Managed Care Summary of Coverage, Cost Sharing and Limits for Medical Assistance

Call your health plan for details about a specific benefit.

If you have questions about your health care program, covered services or copays, you can:
- call your worker
- call your health plan
- ask your provider

Your provider must get approval for some health care services before you get them. The services must be medically necessary.

Medical Assistance (MA)
MA covers the following services. These services are covered through your health plan. Not all covered services are listed. Please see your health plan member handbook for detailed information.
- Child and Teen Checkups (C&TC)
- Chiropractic care
- Dental services (limited for nonpregnant adults)
- Diagnostic services – lab tests and X-rays
- Doctor and other health services
- Emergency medical services and post-stabilization care
- Eye care services
- Family planning services
- Hearing aids
- Home care services
- Hospice
- Hospital services, inpatient and outpatient
- Interpreter services
- Medical equipment and supplies
- Mental and behavioral health services
- Obstetrics and gynecology (OB/GYN) services
- Prescription drugs
- Rehabilitation therapies
- Substance use disorder services
- Surgery
- Telemedicine services
- Transportation to and from medical services
- Urgent care

MA cost sharing
Cost sharing means the amount you pay toward your medical costs. Cost sharing for adults 21 years old or older is as follows:
- $3 copay for nonpreventive visits; no copays for mental health and substance use disorder visits
- $3.50 copay for nonemergency ER visits
- $3 or $1 copay for prescription drugs, up to $12 per month; no copay on some mental health drugs

These people are exempt from cost sharing:
- American Indians and Native Alaskans who have ever received care from an Indian health care provider
- Children
- Pregnant women
- People in hospice care
- People residing in a nursing facility for 30 days or more

These services are exempt from cost sharing:
- Antipsychotic drugs
- Emergency services
- Family planning
- Mental health services
- Preventive services, such as some screenings and immunizations
- Services paid for by Medicare for which MA pays coinsurance and deductible
- Substance use disorder services

If you are not able to pay a copay or deductible, your provider still has to serve you. Providers must take your word that you cannot pay. Providers cannot ask for proof that you cannot pay.

Monthly copays and deductibles are limited to five percent of family income for adults with MA who are not otherwise exempt from copays and deductibles.

Some long-term-care services, such as nursing home care, are not covered under the health plan but may be covered on a fee-for-service basis.
Health Plan Providers
Enrolling in a health plan does not guarantee you can see a particular health plan provider. If you want to make sure, call that provider to ask whether he or she is still part of the health plan. Also ask whether the provider is accepting new patients. The health plan may not cover all your health care costs. Read your member handbook carefully to find out what is covered. You can also call the health plan’s member services.

Managed Care for American Indians
Can I get health care services from the Indian Health Service (IHS) or a tribal clinic?
Yes, American Indians can continue or begin to use tribal and IHS clinics at any time. The health plan will not require prior approval or impose any conditions for you to get services at these clinics. If a doctor or other provider in a tribal or IHS clinic refers you to a health plan provider, you will not have to see your primary care provider for a referral. If you are an American Indian and have any questions or need help, you can call your local IHS or tribal clinic.

Summary 2018* Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Satisfaction Survey Results

<table>
<thead>
<tr>
<th>Medical Assistance – Responses from 18- to 64-year-olds</th>
<th>Rating of health plan</th>
<th>Customer service</th>
<th>Getting needed care</th>
<th>How well doctors communicate</th>
<th>Getting care quickly</th>
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*2018 results are the latest available.
Notice About Your Rights
For people enrolled in a health plan for their Medical Assistance benefits

You have the right to change your health plan at certain times, if there is more than one health plan available in your county.
- You may change your health plan once during the first year you are enrolled in managed care.
- There is an annual health plan selection time each year. During this time the state will explain your right to change your health plan.
- You may change your health plan within 90 days from the date you are first enrolled in the health plan.
- You may ask to change your health plan for cause (including but not limited to: lack of access to covered services or providers experienced in dealing with your health care needs, the plan provided poor quality of care or continuity of care).
- If you want to change your health plan at another time, you may need to request a state appeal (state fair hearing).
- You may change your primary care clinic every 30 days by contacting your health plan.
- See your member handbook for more information.

You have the right to necessary medical care.
- You may ask your health plan for a second opinion. The health plan will give you the name of a doctor you can see.
- Your health plan must tell you in writing if it denies, reduces or stops services you asked for or services your health plan doctor ordered.
- If the health plan is stopping or reducing an ongoing service and you want to appeal the decision, you may be able to keep getting the service during the appeal. You must file a health plan appeal within 10 days of the date on the notice from your health plan, or before the service is stopped or reduced, whichever is later. You must ask for the service to continue. If you lose the appeal, you may be billed for the service, but only if state policy allows this.

If you have a problem with your health plan, you can do any of these things:
- Call your health plan member services. The phone number is on your health plan ID card.
- File a grievance. If you are unhappy with things like the quality of care or failure to respect your rights, you can contact your health plan. Tell them what happened. You will get a response from the plan within 30 days.
- File a health plan appeal. If you have services that are being denied, reduced or stopped, or if the health plan is denying payment for services, call or write your health plan within 60 days of the date on the notice. You can have more time if you have a good reason. Explain why you do not agree with the health plan decision. You can ask a relative, friend, provider or lawyer to help with your appeal.
- Request a state appeal (state fair hearing). You must appeal to the health plan first. After you get the health plan’s determination, you have 120 days to request a state appeal. If you appeal to the health plan and the health plan takes more than 30 days to decide your appeal, you may request a state appeal without waiting any longer. You may bring a friend, relative, advocate or attorney to the hearing. To request a state appeal, mail or fax your request to:
  Minnesota Department of Human Services
  Appeals Division
  PO Box 64941
  St. Paul, MN 55164-0941
  Fax: 651-431-7523
  Or submit your request online with this form: https://edocs.dhs.state.mn.us/lfserv/_Public/DHS-0033-ENG

For help with a grievance or appeal, contact the state ombudsman:
Minnesota Department of Human Services
Ombudsman for State Managed Health Care Programs
PO Box 64249
St. Paul, MN 55164-0249
Phone: 651-431-2660 or 800-657-3729