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About Montana Medicaid and Healthy Montana Kids Plus
Montana Medicaid and Healthy Montana Kids Plus

**Montana Medicaid** is healthcare coverage for some low-income Montanans. Medicaid is run by the Montana Department of Public Health and Human Services (DPHHS).

**Healthy Montana Kids Plus (HMK Plus)** is Medicaid health coverage for low-income children in Montana and is also run by DPHHS.

The State of Montana pays about one-third of the cost of Medicaid and HMK Plus, and the federal government pays the rest.

Medicaid and HMK Plus do not pay money to you. Instead, payments for healthcare services are sent directly to your healthcare providers.

For Medicaid and HMK Plus to pay for healthcare:
- services must be medically necessary;
- services must be provided by a healthcare provider who is a Montana Medicaid or HMK Plus provider; and
- services must be Medicaid or HMK Plus covered services.

Did You Get a Medicaid or HMK Plus Card?

Adults with Medicaid will get a plastic “Montana Access to Health” card in the mail. Kids with HMK Plus will get a plastic “Healthy Montana Kids Plus” card in the mail. Each person will get his or her own card. Keep your card in a safe place. **Always take your card with you to your appointments and show it when you check in.**

If the information on your card is not right, tell the Office of Public Assistance (OPA) right away. If you haven’t received your health coverage card, or have lost your card before you need medical care, contact the Montana Public Assistance Helpline at 1-888-706-1535.

Keep your card, even if your Medicaid or HMK Plus ends. If you get Medicaid or HMK Plus again in the future, you will use the same card.

The front of your card has your name, your member number, and your birth date. The member number is a unique identifier that is not your Social Security Number.

The back of your card has information about using the card and the Medicaid/HMK Plus Member Help Line phone number, 1-800-362-8312. The back of the card also has information for your provider.

If you Move, Get Married, Have a Baby or Have Other Changes

Tell the Office of Public Assistance within 10 days if you have changes in your household. Some examples:
- change your mailing address;
- change your phone number;
- marry or divorce;
- move to a nursing home;
- become pregnant;
- have a baby;
- change jobs;
- get other insurance; or
- have changes in your assets or income.

A case manager will tell you if you are still eligible for Medicaid or HMK Plus.

Nurse First Advice Line

Nurse First is a **free telephone nurse advice** line you can call when you are sick, hurt, or have health questions. Call the Nurse First Advice Line at 1-800-330-7847 and talk with a registered nurse **24- hours a day, 7 days a week**. Nurse First is for members with Medicaid, HMK Plus or Mental Health Services Plan (MHSP) health coverage.

Before you go to your provider or the emergency room, call Nurse First. You may be able to treat the problem at home. Nurses licensed in the State of Montana at Nurse First can guide you to the right care, at the right place, and at the right time.
Nurses at Nurse First can help you with problems like:

- fever;
- earache and headache;
- flu and sore throat;
- skin rash;
- vomiting or upset stomach;
- colds and coughing; and
- back pain.

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

Don't call Nurse First when:

- You have a health concern you are sure is life threatening. In this case, call 911 or go directly to the emergency room;
- It’s time for your child’s next well-child checkup or immunizations. Call your provider’s office directly to schedule an appointment;
- You’ve seen your provider for a specific health problem and a follow-up appointment is needed. Call the office directly to schedule the appointment;
- You’ve seen your provider for a specific health problem, and they refer you to a specialist. Call the specialist’s office directly to set up an appointment; or
- You, or your child, need regular services such as transfusions or dialysis. Make the series of appointments directly with your provider’s office.

Remember, if you are not sure you should go to the emergency room, call the Nurse First Advice Line at 1-800-330-7847. The call is free. Registered nurses are available 24 hours a day, 7 days a week to help you.

What if I’m on the HELP Program?

HELP Program
The Montana Health and Economic Livelihood Partnership (HELP) Program provides health coverage to adults ages 19-64 with incomes up to 138% of the federal poverty level (FPL); who are Montana residents, not eligible for Medicare, and not incarcerated.

Medicaid Card
HELP Program members will receive a Montana Access to Health card.

Benefits
You are eligible to receive Standard Medicaid Benefits. See Covered and Non-Covered Services of this guide.

Providers
You can get health services from any doctor, clinic, or other health care provider who accepts Montana Medicaid.

Premiums
As a member of the HELP Program you pay a monthly premium. Your premium helps cover the cost of your health insurance. The HELP Program premium will total two percent (2%) of your yearly income billed monthly. Submit your payment with the payment stub included in your monthly bill. Premiums are due on the 1st of each month.

For members at or below one hundred percent (100%) of the Federal Poverty Level (FPL), which equals approximately $1,011 per month for an individual, or $2,091 per month for a family of four, failure to pay premiums will not result in dis-enrollment. Unpaid premiums for all members become a debt to the State and will be collected against future tax refunds. You can call DPHHS at 1-866-471-9621 to ask about your premium status.

Premium Rights and Obligations
Even if you cannot pay your premium, you may still be able to keep HELP Program coverage. You will remain in the HELP Program if:

A. Your income is under 100% of the FPL, which is approximately $1,011 a month for an individual, or $2,091 a month for a family of four; or

B. If your income is above 100% of the FPL, 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 Program coverage if you meet two or more of these circumstances, including:

- You have been discharged from the United States military services within the previous 12 months;
- 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;
- You see a primary care provider who is part of a qualified primary care case management program;
- You are in a substance use treatment program;
- You are in a DPHHS approved wellness program.

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 Program. You will still be responsible for payment of your premiums.

If two of the items above describe you, go to https://apply.mt.gov, call 1-888-706-1535, or visit any local Office of Public Assistance.

If you are disenrolled because you have unpaid (delinquent) premiums, you may reenroll in the HELP Program 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.

Mental Health Services Plan

The Mental Health Services Plan (MHSP) covers mental health services for adults 18 and older, who do not otherwise qualify for Medicaid and who have severe and disabling mental illness.

Services are provided through mental health centers and prescribers. The drug coverage of $425 a month is to be used for prescribed psychotropic medications only. For more information on MHSP, contact 1-406-444-3964.

72 Hour Presumptive Eligibility Program (for mental health crisis)

The 72 Hour Presumptive Eligibility program is funded through the Addictive and Mental Disorders Division. The purpose of this program is to provide mental health crisis services to individuals not currently enrolled in Medicaid. For more information on the 72-hour program, contact 1-406-444-3964.

Presumptive Eligibility Program

Presumptive eligibility is short term coverage, for people who are not yet on Medicaid, and is available once every 12 months (or, once per pregnancy). It is designed to provide short-term healthcare coverage to persons with sudden, serious healthcare needs while Medicaid eligibility is explored. PE lasts from the date of determination until a determination of Medicaid program eligibility is made, or until the last day of the month following the month of determination, whichever is earlier.

Hospitals and other designated facilities participating in Montana Medicaid can make presumptive eligibility determinations for the following groups:

- Children (HMK Plus and HMK (CHIP));
- Pregnant women (Ambulatory Prenatal Care);
- Parent/Caretaker Relative Medicaid;
- Former Foster Care Children (ages 18 up to 26); and
- Breast and Cervical Cancer.
If You have Other Questions or Concerns

What if you get a bill?

If you sign an Advanced Beneficiary Notice (private pay agreement) before receiving services, providers may bill you for:

- non-covered services;
- experimental services;
- unapproved services;
- covered but medically unnecessary services;
- unapproved services that require referral from your Passport to Health provider;
- services performed in an inappropriate setting;
- services received when you are not eligible for Medicaid; and
- investigational services.

You are responsible to pay for the service if you signed an agreement. If you think a provider is billing both you and Medicaid or HMK Plus for the same service, or is charging Medicaid, HMK Plus, or you for services you did not receive, call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312.

Medicaid and HMK Plus usually do not pay your provider the full amount the provider charges for services. Your provider has agreed to accept the lower payment amount. You do not pay the amount above what Medicaid or HMK Plus pays.

