Minnesota Department of **Human Services**

04/02/15

You will be enrolled in a high-quality managed health care program as part of your Medical Assistance (MA). The program is called Special Needs BasicCare (SNBC).

Because of changes in state law, people with disabilities who have MA will be enrolled in an SNBC health plan unless they choose not to join SNBC. If you do not want to be enrolled in an SNBC plan, you must act now.

Please read this letter and the enclosed brochure closely. You have options. You may:

- choose to enroll in an SNBC health plan or
- choose not to enroll in an SNBC health plan and keep MA as you have it now.

What you need to do

If you decide you **want** to join SNBC, you can either:

- do nothing and be automatically enrolled in an SNBC health plan or
- choose a plan using the enclosed SNBC Choice Form. Return the form to us as described on the form within 30 days from the date of this letter.

You will get a letter telling you when your coverage through the health plan will start. If you join SNBC and then find you do not like it, you can return to the MA you have now, effective the next month. You can do do that by calling the Disability Linkage Line at 866-333-2466 or TTY at 711.

If you **do not want** to enroll in an SNBC plan, you must check "I would like to opt out of SNBC and stay with the MA I have now" on the SNBC Choice Form. Return the form to us as described on the form. Your MA coverage will continue without change if you decide not to join SNBC.

Note: We must receive your signed choice form within 30 days from the date on this letter. If you do not return the SNBC Choice Form, we will enroll you in the SNBC health plan listed first on the form.

Help is available to decide whether SNBC is right for you

If you need help deciding what to do, call the Disability Linkage Line at 866-333-2466 or TTY at 711.

Special Needs BasicCare (SNBC) Choice Form

Sign and return the form within 30 days from 04/02/15.

CASE NUMBER:	MHCP ID:	NAME:	BIRTH DATE

ADDRESS:	CITY:	STATE: MN	ZIP

Please select only one of the following options.

_____ I would like to enroll in Medica AccessAbility Solution (866-882-5408).
_____ I would like to enroll in UCare Connect (800-707-1711).

_____ I would like to opt out of SNBC and stay with the Medical Assistance I have now.

If you do not choose a plan and do not opt out of SNBC, we will enroll you in the first plan listed above.

I understand that my signature (or the signature of the person authorized to act on my behalf) on this form means that I have read and understand the contents of this form and the letter it came with.

SIGNATURE:	PHONE NUMBER:	DATE:

If you are filling out this form as an authorized representative acting on this person's behalf, you must sign above and provide the following information:

NAME (print):	RELATIONSHIP TO MEMBER:

ADDRESS:	PHONE:

CITY:	STATE:	ZIP:

Fax this form to 651-431-7594.
OR
Return this form in the enclosed envelope.
OR
Call the Disability Linkage Line at 866-333-2466 or TTY at 711.