of any medical conditions and drug allergies you have.

Seeing your PCP regularly can help reduce your chances of needing to go to the ER. You can also call the **24/7 Nurse Advice Line** at **1-877-213-2568**. The nurses can help you decide if you should see your doctor, go to urgent care, or go to the ER.

Do not use the ER for routine care.

WHAT IS PREVENTIVE CARE?

Preventive care helps keep you healthy and is covered by your health plan. Preventive care includes:

- Regular checkups,
- Dental checkups,
- Eye exams,
- Immunizations,
- Mammograms, Pap tests, and other cancer screenings,
- Treatment for some chronic conditions, and
- Other services described in your HELP Plan Participant Guide.

To get preventive care, make an appointment with your PCP. There are no out-of-pocket costs for participants receiving preventive care.

NETWORK PROVIDERS AND PREAUTHORIZATION

WHAT ARE IN-NETWORK PROVIDERS?

In-network providers are providers that have contracted with BCBSMT or MT Medicaid to accept special payment rates for the services they provide to HELP Plan participants. To have your services paid by the HELP Plan, you must use in-network providers, unless you have preauthorization.

There are certain services that are covered when you use an out-of-network provider such as emergency or urgent care services. See your HELP Plan Participant Guide for details and exceptions.

WHEN DO I NEED PREAUTHORIZATION?

You will need preauthorization from BCBSMT to go outside of the plan network of providers. Your primary care doctor has to get permission from BCBSMT before you can be admitted to the hospital, or receive certain services, such as home health care. Contact **Participant Services** at **1-877-233-7055** for a complete listing. Providers may contact **Provider Services** at **1-877-296-8206**. BCBSMT may not approve the request. If the request for these types of services is denied, you and your provider will be contacted and the reason for the denial will be explained.

HOW DO I GET PREAUTHORIZATION?

Your PCP will know which procedures need preauthorization and will contact BCBSMT for you. Providers may contact **Provider Services** at **1-877-296-8206**. To find out if your preauthorization has been approved, call **Participant Services** at **1-877-233-7055**. See your HELP Plan Participant Guide for details.

WHAT IS A SPECIALIST?

Specialists treat medical conditions requiring specialized knowledge beyond that of your primary care doctor. Examples include heart problems, allergies, and diabetes. The specialist must be an in-network provider to be covered.

BEHAVIORAL HEALTH CARE

You have benefits for behavioral health services. This includes mental and emotional problems, alcoholism, and drug-related problems. A care coordinator can help you find which services are covered and if preauthorization is needed for the service.

You can call **Participant Services** at **1-877-233-7055**. They will help you find a provider or help you speak to a care coordinator to get further assistance. Providers may contact **Provider Services** at **1-877-296-8206**.

In an emergency (such as if you feel like hurting yourself or others, or if you are not able to take care of yourself) call **911** or go to the ER.

See your HELP Plan Participant Guide for more information about your behavioral health coverage.

PREMIUMS AND COPAYMENTS

As a participant of the HELP Plan, you will have to pay a monthly premium. Your premium will help cover the cost of your health insurance. The HELP Plan premium cannot be more than two percent (2%) of your yearly household income.

A premium notice will be mailed to you within the month before the due date. Premiums are due by the first of each month. You must return the invoice stub and payment to the mailing address on the invoice. Unpaid premiums become a debt to the State and will be collected against future tax refunds.

A copayment is a payment owed by you to your health care provider for health care services that you receive. Your monthly premiums will go toward any copayments you owe. You will get a statement/bill for the copayment from your provider after the health care service claim has been processed. If the amounts of your copayments are more than your premiums in a given quarter, you will get a bill for your copayments after your provider visit.

You may be charged for more than one copayment for a visit to your doctor. For example, your visit may result in the following copayments: X-rays, lab work, doctor visit and for a facility fee (depending on the place of service). Contact **Participant Services** at **1-877-233-7055** if you have copayment questions.

Premiums and copayments will not exceed more than five percent (5%) of the total yearly household income. Please refer to the HELP Plan Participant Guide for more detailed information on premium, copayments, and consequences of non-payment of premiums.

The following individuals are exempt from copayments:

a. persons under 21 years of age;

b. pregnant women;

c. American Indians/Alaska Natives who are eligible for, currently receiving, or have ever received an item or service furnished by:

   i. an Indian Health Service (IHS) provider;

   ii. a Tribal 638 provider;

   iii. an IHS Tribal or Urban Indian Health provider; or

   iv. through referral under contract health services.

d. persons who are terminally ill receiving hospice services;

e. persons who are receiving services under the Medicaid breast and cervical cancer treatment category; and

f. institutionalized persons who are inpatients in a skilled nursing facility, intermediate care facility, or other medical institution if the person is required to spend for the cost of care all but their personal needs allowance, as defined in ARM 37.82.1320.