If you have questions about a bill from your provider, try to work with your provider’s office to get an answer. If you still need help, call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312.

Can you get help getting to your appointment?

Medicaid or HMK Plus may pay for you to get to your healthcare provider or other healthcare service, if the service is covered by Medicaid or HMK Plus, and if you have no other way to get there. See page 35 for details about transportation coverage.

Do you need an interpreter?

If English is not your first language, or you have trouble understanding English, please ask your case manager or Medicaid or HMK Plus provider for an interpreter who speaks or signs your language. The interpreter can explain Medicaid or HMK Plus to you. Interpreters are free and available, including sign language.

Do you have trouble hearing?

If you are hard of hearing or have a speech disability, call the Montana Telecommunications Access Program (MTAP) at 1-800-833-8503. They will give you more information about louder volume telephones, captioned telephones, and hands-free devices.

If you are deaf or hard of hearing and want direct call relay service, the Montana Relay call service will relay your phone calls – just call 711 or 1-800-253-4091. The Montana Relay customer service number is 1-800-833-8503.

If you have not had Medicaid for months.

To reapply for Medicaid, HMK Plus, or HMK (CHIP) complete an online Medicaid application at http://apply.mt.gov, or complete a paper application and give it to any county Office of Public Assistance (OPA), either in person or by mail. To find the location of your local OPA call the Montana Public Assistance Helpline at 1-888-706-1535.

Offices of Public Assistance (OPA)

To find the location of your local OPA call the Montana Public Assistance Helpline at 1-888-706-1535.
Your Passport to Health

Passport to Health
Passport to Health (Passport) is a medical home program.

What is a medical home?
A medical home is when you choose one provider and ideally one pharmacy that will coordinate most, or all your health care needs.

This means any time you are sick, hurt, need medicine or need to see your doctor for an exam, you see the same provider. You work together to know your health status, any medications you may take, and your health history. This helps you and your provider make good decisions so you get the best healthcare possible.

Most members who have Medicaid or HMK Plus must participate in the Passport program.
Your Passport Provider

You will choose a dedicated Montana Medicaid Passport provider such as a physician, nurse practitioner, physician assistant, community health center, tribal health, Indian Health Service (IHS), or a primary care clinic. Your Passport provider will take care of most of your medical needs, make referrals to other providers as necessary, and keep your medical records up to date and in one place. With some exceptions, all medical appointments must be provided or approved by your Passport provider.

What to Expect from Your Passport Provider

Your Passport provider has agreed to several requirements to help coordinate your care. Your Passport provider should:

- provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordinate your access to specialty care by providing referrals;
- assist you with findingservices;
- provide or arrange for well-child checkups; children’s healthcare (EPSDT) services, lead screenings, and immunizations; and
- offer interpreter services covered by Medicaid.

Who’s not eligible for Passport?

All Medicaid members are in Passport with some exceptions. You are not eligible for Passport if you are:

- eligible for spend down (medically needy),
- living in a nursing home or other institutional setting;
- receiving Medicaid for less than three (3) months;
- eligible for Medicare;
- eligible for Medicaid adoption assistance or guardianship;
- receiving back dated Medicaid eligibility,
- receiving Medicaid home and community based services (HCBS);
- eligible for a non-Medicaid plan like HMK (CHIP), MHSP, or Plan First;
- receiving Medicaid under a presumptive eligible program; and
- living out of the State of Montana.

Effective April 1, 2018, the following populations will not be eligible for Passport:

- eligible for Pregnancy Medicaid; or
- eligible for the Breast and Cervical Cancer program.

Choosing Your Passport Provider

You choose your Passport provider. You can choose the same provider for everyone in your family, or each person can have a different provider according to their healthcare needs. For example, parents may choose a pediatrician for their child, and a family doctor or nurse practitioner for themselves. If you want to keep seeing your current provider, ask if they are a Passport provider. If they are, you may choose that provider.

Need Help Choosing?

Call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312, available Monday through Friday, 8 am to 5 pm. The Help Line staff can tell you about Passport providers near you.

You can also choose your Passport provider anytime online by going to [http://mtpassport.com/](http://mtpassport.com/).

If you do not choose a Passport provider, one will be chosen for you. It’s best if you choose because you know what’s right for you and your family.

After you choose or are assigned your Passport provider, you will get a confirmation letter in the mail with the name of the provider you chose.

The letter will also tell you how to contact your provider during normal work hours and after normal work hours.
American Indians and Passport

If you are American Indian, you can choose an Indian Health Services (IHS) or any other Passport provider. If you choose a Passport provider who is not IHS, you can still go to an IHS for health services without a referral from your Passport provider. However, if IHS refers you to someone who is not with IHS, you must get a referral from your Passport provider before you go. Medicaid and HMK Plus may not pay the bill if you do not get a referral from your Passport provider before seeing another provider. When in doubt, contact your Passport provider.

Changing Your Passport Provider

If you need to change your Passport provider, call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312, available Monday through Friday, 8 am to 5 pm, or log onto http://mtpassport.com/. If you change your provider, you will get a letter in the mail confirming the change.

The change usually happens at the beginning of the next month, depending on when the change is requested.

Passport Referrals

Your Passport provider will provide for most of your healthcare needs, but sometimes you may need to see a specialist or go to urgent care. Your Passport provider will be asked to give the specialist or urgent care a referral. The specialist or urgent care must make sure they have a referral from your Passport provider before they see you.

You don’t need a referral from your Passport provider for all services. See the Covered and Non-Covered Services section beginning on page 14 for services that don’t need Passport referrals.

Can you be Removed from Passport?

Most members with Medicaid or HMK Plus must choose a Passport provider. Sometimes choosing one provider may make it hard to get healthcare when you need it. In some circumstances exceptions may be approved. The Passport program may place time limits on all exemptions. Reasons to be exempt from Passport include if you are:

- enrolled with a case management program through another payer;
- unable to find a primary care provider willing to provide case management;
- living in a county where there are too few primary care providers; or
- participating in Passport would be a hardship.

At the discretion of DPHHS, eligible Medicaid members who are exempt from participating in the Passport program may choose to enroll in Passport.

If you would like to voluntarily enroll or request an exemption from the Passport to Health program. Call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312, available Monday through Friday, 8 am to 5 pm.

Getting Passport Medical Care

Checkups, exams, sick, or hurt

Always go to your Passport provider for regular exams or when you are sick or hurt.

Emergency room care

A medical emergency is when you are sick or hurt and you need medical care right away. Examples of emergencies are if you are bleeding a lot, or having trouble breathing.

You can get emergency treatment without a referral from your Passport provider. If emergency treatment has been done and you still need more care, like getting stitches out, you should go to your Passport provider for that care.
What if you have an emergency?
Call 911 or go to the nearest emergency room.

When should you go to the emergency room?
Go to the emergency room only when you have a medical or behavioral health emergency. See the definition of an emergency on page 31.

Urgent care
Urgent care clinics do not provide the same services as a Passport provider and some do not accept Medicaid. If you go to an urgent care clinic when your Passport provider is not in the office, make sure the urgent care takes Medicaid. Then be sure to ask your Passport provider to give a referral to the urgent care clinic.

Not sure where to go?
If you are not sure if you have an emergency or need to get care right away, you should call Nurse First at 1-800-330-7847. There is more information about Nurse First on pages 4 and 5.

Concerns with Your Passport Provider
If you have concerns with your Passport provider, here are some things you can do:
- Talk to your provider, explain what the problem is and try to work it out;
- Choose a new Passport provider;
- Call the Member Help Line. Tell the person who answers that you are having a problem with your Passport provider; or
- You have the right to file a complaint. To do this, call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312, available Monday through Friday, 8 am to 5 pm.

If You Do Not Have Passport
You can get healthcare from any provider who is a Medicaid or HMK Plus provider.

