Minnesota Health Care Programs(MHCP)
Medical Assistance (MA) - Fee-for-Service (FFS)

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Children and Pregnant Women**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-800-657-3739 or 651-431-2670 (metro area).**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**No deductibles**	
Are there other deductibles for specific services?	No	
Is there an out-of-pocket limit on my expenses?	No	
Is there an overall annual limit on what the plan pays?	No	
Does this plan use a network of providers?	Yes For a list of participating providers, refer to MHCP Provider Directory **or call 1-800-657-3739 or 651-431-2670 (metro area).**	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services.
Do I need a referral to see a specialist?	You do not need a referral to see most specialists. Audiology services require a referral from your primary doctor.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes	Some of the services this plan does not cover are listed on page 4. See your policy or plan document for additional information about **non-covered services.**

- The **allowed amount** is the amount the plan pays for covered services**.** If a participating **provider** charges more than the **allowed amount,** the provider must write off the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, the provider may not ask you to pay the $500 difference. (This is called **balance billing.)**
- This plan requires you to use participating **providers.** Medical services provided by non-participating providers are not covered.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No co-pay	Not covered	MHCP only pays participating providers. When a non-participating provider provides services in an emergency, the provider may or may not choose to enroll with MHCP. If the provider decides not to enroll, the patient is responsible for the bill.
	Specialist visit	No co-pay	Not covered	
	Other practitioner office visit	No-copay	Not covered	
	Preventive care/screening/immunization	No co-pay	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No co-pay	Not covered	
	Imaging (CT/PET scans, MRIs)	No co-pay	Not covered	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	No-copay	Not covered	Covers up to a 30-day supply, 90 day supplies available only for family planning May require prior authorization MHCP only pays participating providers. . If a non-participating provider doesn't enroll with MHCP, the patient is responsible for the bill.
	Preferred brand drugs	No-copay	Not covered	
	Non-preferred brand drugs	No-copay	Not covered	May require prior authorization
	Specialty drugs	No-copay	Not covered	May require prior authorization
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No cost sharing	Not covered	May require prior authorization
	Physician/surgeon fees	No cost sharing	Not covered	May require prior authorization
If you need immediate medical attention	Emergency room services	No cost sharing	Not covered	MHCP only pays participating providers. . If a non-par provider does not enroll with MHCP, the patient is responsible for the bill.
	Emergency medical transportation	No cost sharing	Not covered	
	Urgent care	No cost sharing	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No cost sharing	Not covered	May require prior authorization
	Physician/surgeon fee	No cost sharing	Not covered	May require prior authorization

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No cost-sharing	Not covered	
	Mental/Behavioral health inpatient services	No cost-sharing	Not covered	May require prior authorization
	Substance use disorder outpatient services	No cost-sharing	Not covered	Requires assessment and authorization
	Substance use disorder inpatient services	No cost-sharing	Not covered	Requires assessment and authorization
If you are pregnant	Prenatal and postnatal care	No cost-sharing	Not covered	
	Delivery and all inpatient services	No cost-sharing	Not covered	
If you need help recovering or have other special health needs	Home care (skilled nursing visits, home health aide visits, OT, PT, RT & ST)	No cost-sharing	Not covered	Requires assessment and prior authorization
	Outpatient Rehabilitation services (OT, PT, SLP)	No cost-sharing	Not covered	May require prior authorization
	Skilled nursing care (check with Barb H)	No cost-sharing	Not covered	Requires assessment
	Durable medical equipment (DME)	No cost-sharing	Not covered	
	Hospice service	No cost-sharing	Not covered	
If you need eye care	Eye exam	No-cost-sharing	Not covered	
	Glasses	No cost-sharing	Not covered	Limited to one pair of glasses every two years unless lost, broken or stolen. Selection of frames is limited.
If you need dental care	Dental check-up (exam, bitewing x-rays and cleaning)	No cost-sharing	Not covered	
	Fillings	No cost-sharing	Not covered	Amalgam (silver colored) fillings are preferred. Composite (tooth-colored) fillings are only covered on front teeth and must be medically necessary
	Dentures	No cost sharing	Not covered	Once every three years; partial dentures require prior authorization
	Extractions	No cost sharing	Not covered	Removal of impacted teeth requires prior authorization.
	Orthodontia	No cost sharing	Not covered	Requires prior authorization. Not covered for adults 21 and older.

