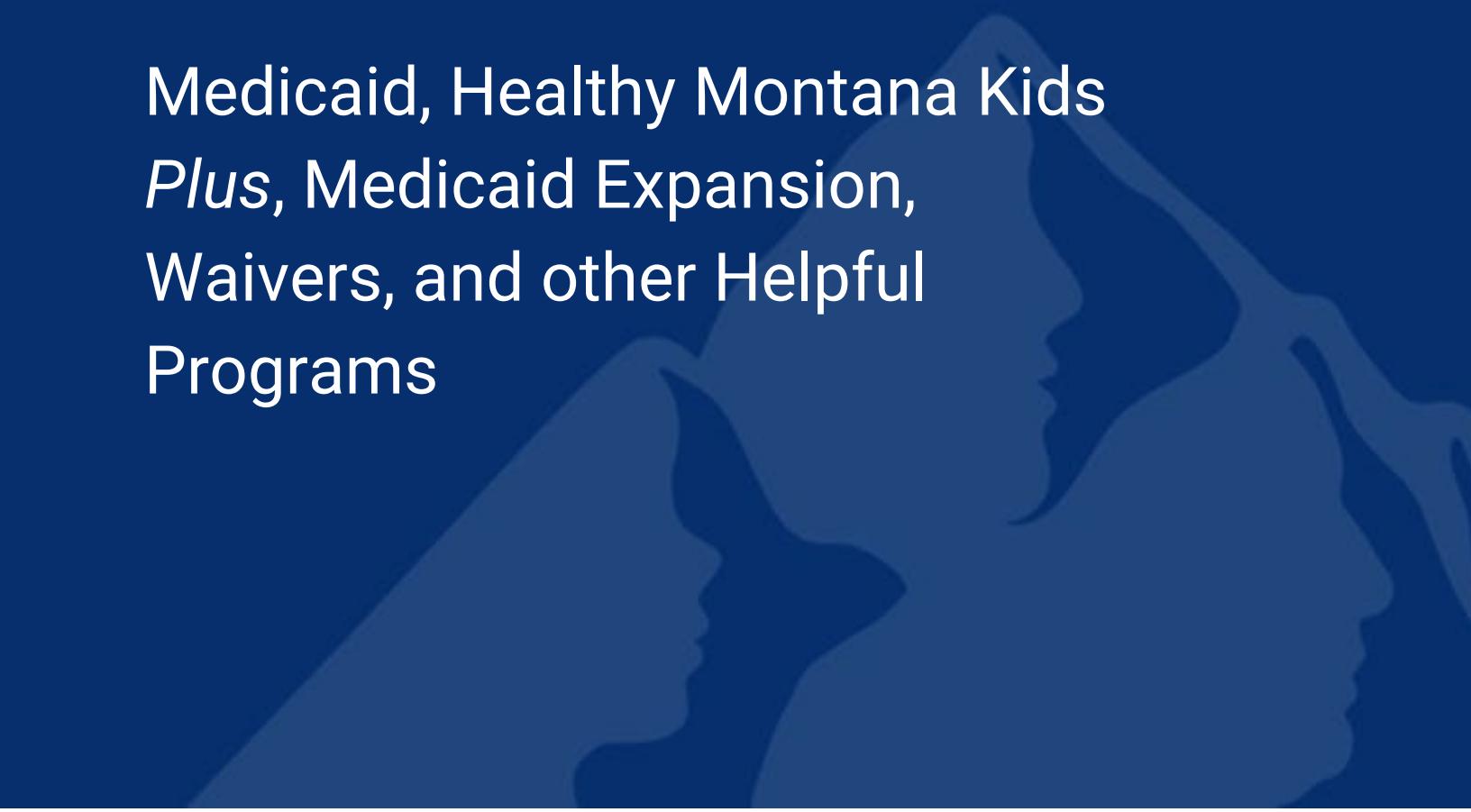
MONTANA MEDICAID MEMBER GUIDE 2026

MONTANA HEALTHCARE PROGRAMS INCLUDING:

Medicaid, Healthy Montana Kids *Plus*, Medicaid Expansion, Waivers, and other Helpful Programs



Greg Gianforte, Governor | Charlie Brereton, Director

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

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WELCOME

MEDICAID'S MISSION

To ensure necessary medical care is available to all eligible Montanans within available funding resources.

YOU MATTER

It is great to be a member of the Montana Healthcare Programs. These programs include Medicaid, Healthy Montana Kids *Plus* (HMK *Plus*), Medicaid expansion (also known as HELP), Waivers, and other helpful programs. With these programs, you can get help with most health needs. Getting and keeping you healthy is important to us.

We want to make sure you get the most out of your health care. We also want to make sure you have coverage if you are eligible. To do that, we need the most up-to-date information about you and your family. You can help us by providing the Office of Public Assistance (OPA) with the most up-to-date information. Please inform the OPA within 10 days if you have any changes in your household.

This guide will help you navigate your coverage and get the most out of your health care. Please read through this guide, it has important coverage details and contact information for these services. In this guide, you will find an explanation of your coverage and benefits. It will also let you know the rights and responsibilities of you and your providers.

ABOUT MONTANA MEDICAID AND HEALTHY MONTANA KIDS *PLUS*

MONTANA MEDICAID AND HEALTHY MONTANA KIDS *PLUS* (HMK *PLUS*)

Montana Medicaid and HMK *Plus* are health care coverage for some low-income Montanans. Medicaid and HMK *Plus* are run by the Montana Department of Public Health and Human Services (DPHHS). Applications and eligibility determinations are run by the OPA. The state pays about one-third of the cost of Medicaid and HMK *Plus* and the federal government pays the rest. These programs do not pay you. Instead, payments for health care services are sent directly to your health care providers. For Medicaid and HMK *Plus* to pay for health care:

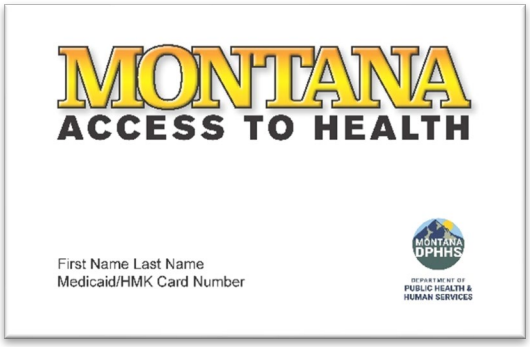
- Services must be medically needed,
- Services must be provided by a health care provider who is a Montana Medicaid or HMK *Plus* provider, and
- Services must be covered by Medicaid or HMK *Plus*.

MEDICAID, HMK *PLUS*, AND OTHER PROGRAM CARDS

Adults on Medicaid or a Medicaid program and children on HMK *Plus* will get a card in the mail. This card will read "Montana Access to Health" and will be your Medicaid insurance card. Each person will get their own card, including children. Keep your card in a safe place. **Always take your card with you to appointments and show it when you check in.**

If the information on your card is not right, tell the OPA right away. If you have not received your Medicaid card or lost your card before you need medical care, call the **Montana Public Assistance Help Line** at **(888) 706-1535.**

Keep your card even if your Medicaid, HMK *Plus*, or other Medicaid program coverage ends. If you get Medicaid, HMK *Plus,* or another Medicaid program again in the future, you will use the same card. The front of your card lists your name, your member number, and your birth date. The member number is a special number and is not your Social Security Number. The back of your card includes information about how to use the card and helpful information for your provider. You can find the **Medicaid and HMK *Plus* Member Help Line phone number, (800) 362-8312,** on the back.



CHANGES IN INCOME OR FAMILY

Tell the OPA within 10 days if you have changes in your home. You can call the Public Assistance Help Line at (888) 706-1535 or change your information online at https://apply.mt.gov. A case manager will tell you if you are still able to get Medicaid or HMK *Plus*. Some examples of changes to report include:

- Mailing address,
- Phone number,
- Marriage or divorce status,
- Moving to a nursing home,
- Getting pregnant,
- Having a baby,
- Job status,
- Insurance, or
- Assets or income.

12-MONTH POSTPARTUM CONTINUOUS ELIGIBILITY

DPHHS expanded postpartum coverage to support women after childbirth. Women can now keep their Medicaid benefits for a full 12 months after giving birth. This includes women on Montana's Medicaid, HMK *Plus*, and Healthy Montana Kids/Children's Health Insurance Program (HMK/CHIP).

If a member becomes pregnant or experiences any changes related to pregnancy, they should inform the OPA. OPA needs to know about your pregnancy or postpartum status to make sure your coverage is extended. Without this information, OPA will not be able to adjust or prolong your coverage.

MEDICAID EXPANSION

Medicaid expansion is also known as the Montana Health and Economic Livelihood Partnership (HELP) Program. It provides health care coverage to adults aged 19-64 with incomes up to 138 percent of the federal poverty level (FPL). To qualify, you must be a Montana resident. You must also be unable to get Medicare and cannot be in jail or prison.

Those on Medicaid expansion will also receive a "Montana Access to Health" card in the mail. Medicaid expansion members can get Standard Medicaid Benefits. Please see the "More Information About Standard Medicaid Benefits and Covered Services" section starting on page 33 of this guide.

Medicaid expansion members can get health services from any provider. This includes doctors, clinics, or other health care providers. The provider must accept Montana Medicaid for the services to be covered. Some services may require prior authorization. Other services may need a referral from your primary care provider.

YOUR RIGHTS AND RESPONSIBILITIES

RIGHTS

A person who has Medicaid or HMK *Plus* has the right to be treated fairly with kindness and respect. Here are some of your rights:

Privacy and Information

- You have the right to have your privacy protected.
- You have the right to discuss all information, treatment options, and outcomes that could happen. This includes discussing with your provider before saying "yes" or "no" to treatment.
- You have the right to request and receive a copy of your medical records. You also have the right to request they be changed (this request must go to the provider).
- You have the right to receive information and instructional materials. You also have the right to request additional information and materials.