Be sure to ask if the provider is a Medicaid or HMK Plus provider before you make an appointment. Here are some common kinds of providers you might see to get healthcare:
- Physicians (doctors), such as internists; pediatricians, obstetricians, gynecologists;
- Mid-level practitioners, such as physician assistants, nurse midwives and nurse practitioners;
- IHS, tribal health, community health center, or a clinic;
- Ambulatory surgical center;
- FQHCs (Federally Qualified Health Centers);
- RHCs (rural health clinics); or
- County or city-county health departments.

To find providers or places to get healthcare that are Medicaid or HMK Plus providers, go to http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices and click on the “Find a Montana Medicaid Provider” link. Once there, you can search by provider type, provider specialty, name, zip code or even county.
Your Rights and Responsibilities
Your Rights as a Member with Medicaid or HMK Plus

A person who is eligible for Medicaid or HMK Plus has the right to be treated fairly and with courtesy and respect.

- You have the right to have your privacy protected and to be treated with dignity by providers and their staff;
- You have the right to get medical care no matter your race, color, nationality, sex, religion, age, creed, disability, marital status, or political belief;
- You have the right to know if the medical services you need are paid for by Medicaid or HMK Plus;
- You have the right to discuss all information on available treatment options and possible results with your provider before accepting or refusing treatment;
- You have the right to use the services of an interpreter, if necessary, at no cost to you;
- You have the right to have a complaint about Medicaid or HMK Plus and to a reply;
- You have the right to choose your provider; and
- You have the right to receive information and instructional materials; and the right to request additional information and materials.

Your Responsibilities as a Medicaid or HMK Plus Member

You and your healthcare provider are a team. Your job is to help your healthcare provider give you the best healthcare. Here’s what you can do:

- Know if you are eligible and understand what benefits are available to you;
- Treat your healthcare providers with respect, just as you like to be treated;
- Call the Nurse First Advice Line – first.
- Nurses are there every day, 24 hours a day to help you decide if you should see your provider, go to the emergency room, or take care of the problem at home. Call 1-800-330-7847;
- Use an ambulance or go to an emergency room only if you have a medical emergency;
- Follow Montana Medicaid’s policies and procedures;
- Receive most of your care through your primary care provider;
- Keep your appointments and call your provider in advance if you cannot make it to your appointment;
- Carry your Montana Medicaid or HMK Plus ID card with you and show it at every appointment;
- Contact the Office of Public Assistance (OPA) about any changes in your case;
- Ask all providers if they are Medicaid or HMK Plus providers before you make an appointment;
- Help your provider get your previous medical records;
- Tell your provider about signs of trouble, such as pain, allergies, or changes you’ve noticed;
- Get complete directions about drugs, treatments, or tests. Write down directions or ask your provider to write them down;
- Make a list of questions before your appointment. Ask about risks, choices, and costs before getting treatments or prescriptions. If you don’t understand what you need to do to get better, ask more questions;
- Take time to decide about treatment. Think about your choices and discuss them with your provider. For some treatments, your provider will need prior authorization or Passport referral before the treatment is done;
- Go to the same pharmacy to get all your prescriptions. The pharmacist will tell you if different drugs together will give you problems or if a drug has side effects. The pharmacist can also answer questions about your prescription drugs;
- Don’t sign anything you don’t understand;
- Pay your copayments.
- Use Medicaid and HMK Plus wisely – only when you are sick or for exams and regular checkups to help prevent sickness; and
- If Medicaid or HMK Plus paid or may pay for medical care for injuries caused by another person, you must give DPHHS the names and addresses of the person or insurance company responsible. Call DPHHS at 1-800-694-3084.
Covered and Non-covered Services
Covered and Non-Covered Services

This section tells you if a service is covered by Medicaid or HMK Plus. For more details on these services, turn to page 29. There may be other services that Medicaid and HMK Plus will pay for that are not listed. Ask your provider if you’re not sure if something is covered, has limits, or requires prior authorization by Medicaid or HMK Plus, or call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312.

All Medicaid and HMK Plus services must be medically necessary.

All Medicaid and HMK Plus services must be provided by a Montana Medicaid provider.

Passport Referral

Some Medicaid and HMK Plus services will need a referral from your Passport provider to see other healthcare providers before Medicaid or HMKPlus will pay for services.

Copayments

Some members with Medicaid are required to make a copayment to the provider for services or prescriptions. Members who do not have copayments are:

- Under age 21;
- American Indians/Alaska Natives who are eligible and have ever received a service from a tribal health, Urban Indian clinic, or Indian Health Services (IHS) provider;
- Inpatient in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the member is required to pay for some of the cost of care;
- Pregnant women;
- Terminally ill members receiving hospice services; and
- Members who are receiving services under the Medicaid breast and cervical cancer treatment category.

Copayments may not be charged to you until the healthcare provider’s claim has been processed and your provider has been notified of the amount you owe. Be sure to get a receipt for any copayments paid. Providers cannot deny services if you are below 100% of the Federal Poverty Level (FPL) and are unable to pay your copayments.

The chart of covered services tells you which services will have a copayment, including the specific copayment amount.

Medicaid services that do not require copayments:

- Emergency;
- Family planning;
- All children’s services;
- Eye glasses purchased by Medicaid through a volume purchasing agreement;
- Hospice;
- Transportation;
- Home and Community Based Waiver;
- Generic drugs;
- Approved preventive; and
- Services where Medicaid is the secondary payer. (If the service is not covered by the first payer, but is covered by Medicaid, there may be a required copayment.)

Or, contact the Medicaid/HMK Plus Member Help Line at 1-800-362-8312.

Members with income at or above 100% of the Federal Poverty Level are responsible for a 10% copayment of the provider’s Medicaid reimbursed amount for any Medicaid covered service. An exception would be for outpatient pharmacy services where the member will be responsible for:

- A $4 copayment for preferred brand drugs; and
- An $8 copayment for non-preferred brand drugs
**Copayment Limits:**
The total of the Medicaid copayments owed by a Medicaid household may not be more than five (5) percent of the family’s income applied quarterly.

Copayment will not be applied to the household members in a quarter once the household has met the quarterly cap.

**Note:** You may need to pay more than one copayment amount, depending on the Medicaid services received. For example, a visit may result in the following copayments, $4 for x-rays, $4 for lab work, $4 for a doctor visit, and $4 for a facility fee (depending on the place of service) for a total copayment amount of $16. Ask your provider’s office if you have copayment questions.

**Prior Authorization**
Some Medicaid and HMK Plus services require authorization before Medicaid or HMK Plus will pay for the services. For transportation services call **1-800-292-7114**.

For other services, talk to your Passport provider or other provider of service. You may also call the Medicaid/HMK Plus Member Help Line at **1-800-362-8312**.

Montana Medicaid and HMK Plus makes every effort to have a complete set of medical policies in place. However, due to the fast pace of medical changes and new medical procedures, Medicaid and HMK Plus may not have a policy to address every service. In those cases, Medicaid and HMK Plus may review other information including current medical literature and other medical resources, and consult with healthcare providers.

The description of Medicaid and HMK Plus covered and non-covered services presented in this chapter is a guide and not a contract to provide medical care. Administrative Rules of Montana, Title 37, Chapters 81 through 88 and 90, govern access and payment of services.
## Covered Services: Standard Medicaid Benefit Chart

### Standard Medicaid Benefit Chart

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<tr>
<td>Ambulatory Surgery Center</td>
<td>Surgical procedures performed at a licensed outpatient/same day surgery facility.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Limited to covered surgical procedures that do not generally last longer than 90 minutes operating time.</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Children’s Healthcare/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Aids families in early identification and treatment of medical, dental, vision, mental health, and developmental screenings or problems for children. For more information see explanation of services in this section, or visit <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/WellChild">http://dphhs.mt.gov/MontanaHealthcarePrograms/WellChild</a></td>
<td>None</td>
<td>None</td>
<td>Limited to children ages 20 and under.</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Federally Qualified Health Center/Community Health Center</td>
<td>Health centers that offer sliding fee scales and provide comprehensive services (dental, behavioral health, and primary care).</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Hospital - Inpatient</td>
<td>Services for members formally admitted as inpatient and the expected hospital stay is more than 24 hours.</td>
<td>$75 Per stay</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, unless pregnancy related.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Hospital - Outpatient</td>
<td>Hospital stays that are expected to last less than 24 hours.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Indian Health Services/Tribal Health Centers</td>
<td>Federal healthcare provider and health advocate for American Indians and Alaska Natives.</td>
<td>None</td>
<td>None</td>
<td>Limited to members of federally recognized Indian tribes and their descendants.</td>
<td>No</td>
<td>Yes, for some services.</td>
</tr>
</tbody>
</table>

