

Minnesota Health Care Programs (MHCP)
MinnesotaCare 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: Parents



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)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$2.65 per adult per case monthly	MHCP deducts the family deductible amount from the first claim it receives in a month that is processed for payment. Emergency services, family planning services, and prescriptions do not apply towards the deductible. You will receive a monthly statement telling you the name of the provider to whom you owe the deductible. The family deductible amount changes annually.
Are there other deductibles for specific services?	No	
Is there an out-of-pocket limit on my expenses?	No	
What is not included in the out-of-pocket limit ?	Non-covered services and premiums	Even though you pay these expenses, they do not count toward the monthly out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
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)	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 excluded services .

Questions: Call **1-800-657-3739** or **651-431-2670 (metro)** or visit us at www.dhs.state.mn.us/healthcare

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If you are not clear about any of the bolded terms used in this form, see the Glossary. **You can view the Glossary at [www. \[insert\]](#) or call 1-800-[insert] to request a copy.**

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- **Co-payments** are fixed dollar amounts (for example, \$3) you pay for covered health care, usually when you receive the service.
- 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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$3 co-pay/visit	Not covered	
	Specialist visit	\$3 co-pay/visit	Not covered	
	Other practitioner office visit	\$3 co-pay for chiropractor , acupuncture and eye exams	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	

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		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition	Generic drugs	\$3 co-pay/ Prescription	Not covered	Covers up to a 30-day supply, 90 day supplies available only for family planning (retail only, no mail order)
	Preferred brand drugs	\$3 co-pay/ prescription	Not covered	(retail only, no mail order)
	Non-preferred brand drugs	\$3 co-pay/ prescription	Not covered	May require prior authorization (retail only, no mail order)
	Specialty drugs	\$3 co-pay/ prescription	Not covered	May require prior authorization (retail only, no mail order)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No cost sharing	Not covered	May require prior authorization
	Physician/surgeon fees	\$3.00 copay, \$2.65 deductible may apply	Not covered	May require prior authorization
If you need immediate medical attention	Emergency room services	\$3.50 copay for nonemergency visits	Not covered	
	Emergency medical transportation	No cost sharing	Not covered	
	Urgent care	\$3.50 copay for nonemergency visits	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Cost sharing based on income	Not covered	May require prior authorization, \$10,000 annual limit for parents with income between 215% and 275% FPG
	Physician/surgeon fee	No cost sharing	Not covered	May require prior authorization

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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	Cost-sharing based on income	Not covered	Requires assessment and authorization \$10,000 annual limit for parents with income between 215% and 275% FPG
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	No cost-sharing	Not covered	Requires assessment
	Durable medical equipment (DME)	No cost-sharing	Not covered	
If you need eye care	Hospice service	No cost-sharing	Not covered	
	Eye exam	\$3.00 copay	Not Covered	
	Glasses	\$25.00 copay	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	Limited to one dental check upper year
	Fillings	No cost-sharing	Not covered	Amalgam (silver colored) fillings are preferred. Composite (tooth-colored) fillings only covered when medically necessary
	Dentures	No cost sharing	Not covered	Once every six years, partial dentures require prior authorization
	Extractions	No cost sharing	Not covered	Removal of impacted teeth requires prior authorization
	Orthodontia	Not covered	Not covered	

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	Root canals	No cost sharing	Not covered	Covered only on anterior (front) and pre-molar teeth
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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Infertility treatment • Experimental or investigative procedures • Orthodontia for adults over age 21 • Fitness centers 	<ul style="list-style-type: none"> • Medical care when traveling outside the U.S. • Medical services provided by a non-participating provider • Medical transportation 	<ul style="list-style-type: none"> • Drugs used for erectile dysfunction, hair growth, or weight loss. • Herbal or homeopathic products • Newborn circumcision • Personal Care Attendant (PCA) services

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Acupuncture (prescribed for treatment of chronic pain) • Bariatric (weight-loss) surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids • Long-term care • Emergency Ambulance 	<ul style="list-style-type: none"> • Dental • Eyeglasses • Interpreters

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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: [<insert link>](#)

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.

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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.

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	

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers: \$4,100

- **Plan pays** \$2,480
- **Patient pays** \$1,620

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	\$800
Co-pays	\$500
Total	\$1,620

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, your costs may be higher.



This is not a cost estimator.

Don't 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 also be different.

See the next page for important information about these examples

Questions and answers about the Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't 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, costs would have been higher. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p> <p>Does the Coverage Example predict my own care needs?</p> <p>✘ 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.</p> <p>Does the Coverage Example predict my future expenses?</p> <p>✘ No. Coverage Examples are not cost estimators. You can't 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, the prices your providers charge, and the reimbursement your health plan allows</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll 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.</p> <p>Are there other costs I should consider when comparing plans?</p> <p>✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
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