Personal and Financial Rights

- You have the right to be treated with respect by providers and their staff.
- You have the right to use the services of an interpreter, if needed. This service is free for members.
- 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 be free from any form of restraint or seclusion. This could be used as a means of coercion, discipline, convenience, or retaliation.
- You have the right to choose your provider.
- You have the right to make a complaint about the Medicaid or HMK *Plus* program. You also have the right to receive a reply to your complaint.
- You have the right to know if the medical services you need are paid for by Medicaid or HMK *Plus*.

RESPONSIBILITIES

Your health care provider is your partner in staying healthy. Your job is to help your health care provider give you the best health care possible. Here is how you can help:

Know Your Benefits

- Make sure you are eligible for Medicaid.
- Learn what services Medicaid covers.

Be Respectful and Prepared

- Treat your health care providers (doctors, nurses, and staff) with respect.
- Bring your Montana Medicaid or HMK *Plus* ID card and any other insurance cards to every visit.
- Fill out and return all form requests from DPHHS and other insurance carriers on time. This includes trauma questionnaires and annual coordination of benefits requests.

Use Services Wisely

- Only use an ambulance or go to an emergency room for real medical emergencies.
- Follow Montana Medicaid's rules (policies and procedures).
- Get most of your care through your primary care provider.
- Keep appointments and call your provider before if you cannot make it.

Keep Your Information Updated

- Tell the OPA if anything changes in your life.
- Make sure your providers have your latest health information and help your provider get your prior medical records.
- Ask all providers if they take Medicaid or HMK *Plus* before you make an appointment.

- Ask all providers if they are in-network providers for any insurance companies you have an active policy with before you make an appointment.
- Tell your provider about any health changes or problems.
- Write down, or ask for a printout of, instructions for drugs, treatments, or tests.
- Make a list of questions before your appointment. Ask about risks, choices, and costs before getting treatments or prescriptions. If you do not understand what steps you need to get better, ask more questions.
- Take time to think about your choices for treatment.

Use Your Pharmacy Wisely

- Try to go to the same pharmacy for all your prescriptions.
- Ask your pharmacist questions about your medications.

Be Careful and Responsible

- Do not sign anything you do not understand.
- Use Medicaid and HMK *Plus* only when you are sick or for routine check-ups. Regular care helps prevent future illnesses.
- Assign rights from a third party to the Medicaid program. This is for medical support and payment of medical care.

If you are hurt because of someone else, tell Medicaid or HMK *Plus* within 30 days and before any agreement for any payment with the accountable party. If Medicaid or HMK *Plus* paid or may pay for medical care for trauma caused by another person, you must give details (names and addresses of your legal agent or lawyer and the person or insurance company that is accountable) to DPHHS. Call DPHHS Third Party Liabilities Program at (800) 694-3084, option seven (7).

TORT RECOVERY

A Medicaid member may need medical items or services because of trauma caused by another organization or person, who we will now refer to as a third party. Trauma could include the action, lack of action, or neglect of a third party. Examples include trauma from a motor vehicle, injury caused by a damaged product (product liability), or injury from a job. Other examples include medical malpractice and mishaps. All of these are referred to as casualty/tort cases. When this happens, the member or member's legal guardian may make a claim for payment. The claim for payment would be for medical and other losses incurred because of the injury. Claims in these cases may or may not be settled in court.

Federal law makes DPHHS recover payment from deals outside of court or court judgments (awards). This is because a third party is responsible for the cost of medical care provided to the members. DPHHS is required to take back, if possible, the full amount spent on a member's medical care from the trauma.

DPHHS may open a claim with a responsible third party on behalf of a Medicaid member, if one has not already been opened. As part of being a Medicaid member, or the

member's legal guardian, you must help with DPHHS efforts to recover Medicaid's costs for medical care related to the trauma. If these rules are not followed, it could result in loss of Medicaid for the member, or the legal guardian. Medicaid eligibility for minors is not affected by failure to follow the rules of DPHHS recovery efforts.

LIEN RECOVERY

To secure recovery of Medicaid payments made, DPHHS may place a lien on real property owned by a Medicaid recipient on a waiver or living in a nursing home or institution. Real property types include but are not limited to, residence, recreational property, farms and ranches, businesses, land with or without improvements, and life estates. The amount of the lien cannot be more than the amount Medicaid paid on behalf of the recipient.

If a lien is placed and the recipient is discharged from the facility or institution and returns home, DPHHS may release the lien based on a written request from the recipient. DPHHS will not place a lien on real property that is the recipient's home, and the home is lawfully resided in by the recipient's spouse, a child of the recipient who has been determined permanently and totally disabled by the Social Security Administration, is blind, or under 21 years of age. Additionally, heirs may retain the property by paying the lesser of the amount the State Medicaid Agency is entitled to recover, or the fair market value of the property.

DPHHS may enforce the lien after the Medicaid recipient's death, or upon the sale, transfer or exchange of the right, title and interest in the real property. In accordance with Social Security Act 1917 § (b)(1)(3)(B), no lien will be imposed on Tribal trust property and improvements to Tribal trust property (buildings or other attachments).

ESTATE RECOVERY

As required by federal law, DPHHS must get Medicaid payments made for the following members after their death:

- Members living in nursing homes,
- Members living in institutions such as the Montana State Hospital and Intensive Behavior Center, and
- Members aged 55 and older at the time they receive services paid by Medicaid.

The State Medicaid Agency may reclaim assets by filing a claim against the deceased member's estate for the amount Medicaid paid on the member's behalf. Recovery may be made from any property the Medicaid member had an interest in prior to their death. This includes both real property (real estate; land with or without upgrades) and personal property including but not limited to:

- Property that is part of the member's probate estate,
- Property that is not part of the member's probate estate,
- Property that is solely owned by the member,

- Property that the member owned jointly with another or others as a joint tenant or tenant-in-common, and
- Property transferred by Beneficiary Deed or Quit Claim Deed.

Medicaid expansion members are not subject to this unless you are a member who had long-term care, such as at a nursing home or through home and community-based services paid by Medicaid. This is required by federal law.

DPHHS will not take from Tribal trust property. This includes real property and upgrades. DPHHS will also not take income from trust resources or Tribal trust property.

QUESTIONS OR CONCERNS

WHAT IF YOU GET A BILL?

It is not common for Medicaid and HMK *Plus* to pay your provider the full amount charged for services. Your provider has agreed to accept the lower payment amount. You do not pay above the amount Medicaid or HMK *Plus* pays. Contact your provider to verify they know you have Medicaid coverage. Ask the provider to bill Medicaid for the service.

In most cases, providers will not send you a bill. This is unless you signed an Advanced Beneficiary Notice (private pay agreement) before getting services. With a signed private pay agreement, providers may bill you for:

- Services not covered by Medicaid,
- Experimental services,
- Services that are not approved,
- Covered but not medically necessary services,
- Not approved services that require a referral from your Passport provider,
- Services performed in a setting that is not approved,
- Services received when you are not eligible for Medicaid, and
- Investigational services.

You are required to pay for the service if you sign an agreement before the service is provided. Call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312 if you think any of the below is happening:

- A provider is sending you a bill and should not be,
- A provider is billing both you and Medicaid or HMK *Plus* for the same service, or
- A provider is billing you, Medicaid, or HMK *Plus* for services you did not receive.

If you have questions about a bill, 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 (800) 362- 8312.

CAN YOU GET A REPORT OF MEDICAL CLAIMS PAID BY MEDICAID?

You have the right to request a report of medical service claims paid by Medicaid. You can request this on your behalf or the behalf of a person in your custody or legal guardianship. A claims report will only be provided to the member, a member's parent, legal guardian, or another authorized person if there is a valid DPHHS release of information on file.

To request a claims report, mail a signed letter that includes the information below. You can also complete and mail a DPHHS Form No. HPS-405 to DPHHS. The mailing address is P.O. Box 202960. The DPHHS Form No. HPS-405 can be found online at https://dphhs.mt.gov/assets/hipaa/RequestForPHI.pdf. Please include the following:

- First and last name of person making the request,
- Relationship to member,
- First and last name of member,
- Member's Social Security Number (SSN),
- Member's Medicaid ID number,
- Member's date of birth (DOB),
- Date span of claims,
- Specific provider name (if applicable), and
- Address where records should be mailed.

Claims reports will be mailed within 30 days from when DPHHS receives the request.

CAN YOU GET HELP TRAVELING TO YOUR APPOINTMENT?

Medicaid or HMK *Plus* may provide travel help for you to get to and from medical appointments. See page 47 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 Medicaid or HMK *Plus* provider for an interpreter. You may also ask your case manager 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 those who speak American 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 (800) 833-8503. MTAP will give you more information about telephones with higher volume, telephones with captions, and hands-free devices. The Montana Relay service can help if you want the direct call relay service. This can help if you are deaf or hard of hearing. The number to call is 711. You can also call (800) 253-4091.

OTHER HELPFUL PROGRAMS FOR PEOPLE WITHOUT MEDICAID

72-HOUR PRESUMED ELIGIBILITY PROGRAM (FOR MENTAL HEALTH CRISIS)

The 72-Hour Presumptive Eligibility program is paid for by the Behavioral Health and Developmental Disabilities Division. This program provides mental health crisis services to people not currently enrolled in Medicaid. For more information, call (406) 444-3964.

PRESUMPTIVE ELIGIBILITY PROGRAM

Presumptive eligibility is short-term coverage for people who are not yet on Medicaid. This is available once every 12 months (or once per pregnancy). It is designed to provide short-term health care coverage.

This coverage is for people with sudden, serious health care needs while Medicaid eligibility is determined. Presumptive eligibility lasts from the date of determination until a determination of Medicaid program eligibility is made. It could also last until the last day of the month after the month of determination. This is decided by whichever happens first.

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

- Children (HMK *Plus* and HMK/CHIP),
- Pregnant women (Ambulatory Prenatal Care),
- Parent/Caretaker Relative Medicaid,
- HELP/Medicaid expansion,
- Former Foster Care Children (ages 18 up to 26), and
- Breast and Cervical Cancer.