17
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Member Copayments Under 100% FPL</th>
<th>Member Copayments Over 100% FPL</th>
<th>Limits/Exclusions</th>
<th>Passport Referral Needed?</th>
<th>Prior Authorization Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Level Practitioners</td>
<td>Services provided by: [✓] Physician Assistants and Advanced Practice Registered Nurses (Nurse Anesthetists, Nurse Practitioners; [✓] Clinical Nurse Specialists; and [✓] Certified Nurse Midwives). See explanation of services in this section.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Non-Certified mid-wife services are not covered.</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Physicians/ Specialists</td>
<td>Services provided by physicians for treatment of illness, injury, primary care, preventive care, and health maintenance. See explanation of services in this section.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Routine podiatric care when a medical condition (such as diabetes) affecting the legs or feet requires treatment. See explanation of services in this section.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Public Health Clinic</td>
<td>Physician and mid-level practitioner services provided by a DPHHS designated Public Health Clinic.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Rural Health Clinics</td>
<td>Health clinics in rural areas that offer outpatient primary care services and basic laboratory services.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
<td>Member Copayments</td>
<td>Member Copayments</td>
<td>Limits/Exclusions</td>
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<tr>
<td>Home Health</td>
<td>Home health services provided by a licensed and certified agency.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
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<tr>
<td></td>
<td>See explanation of services in this section.</td>
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<td>180 visits per year.</td>
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<td>Services exceeding the limit must be prior authorized by DPHHS or its designee.</td>
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<td></td>
<td></td>
<td>Home Health services do not include personal assistance services.</td>
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<td>Therapy services must be provided by a licensed therapist.</td>
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<td></td>
<td>No</td>
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<td></td>
<td></td>
<td></td>
<td>Yes, contact Mountain Pacific Quality Health at 1-800-219-7035.</td>
<td></td>
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</tr>
<tr>
<td>Personal Assistance</td>
<td>Hands-on assistance with activities of daily living.</td>
<td>None</td>
<td>None</td>
<td>There must be a medical or functional need for hands on assistance with an activity of daily living to qualify for services.</td>
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<td></td>
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<td></td>
<td>Limit 80 hours per two-week period.</td>
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<td></td>
<td>Activities of daily living must be delivered in the home.</td>
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<td></td>
<td>No</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Yes, contact Mountain Pacific Quality Health at 1-800-219-7035.</td>
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</table>
### Senior and Long-Term Care Services, continued

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<th>Prior Authorization Needed?</th>
</tr>
</thead>
</table>
| Community First Choice               | Hands-on attendant based services for members needing additional help in their home. | None                             | None                            | Must meet level of care criteria and have a medical or functional need for hands on assistance with an activity of daily living to qualify for services.  
Limit of 86 hours per two-week period.  
Activities of daily living must be delivered in the home. | No                         | Yes, contact Mountain Pacific Quality Health at 1-800-219-7035.               |
| Home Dialysis Attendants             | Attendants who perform home dialysis.                                       | None                             | None                            | Must be diagnosed by a healthcare provider as suffering from chronic end stage renal (kidney) disease.  
When possible, a household member shall be trained as the attendant.  
Attendant must be trained with the member at a certified dialysis center.  
Training and travel time is not reimbursed by Medicaid. | No                         | Contact DPHHS at 1-406-444-4564 for medical necessity determination.          |
<table>
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<tr>
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<th>Limits/Exclusions</th>
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<th>Prior Authorization Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Mental Health</td>
<td>Mental health services provided by:</td>
<td>None</td>
<td>None</td>
<td>See link to Children’s Mental Health Bureau website: <a href="http://www.dphhs.mt.gov/dsd/CMB">www.dphhs.mt.gov/dsd/CMB</a></td>
<td>No</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td></td>
<td>✓ Licensed Professional Counselors (LCPC);</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>✓ Licensed Clinical Social Workers (LCSW);</td>
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</tr>
<tr>
<td></td>
<td>✓ Psychiatrists; and</td>
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<tr>
<td></td>
<td>✓ Psychologists.</td>
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<tr>
<td></td>
<td>Mental Health Center Services include:</td>
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<tr>
<td></td>
<td>✓ day treatment;</td>
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<td></td>
<td>✓ outpatient psychotherapy;</td>
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<td></td>
<td>✓ community based psychiatric community rehabilitation and support;</td>
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<td></td>
<td>✓ comprehensive school and community treatment;</td>
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<td></td>
<td>✓ targeted case management;</td>
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<tr>
<td></td>
<td>✓ home support services.</td>
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<tr>
<td></td>
<td>Therapeutic Group Homes, including extraordinary needs aids.</td>
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<tr>
<td></td>
<td>Therapeutic Foster Care</td>
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<tr>
<td></td>
<td>Psychiatric Residential Treatment Facility</td>
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<tr>
<td></td>
<td>Hospital and Partial Hospitalization Services</td>
<td></td>
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<tr>
<td></td>
<td>Explanation of services can be found at the following website:</td>
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<tr>
<td>Benefit</td>
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<td>Limits/Exclusions</td>
<td>Passport Referral Needed?</td>
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</tr>
<tr>
<td>Adult Mental Health</td>
<td>Mental health services provided by:</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>No</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td></td>
<td>✓ Licensed Professional Counselors (LCPC);</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Licensed Clinical Social Workers (LCSW);</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>✓ Psychiatrists; and</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>✓ Psychologists.</td>
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<tr>
<td></td>
<td>Explanation of services can be found at the following website:</td>
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<tr>
<td></td>
<td><a href="http://www.dphhs.mt.gov/amd/Mentalhealthservices">www.dphhs.mt.gov/amd/Mentalhealthservices</a>.</td>
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</tr>
<tr>
<td>Substance Use Disorder Treatment</td>
<td>Substance Use Disorder services provide by:</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>No limit to medically necessary outpatient psychotherapy sessions.</td>
<td>No</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td></td>
<td>✓ Licensed Professional Counselors (LCPC) or other Mental Health Professional with SUD in their scope.</td>
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<tr>
<td></td>
<td>Substance Use Disorder Treatment services include: screening and assessment, treatment, and recovery support for substance use disorders through outpatient, residential treatment, and non-hospital inpatient treatment.</td>
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<tr>
<td></td>
<td>Chemical Dependency Center services include: medically monitored intensive inpatient clinically managed high-intensity residential; clinically managed low-intensity residential; (continued on next page)</td>
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</tbody>
</table>
### Behavioral Health Related Services, continued

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Member Copayments Under 100% FPL</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder Treatment (Continued)</td>
<td>partial hospitalization; intensive outpatient therapy; outpatient therapy; biopsychosocial assessment; screening, brief intervention, and referral to treatment; drug testing; targeted case management</td>
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<td></td>
<td>Explanation of services can be found at the following website:</td>
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### Transportation Related Services

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<th>Benefit</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ambulance for Emergency Services</td>
<td>Emergency ground or air transport.</td>
<td>None</td>
<td>None</td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>See the definition of emergency services in this section.</td>
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<tr>
<td></td>
<td>If you are not sure if you should go to the emergency room, call the Nurse First Advice Line at 1-800-330-7847, call 911, or call the local emergency number for services.</td>
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</tr>
<tr>
<td>Non-Emergency Transportation (NEMT)</td>
<td>Scheduled non-emergency use of ambulance, wheelchair-lift equipped vans, taxicabs, and buses.</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
<td>No</td>
<td>Yes, call 1-800-292-7114 before travel takes place.</td>
</tr>
</tbody>
</table>
Transportation Related Services, continued