	Root canals	No cost sharing	Not covered	Once per tooth per lifetime
	Crowns	No cost sharing	Not covered	Stainless steel or resin

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This is not a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic procedures and treatment • Fertility drugs and procedures • Experimental or investigative procedures • Orthodontia for adults over age 21 • Fitness centers	• Medical care when traveling outside the U.S. • Medical services provided by a non-participating provider • Job training and educational services	• Drugs used for erectile dysfunction, hair growth, or weight loss. • Herbal or homeopathic products • Newborn circumcision

Other Covered Services (This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture (for treatment of chronic pain) Bariatric surgery (for weight-loss)	• Chiropractic services • Hearing aids • Long-term care • Medical transportation • Personal Care Attendant	• Dental services • Eyeglasses • Interpreter services • Vaccines and immunizations

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you remain eligible. There are exceptions, however, such as if:

- You commit fraud
- You move outside the coverage area

Your Complaint and Appeal Rights:

For questions about your rights, a notice you receive, or assistance, you can contact the MHCP Member Helpdesk at 651-431-2670 (metro) or 1-800-657-3739.

If you are dissatisfied with a decision made by your plan to deny authorization of services or deny payment for benefits, you may be able to **appeal. The denial notice from the plan will tell you how to appeal and who to contact if you have questions.**

To file an appeal under this plan, enrollees must send a written request to:

Minnesota Department of Human Services Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941
Metro: 651-431-3600 (Voice)
Outstate: 1- 800-657-3510
TTY: 1-800-627-3529
Fax: 651-431-7523

The appeal form is available here: https://edocs.dhs.state.mn.us/lfserver/public/DHS-0033-ENG

Time Limits You must file an appeal within 30 days from the date you receive notice of denial. You have 90 days if you have a good reason for filing late. The Appeals Office will send you a hearing date and other information after you file your appeal.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Do not use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will be different.

See the next page for important information about these examples

Having a baby

(Normal delivery)

Amount owed to providers: $7,540

- **Plan pays** $5,490
- **Patient pays** $0.00

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	**No cost to the patient**

Managing type 2 diabetes

(Routine maintenance of a well-controlled condition)

Amount owed to providers: $4,100

- **Plan pays** $2,480
- **Patient pays** No cost to children and pregnant women.

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**
Patient pays:	
Deductibles	
Co-pays	
Total	**No cost to the patient**

Note: These numbers assume the patient is having 15 office visits a year related to their diabetes. If your diabetes diagnosis is new or your diabetes is not well controlled, the costs the plan pays may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in- network providers. If the patient had received care from out-of-network providers, the plan would not cover the services.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles and co-payments** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment is not covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No**. Coverage Examples are **not** cost estimators. You cannot use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you will find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Glossary

Allowed amount: The amount the plan pays for covered services.

Appeal: The process in which a judge formally reviews a decision made by Minnesota Health Care Programs.

Assessment: A meeting with the member to determine if they meet coverage criteria for services and the level of service they need.

Balance billing: When a provider bills the patient for the costs not covered by insurance.

Co-payments: Co-payments or co-pays are an amount (for example, $3) you pay for covered health care, usually when you receive the service.

Cost sharing: Amounts you may be responsible for to pay toward your medical services. Cost sharing amounts include copayments and deductibles.

Covered services: The health care services that are eligible for payment by your health insurance.

Deductible: An amount of money that you are responsible for before your insurance company will make payment toward your medical costs.

Emergency: A condition that needs treatment right away. It is a condition that would reasonably be expected to require prompt care, and without prompt care, could cause: serious physical or mental harm; continuing severe pain; serious damage to body functions, organs, or parts; or death. Labor and childbirth can sometimes become an emergency.

Fee-for-Service: A method of payment for health services. The medical provider bills the Minnesota Department of Human Services (DHS) directly. DHS pays the provider for the medical services. This method is used when you are eligible for Minnesota Health Care Programs but are not enrolled in a health plan.

Hospice: A special program for people who are terminally ill and not expected to live more than six months. It offers special services for the person and his or her family.

Inpatient hospital stay: A stay in a hospital or treatment center that usually lasts 24 hours or more.

Network: The group of providers who have agreed to participate with the insurance company or are enrolled with the health care program.

Non-covered services: Services your insurance does not cover.

Out-of-network services: Health care provided to a member by a non-enrolled provider.

Out-of-pocket expenses: Costs that the member needs to pay.

Out-of-pocket limit: The maximum amount of costs that the member needs to pay.

Outpatient hospital services: Services provided at a hospital or outpatient facility, which are not at an inpatient level of care. These services may also be available at your clinic or other health facility.

Prescriptions: Medicines and drugs that are ordered by a licensed medical provider.

Preventive services: Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help to find and prevent health problems. Follow-up on conditions that were already diagnosed (like a diabetes checkup) are not preventive.

Prior authorization: A review of a medical service to determine that the service is medically necessary and meets coverage criteria before the service is given.

Providers: Clinics, hospitals, pharmacies, doctors and other health professionals who provide health services.

Referral: Written consent from your primary care provider or clinic that you may need to get before you see certain providers, such as specialists, for covered services.

Specialist: A medical practitioner who has skills and knowledge about a specific kinds of diseases, parts of the body or a group of certain patients.

Urgent care: Care for a condition that needs prompt treatment to stop the condition from getting worse. An urgent condition is not as serious as an emergency.