ADDITIONAL QUESTIONS?

If you have more questions, contact your OPA. To find your local OPA, call the Montana Public Assistance Help Line at (888) 706-1535.

Passport to Health (Passport): Your Medical Home

Passport is a program that gives you a medical home.

What is a Medical Home?

A medical home means you pick one main doctor, and usually one pharmacy, for most of your health needs. The doctor becomes your partner in staying healthy. What this means for you:

- You see the same doctor when you are sick, hurt, or need a check-up.
- Your doctor gets to know you and your health history.
- You work together to make good choices about your health.
- You can get the best possible care.

Who Needs to Join?

If you have Medicaid, Medicaid expansion (HELP), or HMK *Plus*, you usually need to be part of the Passport program.

Having a medical home helps you and your doctor work as a team.
This way, you can get the care you need to stay healthy!

PASSPORT TO HEALTH (PASSPORT)

YOUR PASSPORT PROVIDER

You will get to pick a Montana Medicaid Passport provider. This can include a provider such as a physician (doctor), nurse practitioner, physician assistant, or community health center. This could also include a provider such as Tribal health, Indian Health Service (IHS), or a primary care clinic.

Your Passport provider will take care of most of your health (medical) needs. They will also refer you to other doctors if you need special care. Your Passport provider will keep your health information (medical records) up-to-date and in one place.

Remember: You should see your Passport provider for all your health visits. If you need to see another provider, ask your Passport provider first. There may be times when you can see other providers without asking. Your Passport provider can tell you more about this.

WHAT TO EXPECT FROM YOUR PASSPORT PROVIDER

Your Passport provider has agreed to several requirements. They are here to help you stay healthy. Here is what you can expect from them:

- Regular check-ups and care to keep you healthy,
- Help when you are sick or hurt,
- Referrals to special doctors if you need extra care,
- Help finding other health services you might need,
- Translator if you need one (Medicaid pays for this), and
- Care of your kids' health needs, including:
    - Regular check-ups,
    - Shots to prevent diseases, and
    - Tests to check for lead.

WHO IS NOT ELIGIBLE FOR PASSPORT?

Most people with Medicaid are part of the Passport program, but some people do not need to join. You do not have to be in 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 months,
- Eligible for Medicare,
- Receiving backdated Medicaid eligibility,
- Receiving Medicaid Home and Community-Based Services (HCBS),
- Eligible for a different Medicaid plan like the Mental Health Services Plan (MHSP) or Plan First,
- Receiving Medicaid under a presumptive eligibility program,
- Living outside of the State of Montana,
- Eligible for Pregnancy Medicaid, or
- Eligible for the Breast and Cervical Cancer program.
- HMK/CHIP program members are not eligible for Passport.

CHOOSING YOUR PASSPORT PROVIDER

You get to choose your Passport provider. This can be the same provider for everyone in your family or each person can have a different one based on their health needs. For example, parents may choose a pediatrician for their child(ren) and a family doctor for themselves. If you want to keep seeing your current provider, ask if they are a Passport provider. If they are, you may choose them.

NEED HELP CHOOSING?

If you need help picking a provider, call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312. They are available Monday through Friday from 8:00 a.m. to 5:00 p.m. and the staff can tell you about Passport providers near you. You can also choose your Passport provider online by going to: https://mtaccesstohealth.portal.conduent.com/mt/general/enrollBroker.do.

If you do not choose a Passport provider, one will be chosen for you. It is best to pick one yourself because you know what's right for you and your family. After you choose or are assigned a Passport provider, you will get a confirmation letter in the mail with the provider's name and how to contact them.

AMERICAN INDIANS AND PASSPORT

If you are American Indian, you can choose an IHS provider, a Tribal Health provider, an Urban Indian Organization (I/T/U), or any other enrolled Passport provider. American Indian members may visit I/T/U providers without a Passport referral. Medicaid and HMK *Plus* may not pay for visits to other providers unless you get a referral first. An I/T/U can also refer members to another provider even if they are not the member's Passport 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 (800) 362-8312. They are available Monday through Friday from 8:00 a.m. to 5:00 p.m. You can also do this online at: https://mtaccesstohealth.portal.conduent.com/mt/general/enrollBroker.do.

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; the date is dependent on when the change is requested.

PASSPORT REFERRALS

Your Passport provider is your main doctor or health care provider, who takes care of most of your health care needs. Sometimes, you may need to see a specialist or go to urgent care. In these cases, your Passport provider will be asked to give a referral to the specialist or urgent care. The specialist needs to have this referral before they can see you. Urgent care also needs a Passport referral. If your Passport provider is not available at the time you are seen at urgent care, they may provide the referral after.

You do not need a referral from your Passport provider for all services. To find out which services do not require a referral, check the "Benefit Chart for Standard Medicaid Benefits and Covered Services" section of this guide starting on page 21 and 22.

WHICH MEMBERS ARE EXEMPT FROM TAKING PART IN PASSPORT?

Most members with Medicaid or HMK *Plus* must choose a Passport provider. Sometimes having one provider may make it hard to get the care you need when you need it. In these cases, you may not have to choose a Passport provider. This is called an exemption. The Passport program may place time limits on all exemptions. You might not need a Passport provider if you are:

- Enrolled with a case management program through another payor,
- Participating in the Health Insurance Premium Payment (HIPP) program,

- Unable to find a primary care provider willing to provide case management,
- Living in a county where there is a shortage of primary care providers, or
- Participating in Passport would be a hardship.

If you get an exemption, it may only last for a certain amount of time. The Passport program decides how long each exemption will last. Call the Member Help Line at (800) 362-8312 for more information.

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 medical emergencies include excessive bleeding or difficulty breathing.

You can get emergency treatment without a referral from your Passport provider. If emergency treatment has been given and you still need more care, you should go to your Passport provider. This could include services like getting stitches removed.

What if you have an emergency?

You are eligible to receive Standard Medicaid Benefits. See "More information About Standard Medicaid Benefits and Covered Services" of this guide starting on page 33.

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 39.

Urgent Care

Sometimes you might need to go to urgent care when you are not feeling well. Urgent care is different from your regular Passport provider. Here is what you should remember:

- Not all urgent cares take Medicaid. Before you go, make sure they accept your Medicaid card.
- If your Passport provider is not available and you need help right away, it is okay to go to urgent care.
- After you visit urgent care, tell your Passport provider about it. They need to give you a referral. Urgent cares need a referral for your visit.

Remember your Passport provider is still your main provider, but urgent care is there when you need quick help and cannot see your regular provider.

CONCERNS WITH YOUR PASSPORT PROVIDER

If you have problems with your Passport provider, here are the steps you can take:

- Talk to your provider. Explain what the problem is and try to work it out together.
- If you are not happy with your Passport provider, you can pick a different one.
- You can call the Member Help Line at (800) 362-8312. Tell the person who answers that you are having a problem with your Passport provider and want to pick a new one.
- If needed, you have the right to file a complaint. Call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312. They are available Monday through Friday from 8:00 a.m. to 5:00 p.m.

For complaints about quality of care, contact the Department of Labor and Industry at (406) 444-2840.

IF YOU DO NOT HAVE A PASSPORT PROVIDER

If you are not required to have a Passport provider or have not chosen one yet, you can still get health care services. You can see any provider who accepts Medicaid or HMK *Plus*. Be sure to ask if the provider accepts these programs before you make an appointment. Here are some common kinds of providers you might see to receive health care:

- Physicians (doctors): This includes internists, pediatricians, obstetricians, and gynecologists.
- Mid-level practitioners: This includes physician assistants, nurse midwives, and nurse practitioners.
- Ambulatory Surgical Center: Places for outpatient surgery.
- Federally Qualified Health Center (FQHC): These centers provide care for everyone.
- Rural Health Clinics (RHC): Clinics that serve rural areas.
- County or City Health Departments: Provides local health services.
- American Indian members may visit an IHS, a Tribal Health Clinic, or a I/T/U to receive health care services without a Passport referral.

To find a Medicaid or HMK *Plus* approved provider, visit https://mtdphhs-provider.optum.com. Use the “Find a provider” button to search by type, specialty, or location.

SPECIALTY COVERED AND NON-COVERED SERVICES

This section will tell you if a service is covered by Medicaid or HMK *Plus*. For more details on non-covered services, turn to page 32. There may be other services Medicaid and HMK *Plus* will pay for that are not listed. Ask your provider if you are not sure if something is covered, has limits, or requires prior authorization. You can also call the Medicaid/HMK

Plus Member Help Line at (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 REFERRALS

Your Passport provider might not be able to do all the services covered by Medicaid and HMK *Plus*. If this happens, your Passport provider should:

1. Send you to the right health care provider for what you need, and
2. Give that provider a referral (a referral is like a permission slip. It lets Medicaid or HMK *Plus* pay for other services you need from other providers).

PRIOR AUTHORIZATION

Some Medicaid and HMK *Plus* services need approval before Medicaid or HMK *Plus* will pay for them. This is called prior authorization. Here is what you need to know:

- For transportation services call (800) 292-7114.
- For other services, talk to your Passport provider or the provider giving the service.
- You can also call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312, if you have questions.

Montana Medicaid and HMK *Plus* try to have rules for all medical services, but sometimes new treatments come out and there are no rules for them yet. When this happens, Medicaid and HMK *Plus* look at other information to decide if a service should be covered. Medicaid and HMK *Plus* might learn about new medical treatments, ask doctors what they think, or look at what other health plans do. Your member guide tells you what services Medicaid and HMK *Plus* usually cover, but it is not a promise to pay for everything. The official rules are in the Administrative Rules of Montana, which decide what gets covered and paid. Remember: If you are not sure something is covered, it is always best to ask before you get the service.