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>Reimbursement for personal vehicle mileage or bus ticket to travel to a healthcare provider or other Medicaid covered healthcare service. See explanation of services in this section.</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
<td>No</td>
<td>Yes, call 1-800-292-7114 before travel takes place.</td>
</tr>
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Dental Related Services

<table>
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<tr>
<th>Benefit</th>
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</thead>
<tbody>
<tr>
<td>Dental</td>
<td>Dental services (exams, cleanings, X-rays, fillings, crowns, dentures, orthodontia). See explanation of services in this section.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Adults ages 21 and over are limited to $1,125 of dental treatment benefits annually (July-June). Anesthesia, dentures diagnostic and preventative services do not count towards the annual dental limit. Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual dental treatment limit, however, service limits may apply.</td>
<td>No</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Dentures</td>
<td>Dentures are covered if medically necessary. See explanation of services in this section.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Partial dentures may be replaced every 5 years. Full dentures may be replaced every 10 years.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
<td>Member Copayments Under 100% FPL</td>
<td>Member Copayments Over 100% FPL</td>
<td>Limits/Exclusions</td>
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</tr>
<tr>
<td>Optometric/ Opticians</td>
<td>Eye exams or diagnosis and treatment of eye diseases. See explanation of services in this section.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>One eye exam every 12 months.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>Corrective lenses and/or frames to aid and improve vision. See explanation of services in this section.</td>
<td>None, if received through the Medicaid eyeglass contractor.</td>
<td>None, if received through the Medicaid eyeglass contractor.</td>
<td>One eye exam every 365 days for members age 20 and under. One eye exam every 730 days for members age 21 and over. One pair of glasses every 365 days for members age 20 and under. One pair of glasses every 730 days for members age 21 and over. Frames must be Medicaid approved frames. Medicaid will not pay for most add-ons such as photo-grey or transition lenses, progressive or no line bifocal lenses, round bifocals, tints other than rose 1 or 2, polycarbonate or shatter resistant material in lenses, scratch-resistant coating and ultra-violet coating. Contact lenses are covered only when medically necessary and not for cosmetic reasons.</td>
<td>No</td>
<td>Some features may require authorization.</td>
</tr>
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## Miscellaneous Services

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<tr>
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<th>Prior Authorization Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audiology/ Hearing Aids</strong></td>
<td>Hearing aids, evaluations, and basic hearing assessments for members with hearing disorders.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Hearing aids must be ordered by a medical provider.</td>
<td>No</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>Chiropractic care is covered for children through age 20.</td>
<td>None</td>
<td>None</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>Equipment or supplies to treat a health problem or a physical condition.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Equipment or supplies must be ordered by a medical provider.</td>
<td>No</td>
<td>Yes, for some equipment. Call 1-877-443-4021.</td>
</tr>
<tr>
<td><strong>Dialysis Clinic</strong></td>
<td>Outpatient dialysis services provided to members who have been diagnosed with end-stage renal (kidney) disease.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Must be diagnosed by a provider as suffering from chronic end stage renal (kidney) disease.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Habilitative Care</strong></td>
<td>Habilitative services when you require help to maintain, learn, or improve skills and functioning for daily living, or to prevent deterioration. Services may be provided in a variety of inpatient and/or outpatient settings.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Services include, but are not limited to physical therapy, occupational therapy, speech therapy, and behavioral health professional treatment. Applied behavior analysis for adults is excluded. Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a healthcare provider.</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
</tbody>
</table>
## Miscellaneous Services Continued

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Member Copayments Under 100% FPL</th>
<th>Member Copayments Over 100% FPL</th>
<th>Limits/Exclusions</th>
<th>Passport Referral Needed?</th>
<th>Prior Authorization Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Infusion Therapy</strong></td>
<td>Comprehensive treatment program of pharmaceutical products and clinical support services provided to members who are living in their home, a nursing facility, or any setting other than a hospital. See explanation of services in this section.</td>
<td>$4 per therapy span.</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Medications which can be appropriately administered orally, through intramuscular or subcutaneous injection, or through inhalation. Drug products that are not FDA-approved or whose use in the non-hospital setting present an unreasonable health risk are not covered.</td>
<td>No</td>
<td>Yes, for most services.</td>
</tr>
<tr>
<td><strong>Independent Diagnostic Testing Facility (IDTF)</strong></td>
<td>Diagnostic testing services provided under supervision of a physician independent of a hospital.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Lab is not covered under IDTF. The provider must enroll as an independent lab to bill lab procedures.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Independent Lab and X-Ray</strong></td>
<td>Tests and imaging provided by an independent (non-hospital) lab or imaging facility.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>N/A</td>
<td>Yes, for some services.</td>
<td>No</td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td>Nutritionist or dietician services.</td>
<td>None</td>
<td>None</td>
<td>Limited to children ages 20 and under. Services must be ordered by a healthcare provider.</td>
<td>Yes, for some services.</td>
<td>No</td>
</tr>
</tbody>
</table>
### Miscellaneous Services Continued

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Member Copayments Under 100% FPL</th>
<th>Member Copayments Over 100% FPL</th>
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<th>Prior Authorization Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>Prescribed medications (prescription or over the counter). See explanation of services in this section.</td>
<td>Generics – None</td>
<td>Generics – None</td>
<td>Generic drugs are required when possible. Drugs prescribed: To promote fertility; For erectile dysfunction; For weight reduction; and For cosmetic purposes or hair growth are not covered.</td>
<td>No</td>
<td>Yes, for some medications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preferred Brand - $4</td>
<td>Preferred Brand - $4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-preferred Brand drugs - $8</td>
<td>Non-preferred Brand drugs - $8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Skilled nursing services for children with severe medical problems who are not in a hospital.</td>
<td>None</td>
<td>None</td>
<td>Limited to children ages 20 and under. Services must be ordered by a healthcare provider. Services do not include taking care of a child to give the regular caretaker a break (respite care).</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rehabilitative Care</td>
<td>Services when you need help to keep, get back or improve skills and functioning for daily living that have been lost or impaired. Services may be provided in a variety of inpatient and/or outpatient settings.</td>
<td>$4</td>
<td>10% not to exceed 5% of family income quarterly.</td>
<td>Services include, but are not limited to physical therapy, occupational therapy, speech therapy, and behavioral health professional treatment. Applied behavior analysis for adults is excluded. (continued on next page)</td>
<td>Yes, for some services.</td>
<td>Yes, for some services.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
<td>Member Copayments Under 100% FPL</td>
<td>Member Copayments Over 100% FPL</td>
<td>Limits/Exclusions</td>
<td>Passport Referral Needed?</td>
<td>Prior Authorization Needed?</td>
</tr>
<tr>
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</tr>
<tr>
<td>Rehabilitative Care (continued)</td>
<td></td>
<td></td>
<td></td>
<td>Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a healthcare provider.</td>
<td>.</td>
<td></td>
</tr>
</tbody>
</table>
Non-covered Services
The following are examples of medical and non-medical services that are not covered by Standard Medicaid:

- Adult Chiropractic;
- Acupuncture;
- Naturopathic;
- Dietician, for those over the age of 21;
- Surgical technicians who are not physicians or mid-level practitioners;
- Nutritional;
- Massage Therapy;
- Dietary supplements;
- Homemaker, unless covered by a waiver;
- Remodeling of home, plumbing, car repair, and/or modification of an automobile;
- Childbirth services not provided in a licensed healthcare facility or nationally accredited birthing center, unless as an emergency service;
- Infertility or sterilization reversals;
- Experimental, unproven, investigational, and services in an inappropriate setting;
- Invasive medical procedures for the purpose of weight reduction (gastric bypass, gastric banding, or bariatric surgery); and
- Unauthorized circumcisions.

This is not a complete list.

More Information about Standard Medicaid
This section includes examples of Standard Medicaid. If you are on Medicaid, including the HELP Program, or HMK Plus you receive the Standard Medicaid benefit. Not all services are listed, and not all details about each service are shown.

Ask your Passport provider or primary care provider for more information. You can also call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312 for more information.

