Managed Care Summary of Coverage, Cost Sharing and Limits for MinnesotaCare

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 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.

MinnesotaCare

Children under 19

There are no copays, deductibles or inpatient limits. MinnesotaCare covers the following services. Not all covered services are listed. Please see your 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 (covered only for MinnesotaCare members under age 19)
- Urgent care

MinnesotaCare

Parents, caretakers, adults without children, and children who are 19 or 20 years old

Coverage is the same as MinnesotaCare for children except these services are limited:
- Dental care (limited for nonpregnant adults)
- Medical transportation (emergency only)

Also, these services are not covered:
- Care in an intermediate care facility
- Nursing home care
- Orthodontic services
- Personal care assistance (PCA) services
- Private duty nursing

MinnesotaCare Cost Sharing and Limits

Some people 21 years old and older with MinnesotaCare pay cost sharing. Cost sharing means the amount you pay toward your medical costs. Cost sharing is as follows:
- $75 copay for ER visits
- $25 copay for nonpreventive visits; no copays for chemical health and mental health visits
- $250 per inpatient hospital admission
- $100 ambulatory surgery
- $25 copay for eyeglasses
- $7 or $25 copay for prescription drugs up to $70 per month; no copay for some mental health drugs
- $40 per visit for radiology services
- $15 per non-routine dental visit

'American Indians who are members of a federally recognized tribe are exempt from cost sharing.

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for medical 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></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>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Plus</td>
<td>55%</td>
<td>64%</td>
<td>51%</td>
<td>81%</td>
<td>60%</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>57%</td>
<td>74%</td>
<td>58%</td>
<td>87%</td>
<td>58%</td>
</tr>
<tr>
<td>Hennepin Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itasca Medical Care</td>
<td>54%</td>
<td>64%</td>
<td>50%</td>
<td>76%</td>
<td>61%</td>
</tr>
<tr>
<td>PrimeWest Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Country Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCare</td>
<td>55%</td>
<td>63%</td>
<td>57%</td>
<td>82%</td>
<td>62%</td>
</tr>
<tr>
<td>Average rating</td>
<td>55%</td>
<td>67%</td>
<td>54%</td>
<td>81%</td>
<td>61%</td>
</tr>
</tbody>
</table>

* 2018 results are the latest available.
Notice About Your Rights

For people enrolled in a health plan for MinnesotaCare 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