TRIBAL HEALTH IMPROVEMENT PROGRAM

Montana Medicaid operates a Primary Care Case Management entity program known as the Tribal Health Improvement Program (T-HIP). T-HIP provides care management services for eligible American Indian members who reside on a reservation. This is a voluntary program, and as a Montana Medicaid member, you have the right to opt out any time you choose. The program was created to help you understand your health care. This includes helping to coordinate services, advocating on your behalf, improving your understanding of disease management, and increasing self-management skills. Members who are eligible are contacted by T-HIP on their reservation through letters and phone calls. If you feel this program would be of benefit to you and your health, but have never received a call or letter regarding this program, you can contact the Health Resources Division at (406) 444-1292 to confirm eligibility and get connected with the local T-HIP.

DIRECT PRIMARY CARE PROVIDER

A Direct Primary Care (DPC) provider is a doctor, nurse practitioner, or physician assistant who creates an agreement with a person to provide a list of services for a monthly fee paid directly to the provider. Montana Medicaid members can go to DPC providers, and in doing so, can choose not to be a part of the Passport program.

DPC providers typically do not bill any insurance, including Medicaid. Medicaid does not pay the monthly and/or enrollment fee for the DPC provider. Members need to know they are responsible for paying their out-of-pocket fees directly to the DPC provider.

DPC providers who are enrolled in Montana Medicaid as Ordering, Referring, and Prescribing (ORP) providers can refer to other providers for services, or order prescription medications from the pharmacy that Medicaid could cover if they are considered allowable services or medications. For more information about an ORP provider, please see below.

Members who see a DPC provider and do not want to be part of the Passport program will need to fill out a form with their DPC provider. For more information on how to get the form and where to send it, members can call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312.

ORDERING, REFERRING, AND PRESCRIBING PROVIDERS

Ordering, Referring, and Prescribing (ORP) providers are doctors, nurse practitioners, or physician assistants enrolled with Montana Medicaid but do not bill the program directly for services. ORPs can refer members for services, order tests, or prescribe medications. These services or medications could be covered if allowed by Medicaid.

If a provider who is signed up with Medicaid sends a bill for services that were ordered by someone who is not signed up, the bill will be denied. Members should also know ORPs can bill them directly for the services they provide. Before getting these services, members must sign an Advanced Beneficiary Notice form that explains the cost and confirms they agree to pay for that specific service.

For more information about ORPs, members can call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312.

BENEFIT CHARTS FOR STANDARD MEDICAID BENEFITS AND COVERED SERVICES

These charts are a summary of covered service benefits. For additional details, see the “More Information About Standard Medicaid Benefits and Covered Services” section starting on page 33.

BEHAVIORAL HEALTH RELATED SERVICES

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Adult Mental Health	Mental health services provided by LCPC, LCSW, LMFT, Psychologists, and Psychiatrists. Additional services include intensive community-based rehabilitation, program of assertive community treatment, crisis stabilization, day treatment, dialectical behavior therapy, mental health outpatient therapy, peer support, community based psychiatric rehabilitation support, mental health targeted case management, hospital and partial hospitalization services, adult group home and adult foster care services, and illness management and recovery services. Explanation of services can be found at: https://dphhs.mt.gov/amdd/mentalhealthservices/index.	N/A	No	Yes, for some services.
Applied Behavior Analysis (ABA) Services	ABA is a type of therapy that can improve social, communication, and learning skills through positive reinforcement. ABA services are provided by Board-Certified Behavior Analysts (BCBA). If a member is referred for ABA services, a parent or guardian may search for a BCBA on the provider search portal here: https://mtdphhs-provider.optum.com/tpa-ap-web/?navDeepDive=MT_publicFindAProviderNew More information is on the Developmental Disabilities Program web page: https://dphhs.mt.gov/BHDD/DisabilityServices/developmentaldisabilities/ABAS/	Members must meet at least one of the following criteria: diagnosis of Autism Spectrum Disorder (ASD) and no older than 20 years of age, diagnosis of Serious Emotional Disturbance (SED) and no older than 17 years of age and no older than 20 years of age if enrolled in an accredited secondary school and meet certain functional impairment criteria, or determined eligible for state-administered developmental disabilities services and no older than 20 years of age and meet certain functional impairment criteria.	No	Yes, after initial 180 days or 1,260 units are used (whichever occurs first).

BEHAVIORAL HEALTH RELATED SERVICES CONTINUED

Benefit	Description	Limit/ Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Children's Mental Health	Mental health services provided by Licensed Professional Counselors (LCPC), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Psychologists, and Psychiatrists. Mental health services include day treatment, outpatient psychotherapy, community-based psychiatric community rehabilitation and support, comprehensive school and community treatment (CSCT), targeted case management (TCM), home support services, therapeutic foster care, mental health intensive outpatient therapy, therapeutic group home, including extraordinary needs aides, psychiatric residential treatment facility, acute inpatient services, partial hospitalization services, and therapeutic home visits if the member is in a psychiatric residential treatment facility or therapeutic group home. Explanation of services can be found at: https://dphhs.mt.gov/BHDD/cmb/childrensmentalhealthservices.	See link to Children's Mental Health Bureau website: https://dphhs.mt.gov/BHDD/cmb/	No	Yes, for some services.
Substance Use Disorder (SUD) Treatment	SUD services provided by LCPC, LCSW, or other mental health professionals with SUD in their scope. SUD treatment services include screening and assessment, medication assisted treatment, recovery support, and clinically managed low intensity residential services for substance use disorders through outpatient, residential treatment, and non-hospital inpatient treatment. Chemical dependency center (state-approved program) services include peer support, medically monitored intensive inpatient, clinically managed high-intensity residential, clinically managed low-intensity residential, partial hospitalization, intensive outpatient therapy, outpatient therapy, biopsychosocial assessment, screening, brief intervention and referral to treatment, drug testing, and targeted case management. Explanation of services can be found at: https://dphhs.mt.gov/BHDD/SubstanceAbuse/			

DENTAL SERVICES

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Dental	Dental services (exams, cleanings, X-rays, fillings, crowns, dentures, orthodontia).	Adults aged 21 and over are limited to $1,205 of denture treatment benefits annually (July 1 - June 30). Anesthesia, dentures, diagnostic, and preventative services do not count towards the annual dental limit. Some dental services, like getting a cleaning, do have limits on the number of times a member can get the service. Members should ask their dentist about service-specific limits. Adults who qualify for a type of Medicaid called Aged, Blind, and Disabled (ABD) do not have a yearly dollar limit on their dental care.	No	Yes, for some services.
Dentures	Dentures are covered if medically necessary.	Partial dentures may be replaced every five (5) years. Full dentures may be replaced every 10 years.	No	No

HOSPITAL, CLINIC, AND PHYSICIAN-RELATED SERVICES

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Ambulatory Surgical Center (ASC)	Surgical procedures performed at a licensed outpatient/same day surgery facility.	Not all procedures are covered.	Yes, for some services.	Yes, for some services.
Children's Health Care/EPSDT	Early identification and treatment of medical, dental, vision, mental health, and developmental issues for children.	Limited to children aged 20 and under.	Yes, for some services.	Yes, for some services.
Dialysis Clinic	Outpatient dialysis services provided to members who have been diagnosed with end-stage renal (kidney) disease.	Must be diagnosed by a provider as suffering from chronic end-stage renal (kidney) disease.	No	No

HOSPITAL, CLINIC, AND PHYSICIAN-RELATED SERVICES CONTINUED

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Federally Qualified Health Center/Community Health Center	Health centers that provide comprehensive services (dental, behavioral health, chemical dependency, pharmaceutical, peer support, and primary care).	N/A	Yes, for some services.	Yes, for some services.
Hospital – Inpatient	Services for members formally admitted as inpatient with an expected hospital stay of more than 24 hours.	N/A	Yes, unless pregnancy related.	Yes, unless pregnancy related.
Hospital – Outpatient	Hospital stays expected to last less than 24 hours.	N/A	Yes, unless pregnancy related.	Yes, unless pregnancy related.
Indian Health Services/Tribal Health Centers	Federal or Tribal health care services for American Indians and Alaska Natives.	Only for members of federally recognized Indian tribes and their descendants.	No	Yes, for some services.
Mid-Level Practitioners	Services provided by Physician Assistants and Advanced Practice Registered Nurses (Nurse Anesthetists, Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse Midwives).	Non-certified midwife services are not covered.	Yes, for some services.	Yes, for some services.
Physician/ Specialists	Services provided by physicians for treatment of illness, injury, primary care, preventive care, and health maintenance.	N/A	Yes, for some services.	Yes, for some services.
Podiatry	Routine podiatric care when a medical condition (such as diabetes) affecting the legs or feet requires treatment.	N/A	Yes, for some services.	Yes, for some services.
Public Health Clinic	Physician and mid-level practitioner services provided by a DPHHS designated Public Health Clinic.	N/A	Yes, for some services.	Yes, for some services.
Rural Health Clinic	Health clinics in rural areas that offer outpatient services (such as primary care and behavioral health).	N/A	Yes, for some services.	Yes, for some services.