All covered treatments and services must be medically necessary and provided by an enrolled Medicaid provider.

Alcohol and Other Drug Treatment (Substance Use Disorder)
There are several different kinds of alcohol and drug treatment services. Services must be ordered by a licensed healthcare professional trained in substance use disorder treatment services provided by a substance use disorder program approved by Medicaid. Treatment must be medically necessary.

- Hospital Inpatient;
- Partial Hospitalization (Day Treatment);
- Non-hospital inpatient treatment; and
- Non-hospital outpatient treatment.

The following outpatient services are covered:

- Screening and assessment to find out if you have an alcohol or drug problem;
- Individual, group or family counseling;
- Multi-family counseling; and
- Targeted case management for youth.

Autism Services
Services available include occupational therapy, physical therapy, speech therapy and other Medicaid services as referred by a primary care practitioner.

Birth Control
Birth control pills, condoms, shots, and most other types of birth control and family planning supplies are covered. Birth control must be prescribed by a healthcare provider.

Case Management (Targeted)
The cost of targeted case management may be covered. You may be able to receive targeted case management if you fall into one of the following groups:

- High-risk pregnant women up to sixty days after childbirth and babies of high risk pregnant women up to one year of age;
- Members 18 years and older with severe disabling mental illness;
- Members 16 years and older with
developmental disabilities or who reside in a child’s developmental disabilities group home;

- Children and youth ages 5-17, or to the age of 20 if the youth is still in secondary school with serious emotional disturbance;
- Children and youth between the ages of birth and 18 with special healthcare needs;
- Children age 20 and under with substance use related disorders;
- Adults 21 years and older with substance use related disorders; and
- Children and youth under age 18 with serious emotional disturbance in out-of-state psychiatric treatment facilities.

Children’s Healthcare (EPSDT)

If you take your child to a provider for a well-child check-up or because they are feeling sick, this is the “Early and Periodic Screening” part of EPSDT. Children need regular visits to a provider to make sure that they are growing and are healthy. It’s also important to catch problems early so they can be treated. You can read more about well-child checkups on page 36.

If your child’s provider finds something that needs to be treated or looked into further, this is the “Diagnosis and Treatment” part of EPSDT. If the treatment is ordered by a provider and is medically necessary, it is covered.

If you feel that your child is not receiving what they need, call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312.

Chiropractic Services

Chiropractic services for children ages 20 and under are covered. Adults with Medicare and Medicaid may receive copayment, coinsurance, and deductible reimbursement for limited chiropractic services.

Chiropractic services for children ages 20 and under include:

- Spine adjustment;
- X-rays; and
- Evaluation and management.

Circumcision

Circumcision may be covered if medically necessary. Please contact your provider for more information.

Community First Choice (CFC)

The type of care authorized is developed with each member in a person-centered manner and is dependent upon specific needs and living situation. Services available through the CFC program include:

- Assistance with activities of daily living: bathing, dressing, grooming, toileting, eating, medication assistance, ambulation, and exercising;
- Limited assistance with instrumental activities of daily living: grocery shopping, housekeeping, laundry, community integration, yard hazard removal for providing safe access and entry to the home, and correspondence assistance;
- Personal emergency responsesystem monitoring; and
- Medical escort.

Services may not be provided in a hospital, a hospital providing long term care, a nursing home, an assisted living facility, or group homes.

Dental Braces (Orthodontia)

Non-cosmetic braces may be covered for children ages 20 and under and must be prior authorized.

Dental Services

Most routine dental services are covered for members with Standard Medicaid and HMK Plus (children through age 20).
**Children 20 and under**
- Can get dental exams and cleanings as often as necessary;
- Should visit a dentist by their first birthday, and then at least once every six months after the first tooth comes in;
- During a well-child checkup, providers should do an oral exam, including the application of fluoride varnish if needed;
- Bridges and tooth-colored crowns are available; and
- Dentures are covered.
- Children are not subject to the annual dental treatment limit.

**Adults with Standard Medicaid Benefits**
- Adults ages 21 and older are limited to $1,125 of dental treatment benefits annually (July-June);
  - Covered anesthesia services, dentures, diagnostic and preventative services do not count towards the annual dental limit.
  - Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual dental treatment limit, however, service limits may apply.
- Can have dental exams and cleanings every six months; and
- Can have basic treatment services, such as fillings and extractions, up to the $1,125 annual limit.
- Can get two porcelain crowns per calendar year; and
- Dentures (see next section).

Adult members are responsible to pay for non-covered dental services and any dental treatment services received above the annual $1,125 limit.

**Dentures for Adults**
- Dentures are covered for adults;
- Partial dentures may be replaced if the dentures are 5 years old or older;
- Full dentures may be replaced if the dentures are 10 years old or older; and
- One lost pair of dentures in a person’s lifetime is covered.

**Dialysis**
Dialysis is a medical process to temporarily purify the blood for someone in kidney failure. Services covered at dialysis clinics include outpatient dialysis and training for self-dialysis.

**Drugs (Prescriptions)**
To find out if a drug you need is covered or to find out if a drug needs prior authorization, talk to your pharmacist or your healthcare provider. Medicaid usually pays for a 34-day supply. You may get a 90-day supply of some drugs taken all the time, such as drugs for heart disease, high blood pressure, diabetes, thyroid conditions, women’s health, and birth control. Your pharmacist can tell you if you can get a 90-day supply.

**Drugs (Over-the-counter)**
The following over-the-counter drugs are covered if they are prescribed for you by your healthcare provider:
- Antacids;
- Aspirin;
- Diphenhydramine;
- Doxylamine;
- Folic Acid;
- H2 antagonist GI products;
- Ketotifen ophthalmic solution;
- Insulin;
- Laxatives;
- Levonorgestrel;
- Non-sedating antihistamines;
- Nicotine patches, gum and lozenges;
- Oxybutynin transdermal;
- Proton pump inhibitors;
- Pyridoxine; and
- Steroid Nasal Spray.

Nursing homes pay for over-the-counter laxatives, antacids, and aspirin for their residents.
Emergency Services
Emergency services are covered. An emergency means the symptoms or a medical or behavioral health condition are severe enough that a person with an average knowledge of health and medicine would expect there might be danger to the health or cause serious harm to any body part of the person or unborn child if the person is not treated right away.

Family Planning Services
Most family planning services are covered, including, but not limited to:
- Physical exams, with breast exams;
- Pap tests (to test for pre-cancerous conditions);
- Pregnancy tests;
- Birth control;
- Testing and treatment for sexually transmitted infections;
- Vaccines, including Human papillomavirus (HPV); and
- Sterilization information and counseling.

Sterilization is covered for members who are mentally competent and 21 years old or older at the time the consent form is signed. The consent form must be signed by the member at least 30 days before the scheduled sterilization.

Infertility services and paternity (to identify fatherhood) tests are not covered.

Foot Care (Podiatry)
Covered services include:
- Cutting or removing corns or calluses;
- Trimming nails;
- Applying skin creams;
- Measuring and fitting foot or ankle devices;
- Lab services and supplies; and
- Orthopedic shoes are covered if:
  - you are age 20 or under; or
  - you have a brace or a device attached to your shoe.

Group Medical Visits
A provider may see many patients at the same time for follow-up or routine care. This is a group visit, which may be covered by Medicaid. Your provider can let you know if he or she offers covered group visits.

Home and Community-Based Waiver Services (HCBS)
You must live in a county that has waiver services. Members who may be eligible for HCBS waivers:
- Physically disabled;
- Elderly;
- Members with a brain injury;
- Members with severe disabling mental illness (SDMI); and
- Members with developmental disabilities.

Services are different in each HCBS waiver and are determined by your needs. Here is a partial list of HCBS services:
- Case management;
- Personal assistance for supervision and socialization;
- Modifications to home or vehicle;
- Supported living and assisted living;
- Clinical and therapy services;
- Substance use disorder treatment;
- Communication and social interaction skill building;
- Homemaking;
- Private nursing;
- Adult day care;
- Adult group and fosterhome;
- Community-based psychiatric rehabilitation and support;
- Specially trained attendant care;
- Service dogs;
- Home delivered meals;
- Respite care (temporary care to give the usual caregiver a break);
- Illness management and recovery;
- Health and wellness;
- Pain and symptom management;
- Peer support services; and
- Other services defined under a waiver.