Getting Medical Care

The following service categories are exempt from copayments:

- Preventive health screenings,
- Family planning,
- Eyeglasses,
- Transportation,
- Emergencies in the emergency room,
- Immunizations, and
- Medically necessary health screenings ordered by a health care provider.

Mail your HELP Plan monthly premium to:

The Montana HELP Plan
P.O. Box 650213
Dallas, TX 75265-0213

If you have questions about your copayments or premiums, call **Participant Services** at **1-877-233-7055**.

DISENROLLMENT

Even if you cannot pay your premium, you may still be able to keep HELP Plan coverage. You will remain in the HELP Plan if:

A. Your income is under 100% of the federal poverty level, which is approximately $990 a month for an individual, or $2,025 a month for a family of four; or

B. If your income is above 100% of the federal poverty level, you may lose your coverage if you fail to pay your premiums. You are still responsible for the payment of your premiums. The unpaid premium balance will be transferred to the State of Montana for collection from your state income tax refund.

Even if you cannot pay your premiums, you may be able to keep HELP Plan coverage under certain circumstances including:

- You have been discharged from the United States military service within the previous 12 months;
- You are enrolled for credit in any Montana University System unit, a tribal college, or any other accredited college within Montana offering at least an associates degree;
- You see a primary care provider who is part of a patient-centered medical home;
- You are in a substance use treatment program; or
- You are in a DPHHS approved healthy behavior activity program administered by DPHHS or BCBSMT. The list of approved programs is located at **HELPPlan.mt.gov** or call **1-855-324-6259**.

If Montana DPHHS determines that you meet two or more of these conditions, you will continue to have access to the health care services covered by the HELP Plan. You will still be responsible for payment of your premiums.

If two of the following describe you, call **888-706-1535**.

You have been discharged from the United States military service within the past 12 months; or	To let us know you were in college or in the military go to apply.mt.gov, or call **888-706-1535** or visit any local Office of Public Assistance.
You are enrolled for credit in a Montana university, tribal college, or any other accredited college in Montana that offers at least a two-year degree; or	
You are in an approved HELP Healthy Behavior Plan wellness program; or You are in a substance use treatment program; or You see a primary care provider who is part of a patient- centered medical home. You can find out by asking your doctor's office.	To find out more about the Healthy Behavior programs or to sign up please go to **HELPPlan.mt.gov** or call BCBSMT Participant Services at **1-877-233-7055**. You can find out by asking your doctor's office. To let us know, go to **apply.mt.gov**, or call **888-706-1535** or visit any local Office of Public Assistance.

As long as you are in the HELP Plan, you have access to the health care services covered by the plan. You are still responsible for the payment of your premiums and copayments.

If you are disenrolled because you have unpaid premiums, you may reenroll in the HELP Plan after:

A. You have paid your unpaid premium balance in full; or

B. You have received notice from the State of Montana that your unpaid premium balance has been assessed against your future state income tax. This assessment occurs once per calendar quarter.

Participants that would like to reenroll should contact the Montana Public Assistance Help Line at **844-792-2460** or **apply.mt.gov**.

Premiums unpaid for more than 30 days will be transferred to the State of Montana for collection from any future state income tax refunds to which you are entitled. Premiums unpaid for more than 90 days will result in an end to your health care coverage unless you have individual circumstances, described above, that allow you to remain in the HELP Plan.

HELP HEALTHY BEHAVIOR PLAN

BCBSMT has implemented a comprehensive health and wellness program for participants in the HELP Plan, with a focus on engaging participants and providers. This program is called the BCBSMT HELP Healthy Behavior Plan.

Participants may call BCBSMT Participant Services 1-877-233-7055 and ask to be enrolled in one of the approved programs, or ask to speak with a Care Coordinator to learn more about this benefit. There are several DPHHS approved wellness programs available throughout the state of Montana. Descriptions of these programs are available on the BCBSMT participant portal, Blue Access for Members (BAM) at **http://www.bcbsmt.com/mthelpplan** and DPHHS' website at **http://dphhs.mt.gov/publichealth/chronicdisease/CommunityBasedPrograms** or by calling **1-855-324-6259**.