MISCELLANEOUS SERVICES

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
MT Asthma Home Visiting Program (MAP)	Six contacts over one year with a health professional trained in asthma education, care coordination, and home environment assessments. In-person home visiting is available in over 20 counties and virtual home visiting is offered statewide.	Members must have had an emergency department visit, hospitalization, or unscheduled medical office visit for asthma or an Asthma Control Test score of less than 20 in the last year. Members with an asthma diagnosis who do not meet these requirements are still eligible for MAP with a direct referral from their health care provider.	No	No
Audiology/ Hearing Aids	Hearing aids, evaluations, and basic hearing assessments for members with hearing disorders.	Hearing aids must be ordered by a medical provider. Over-the-counter hearing aids, wax filters, wax picks, domes, and earplugs are not covered.	No	Yes, for some services.
Chiropractic	Adjustments, x-rays, and evaluations and management.	Chiropractic care is offered to children through age 20. Services must be ordered by a health care provider.	Yes	No
Diabetes Prevention Program (DPP)	Trained lifestyle coaches facilitate 16 weekly and biweekly sessions followed by six monthly sessions. DPP is a national program.	Offered to adults 18 years and older who are at risk for developing type 2 diabetes. Authorized providers must be approved by the Division of Public Health and Safety.	No	No
Diabetes Self-Management Education and Support (DSMES)	Certified diabetes care and education specialists deliver ongoing diabetes education and self-management sessions to people with diabetes. For individuals who have a documented diagnosis of type 1, type 2, or gestational diabetes, and a written referral from the treating physician or qualified non-physician practitioner.	A new referral is required for follow-up visits after one year. Individual DSMES must be provided by an accredited/recognized program with up to six units (three hours/day). Group DSMES must be provided by an accredited/recognized program with up to 12 units (six hours/day). There is no age limit and no monthly/annual limit.	Yes	No

MISCELLANEOUS SERVICES CONTINUED

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Durable Medical Equipment (DME)	Equipment or supplies to treat a health problem or physical condition.	Equipment or supplies must be ordered by a medical provider.	No	Yes, for some equipment. Call (800) 362-8312.
Habilitative Care	Habilitative services are when you require help to maintain, learn, or improve skills and function for daily living, or to prevent decline. Services may be provided in various inpatient and/or outpatient settings.	Services include, but are not limited to, physical therapy, occupational therapy, speech therapy, and professional behavioral health treatment. Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a health care professional. Applied behavior analysis for adults is excluded.	Yes, for some services.	Yes, for some services.
Home Infusion Therapy (HIT)	A full treatment program that gives medicine and support services to members who live at home, a nursing facility, or any setting that is not a hospital.	HIT is not covered if: • The medicine can be taken by mouth, a shot (in the muscle or skin), or by breathing it in (inhalation). • The medicine is not approved by the FDA. Use of the medication outside of a hospital is a health risk.	No	Yes, for most services.
Independent Diagnostic Testing Facility (IDTF)	Diagnostic testing services provided under supervision of a physician independent of a hospital.	Lab work is not covered under IDTF. The provider must enroll as an independent lab to bill lab procedures.	No	No
Independent Lab and X-Ray	Tests and imaging provided by an independent (non-hospital) lab or imaging facility.	N/A	Yes, for some services.	No
Nutrition	Nutritionist or dietician services.	Limited to children aged 20 and under. Services must be ordered by a health care provider.	Yes, for some services.	No

MISCELLANEOUS SERVICES CONTINUED

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Pharmacy	Prescribed medications (prescription or over-the-counter).	Generic drugs are required when possible. Drugs prescribed for the following are not covered: • to promote fertility, • for erectile dysfunction, • for weight reduction, and • for cosmetic purposes or hair growth.	No	Yes, for some medications.
Private Duty Nursing	Skilled nursing services for children with severe medical problems who are not in a hospital.	Limited to children aged 20 and under. Services must be ordered by a health care provider. Services do not include taking care of a child to give the regular caretaker a break (respite care).	No	Yes
Rehabilitative Care	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.	Services include, but are not limited to, physical therapy, occupational therapy, speech therapy, and professional behavioral health treatment. Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a health care professional. Applied behavior analysis for adults is excluded.	Yes, for some services.	Yes, for some services.

SENIOR AND LONG-TERM CARE SERVICES

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Big Sky Waiver (BSW)	Allows members who may otherwise need institutionalized care to live in their own homes or communities. Members work with a Case Management Team (CMT) to make a person-centered service plan for medical, social, and personal needs.	The program supports members with physical disabilities and/or older adults. Members must be Medicaid eligible and meet level of care as determined by Mountain Pacific.	No	Yes, contact Mountain Pacific at (800) 219-7035.

SENIOR AND LONG-TERM CARE SERVICES CONTINUED

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Community First Choice Services (CFCS)	Hands-on assistance with activities of daily living.	The member must meet an institutional level of care. There also must be a medical or functional need for hands-on assistance with activities of daily living. Limited to 84 hours per two-week period. Daily living activities must be delivered in the home.	No	Yes, contact Mountain Pacific at (800) 219-7035.
Home Health	Home health services provided by a licensed and certified agency.	There must be a medical need for home health services to be delivered in the member's residence, which is anywhere that normal life activities occur. A physician must certify a member is eligible for home health services and establish a plan of care which is reviewed every 60 days. Home health services are limited to 180 visits per year. DPHHS may exceed the limitation on existing covered services if its medical staff determines they are medically necessary. Home health aide services are only provided when personal care attendant services are unavailable through the personal assistance program. Home health services do not include audiology or respite. Therapy services must be provided by a licensed therapist.	No	Yes, for aide services. Contact Mountain Pacific at (800) 219-7035.

SENIOR AND LONG-TERM CARE SERVICES CONTINUED

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Hospice	Hospice is a program of care and support for people who are terminally ill and have chosen not to pursue curative treatment.	The member's doctor and the hospice medical director must certify the member is terminally ill with six months or less to live if the illness runs its normal course. The member must sign a statement choosing hospice care instead of other covered benefits to treat terminal illness.	No	No
Money Follows the Person (MFP)	Assistance moving from an institutional setting (nursing home, hospital, etc.) back into the community.	Eligible participants include those who have resided in an institutional setting (nursing home, hospital, etc.) for at least 60 days and whose care has been paid for by Medicaid for at least one of those 60 days. Participants must also be eligible for one of the Montana Waiver Partner programs (i.e., Big Sky Waiver, Severe Disabling Mental Illness Waiver, or Developmental Disability Waiver).	NO	Yes, contact Mountain Pacific at (800) 219-7035.
Nursing Home	Provides room, board, daily attendant and nursing home services, ancillary items, and some specialty care in nursing homes.	Admission requires level of care screening.	No	Yes, contact Mountain Pacific at (800) 219-7035.
Pediatric Complex Care Assistant (PCCA)	Allows limited and specific authorized skilled tasks to be performed by a licensed PCCA.	Members must be under 21 years old. Services require a physician's order and must be consistent with the member's plan of care. Services may not duplicate Private Duty Nursing, Community First Choice Services, or Personal Care Services.	No	Yes, contact Mountain Pacific at (800) 219-7035.
Personal Care Services (PCS)	Hands-on assistance with activities of daily living.	There must be a medical or functional need for hands-on assistance with an activity of daily living to qualify for services. There is a limit of 80 hours per two-week period. Activities of daily living must be delivered in the home.	No	Yes, contact Mountain Pacific at (800) 219-7035

TRANSPORTATION SERVICES

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Ambulance for Emergency Services	Emergency ground or air transport.	If the transport is denied as not medically necessary, you will be responsible for the bill.	No	No
Non-Emergency Medical Transportation (NEMT)	Transportation is covered to and from the member's appointment. The transportation method is based on the member's medical needs. NEMT includes commercial transportation, such as a taxi or bus.	NEMT is available when members have no other way of getting to their appointment, and it must be to a covered Medicaid service.	No	Yes, call (800) 292-7114 before traveling.
Per-Diem	Meals and lodging are covered when the member must remain overnight when accessing Medicaid covered services.	Coverage of meals begins on the second day of the member's stay.	No	Yes, call (800) 292-7114 before traveling.
Personal Transportation	Reimbursement for personal (family, friend, or private car) gas mileage.	For transportation to the site of a medical service or provider closest to where the member is located.	No	Yes, call (800) 292-7114 before traveling.
Specialized NEMT	Specialized NEMT includes scheduled non-emergency use of ambulances and wheelchair-lift or stretcher vans.	Specialized NEMT is limited to people with disabilities.	No	Yes, call (800) 292-7114 before traveling.

VISION-RELATED SERVICES

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Optometric/ Opticians	Eye exams, diagnosis, and treatment of eye diseases.	Members can get one eye exam every year (once every 365 days).	No	No

VISION-RELATED SERVICES CONTINUED

Benefit	Description	Limit/Exclusion	Passport Referral Needed?	Prior Authorization Needed?
Eyeglasses	Corrective lenses and/or frames to aid and improve vision.	Members can get one pair of glasses every year (one every 365 days). Eyeglass frames must be Medicaid-approved. For adults (over age 20) Medicaid does not pay for some extra features for lenses. This includes: • Lenses that change color in the sun (photo-grey or transition lenses). • Lenses that have no visible line between prescriptions (progressive or no-line bifocals). • Tints (colored lenses), except for a light rose color. • Extra coatings like shatter-resistant (polycarbonate) or ultra-violet (UV) coating. Contact lenses are covered only when medically necessary. They are not covered for cosmetic reasons.	No	Some features may require prior authorization.

NON-COVERED SERVICES

Standard Medicaid does not pay for some medical and non-medical services. Here are some examples:

- Adult chiropractic,
- Acupuncture,
- Naturopathic treatments,
- Dietician services, for members aged 21 and over unless participating in the DPP or DSMES program(s),
- Services provided by surgical technicians who are not physicians or mid-level practitioners,
- Massage therapy,
- Dietary supplements,
- Homemaker services,
- Home remodeling or car repairs/modifications,
- Childbirth services not provided in a licensed health care facility or nationally accredited birthing center (except for emergencies or an approved home birth with a midwife),

- Sterilization reversals,
- Experimental, unproven, and investigational services,
- Services provided in an unapproved setting,
- Invasive medical procedures for weight loss (gastric bypass, gastric banding, or bariatric surgery), and
- Circumcisions without approval.

Remember, this list does not include everything. There are other services Medicaid might not cover. Talk with your provider first before agreeing to treatment to make sure it is covered.

MORE INFORMATION ABOUT STANDARD MEDICAID BENEFITS AND COVERED SERVICES

This section includes examples of Standard Medicaid benefits. If you are on Medicaid, Medicaid expansion (HELP), or HMK *Plus,* you receive the Standard Medicaid benefit. Not all services are listed. Not all details about each service are shown.