For more information about these HCBS
waiver programs, call:
- Physically disabled and elderly waivers 1-406-444-4077;
- SDMI waiver 1-406-444-3964;
- Developmentally disabled waivers 1-406-444-2995; and
- Children’s Autism waiver 1-406-444-6047.

Home Health Services
Home Health services are part-time nursing and restorative therapy services provided in the home to eligible people who require these services. The goal of the Home Health Services Program is to avoid unnecessary hospital or nursing facility stays by providing skilled nursing or therapy services in the home. 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. This is only available when personal assistance services are not available;
- Physical therapy, occupational therapy or speech therapy by a licensed therapist; and
- Non-routine medical supplies suitable for home use.

Home Health Services require prior authorization.

Home Infusion Therapy
Some drug treatments must be given in your veins (intravenously). For some members, these treatments may be given in their homes. 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. Services must be prior authorized.

Hospice
Hospice manages all care related to a terminal illness. Grief counseling is also available for the family. Hospice is provided by a licensed and certified agency.

Hospital Services
Services you get in a hospital, whether you stay in the hospital overnight or not, are covered.

Some examples of services you might get in a hospital are:
- Emergency room services;
- Medical services for which your provider admits you to the hospital;
- Physical therapy;
- Lab services;
- X-rays;
- Cardiac (heart) rehabilitation; and
- Pulmonary (breathing) rehabilitation.

Many hospital services must be prior authorized before you go to the hospital. For more information about hospital services, call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312.

Interpreter Services
Interpreter services will be provided if you are not a comfortable English speaker. Interpreter services are covered if you get a covered service. Your provider or case manager can help arrange for a qualified interpreter to provide services. You may request a friend or family member to be your interpreter. There is no cost to you for using interpreter services.
Lead Screening

Blood lead testing is covered by Medicaid and HMK Plus. The symptoms of lead poisoning can be difficult or impossible to recognize, making blood lead testing the only way to confirm exposure.

HMK Plus children should be tested for lead poisoning at 12 and 24 months of age. Children up to age 6 who have not been checked for lead poisoning before should also be tested. All HMK Plus children at other ages should be screened for risk of lead poisoning.

Mental Health Services for Adults

Medicaid covers these mental health services for all adults:
- Crisis and emergency services;
- Individual, group, and family counseling;
- Inpatient and outpatient therapy;
- Medication management; and
- Psychological testing.

Medicaid also covers these services for adults with Severe Disabling Mental Illness (SDMI):
- Adult group and foster home;
- Community-based psychiatric rehabilitation and support;
- Illness management and recovery;
- Dialectical behavior therapy (including coping skills);
- Assertive community treatment;
- Crisis intervention facility;
- Targeted case management;
- Partial hospitalization;
- Day treatment half day; and
- Intensive community-based rehabilitation.

Nursing Homes

Covered services include a shared room (or a private room if your provider says it’s medically necessary), laundry service, travel for medical appointments, meals, minor medical or surgical supplies, nursing services, social services, and activity programs. The nursing home will provide you with a list of other services you will receive and will know which services need prior authorization.

OB (Obstetric) Services

Routine care during pregnancy, including individual and group prenatal visits and checkups for the mother after she gives birth are covered.

A baby’s delivery must be in a licensed hospital or birthing center to be covered. For group prenatal visits, please check with your healthcare provider for additional information. Not all healthcare providers offer this service.

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. The out-of-state hospital must become a Montana Medicaid or HMK Plus provider to get paid;
- A hospital provider, 100 miles or less outside the Montana border is considered an in-state provider and Medicaid or HMK Plus will pay for services if the provider is enrolled in Montana Medicaid or HMK Plus;
• All out-of-state hospital inpatient services need prior authorization before you get services unless you have an emergency; and
• Services received outside the United States including Canada or Mexico, are not covered.

**Respiratory (Breathing) Therapy**

Respiratory therapy is covered for children ages 20 and under, and includes treatment by a licensed respiratory therapist. Services are ordered by your child’s healthcare provider. If your child has Passport, the Passport provider must approve the service.

**Drug Therapy Management**

Montana Medicaid covers shared drug therapy management services provided by a Clinical Pharmacist. Please see your healthcare provider for additional information as not all healthcare providers offer this service.

**School-Based Services**

Children can get some HMK Plus services at school. These services are called school-based services. If your child has Passport, their Passport provider may need to approve some services. Examples of services your child may get at school are:
• Speech therapy;
• Occupational therapy;
• Physical therapy;
• Private duty nursing;
• Help with daily living activities;
• Specialized transportation;
• Mental health; and
• Orientation and mobility services for blind or low vision.

**Tobacco and Smoking**

Everyone in Montana can get help to stop smoking or chewing by calling the Tobacco Quit Line at 1-800-QUIT-NOW or 1-800-784-8669.

Smoking products and counseling are covered. Talk to your healthcare provider or call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312 for more information.

**Transplants**

Most transplants are covered. All transplant services, except for corneal transplants, require prior authorization.

**Transportation**

Medicaid may provide travel assistance benefits to help you get to and from medical appointments.

The following are the rules used to decide if travel funds will be given:
• 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;
• Medicaid will reimburse for travel to your Passport provider or to the closest, approved provider of other medical services;
• Travel funds can be provided for out-of-town or out-of-state services if the service is not available near you. Advance payment will be on a case-by-case basis; and
• You must be eligible for Medicaid or HMK Plus on the date of the medical appointment.

If you used a personal vehicle for emergency travel you must call 1-800-292-7114 within 30 days of the emergency 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 Medicaid covered 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 transportation center will contact your provider’s office to make sure you went to your appointment before paying.

**Well-Child Checkups**

All members ages 20 and under should have regular well-child services or visits. When you make an appointment for a well-child visit, be sure to say that it is a well-child visit so enough time will be scheduled with your doctor.

Your child, age 20 and under, should receive the following during a well-child visit:

- Head-to-toe unclothed physical exam;
- Eye check;
- Oral check by provider, including application of fluoride varnish if needed;
- Hearing check;
- Nutrition check-up;
- Growth and development check-up;
- Blood and urine tests, if needed;
- Immunizations, if needed;
- Speech and language checkup; and
- Lead screening at ages 1 and 2, or up to 6 years if not previously tested.

During the well-child visit, you will also receive health education. If problems or concerns are found during the well-child visit, your child may be referred to another provider for more exams and treatment.

Your child should visit a dentist by their first birthday and at least once every six months after the first tooth comes in.

You can request that your child get a well-child screen during any visit for an illness or injury.

**Immunizations**

It’s important for a child to visit a provider, Community Health Center, or Public Health Clinic to get the right immunizations. Getting immunizations not only protects the child, but also anyone the child meets.

A child’s provider will know which immunizations the child should get and when he or she should get them. Immunizations protect against many diseases including:

- Hepatitis A and B;
- Diphtheria;
- Tetanus;
- Pertussis (whooping cough);
- Polio;
- Pneumococcal disease;
- MMR (measles-mumps-rubella);
- Varicella (chicken pox);
- Influenza (flu);
- Hib (Haemophilus Influenzae Type B);
- HPV (Human papillomavirus);
- Meningococcal (Meningitis) disease; and
- Rotavirus.

If a child misses an immunization, follow up with the primary care physician as soon as possible. Keep an immunization record filled out by the healthcare provider. You will need this record when a child starts day care, school, and college.

Medicaid has adopted the American Academy of Pediatrics Bright Futures Periodicity Schedule. The full nationwide schedule can be found at [http://brightfutures.aap.org/](http://brightfutures.aap.org/).
More Helpful Programs
Assistance for Members with Medicare

If you have Medicare and Medicaid, most of your healthcare costs are paid by Medicare. Medicaid may help with costs that Medicare doesn’t pay.

