For people with Medicare: Medical Assistance (MA) cannot pay for any drugs in the Medicare prescription drug benefit. If you have Medicare coverage through your SNBC plan, you will get your Part D drug coverage through the plan. There may be different copays for prescriptions through Part D. MA does not cover Part D copays. Check with your SNBC plan to find out whether your Medicare drug coverage is through SNBC or through another prescription drug plan.

Managed Care Summary of Coverage, Cost Sharing and Limits for Special Needs BasicCare (SNBC)

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) Through SNBC**

MA covers the following services. These services are covered through your health plan. Not all covered services are listed. Please see your evidence of coverage or member handbook for detailed information.

- Care coordination
- Child and Teen Checkups (C&T C)
- 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
- Nursing home services
- Obstetrics and gynecology (OB/GYN) services
- Prescription drugs
- Preventive care and screening tests
- Rehabilitation therapies
- Substance use disorder services
- Surgery
- Telemedicine services
- Transportation to and from medical services
- Urgent care

**Cost sharing**

People enrolled in Special Needs BasicCare (SNBC) do not pay cost sharing for MA services they get through an SNBC health plan.

SNBC is a voluntary program. If disenrolled from SNBC, cost sharing may apply.

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 copay for mental health visits
- $3.50 copay for nonemergency ER visits
- $3 or $1 copay for prescription drugs, up to $12 per month; no copay for 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
- Pregnant women
- People in hospice care
- People in nursing homes or intermediate care facilities for people with developmental disabilities (ICF-DDs)

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.

Coverage for some long-term care, including nursing home care, may require a separate application to determine whether MA can pay for it. Ask your worker for more information.
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>Special Needs BasicCare (SNBC) – Responses from 18- to 64-year-olds</th>
<th>Percentage of enrollees who gave the plan a high rating for the category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of health plan</td>
<td>Customer service</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>64%</td>
</tr>
<tr>
<td>Hennepin Health</td>
<td>57%</td>
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<tr>
<td>Medica</td>
<td>58%</td>
</tr>
<tr>
<td>PrimeWest Health (PWH)</td>
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<tr>
<td>South Country Health Alliance (SCHA)</td>
<td>68%</td>
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<tr>
<td>UCare</td>
<td>60%</td>
</tr>
<tr>
<td>Average rating</td>
<td>62%</td>
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</tbody>
</table>
Notice About Your Rights
For people enrolled in Special Needs BasicCare (SNBC)

Change your health plan or clinic.
- If you do not get your Medicare benefits through SNBC, you may enroll or disenroll from Special Needs BasicCare (SNBC) at any time. Your enrollment will begin or end on the first day of the next available month.
- If you sign up to get your Medicare benefits through SNBC, you may disenroll at certain times of the year but not monthly.
- If you disenroll from your SNBC health plan, you may need to choose a Medicare Part D prescription drug plan.
- You may change to a different SNBC health plan if there is more than one choice in your county.
- Call Disability Hub MN at 866-333-2466 for help with any changes listed above.
- If you want to change your primary care clinic, call your health plan.
- See your evidence of coverage or member handbook for more information.

You will receive notice of health plan decisions.
- Your health plan must tell you in writing if it denies, reduces or stops services you asked for or services your doctor ordered.
- If the health plan is stopping or reducing an ongoing service, you may be able to keep getting the service. 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.

You can get a second opinion.
- You may ask your health plan for a second opinion. The health plan will give you the name of a doctor you can see.

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 health 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 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/lfserver/Public/DHS-0033-ENG

For help with a grievance, appeal or state fair hearing, 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

You may have additional rights.
Please refer to your health plan evidence of coverage or member handbook for more information.