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

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

APPLIED BEHAVIORAL ANALYSIS (ABA) SERVICES

ABA is a type of therapy that uses positive reinforcement. It aims to improve social, communication, and learning skills. This therapy is provided by a licensed Board-Certified Behavior Analyst (BCBA). ABA services include:

- Assessment,
- Treatment plan development, and
- Service delivery by a Registered Behavior Technician and supervision by a BCBA.

ABA services generally occur face-to-face. They can be offered in the home, community, or an office setting. The services may also be delivered individually or to two or more people at the same time. Training and support may also be provided to parents, guardians, or caregivers. To learn more about ABA services, please visit: https://dphhs.mt.gov/BHDD/DisabilityServices/developmentaldisabilities/ABAS/index.

ALCOHOL AND OTHER DRUG TREATMENT (SUBSTANCE USE DISORDER)

There are several kinds of alcohol and drug treatment services. Services must be ordered by a licensed health care professional trained in substance use disorder treatment services. They must also be provided by a substance use disorder (SUD) program

approved by Medicaid. Treatment must be medically necessary. These include:

- Medically monitored inpatient (non-hospital),
- Clinically managed residential,
- Partial hospitalization (day treatment),
- Intensive outpatient,
- Screening and assessment,
- Individual, group, and family counseling,
- Targeted case management (adult and youth),
- Drug testing, and
- Peer support.

Some services require prior authorization.

MONTANA ASTHMA HOME VISITING PROGRAM (MAP)

MAP provides free asthma education. This can be provided to anyone with asthma that is not controlled. Examples of topics covered include:

- What is asthma?
- How to control your asthma.
- How to avoid asthma triggers.

MAP was developed based on medical guidelines and research from the Centers of Disease Control and Prevention (CDC). The program includes six interactions with a trained health care provider over the course of one year. During these, participants receive:

- Personalized asthma education,
- Home environmental assessment to identify possible asthma triggers, and
- Incentives including a spacer for medication administration, a High Efficiency Particulate Air (HEPA) air purifier, and replacement HEPA filters.

MAP is free to all eligible Montanans and is not covered by Medicaid. Virtual visits are available in all 56 counties. For more information and to register for the program, go to this website: https://dphhs.mt.gov/publichealth/asthma/asthmahomevisiting.

BREAST PUMPS

Members who are at least 28 weeks pregnant or breastfeeding can receive one breast pump per pregnancy. To order a double electric breast pump, you must complete a two-part process:

1) The mother must see her health care provider. The provider will fax Medicaid a prescription for the pump, and
2) The mother must visit https://aeroflowbreastpumps.com/montana-medicaid and complete the order form online.

CASE MANAGEMENT (TARGETED)

Targeted Case Management is help for members who need extra support with their health and daily life. It is having a helper, called a case manager, who knows about different services and can connect you to the right ones. The case manager works with you to figure out what you need and helps you get it.

This help is for specific groups of people who might need more support than others. Here are the groups who can get this help:

- Women with high-risk pregnancies up to 12 months after end of pregnancy,
- Adults (18 years and older) with very serious mental health conditions also known as severe disabling mental illness (SDMI),
- People with developmental disabilities who are 16 or older or enrolled in the 0208 Waiver for people with intellectual or developmental disabilities,
- Kids and teens up to age 17 (or age 20 if still in high school) with serious emotional problems,
- Kids up to age 18 with special health care needs,
- Kids and adults with substance-use-related disorders, and
- Kids under 18 with serious emotional problems who are in special treatment homes (psychiatric residential treatment facility or therapeutic group home).

If you are in one of these groups, you might be able to get this help. It can make dealing with health issues easier. This help can include:

- Finding the right doctors,
- Getting to appointments,
- Understanding your health needs, and
- Making sure you get the care you need.

CHILDREN'S HEALTH CARE (EPSDT)

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

Early and Periodic Screening means:

- Taking your child to the doctor regularly,
- Getting check-ups, even when they are healthy,
- Seeing the doctor when they are sick, and
- Finding health problems early.

Diagnosis and Treatment mean:

- If the doctor finds a problem, they will figure out what it is,
- Your child will get the care they need, and
- If your doctor says your child needs treatment (medically needed), it is covered.

Regular check-ups help make sure your child is growing well and staying healthy. It is important to find and treat problems early to ameliorate (make something better) any

health issues before they become serious.

If you think your child isn't getting the care they need, call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312.

CHIROPRACTIC SERVICES

Chiropractic services are for kids/children, aged 20 and younger. Adult chiropractic services are not a covered service of Medicaid. Adults who are in the Qualified Medicare Beneficiary (QMB) program (helps people with low-income pay for their health care costs), may qualify for payment of the copayment, coinsurance, and deductible reimbursement for chiropractic services.

For kids 20 and younger:

- Medicaid covers chiropractic care including:
  - Spine adjustments,
  - X-rays, and
  - Check-ups and treatment plans.

For adults:

- Medicaid does not cover chiropractic care, and
- If you are a Qualified Medicare Beneficiary, you may have help paying for some of the cost.

CIRCUMCISION

Medicaid might pay for a circumcision if it is needed for health reasons. Ask your doctor if you want to know more.

COMMUNITY FIRST CHOICE SERVICES (CFCS)

This type of care is chosen with each member in a person-centered manner. It is dependent upon specific needs and living situations. Services available through the CFCS 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, such as grocery shopping, housekeeping, laundry, community integration, yard hazard removal for providing safe access and entry to the home, and correspondence assistance,
- Personal emergency response system 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 aged 20 and under. These must be prior authorized.

DENTAL SERVICES

Most routine dental services are covered for members with Standard Medicaid and HMK *Plus* (children through age 20).

Kids/Children 20 and Under:

- Can get their teeth checked and cleaned as often as they need.
- Should visit a dentist by their first birthday. They should also visit at least once every six months after the first tooth comes in.
- During a well-child checkup, providers should do an oral exam. This should include the application of fluoride varnish if needed.
- Bridges and tooth-colored crowns are available.
- Dentures are covered.
- Kids do not have a limit on how much, or how often, they can get dental care each year.

Adults with Standard Medicaid Benefits:

- Adults aged 21 and older are limited to $1,205 of dental treatment benefits annually (July-June). Adult members are responsible to pay for non-covered dental services and any dental treatment services above this limit.
- 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 (ABD) Medicaid are not subject to the annual dental treatment limit. However, service limits may apply.
- Can have dental exams and cleanings every six months.
- Can have basic treatment services, such as fillings and extractions, up to the $1,205 limit per year.
- Can get two porcelain crowns per calendar year.
- Dentures (see next section).

Dentures for Adults:

- Dentures are covered for adults.
- Partial dentures may be replaced if the dentures are five years old or older.
- Full dentures may be replaced if the dentures are ten years old or older.
- One lost pair of dentures in a person's lifetime is covered.

DIABETES PREVENTION PROGRAM (DPP)

The National Diabetes Prevention Program is an evidence-based public health program. It supports healthy lifestyle changes for adults who are at risk of developing type 2

diabetes. Trained lifestyle coaches deliver the program through several organizations across the state. DPP is a covered service through Montana Medicaid if provided by a Montana Medicaid provider. That provider must be authorized through the Montana Public Health & Safety Division. For more information visit: https://diabetes-prevention-mtdphhs.hub.arcgis.com/

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES)

DSMES is a way to continually learn about diabetes and get tips on how to better manage it yourself. DSMES includes activities that assist a person in changing and keeping the behaviors learned. This is needed for a person to manage his or her condition on an ongoing basis. DSMES is provided by Certified Diabetes Care and Education Specialist (CDCES). CDCES are trained to support individuals who have been diagnosed with type 1, type 2 or gestational diabetes. This is a covered service through Montana Medicaid if provided by a Montana Medicaid provider. For more visit: https://diabetes-self-management-education-services-mtdphhs.hub.arcgis.com/.

DIALYSIS

Dialysis is a medical process to temporarily purify the blood for people in renal (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 needs prior authorization, talk to your pharmacist or your health care provider. Medicaid usually pays for a 34-day supply. You may get a 90-day supply of some drugs you take all the time. This could include drugs for heart disease, 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)

Some over-the-counter drugs are covered if they are prescribed to you by your health care provider. A list of these drugs can be found on the pharmacy provider web page at https://medicaidprovider.mt.gov/19 under the "Over-the-Counter" tab.

Nursing homes pay for over-the-counter laxatives, antacids, and aspirin for their residents.

DURABLE MEDICAL EQUIPMENT (DME)

Some medical equipment, otherwise known as Durable Medical Equipment (DME), are covered. Some services require prior authorization. For more information about equipment coverage or prior authorization requirements, please talk to your medical provider, your DME supplier, or call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312.

EMERGENCY SERVICES

Emergency services are covered. An emergency means the symptoms or condition (medical or behavioral), are severe enough that a person with an average knowledge of health and medicine would expect there might be danger. This includes the belief there will be danger to the health or 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. They also must be 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. 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 aged 20 or under, or
  - you have a brace, or a device attached to your shoe(s).

GROUP MEDICAL VISITS

A provider may see many members 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.

HEALTH COACHES FOR HYPERTENSION CONTROL (HCHC)

Health Coaches for Hypertension Control (HCHC) is an evidence-based program geared toward improving blood pressure control. The HCHC program is an eight-week course for people with high blood pressure who want to take an active role in their health. Topics covered over the length of the program include blood pressure basics, nutrition, exercise,

stress management, tobacco cessation, medications, the use of a home blood pressure monitor and goal setting. Participants are given a home blood pressure monitor and other educational materials. The class is free. For information, including locations of the class, please visit:
https://storymaps.arcgis.com/stories/b972f7ba066c497e8614ad9c855321ff

HEARING AIDS

Hearing aids, repairs, and some related items are covered. To see if you qualify for hearing aids, your physician must refer you to an audiologist who is a Medicaid provider. The audiologist will perform tests and request prior authorization.

Some items might not be covered by Montana Health Care Programs and include the following:

- Over-the-counter hearing aids,
- Wax filters,
- Domes,
- Wax picks, and
- Ear plugs.