Members who have Medicare with incomes too high to get Medicaid may be able to get Medicare monthly premiums paid. There are three programs called Medicare Savings Programs you may apply for at the Office of Public Assistance. For Medicaid members who qualify, Medicaid will pay:

- Qualified Medicare Beneficiary Program (QMB) may pay a portion of your Medicare Part A and B monthly premium, coinsurance, and deductibles;
- Specified Low-Income Medicare Beneficiary Program (SLMB) may pay a portion of your Medicare Part B monthly premium;
- Qualifying Individual Program (QI) may pay a portion of your Medicare Part B monthly premium; and

Big Sky Rx may pay all or part of your Medicare drug plan monthly premium.

- Big Sky Rx is a state funded program run by DPHHS. Big Sky Rx is for people who have Medicare and don’t qualify for Medicaid or the Medicare Savings Programs listed above.

For more information about Big Sky Rx, call 1-866-369-1233 or visit http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.

You can get more information about Medicare and related services from SHIP (State Health Insurance Assistance Program) at 1-800-555-3191.

Plan First

If you lose, or are not eligible for Medicaid or HMK Plus, family planning services may be paid by Plan First. Plan First is a separate Medicaid program that covers family planning services for eligible women. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of sexually transmitted diseases (STDs).

You may be eligible if you are:

- Montana resident;
- Female, age 19 through 44;
- Able to bear children and not presently pregnant;
- Annual household income up to and including 211% FPL; and
- Not enrolled in Medicaid.

To apply or for more information visit the Plan First Website at https://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst.

Health Insurance Premium Payment (HIPP) Program

HIPP may pay private health insurance premiums for members with Medicaid or HMK Plus who also have other health insurance coverage.

Here are some ways you may be eligible for HIPP:

- You have insurance either through your job or through an individual healthcare policy;
- Your job offers insurance, but you haven’t signed up because it costs too much; or
- You had insurance through your job but you are no longer working and can’t pay the COBRA continuation coverage premiums.

For more information about HIPP, call 1-800-694-3084 and press 1 when prompted.
Waiver for Additional Services and Populations

The Waiver for Additional Services and Populations (WASP) provides Standard Medicaid benefits for individuals on the Mental Health Service Plan (MHSP) who are age 18 or older, have severe and disabling mental illness (SDMI), and are otherwise ineligible for Medicaid benefits.

To apply or for more information contact the Addictive & Mental Disorders Division at 1-406-444-3964, email hhsamddmhswaiver@mt.gov or visit the WASP website at http://dphhs.mt.gov/amdd/Mentalhealthservices/Waiver.
<table>
<thead>
<tr>
<th>Organization or Service</th>
<th>Website</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Special Health Services</td>
<td><a href="http://www.cshs.mt.gov/">www.cshs.mt.gov/</a></td>
<td>1-800-762-9891</td>
</tr>
<tr>
<td>Citizen's Advocate (Governor's Office)</td>
<td><a href="http://www.citizensadvocate.mt.gov/">www.citizensadvocate.mt.gov/</a></td>
<td>1-800-332-2272</td>
</tr>
<tr>
<td>Elder Abuse Information (Aging Services)</td>
<td><a href="http://dphhs.mt.gov/SLTC/APS.aspx">http://dphhs.mt.gov/SLTC/APS.aspx</a></td>
<td>1-800-551-3191</td>
</tr>
<tr>
<td>Healthy Montana Kids (CHIP)</td>
<td><a href="http://www.hmk.mt.gov">www.hmk.mt.gov</a></td>
<td>1-877-543-7669</td>
</tr>
<tr>
<td>Legal Services</td>
<td><a href="http://www.montanalawhelp.org">www.montanalawhelp.org</a></td>
<td>1-800-666-6124</td>
</tr>
<tr>
<td>Medicaid Fraud Line</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/fraudandabuse.aspx">https://dphhs.mt.gov/MontanaHealthcarePrograms/fraudandabuse.aspx</a></td>
<td>1-800-201-6308</td>
</tr>
<tr>
<td>Montana Public Assistance Help Line (OPA)</td>
<td><a href="http://dphhs.mt.gov/contact/hotlinenumbers.aspx">www.dphhs.mt.gov/contact/hotlinenumbers.aspx</a></td>
<td>1-888-706-1535</td>
</tr>
<tr>
<td>Medicaid Transportation Center</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/MontanaHealthcareTransportation">http://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/MontanaHealthcareTransportation</a></td>
<td>1-800-292-7114</td>
</tr>
<tr>
<td>Medicare</td>
<td><a href="http://www.mymedicare.gov">www.mymedicare.gov</a></td>
<td>1-800-633-4227</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td><a href="http://dphhs.mt.gov/amdd/substanceabuse">www.dphhs.mt.gov/amdd/substanceabuse</a></td>
<td>1-406-444-3964</td>
</tr>
<tr>
<td>Tobacco Quit Line</td>
<td><a href="http://dphhs.mt.gov/publichealth/mtupp/quitline">http://dphhs.mt.gov/publichealth/mtupp/quitline</a></td>
<td>1-800-784-8669</td>
</tr>
<tr>
<td>WIC Nutrition Information</td>
<td><a href="http://www.dphhs.mt.gov/publichealth/wic">www.dphhs.mt.gov/publichealth/wic</a></td>
<td>1-800-433-4298</td>
</tr>
</tbody>
</table>
Grievances and Appeals
If You Experience Discrimination

DPHHS may not exclude, deny benefits to, or otherwise discriminate against any person because of race, color, national origin, age, physical or mental disability, marital status, religion, creed, gender, sexual orientation, political belief, genetic information, veteran status, culture, social origin or condition, or ancestry.

Discrimination may not occur regarding admission, participation, or receipt of services or benefits of any programs, activities, or employment, whether carried out by DPHHS, through a contractor, or other entity.

To file a complaint for discrimination, forms are available by request at Medicaid/HMK Plus Member Help Line at 1-800-362-8312 or go to http://dphhs.mt.gov/NondiscriminationPolicy or contact:
Complaint Coordinator
Phone: 1-406-444-4211
TTY: 1-866-735-2968

You may file a complaint with the federal Office of Civil Rights. To do so 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
TTY: 1-303-844-3439

If You Disagree with a Decision by Medicaid or HMK Plus

You may act for yourself or for someone else, for one of the reasons listed below.

If you are denied Medicaid or HMK Plus eligibility: There is a form you may use to request a fair hearing on the back of the notices that are sent out by the Office of Public Assistance. You may also call the Montana Public Assistance Helpline at 1-888-706-1535 to find out why you were denied eligibility.

If Medicaid or HMK Plus won’t pay the healthcare bill or you disagree with a decision:

If Medicaid or HMK Plus didn’t pay for a service you think they should, or you disagree with any decision, you may call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312.

You can always request a fair hearing with the DPHHS Office of Fair Hearings if you disagree with a decision on eligibility, payment of your bill, or any other adverse action taken against you. A fair hearing is an impartial administrative hearing. For information on how to request a hearing or to file a request, contact:
Department of Public Health and Human Services
Office of Fair Hearings
PO Box 202953
2401 Colonial Drive, Third Floor
Helena, MT 59620
406-444-2470
Fax: 406-444-3980
E-mail: hhsofh@mt.gov

Let Us Know How Medicaid is Working for You

We want you to be happy with your Medicaid coverage. To let us know how we are doing call the Medicaid/HMK Plus Member Help Line at 1-800-362-8312. We are here to help you with questions or problems. Talking about a problem or filing a complaint or an appeal will not affect your coverage or benefits.

Protected Health Information

The Notice of Protected Health Information is available upon request through the Medicaid/HMK Plus Member Help Line at 1-800-362-8312 or go to http://dphhs.mt.gov/.
DPHHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-406-444-1386 (TTY: 1-800-833-8503)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-406-444-1386 (TTY: 1-800-833-8503) まで、お電話にてご連絡ください。