NOTES

The benefit information provided is a brief summary, not a complete description of benefits. For more information refer to your HELP Plan Participant Guide included in your Welcome Kit or at **www.bcbsmt.com/mthelpplan**.

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

This project is funded in whole or in part under a contract with the Montana Department of Public Health and Human Services.
The statements herein do not necessarily reflect the opinion of the Department.

Montana HELP Demonstration

Operations Protocol

Appendix D

Notice of Eligibility Determination

(4 pages)

Office of Public Assistance
PO BOX 202925
Helena, Montana 59620-2959

[redacted]

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

Steve Bullock
GOVERNOR

Richard H. Opper
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210
HELENA, MT 59604-4210

Case #:
Document #: [redacted]
Print Date: 05/23/2016
Contact Phone: 1-888-706-1535

About Your Case

Dear [redacted],

The first part of this letter is a summary of your benefits.

Please report changes according to each program's reporting requirements so your benefits can be determined correctly.

Health Coverage

Your health coverage information is listed below. Please read this entire letter.

Date of Application: 04/26/2016

Effective Date	Action	Person(s)	Monthly Charge	Explanation
04/01/2016	Approved	[redacted]	$10.00	For more information, please see the **Information on Your Health Coverage**, **Additional Services Available to You**, **Your Health Coverage Change Reporting Requirements**, and **Estate Recovery** Section.

[1]This health coverage is dependent upon waiver approval from Centers for Medicare and Medicaid Services (CMS).The premium amount may be reduced or eliminated for some individuals based on final approval from CMS.

If you have any questions, please call the Montana Public Assistance Helpline at 1-888-706-1535.

Your Health Coverage Benefits

Information on Your Health Coverage

BlueCross BlueShield of Montana will send you an insurance card and a participant guide within 4 weeks after your coverage begins. Please review the participant guide. It has important information about your benefits, including information regarding any premium you owe. Always take your insurance card to all medical and dental appointments. For information, contact BCBSMT at 1-877-233-7055 or www.bcbsmt.com.

Information on Your Health Coverage

If you feel you have a physical, mental or emotional health condition that causes limitations in activities

(like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home, please contact us at the Montana Public Assistance Helpline at 1-888-706-1535.

Wellness Program
The goal of this program is to improve the overall health of participants using innovative models of care, participant education, and other wellness services. Examples of services may include: health screenings, nutrition awareness, active lifestyle education, tobacco cessation, and disease management. For more information, please visit TPA website.

Additional Services Available to You

HELP-Link, a Montana Department of Labor and Industry workforce program
For more information about this program, please visit **www.jobs.mt.gov** or stop by your local Job Service Office. This high quality, free program will provide you with a customized employment plan, connect you with local employers, and open access to training resources to help you find employment or grow your own earning capacity.

To find out what services are covered or not covered, copayment amounts, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services go to the member page at **http://dphhs.mt.gov/MontanaHealthcarePrograms.** Here you can see the member guide and find out how to get a copy sent to you, member newsletters, and phone numbers for the Member Helpline and Nurse First Advice Line.

Your Health Coverage Change Reporting Requirements
You are required to report changes related to your Health Coverage, further details listed below:

Important things to remember about Medicaid:
- Tell your health care provider (doctor, hospital, clinic, etc.) you have Medicaid. Ask if your provider accepts Medicaid. If they don't, you may be responsible for the bill.
- Take your Montana Access to Health card or Healthy Montana Kids Plus card to each medical visit. If you need a new card, call the Montana Public Assistance Helpline at 1-888-706-1535.
- Medicaid does not cover some services. Check with your provider to see if the service is covered.
- Some people may pay a small amount (co-payment or cost share) for some medical services. There is no co-payment if you are under 21, pregnant, or an enrolled Native American or Alaska Native.
- Call Medicaid Transportation at 1-800-292-7114 if you need help paying for travel to get to a doctor's appointment or other medical service.

If you have questions about Medicaid services, ask your medical provider, review the Medicaid member guide online at http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices, or call the Montana Medicaid Helpline at 1-800-362-8312 to have a copy mailed to you.

If you enroll in new health insurance coverage, your new carrier may require proof of past health insurance coverage, including Medicaid. Call the Montana Public Assistance Helpline at 1-888-706-1535 if you need proof of the dates you were covered by Medicaid.

If health insurance is available for your household, report it to the Montana Public Assistance Helpline at 1-888-706-1535.

Estate Recovery
An individual's estate may be required to repay medical bills that Medicaid paid for individuals aged 55 or older, or anyone who lived in a nursing home (regardless of age).

Legal basis for this action is:

Name: [redacted]	Case #: [redacted]	Phone: [redacted]
Address: [redacted]	City: [redacted]	Zip Code: [redacted]
Address, if different from above:		
Phone, if different from above:		

This letter is your notice that on 05/23/2016 the Department of Public Health and Human Services (DPHHS) has made a decision regarding the Health Coverage benefits in your case.

If you think the decision is wrong and want someone to review this action, you may request a hearing. You must appeal the decision and request a hearing by 08/21/2016.

TWO WAYS TO REQUEST A HEARING

1. If you disagree with our decision complete the following request (1a-d) and mail to: Office of Fair Hearings, PO Box 202953, Helena, MT 59620 or fax to: Office of Fair Hearings, 406-444-3980.

a. I disagree with DPHHS' decision and I appeal the decision about my:

☐ Supplemental Nutrition Assistance Program (**SNAP**) benefits
(Oral requests are allowed for **SNAP**. Call 1-888-706-1535.)

☐ Temporary Assistance for Needy Families (**TANF**) benefits.

☐ Health Coverage benefits

b. I appeal the decisi[redacted]
_____
_____
_____

c. If you receive SNAP or Health Coverage **benefits, the benefits may automatically continue, as allowable,** unless you tell us you do not want continued benefits. **TANF** cash assistance is different from other programs and **does not continue** unless you tell us you want continued benefits. You must repay the amount of continued benefits if the fair hearing decision is not in your favor.

I do **NOT** want benefits to continue for: ☐ SNAP ☐ TANF ☐ Health Coverage

I want benefits to continue for: ☐ TANF

d. _____ _____
Signature (Claimant or Authorized Representative) Date

OR

2. Call the Montana Public Assistance Helpline at 1-888-706-1535 and ask for help to request a hearing.

If you want an attorney but cannot afford one, the Montana Legal Services Association at 1-800-666-6899 may help you.

Montana HELP Demonstration

Operations Protocol

Appendix E

Premium Invoice

(4 pages)

P.O. Box 3387
Scranton, PA 18505

1

GREAT
FALLS, MT 59405

HELP Plan Participants - Premium Rights and Obligations

As a participant of the HELP Plan, you are required to pay a monthly premium. The monthly premium will total 2% of your yearly income billed monthly. BCBSMT will send you a monthly bill for your premium. Submit your payment with the payment stub included in your monthly bill. Premiums are due on the 1st of each month.

WHAT IF I CANNOT PAY MY PREMIUM?

Even if you cannot pay your premium, you may still be able to keep HELP Plan coverage. You will remain in the HELP Plan if:

A. If your income is under 100% of the federal poverty level (approximately $990 a month for an individual, or $2,025 a month for a family of four you will be able to remain in the HELP Plan.
B. If your income is above 100% of the federal poverty level, you may lose your coverage if you fail to pay your premiums. You are still responsible for the payment of your premiums. The unpaid premium balance will be transferred to the State of Montana forcollection from your state income tax refund.

WHAT IF I HAVE SPECIAL CIRCUMSTANCES AND CANNOT PAY MY PREMIUM?

Even if you cannot pay your premiums, you may be able to keep HELP Plan coverage under certain circumstances including:

- You have been discharged from the United States military service within the previous 12 months;
- You are enrolled for credit in any Montana University System unit, a tribal college, or any other accredited college within Montana offering at least an associate degree;
- You see a primary care provider who is part of a patient-centered medical home;
- You are in a substance use treatment program; or
- You are in a DPHHS approved health behavior activity program administered by DPHHS or BCBSMT.

The list of approved programs is located at HELPPlan.mt.gov or call 1-855-324-6259.

If Montana DPHHS determines that you meet two or more of these conditions, you will continue to have access to the health care services covered by the HELP Plan. You will still be responsible for payment of your premiums.

If two of the following describe you, call 888-706-1535:

<table>
<tr><td>▪ You have been discharged from the United States military service within the past 12 months; or</td><td rowspan="2">To let us know you were in college or in the military go to apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance.</td></tr>
<tr><td>▪ You are enrolled for credit in a Montana university, tribal college, or any other accredited college in Montana that offers at least a two-year degree; or</td></tr>
<tr><td>▪ You are in an approved HELP Healthy Behavior Plan wellness program; or

You are in a substance use treatment program; or

You see a primary care provider who is part of a patient-centered medical home. You can find out by asking your doctor’s office.</td><td>To find out more about the Healthy Behavior programs or to sign up please go to HELPPlan.mt.gov or call BCBSMT Participant Services at 1-877-233-7055.

You can find out by asking your doctor’s office. To let us know, go to apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance.</td></tr>
</table>

CAN I REENROLL IN THE HELP PLAN IF I HAVE UNPAID PREMIUMS?

Yes, you may reenroll after

A. You have paid your unpaid (delinquent) premium balance in full, or
B. You have received notice from the State of Montana that they have assessed your unpaid premium balance against your future state income tax. This assessment occurs once per calendar quarter.

Participants that would like to reenroll should contact the Montana Public Assistance Help Line at 844-792-2460 or apply.mt.gov.

PREMIUM NOTICE

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

BlueCross BlueShield of Montana

The HELP Plan is administered by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Montana HELP Plan
P.O. Box 3387
Scranton, PA 18505

Participant Services
Toll-free: 1-877-233-7055 (TTY can call: 711)
Monday through Friday 8:00 am - 8:00 pm MST

Participant Name:
Participant ID:
Notice Date: 9/23/2016
Payment Due Date: 8/27/2016

Statement ID: 000000170591

Activity Description as of August 2016	Amount
Montana HELP Plan Premium for Current Month as of August 2016	$47.00
1-30 Days Overdue Outstanding Balance	$47.00
31-60 Days Overdue Outstanding Balance	$47.00
61-90 Days Overdue Outstanding Balance	$47.00
Greater than 90 Days Overdue Outstanding Balance	$188.00
Total	$376.00

Please Note: Unpaid premiums could result in an end to your health care coverage. If you have unpaid premiums for more than 90 days, the unpaid balance will be communicated to the State of Montana for collection against your future state income tax refunds. In addition, unless you have individual circumstances that allow you to remain in the HELP Plan, your health care coverage will end. Please see the reverse side of this invoice for HELP Plan Participant - Premium Rights and Obligations.

If this is your first statement, please note that an outstanding balance may have resulted due to late enrollment in a prior month's coverage period. If you have any questions or concerns please contact customer service at 1-877-233-7055 (TTY can call: 711)

For your records: Date Paid: _____ Check#: _____ Amount: _____

Detach and Return with payment

Participant Name:

Please make your check or money order payable to the Montana HELP Plan and write your Participant ID number on it. Do not send cash. Do not staple this to your check or money order. Thank you.

Total amount due	$376.00
Date due	8/27/2016

Group ID MT000001	**Plan ID** MT000006
Participant ID	**Statement Number** 000000170591

Amount Enclosed: $ _____

The Montana HELP Plan
P.O. Box 650213
Dallas TX 75265-0213

00115890 2MT000001000000170591000037600 1

Montana HELP Demonstration

Operations Protocol

Appendix F and G

Explanation of Benefits

(4 pages)

Participant: <MEMBER_NAME>
<ADDRESS1>
<ADDRESS2>
<ADDRESS3>
<CITY>, <STATE> <ZIP>

ID: <MEMBER_ID>

BlueCross BlueShield of Montana

MONTANA DPHHS

HELP PLAN

<PRINT_DATE>

HELP Plan Explanation of Benefits

This is NOT a bill. This explains the amount you are responsible to pay. Your provider will bill you for this copay.

Servicing Provider: <PRPR_NAME>
NPI: <PRPR_NPI>

Claim Number: <CLCL_ID>
Plan: <PDDS_DESC>

Dates of Service	Total Charges	Participant Responsibility			Plan Disallow	Amount Paid	Remarks
		<100%FPL Copay	>100%FPL Copay	Non-Covered			
<CDML_FROM_DT> <CDML_TO_DT>	<CDML_CHG_AMT>	<CDML_COPAY_AMT>	<CDML_COINS_AMT>	<NON_COV_AMT>	<CDML_DISALLOW_AMT>	<CDML_PAID_AMT>	<CDML_DISALL_EXCD>

Description of Service: <BILL_CODE_DESC> (Billing Code <BILL_CODE>)

CLAIM PRIMARY PAYOR PAYMENT: <PRIM_PAY_PMT>

CLAIM PRIMARY PAYOR ADJUSTMENT: <PRIM_PAY_ADJ>

CLAIMS TOTALS:	<CDML_CHG_AMT_TOT>	<CDML_COPAY_AMT_TOT>	<CDML_COINS_AMT_TOT>	<NON_COV_AMT_TOT>	<CDML_DISALLOW_AMT_TOT>	<CDML_PAID_AMT_TOT>
GRAND TOTALS:	<CDML_CHG_AMT_GRAND_TOT>	<CDML_COPAY_AMT_GRAND_TOT>	<CDML_COINS_AMT_GRAND_TOT>	<NON_COV_AMT_GRAND_TOT>	<CDML_DISALLOW_AMT_GRAND_TOT>	<CDML_PAID_AMT_GRAND_TOT>

Participant: <MEMBER_NAME>
<ADDRESS1>
<ADDRESS2>
<ADDRESS3>
<CITY>, <STATE> <ZIP>

ID: <MEMBER_ID>

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HELP PLAN

Reason Codes

<LIST_CDML_DISALL_EXCD> <LIST_EXCD_SHORT_TEXT>

If you do not agree with this decision please review the attachment.

For Participant Services Call
BCBSMT <1-877-233-7055>

Hours of Operation:
<8:00a.m.-8:00pm MST >

TTY for the hearing impaired
<711>

COMMITMENT AGAINST FRAUD:
If you feel you or the Plan has been billed for services you did not receive, please contact the confidential hotline at: <1-800-543-0867>

IMPORTANT INFORMATION
(Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a requested treatment or service then this document serves as part of your notice of an adverse determination. **Contact us at the number on the back of your ID card if you need assistance understanding this notice or your adverse determination.**

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. However, you only have 90 days from the date you receive the notice of adverse determination to file an internal appeal.

Who may file an internal appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate an authorized representative by completing the necessary forms. For more information on how to do so, contact us at the number on the back of your ID card.

How do I file an internal appeal? For claim appeals, you may contact us at the number on the back of your ID card and request an internal appeal or send a written request.

Blue Cross Blue Shield of Montana
Attn; Appeals and Grievances Department
P.O. Box 27838
Albuquerque, NM 87125-9705
Telephone: 1-877-232-5520
Confidential Fax: 1-866-643-7069

What about eligibility-related denials and rescissions? Please refer to your HELP Plan Participant Guide and/or HELP Evidence of Coverage found at http://dphhs.mt.gov/helpplan or call Toll Free 1-877-232-5520 for additional specifics. You may also contact us at the number on the back of your ID card.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted as soon as possible. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information once you initiate your appeal. You will also have the option of presenting evidence and testimony. In addition, we will provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a reasonable opportunity to respond before a final decision is made.

Can I request copies of information relevant to my claim? Yes, you may request and receive copies relevant to your claim free of charge. For example, upon request, you may receive the diagnosis and treatment codes (and their corresponding meanings) associated with an adverse determination. In addition, if we rely on a rule or guideline (such as a provision excluding certain benefits within your policy booklet) in making an adverse determination, we will provide that rule or guideline to you free of charge upon request. You can request copies of this information by contacting us at the number on the back of your ID card.

What happens next? You may do the following:
For Medical and Surgical Denials-
If you do not agree with the First Level appeal determination, you may choose to make a Second Level Appeal with the Department of Public Health and Human Services.

You may fax your Second Level appeal request to 1-866-643-7069 within 90 days of receiving the First Level determination or mail it to the address below:

Office of Fair Hearings
Montana Department of Public Health and Human Services
P.O. Box 202953
Helena, MT 59620-2953

The Office of Fair Hearings will contact you to conduct an impartial administrative hearing and/or a Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

Other Resources to Help You
For questions about your rights, this notice, or for assistance, you can contact a consumer assistance program or ombudsman.

Office of the Commissioner of Securities and Insurance
840 Helena Ave
Helena, Montana 59601
www.csi.mt.gov
Telephone: (800) 332-6148

You may be eligible to receive your adverse determination and this notice in a language listed below. In addition, you may call us to receive assistance in these languages.

SPANISH (Español): Para asistencia en Español, por favor llame al numero ubicado en la parte posterior de su tarjeta de identificacion.

TAGALOG (Tagalog): Upang humingi ng tulong sa Tagalog, paki tawagan ang numero na nakasulat sa inyong kard.

CHINESE (中文): 如果需要中文幫助，請撥打您卡上的電話號碼。

NAVAJO (Dine): Dinék'ehji áka'a'doowoo ł biniiyé, t'áá shǫǫdi koji' hodiilnih béésh bee haane'i bi numbo bee nééh ho'dólzinigii binuyé nanitinigii bine'dęę' bikáá'