HOME AND COMMUNITY-BASED WAIVER SERVICES (HCBS)

Members who may be eligible for HCBS waivers are:

- Members with a physical disability(s),
- Members who are elderly,
- Members with a brain injury,
- Members with 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 that may be available in one or more of the HCBS waivers:

- 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,
- Community-based psychiatric rehabilitation and support,
- Homemaking,
- Private nursing,
- Adult daycare,
- Adult group and foster home,
- Specialty trained attendant care,
- Service animals,

- Home delivered meals,
- Respite care,
- 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:

- Big Sky Waiver (Elderly and/or Physically Disabled Waiver) (406) 444-4077
- SDMI Waiver (406) 444-3964
- Developmentally Disabled Waiver (406) 444-2995

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. The cost of the person who comes to your home to give you drug treatment is also covered. Services must be prior authorized.

HOME HEALTH SERVICES

Home Health Services are intermittent, part-time nursing, and restorative therapy services. They are 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. This is done by providing skilled nursing or therapy services in the home. Covered services include:

- Intermittent, part-time care in your home from a skilled nurse.
- Home health aide care services for a short, definite time period to assist in the activities of daily living. This can include the 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.
- Medical equipment, appliances, and medical supplies.

HOSPICE

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

HOSPITAL SERVICES

Services 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 have prior authorization before you go to the hospital. For more information about hospital services, call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312.

IMMUNIZATIONS

It is important for children to visit a primary care 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.

The child's provider will know which immunizations the child should have 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 health care provider. You will need this record when the child starts daycare, school, and college.

Medicaid has adopted the American Academy of Pediatrics Bright Futures Periodicity Schedule. The full national schedule can be found here: https://www.aap.org/en/practice-management/bright-futures.

INTERPRETER SERVICES

Interpreter services will be provided if you are not a comfortable English speaker. These 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 use interpreter services.

LEAD SCREENING

Blood lead testing is covered by Medicaid and HMK *Plus*. The symptoms of lead poisoning are not always noticed. This means blood lead testing is the only way to confirm exposure.

HMK *Plus* children should be tested for lead poisoning at 12 and 24 months of age. Kids 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 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.

Some services require prior authorization.

MENTAL HEALTH SERVICES FOR CHILDREN

HMK *Plus* covers these mental health services for children:

- Individual, group, and family counseling,
- Outpatient mental health assessments,
- Acute inpatient hospital services,
- Partial hospitalization services,
- Targeted case management,
- Day treatment services,
- Psychological testing,
- Community-based psychiatric rehabilitation and support,
- Comprehensive school and community treatment,

- Therapeutic group home,
- Extraordinary needs aide if in a group home,
- Home support services,
- Therapeutic family and foster care,
- Psychiatric residential treatment facility,
- Therapeutic Home Visit while in a Psychiatric Residential Treatment Facility or Therapeutic Group Home, and
- Mental Health Intensive Outpatient Therapy.

Some services require prior authorization.

MIDWIFE HOMEBIRTHS

Montana Medicaid allows eligible members to have home birthing options. To be eligible for a home birth, it must be determined there is a low risk of adverse birth outcomes. Approved home births are those attended by a certified nurse midwife or direct entry midwife as licensed under Montana law. Please contact your provider for more information.

MONEY FOLLOWS THE PERSON

Montana's Money Follows the Person (MFP) is a grant-funded project through the Centers for Medicare and Medicaid Services (CMS). MFP has been authorized through 2027. MFP assists seniors and members with disabilities. It helps them move out of institutional settings (nursing home, hospital, etc.) and back into their communities.

Members who are eligible must have resided in an institutional setting for at least 60 days. They must also have had their care paid for by Medicaid for at least one of those 60 days. Members must also be eligible for one of the Montana Waiver Partner programs. This could include the Big Sky Waiver, Severe Disabling Mental Illness Waiver, or Developmental Disability Waiver.

MFP assists members with their transition into the community by providing services that remove barriers. These can include, but are not limited to:

- Payment of the move in deposit and utility deposits, when necessary.
- Help with past housing fees (such as utility bills, etc.).
- Purchase of household goods and services. This can include (limited) basic household furnishings, bedding, kitchenware, etc.
- Environmental and/or vehicle modifications.

Members must transition to an MFP-qualified residential setting. Such housing options include:

- A home owned or leased by a member or their family.
- An apartment with an individual lease and secure access. It also must have a living, sleeping, bathing, and cooking area where a member or their family has control.

- A community-based residential setting such as a group home. This can have a maximum of four unrelated people (excluding caregivers or personal attendants).

To make a referral or for more information, please contact Money Follows the Person:

- Email MoneyFollowsThePerson@mt.gov,
- Call (406) 439-6870,
- Fax (406) 655-7646, or
- Submit a secure referral form via the Money Follows the Person website at https://dphhs.mt.gov/sltc/mfp.

NURSING HOMES

Covered services include:

- A shared room (or a private room if your provider says it is 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 get. The nursing home will know which services need prior authorization. Admission to a nursing home requires a level of care screening. Contact Mountain Pacific at (800) 219-7035.

OB (OBSTETRIC) SERVICES

Medicaid covers routine care during pregnancy. It also covers individual and group prenatal visits and postpartum checkups for the mother after she gives birth.

A baby's delivery must be in a licensed hospital or birthing center to be covered. The delivery will also be covered if it is an approved midwife homebirth. For group prenatal visits, please check with your health care provider for additional information. Not all health care providers offer this service.

OUT-OF-STATE SERVICES

You may need to get medical services outside of Montana. This includes:

- If you have an accident, crisis or something that cannot wait until you are 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.
- Services received outside the United States, including Canada or Mexico, are not covered.

PEDIATRIC COMPLEX CARE ASSISTANT SERVICES (PCCA)

PCCA services support members under 21 with medically complex needs by paying a parent, guardian, family member, kinship care, or foster care provider who elects to become a licensed PCCA. Services include:

- Medication Administration,
- Tracheostomy Care (routine care, suctioning, emergency ventilation, and tube placement),
- Enteral Care and Therapy,
- Airway Clearance (includes oral suction and device setup and cleaning), and
- Additional Tasks (ostomy, central line, IV fluid, and oxygen management, including CPAP/BIPAP/ventilator support per regulatory rules).

Note: PCCA does not duplicate health maintenance activities available under CFCS. Certified Nurse Aide (CNA) is not a reimbursable service under PCCA but may be covered elsewhere. Medical complexity may allow for bowel, bladder, and wound care under PCCA, but in most cases, these services may be covered elsewhere.

PERSONAL CARE SERVICES (PCS)

PCS are in-home services provided for seniors and persons who are disabled. PCS provides hands-on assistance with ambulation, exercise, bathing, dressing, eating, hygiene, meal preparation, laundry, light housekeeping, medical escort, medication reminders, shopping for essentials, toileting, and transfer assistance. Additional services that may be available under the Self-Directed option include medication administration, bowel care, urinary system management, and wound care.

RESPIRATORY (BREATHING) THERAPY

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

SCHOOL-BASED SERVICES

Children can get some HMK *Plus* services at school. These 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

THERAPY MANAGEMENT FOR DRUGS

Montana Medicaid covers shared drug therapy management services. They must be provided by a Clinical Pharmacist. Please see your health care provider for additional information. Not all health care providers offer this service.

TOBACCO AND SMOKING

Tobacco cessation products and counseling are covered by Medicaid. Talk to your health care provider or call the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312 for more information.

The Montana Tobacco Quit Line is a free service for all Montanans. The Quit Line helps Montanans quit cigarettes, chew, cigars, and e-cigarettes. The Quit Line offers free counseling and free Nicotine Replacement Therapy (patches, gum, or lozenges). The Quit Line has special programs for pregnant and post-partum women, American Indians ((855) 5AI-QUIT), and for youth under 18 (My Life My Quit, (855) 891-9989). Call the Montana Tobacco Quit Line at (800) QUIT-NOW or visit quitnowmontana.com.

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 appointment you are traveling to must be covered by Medicaid or HMK *Plus*. To be eligible, you must have no other way of getting to the appointment.

There are different rules and reimbursement rates for different kinds of transportation. Transportation types can include commercial transportation (taxicabs and buses), specialized transportation (wheelchair or stretcher-accessible vans and non-emergency ambulances), and personal transportation (family, friend, or your own private car).

The following are some of the rules used to decide if travel funds will be given:

- You must be eligible for Medicaid or HMK *Plus* on the date of the medical appointment and transportation.
- All transportation must be approved before you go, and if your appointment is changed, you must get your transportation approved again. Call (800) 292-7114 for approval.
- You must use the least costly way to travel that still meets your needs.
- You must travel to your closest approved provider.

- Travel funds can be provided for out-of-town or out-of-state services if the service is not available near you.

If you used a personal vehicle for emergency travel, you must call (800) 292-7114 within 30 days of the emergency to be considered for payment. Be sure to call the Medicaid Transportation Center at (800) 292-7114 before you arrange any travel. Reimbursement is made 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.

VISION AND EYEGLASS SERVICES

Medicaid adults and Healthy Montana Kids *Plus* children are eligible for eye exams and eyeglasses. See specifics of benefits for adults and children below:

- Frequency
  - You can get one eye exam every year (once every 365 days).
  - You can get one new pair of eyeglasses every year (once every 365 days).

- Adults (Aged 21 and older)
  - Vision Change: If you have a change in your prescription, Medicaid will only pay to replace the lenses in your current frames.
  - Lost, Stolen, or Broken Glasses: If your eyeglasses are lost, stolen, or broken, Medicaid will not pay for a replacement.

- Children (Aged 20 and younger)
  - Lost, Stolen, or Broken Glasses: If your eyeglasses are lost, stolen, or broken, you are eligible for one replacement. The replacement does not include any extra features on your old eyeglasses. You are responsible for paying for the additional features.

- Where to Get Eyeglasses
  - Medicaid uses one company (a sole vendor) to provide eyeglasses. You should check with your provider to make sure they work with the Medicaid eyeglass provider. If they do not work with the Medicaid eyeglass provider, you will need to find a provider who does.
  - Eyeglasses must be ordered and given to you by an enrolled eye doctor (optometrist or ophthalmologist).

- Services
  - The Benefit Chart for Standard Medicaid Benefits and Covered Services (starting on page 21 and 22) is a list of covered and non-covered vision services.
  - If you choose to receive non-covered items, you are responsible for paying your provider who is ordering your glasses.

- Contact lenses are covered only when medically necessary. They are not covered for cosmetic reasons.

WELL-CHILD CHECKUPS

Children aged 20 and under need regular check-ups (well-child visits). When you call for an appointment, say it is for a well-child visit. This helps doctors plan enough time for your child.

During a well-child visit, your child will get:

- Head-to-toe unclothed physical exam,
- Eye check,
- A mouth check by the provider, and if needed, they may put a special liquid on their teeth to keep them healthy (this is called fluoride varnish),
- Hearing check,
- A talk about food and eating,
- Checks to see how your child is growing and learning,
- Blood and pee tests, if needed,
- Shots (immunizations), if needed,
- A check on how your child talks, and
- A test for lead at ages 1 and 2 (or up to 6 years if not done before).

The doctor will also teach you about keeping your child healthy. If they find any problems, they might send you and your child to another doctor for more help.

Remember:

- Take your child to a dentist by their first birthday, and
- See a dentist every six months after their first tooth comes in.

You can also ask for a well-child check-up when your child is sick or hurt.

MORE HELPFUL PROGRAMS

ASSISTANCE FOR MEMBERS WITH MEDICARE

If you have Medicare and Medicaid, most of your health care costs are paid by Medicare. Medicaid may help with costs that Medicare does not 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 these at the OPA. For Medicaid members eligible for these programs (listed below), Medicaid may pay:

- Qualified Medicare Beneficiary Program (QMB) – a portion of your Medicare Part A and B monthly premium, coinsurance, and deductibles.
- Specified Low-Income Medicare Beneficiary Program (SLMB) – a portion of your

Medicare Part B monthly premium.
- Qualifying Individual Program (QI) – a portion of your Medicare Part B monthly premium.

An additional program, Big Sky Rx, may pay for all or part of your Medicare drug plan monthly premium. This is a state-funded program run by DPHHS. Big Sky Rx is for people who have Medicare and do not qualify for Medicaid, or the Medicare Savings Programs listed above. You can get more information about Medicare and related services from the State Health Insurance Assistance Program (SHIP) at (800) 551-3191.

For more information about Big Sky Rx, call (866) 369-1233 or visit https://dphhs.mt.gov/SLTC/aging/BigSky.

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

The Health Insurance Premium Payment Program (HIPP) is a Medicaid program that may pay for group or individual health plan premiums. These must be deemed "cost effective" by the HIPP program.

Medicaid and HMK *Plus* members can carry multiple health coverages without any impact to their Medicaid eligibility. Members with Medicare or HMK/CHIP coverage are not eligible for the HIPP program. Here are some ways you may be eligible for HIPP:
- You have insurance either through your job, university, or through an individual health care policy,
- Your job or university offers insurance, but you have not signed up because it costs too much, or
- You had insurance through your job, but you are no longer working and cannot pay the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage premiums.

For more information about HIPP, call (800) 694-3084 and press nine when prompted.

PLAN FIRST

If you lose, or are not eligible for Medicaid or HMK *Plus*, family planning services may be paid by Plan First. It is a separate Medicaid program that covers family planning services for eligible women. Some of the services covered by Plan First 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, aged 19 through 44,
- Able to bear children and not presently pregnant,
- Annual household income up to and including 211 percent FPL, and
- Not enrolled in Medicaid.

To apply or for more information visit the Plan First Website at

https://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst.

WAIVER FOR ADDITIONAL SERVICES AND POPULATIONS

The Waiver for Additional Services and Populations (WASP) provides Standard Medicaid benefits for individuals who qualify for or are enrolled in the MHSP. They must be 18 or older, have SDMI, and are otherwise ineligible for Medicaid benefits.

WASP also covers additional dental services above the $1,205 State Plan treatment cap. To receive this, you must be determined categorically eligible for Medicaid in the ABD category.

To apply or for more information contact the Behavioral Health and Developmental Disabilities Division at (406) 444-3055. You can also email icoy@mt.gov or visit https://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/Medicaid1115Waiver.

GRIEVANCES AND APPEALS

IF YOU EXPERIENCE DISCRIMINATION

DPHHS may not exclude, deny benefits to, or otherwise discriminate against any person. This includes discrimination based on:

- Race, color, national origin, culture, social origin or condition, or ancestry,
- Age,
- Physical or mental disability,
- Marital status, gender, sexual orientation, or genetic information,
- Political belief, creed, or religion, or
- Veteran status.

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

To file a complaint for discrimination, forms are available by request by calling the Medicaid/HMK *Plus* Member Help Line at (800) 362-8312. You can also go online: https://dphhs.mt.gov/NondiscriminationPolicy or contact:

Complaint Coordinator
Phone: (406) 444-4211
V/TTY: (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 08-148
Denver, CO 80294

Phone: (303) 844-7815
TDD: (800) 537-7697

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 sent out by the OPA. You may also call the Montana Public Assistance Help Line at (888) 706-1535 to find out why you were denied eligibility.

If Medicaid or HMK *Plus* will not pay the health care bill or you disagree with a decision:
If Medicaid or HMK *Plus* did not 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 (800) 362-8312.

You can always request a fair hearing with the DPHHS Office of Administrative 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:

DPHHS
Office of Administrative Hearings
PO Box 202922
Phone: (406) 444-2470
Fax: (406) 444-6565

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 (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 (800) 362-8312. You can also visit https://dphhs.mt.gov/.

RESOURCES

Organization or Services	Website	Phone Number
Aging Services	https://dphhs.mt.gov/sltc/aging/	(800) 551-3191
AIDS or Sexually Transmitted Diseases	https://dphhs.mt.gov/publichealth/hivstd/	(406) 444-3565
Child Abuse and Neglect	https://dphhs.mt.gov/cfsd/	(866) 820-5437
Child Support Customer Service	https://dphhs.mt.gov/cssd/	(800) 346-5437
Childhood Lead Poison Prevention Information	https://dphhs.mt.gov/publichealth/cdepi/diseases/Lead	(406) 444-0340
Children's Special Health Services	https://dphhs.mt.gov/ecfsd/cshs/	(800) 762-9891
Citizen's Advocate (Governor's Office)	(no website available)	(406) 444-3468
Elder Abuse Information (Adult Protective Services)	https://dphhs.mt.gov/SLTC/aps/index	(844) 277-9300
Legal Services	https://www.montanalawhelp.org/	(800) 666-6899
DPHHS Language Assistance Services	https://dphhs.mt.gov/languageassistance	(800) 368-1019
Medicaid Breast Pumps	https://aeroflowbreastpumps.com/montana-medicaid	(844) 867-9890
Medicaid Fraud Line	https://dphhs.mt.gov/MontanaHealthcarePrograms/fraudandabuse	(800) 201-6308
Medicaid/HMK *Plus* Member Help Line	(no website available)	(800) 362-8312
Medicaid Transportation	https://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/MontanaHealthcareTransportation	(800) 292-7114
Medicare	https://www.medicare.gov/	(800) 633-4227
Medicare Prescription Assistance Programs (Big Sky Rx)	https://dphhs.mt.gov/SLTC/aging/BigSky	(866) 369-1233
Mental Health Ombudsman	https://mhombudsman.mt.gov/	(888) 444-9669
Mental Health Services for Adults	https://dphhs.mt.gov/BHDD/mentalhealthservices/index	(888) 866-0328
Mental Health Services for Children/Youth	https://dphhs.mt.gov/BHDD/cmb/	(406) 444-5978

Montana Public Assistance Help Line (OPA)	https://dphhs.mt.gov/hcsd/officeofpublicassistance	(888) 706-1535
National Alliance on Mental Illness-Montana Chapter	http://www.namimt.org/	(406) 443-7871
National Domestic Violence Hotline	https://www.thehotline.org/	(800) 799-7233
Poison Control	https://dphhs.mt.gov/publichealth/EMSTS/prevention/poison	(800) 222-1222
Senior and Long-Term Care Community Services Programs	https://dphhs.mt.gov/SLTC/csb/	(406) 444-4077
Social Security Administration	https://www.ssa.gov/	(800) 772-1213
Substance Abuse Treatment	https://dphhs.mt.gov/BHDD/SubstanceAbuse/index	(406) 444-3964
Suicide Prevention	https://dphhs.mt.gov/suicideprevention/suicideresources	Call, text, or chat 988 or call (800) 273-8255 or text "MT" to 741-741
Teen Dating Abuse Help Line	https://www.loveisrespect.org/	(866) 331-9474
Tobacco Quit Line	https://dphhs.mt.gov/publichealth/mtupp	(866) 485-7848
WIC Nutrition Information	https://dphhs.mt.gov/ecfsd/wic/	(800) 433-4298

DPHHS complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-406-444-1386 (TTY: 1-800-833-8503).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-406-444-1386 (TTY: 1-800-833-8503).

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**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-406-444-1386 (TTY: 1-800-833-8503).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-406-444-1386 (TTY: 1-800-833-8503).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-406-444-1386 (TTY: 1-800-833-8503) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-406-444-1386 (رقم هاتف الصم والبكم: 1-800-833-8503).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-406-444-1386 (TTY: 1-800-833-8503).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-406-444-1386 (TTY: 1-800-833-8503).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-406-444-1386 (TTY: 1-800-833-8503).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-406-444-1386 (телетайп: 1-800-833-8503).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-406-444-1386 (TTY: 1-800-833-8503).

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES