#05-21-05

Bulletin

August 12, 2005

Minnesota Department of Human Services □ 444 Lafayette Rd. □ St. Paul, MN 55155

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- Mille Lacs Tribal TANF
- Financial Assistance Supervisors
- Financial Workers
- MinnesotaCare Managers, Supervisors and Enrollment Representatives
- County Attorneys

ACTION

Implement all changes provided in this bulletin.

DUE DATE

All changes are effective July 1, 2005, unless otherwise noted.

2005 Legislative Changes Effective July 1, 2005, Affecting Minnesota Health Care Programs

TOPIC

The 2005 Minnesota Legislature, Regular Session and Special Session, enacted several changes to Minnesota Health Care Programs including Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare. This bulletin provides information on changes effective July 1, 2005, and a summary of other legislative changes with effective dates after July 1, 2005.

PURPOSE

Provide information and implementation instructions regarding eligibility policy changes affecting Medical Assistance (MA) effective July 1, 2005, and provide a brief summary of other legislative changes affecting Minnesota Health Care Programs and their effective dates.

CONTACT

MinnesotaCare Operations, Counties and Tribal Agencies should submit questions to HealthQuest.

Direct all other questions to:
HCEA, 444 Lafayette Road, St. Paul, MN 55155-3848

SIGNED

BRIAN J. OSBERG
Assistant Commissioner
Health Care Administration

I. Background

The 2005 Minnesota Legislature, Regular Session and First Special Session, passed legislation affecting eligibility, benefits and cost sharing in Minnesota Health Care Programs. These changes have various effective dates in 2005, 2006 and 2007.

This bulletin includes the following legislative changes that are effective July 1, 2005:

- Expanded authority to recover uncompensated transfers made by individuals who receive MA long term care (LTC) services; and
- Clarification of MA eligibility for people participating in work release programs.

This bulletin also includes various attachments that summarize other legislative changes related to eligibility, benefits and cost-sharing, as well as information regarding legislative changes that has been sent to enrollees/recipients. The Department of Human Services (DHS) will also issue a bulletin related to trusts established on or after July 1, 2005, and additional bulletins to provide implementation instructions for other legislative changes with effective dates after July 1, 2005.

II. Action Required

A. Expanded Authority to Recover Uncompensated Transfers Made by Individuals Who Receive MA Long Term Care (LTC) Services

The 2005 Minnesota Legislature expanded authority for a state or county agency to seek recovery from a person(s) who receives an uncompensated transfer from an MA LTC applicant or enrollee when the county agency cannot impose the first, and sometimes only, month of a penalty period because the timely report is made after the date the county agency can send a 10-day notice to the enrollee. The authority to sue the person who received the uncompensated transfer does not apply to situations where an MA LTC enrollee timely reports a transfer but continues to receive LTC services because the county agency did not act timely on the reported change. **This policy only applies to transfers made on or after July 1, 2005.**

Prior to July 1, 2005, the state or county agency only had authority to sue people who received an uncompensated transfer of income and/or assets from an MA LTC applicant or enrollee when the transfer was not reported timely to the county agency. When an MA LTC enrollee had timely reported an uncompensated transfer, the MA LTC enrollee continued to receive LTC services in the first, and sometimes only, month of the penalty period because the county agency received the timely report after 10-day notice cut-off.

Effective for uncompensated transfers made on or after July 1, 2005, the state or county agency has the authority to sue people who receive an uncompensated transfer of income

and/or assets from an MA LTC enrollee when the MA LTC enrollee timely reports the transfer after the date the county agency can send a 10-day notice for the first, and sometimes only, month of the penalty period.

The amount the person can be sued for is the fair market value of the uncompensated transfer or the cost of LTC services paid for by MA in the first month of the penalty period that could not be imposed, ***whichever is less***.

Example
Mr. Smith applied for MA LTC on May 5, 2005, and was approved for MA on June 17, 2005, retroactively to May 1, 2005. On August 25, Mr. Smith, an MA LTC recipient, timely reports that he received a $10,000 inheritance from the estate of his deceased brother on August 17 and immediately gave it to his son. The county worker calculates a 2.43 month penalty period to begin in September (the month following the month in which the transfer occurred). The penalty period cannot be imposed beginning in September because the worker is unable to give a 10-day advance notice to the enrollee. MA paid $6,123 for LTC services for Mr. Smith in September.

The worker takes the following steps:

1. Calculates a penalty period by dividing the amount of the uncompensated transfer by the July 1, 2004, monthly statewide average payment for a skilled nursing facility (SAPSNF) in effect at the time of Mr. Smith's MA application:

   $10,000 ÷ $4,111 = 2.43 months

   The calculated penalty period is September, October, and the first $1,768 of LTC services incurred in November ($4,111 x .43).

2. Sends a 10-day notice to the enrollee notifying him of ineligibility for payment of LTC services for the month of October (the first month that timely notice can be provided) and the first $1,768 of LTC services incurred in November.

3. Refers the case to the county attorney to take legal action against Mr. Smith's son. Mr. Smith's son could be sued for $6,123. This is the lesser of the fair market value of the uncompensated transfer or the cost of LTC services paid by MA for the month of September.

Apply this policy to all situations in which a transfer for less than fair market value occurs on or after July 1, 2005, when the county agency must delay imposing the penalty period because the MA LTC enrollee timely reported the transfer after 10-day notice cut-off. Refer these situations to your county attorney to make the determination whether to take legal action.

B. Statutory Clarification of MA Eligibility for People Participating in Work Release Programs

New statutory language clarifies when a person serving a sentence and participating in a work release program may be eligible for MA.

A person who is serving a sentence but participating in a work release program while living in the community ***may*** be eligible for MA. These individuals may be residing in their own home (even when subject to electronic monitoring), half-way house, or other non-secure residence.

Individuals serving a sentence in a state prison receive approval for work release and their living arrangements in the community from the Commissioner of the Department of Corrections. Individuals serving a sentence in a county jail must receive approval for work release and approval to reside in the community under a court order from a judge.

Some individuals, even though approved for work release, will continue to reside in a secure corrections facility and will therefore not qualify for MA. These include: a person approved for work release from prison by the Commissioner of the Department of Corrections but who resides at the county jail; or a person serving a sentence at a county jail, approved for daily work release but who must return to the county jail or other secure corrections facility when not working.

III. Other Legislative Changes Affecting Minnesota Health Care Programs

The following attachments are included with this bulletin:

- **Attachment A: 2005 Legislative Changes Affecting Minnesota Health Care Programs Eligibility** provides a brief summary of changes related to program eligibility and administration of the Minnesota Health Care Programs. This summary is provided for informational purposes only. Additional information on specific provisions will be provided through bulletins or other communications from DHS when necessary to provide implementation instructions to county agencies.

- **Attachment B: 2005 Legislative Changes Affecting Minnesota Health Care Programs Benefits and Cost Sharing** provides a brief summary of changes related to program benefits and cost sharing in the Minnesota Health Care Programs. This summary is provided for informational purposes only. Additional information on specific provisions will be provided through bulletins or other communications from DHS when necessary to provide implementation instructions to county agencies.

- **Attachment C: Minnesota Health Care Programs (MHCP) 2005 Legislative Notice to Enrollees/Recipients** is the notice that was mailed to current MHCP enrollees/recipients between August 11, 2005 and August 16, 2005.

- **Attachment D: Notice About Your Rights for Minnesota's Managed Health Care Programs** was mailed to current MHCP recipients enrolled in managed care.

- **Attachment E: Your Notice About Third-Party Liability** was mailed to current MHCP enrollees/recipients.

IV. Legal References

Laws of Minnesota 2005, Regular Session, Chapter 155, Article 3, Section 1
Laws of Minnesota 2005, First Special Session, Chapter 4, Article 8, Section 19

V. Special Needs

This information is available in other forms to people with disabilities by contacting HCEA at (651) 282-6494 (voice) or (800) 938-3224, or through the Minnesota Relay Service at 7-1-1 (TDD) or 1-800-627-3848.

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM ELIGIBILITY

EFFECTIVE DATE	GENERAL ASSISTANCE MEDICAL CARE (GAMC)	MINNESOTACARE	MEDICAL ASSISTANCE (MA)
7/1/2005	***Business Process Redesign (BPR)*:** Authorizes DHS to test and evaluate various administrative models in coordination with the development and implementation of HealthMatch. Duration of test sites shall not exceed 1 year. The commissioner is required to recommend the most efficient and effective model for statewide implementation.	***BPR*:** Authorizes DHS to test and evaluate various administrative models in coordination with the development and implementation of HealthMatch. Duration of test sites shall not exceed 1 year. The commissioner is required to recommend the most efficient and effective model for statewide implementation. Allows counties to keep one half of the nonfederal share of MinnesotaCare recoveries when the recovery is made by the county agency. Authorizes DHS to initiate an administrative disqualification hearing (ADH) for a MinnesotaCare enrollee suspected of wrongfully obtaining benefits when DHS determined eligibility.	***BPR*:** Authorizes DHS to test and evaluate various administrative models in coordination with development and implementation of HealthMatch. Duration of test sites shall not exceed 1 year. The commissioner is required to recommend the most efficient and effective model for statewide implementation. For transfers made on or after July 1, 2005, authorizes the state or county agency to sue (file a cause of action against) the person(s) who received an uncompensated transfer when the county agency could not impose the first month of a penalty period due to timely notice requirements. Clarifies that individuals serving a sentence participating in a work release program while living in the community ***may*** be eligible for MA. MA liens and Notices of Potential Claims **filed after** August 1, 2003, on life estates and jointly owned interests in land that were **created before** August 1, 2003, will end and no longer be enforceable when the enrollee dies.*

*Repealed the laws directing the state to file a lien against property to recover Alternative Care (AC) payments. All recorded AC liens are no longer liens against property. However, the state and counties will continue to file claims against probate estates to recover AC payments.

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM ELIGIBILITY

EFFECTIVE DATE	GENERAL ASSISTANCE MEDICAL CARE (GAMC)	MINNESOTACARE	MEDICAL ASSISTANCE (MA)
7/15/2005			Requires DHS to apply for a federal waiver to charge sliding scale premiums, based on the MinnesotaCare sliding scale, to MA enrollees with gross family incomes greater than 175% of Federal Poverty Guidelines (FPG).
8/1/2005		Repeals MinnesotaCare outreach grants.	*MA-EPD*: Cost of living (COLA) increases in RSDI/SSDI benefits are not counted as income until July 1 of each year. Clarifies that enrollees of all health care programs must give notice of possible claims for recovery of medical expenses (third party liability).
8/5/2005		MinnesotaCare enrollees, who are members of the military, and their families, may voluntarily disenroll without penalty when a family member is called to active military duty. *Note: Instructions regarding this change can be found in Bulletin #05-21-04.*	
9/1/2005		A woman who is enrolled in Minnesota Care and later reports she is pregnant is eligible for all services provided under the MA program retroactive to the date of conception. Requires verification of all earned and unearned income at the time of application and renewal. Requires applicants and enrollees to provide the name of their employer, a contact name and telephone number for purposes of verifying access to employer subsidized insurance (ESI) coverage. Establishes that a person who is entitled to Medicare Part A or is enrolled in Medicare Part B	Mandates several new eligibility verification provisions including: • Pregnant women must update income and asset information at the end of the 60 day postpartum period and provide verifications if reported changes effect eligibility; • The health care programs application must be modified to require more detailed information related to income and assets; • All income and assets must be verified at application and renewal; • Enrollees must report new or

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM ELIGIBILITY

EFFECTIVE DATE	GENERAL ASSISTANCE MEDICAL CARE (GAMC)	MINNESOTACARE	MEDICAL ASSISTANCE (MA)
		is considered to have other health coverage and therefore ineligible for MinnesotaCare. A person cannot refuse Medicare Part A to gain MinnesotaCare eligibility.	increased earned income within 10 days and provide verification of new or increased income that affects eligibility; and • Counties must determine if newborns have access to private sector health coverage and, if so, submit it for evaluation under cost effective insurance provisions. Eliminates state-funded coverage of undocumented and non-immigrant pregnant women who have other health insurance. (These women may still be eligible for EMA to cover labor and delivery.) The managed care cost effective exclusion has been updated to exclude only persons with cost effective non-Medicare policies. Recipients with Medicare supplemental policies that do not meet another managed care exclusion reason must enroll in a managed care health plan. Recipients with private health insurance coverage through an HMO licensed under Minnesota Statutes Chapter 62D may select the same managed care health plan as their private HMO or be excluded from managed care enrollment.
12/15/2005			Mandates a report on the amount of time it takes counties to process applications for LTC services. *Note: An updated report is also required to be submitted to the legislature on 12/15/2006.*

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM ELIGIBILITY

EFFECTIVE DATE	GENERAL ASSISTANCE MEDICAL CARE (GAMC)	MINNESOTACARE	MEDICAL ASSISTANCE (MA)
1/1/2006			Repeals the state-funded Prescription Drug Program (PDP). These individuals will need to obtain their prescriptions through Medicare Part D.
7/1/2006			*Family Planning Waiver:* Implementation of new program that covers family planning services for persons age 15-50 who are not enrolled in or are exiting a Minnesota health care program. *Note: Authority to seek federal approval for this program was legislated in 2001. CMS approved the waiver on July 20, 2004. This program will be implemented during the 2006-2007 biennium.*
9/1/2006	*GAMC to MinnesotaCare:* Shifts certain GAMC applicants and enrollees to the MinnesotaCare program. Excludes some individuals from moving to MinnesotaCare and allows them to remain on GAMC. Excluded individuals include those who are receiving GA, GRH, applying for SSI or Social Security disability, applying for a disability determination through SMRT, or who do not have a permanent address. • Parents of children ages 19-21 and stepparents are no longer eligible for GAMC unless they are in one of the exception groups noted above. • Applicants will move to MinnesotaCare on the first day of the first month in which they can be enrolled in a MinnesotaCare managed care plan. Current enrollees will move to MinnesotaCare at the time of their	*GAMC to MinnesotaCare:* See the GAMC column to the left.	

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM ELIGIBILITY

EFFECTIVE DATE	GENERAL ASSISTANCE MEDICAL CARE (GAMC)	MINNESOTACARE	MEDICAL ASSISTANCE (MA)
	next renewal on or after 9/1/2006. • GAMC covered services will be paid for through fee for service until the individual is enrolled in a MinnesotaCare managed care plan. • Individuals will not be subject to MinnesotaCare eligibility rules or pay premiums for the first six-month budget period. • Counties will process applications and provide case management for these cases. • Counties will pay MinnesotaCare premiums during the initial six-month budget period for all months in which the individual is enrolled in a MinnesotaCare managed care plan. • Individuals will be subject to MinnesotaCare eligibility rules and be required to begin paying premiums at the end of the first six month budget period. Counties may choose to continue paying premiums on behalf of these individuals beyond the first six month budget period. • Individuals who lose MinnesotaCare eligibility after the shift from GAMC may reapply for GAMC. • A one-time, $1 million appropriation is made to counties to cover the costs of training		

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM ELIGIBILITY

EFFECTIVE DATE	GENERAL ASSISTANCE MEDICAL CARE (GAMC)	MINNESOTACARE	MEDICAL ASSISTANCE (MA)
	county workers to enroll and maintain eligible GAMC clients in MinnesotaCare. The appropriation will be based on the average number of GAMC clients in calendar year 2004 and will be sent to counties by 1/15/2006.		
8/1/2007 or when HealthMatch is implemented, whichever is later.	Adds an exception to the Social Security number requirements for individuals with a well established religious objection.	Specifies that MinnesotaCare income is calculated to reflect a six-month period. Requires the use of MA Method A to calculate gross individual or gross family income for non-farm self–employed. Codifies MinnesotaCare Social Security number requirements with exceptions for newborns and applicants who have applied and are awaiting the receipt of their social security number. Provides an exception to the Social Security number requirements for individuals with a well-established religious objection. Requires individuals and families applying for MinnesotaCare to take all necessary steps to obtain other benefits as required under federal law, within 30 days of notification. Requires that coverage begins for new family members the first day of the month following the month in which the change is reported. Eligibility for newly adopted children is the month of placement. Provides that the first six-month period of eligibility begins the month the application is received.	Allows Client Option Spenddown recipients to make spenddown payments on or before the last business day of the month. Specifies that retro MA eligibility is determined independently from eligibility for the month of application and future months. The 12 month redetermination period begins with the month of application.

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM ELIGIBILITY

EFFECTIVE DATE	GENERAL ASSISTANCE MEDICAL CARE (GAMC)	MINNESOTACARE	MEDICAL ASSISTANCE (MA)
Upon federal approval		Increases premiums 8% for all adults; increases premiums 8% for children with income >150% of FPG. Requires adjustment of monthly premiums based upon both increases and decreases in enrollee income at the time the change in income is reported. Eliminates MinnesotaCare coverage for children under age 21 who are enrolled in a program of study at a postsecondary education institution and who have access to health coverage through the postsecondary education institution.	If federal law changes to allow, establishes the Minnesota partnership program for long-term care that will permit purchasers of qualified LTC insurance policies to exclude their assets from consideration for eligibility and estate recovery purposes when they apply for MA after exhausting the LTC policy benefits. A transitional support allowance is available to all persons under a home and community based waiver who are moving from a licensed setting to a community setting. This allowance is a one time payment of $3,000 to cover the costs not covered by other sources associated with moving to the community.

ATTACHMENT B

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM BENEFITS AND COST SHARING

NOTE: ALL PROVISIONS APPLY TO ALL MINNESOTA HEALTH CARE PROGRAMS UNLESS OTHERWISE NOTED.

EFFECTIVE DATE	BENEFIT CHANGES	COST SHARING CHANGES
7/1/2005	Prior authorization may be required for prescribing new drugs approved by the Food and Drug Administration (FDA) on or after July 1, 2005. Enrollees can continue to receive brand name drugs for treating mental illness for up to 60 days following FDA approval of a generic equivalent. Physicians can prescribe the generic equivalent or request prior authorization to continue the brand name drug during the 60 day period.	
7/15/2005		Requires DHS to apply for a federal waiver to charge sliding scale premiums, based on the MinnesotaCare sliding scale, to **MA** recipients with gross family incomes greater than 175% of FPG.
8/1/2005	Sex reassignment surgery is no longer covered.* Extended, psychiatric inpatient services in community hospitals is expanded to include stays longer than 45 days based on an individual review of medical necessity. * *Note: This provision requires federal approval.* DHS is authorized to develop a Program for All Inclusive Care of the Elderly (PACE). The White Earth reservation pilot project allowing the Tribe to manage the Elderly Waiver and personal care assistant (PCA) services for its members is expanded to all Minnesota tribes. Changes to PCA services will include requiring PCA providers to keep specific documentation on file for each client, including a statement of need; establishment of an on-going auditing process by the Department and department authority to address fraud and abuse; tightening of responsible party delegations; establishing limitations for the flexible use of PCA services; and requiring flexible use PCA services to be prior authorized.*	

*These benefit changes will become effective for prepaid health plan enrollees effective January 1, 2006. The contracts between DHS and Managed Care Organizations stipulate that covered benefits remain unchanged until the end of the contract year (December 31, 2005).

ATTACHMENT B

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM BENEFITS AND COST SHARING

NOTE: ALL PROVISIONS APPLY TO ALL MINNESOTA HEALTH CARE PROGRAMS UNLESS OTHERWISE NOTED.

9/1/2005	Circumcision is no longer covered unless medically necessary or required because of a well-established religious practice.* Drugs used for the treatment of erectile dysfunction are no longer covered with the exception of Viagra which will be covered for the treatment of pulmonary arterial hypertension if prior authorized.** The following services require prior authorization for a prepaid health plan (unless the health plan is using evidence-based practices to address these services:* • Outpatient high-technology imaging (PET scans, MRI, CT, nuclear cardiology) • Non-emergency spinal fusion • Bariatric surgery • Non-emergency cesarean section • Non-emergency insertion of tympanostomy tubes • Hysterectomy • Orthodontia The following services are added to fee-for-service prior authorization: • Outpatient high-technology imaging (PET scans, MRI, CT, nuclear cardiology) • Non-emergency spinal fusion • Non-emergency cesarean section • Non-emergency insertion of tympanostomy tubes • Hysterectomy	Increases **MinnesotaCare** premiums 8% for all adults; increases premiums 8% for children with income >150% of FPG. *Note: Premium increases for federally funded groups require federal approval. Premium increases will go into effect on 9/1/2005 or upon federal approval, whichever is later.*
10/1/2005	**MA** and **MinnesotaCare** will no longer cover visits to or services provided by a hospital emergency room that are not for emergency and emergency stabilization or post stabilization care or urgent care.*	
1/1/2006	The **MinnesotaCare Limited Benefit** $5,000 annual cap on non-inpatient services is removed. Diabetic supplies and equipment, psychologist and licensed clinical social worker services are added to the **MinnesotaCare Limited Benefit**. The $500 per calendar year limit on dental services for adults is removed. State funded prescription drug program **(PDP)** is repealed. **MA** does not cover drugs that are covered under Medicare Part D for individuals eligible for Medicare Part D.	A $5 co-payment for non-preventive chiropractor, psychologist, and licensed clinical social worker services is added for **MinnesotaCare Limited Benefit.** A $3 co-payment for non-preventive visits and a $6 co-payment for non-emergency emergency room visits are required for all **MinnesotaCare** adults, except pregnant women and those enrolled in the **MinnesotaCare Limited**

**This change will be effective September 1, 2005, for health plan enrollees. An exception included in the contracts allows changes to Pharmacy coverage during the contract year.

2005 LEGISLATIVE CHANGES AFFECTING MINNESOTA HEALTH CARE PROGRAM BENEFITS AND COST SHARING

NOTE: ALL PROVISIONS APPLY TO ALL MINNESOTA HEALTH CARE PROGRAMS UNLESS OTHERWISE NOTED.

	Coverage is expanded to include psychiatric consultation to primary care physicians. Coverage is expanded to allow mental health services to be provided via two-way interactive video if medically appropriate.	**Benefit.** **MA** and **GAMC** prescription drug co-payment limit is reduced from $20 to $12 per month. $3 co-payment for non preventive office visits in **GAMC** is eliminated.
7/1/2006	**MA** coverage is expanded to include treatment foster care for children with a severe emotional disturbance and Assertive Community Treatment (ACT) for children 16 and older with emotional disturbance who are in transition to the adult mental health system. *Subject to federal approval.*	

Minnesota Health Care Programs (MHCP)

2005 Legislative Notice to Enrollees/Recipients

The 2005 Minnesota Legislature made several changes to Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, the Prescription Drug Program (PDP). The changes may affect:

- **your eligibility for health care coverage,**
- **what your coverage will pay for,**
- **what you may have to pay,**
- **and more.**

The changes are listed inside this notice. Please read it carefully.

Note: An insert is included with this notice to save on postage costs.
Call the number on the insert if you have questions.

Medical Assistance (MA)

Changes that began July 1, 2005

Giving away or selling assets

We may not pay for some of your long-term care if you give away money or property for less than it is worth. We will keep paying your long-term care costs if we do not have time to tell you 10 days ahead of time that we will not pay, but the person you gave the money or property to may be sued. This is done to repay what MA paid for you.

People on work release

Some people who leave prison to go on work release may be able to get MA. You can get MA if you do not live in a locked correctional facility in the community or a local jail. For example, someone who lives in a half-way house or is on house arrest may be able to get MA.

Changes starting September 1, 2005

Proof of income and assets

You must give proof of all income and assets at renewal. You also must tell your worker when you have new income or your income goes up. You must tell your worker within 10 days of any change. You may have to give proof of the changes. Proof can be pay stubs from the past 30 days or a statement from your employer.

Pregnant women

You will have to tell your worker about your income and assets within two months after your baby is born, if you want to keep getting MA for yourself. You may have to give proof of any changes. This will not affect your baby's coverage.

Medical Assistance for Employed Persons with Disabilities (MA-EPD)

We will not count increases in your Social Security benefits as income until July 1 of each year.

Minnesota's Prescription Drug Program

The Prescription Drug Program (PDP) will end December 31, 2005. The new Medicare Prescription Drug Coverage (Part D) will help pay for prescription drugs starting January 1, 2006. All PDP enrollees can get Medicare Prescription Drug Coverage. If you want help signing up, call the Senior LinkAge Line® toll free at (800) 333-2433.

State liens to recover MA and Alternative Care payments

Liens on life estates and jointly owned property

MA liens and Notices of Potential Claims **filed after** August 1, 2003 on life estates and jointly owned interests in land that were **created before** August 1, 2003 will end and no longer be enforceable when the MA enrollee dies.

Liens for past Alternative Care (AC) services

The laws directing the state to file a lien against your property to recover AC payments made for you have been repealed. All recorded AC liens are no longer liens on your property. However, the state and counties will continue to file claims in your probate estate to recover AC payments made for you during your lifetime.

Questions about the changes on this page? Call your county worker.

MinnesotaCare

Changes that began August 5, 2005

Military duty

You can stop your MinnesotaCare while you or someone in your family is on active military duty. You can come back on the program when the tour of duty ends. We will not count changes to your income or assets until your next renewal date.

Changes starting September 1, 2005

Proof of income

You will have to give proof of all income at renewal. This includes income from jobs, unemployment, child support, rent, pensions and any other income.

Employer information

You must give your employer's name, a contact person and phone number at renewal. This is needed to find out if you can get health insurance from your employer. You cannot be on MinnesotaCare if your employer offers insurance and pays more than half of the monthly premium.

People eligible for Medicare

You cannot get MinnesotaCare if you can get Medicare Part A or B. At your next renewal, we will look to see if you can get Medicare. If you can get Medicare, your MinnesotaCare coverage will end.

Monthly premiums

The amount of your premium may change. If this happens, you will see the change on your monthly premium notice.

- Premiums may go up by 8 percent for all adults and for children in families that have income higher than the amounts listed in the chart below. (You can estimate how much it could go up by multiplying your current premium by .08.)

Family Size of:	1	2	4	6
	$1,197	$1,605	$2,013	$3,237

- Your premium may change right away when your income goes up or down. You must tell your worker about changes within 10 days of any change.

Students

MinnesotaCare may end for people under age 21 who can get health insurance through a college or vocational program they are attending. We will ask about this at renewal. We will send you a notice if it affects you or your child.

These changes (Monthly premiums and Students) will take effect if the federal government approves them.

General Assistance Medical Care (GAMC)

Changes starting September 1, 2006

The changes we are explaining below will not apply to you if you:

- are getting General Assistance or Group Residential Housing payments
- are applying for SSI or Social Security disability
- are applying for a disability determination through the state
- do not have a permanent address.

Parents of children ages 19 and 20 and stepparents

Your GAMC coverage will end if you are a parent of a child(ren) age 19 or 20 or a stepparent. You can keep getting GAMC if you fall into one of the groups listed above.

Coverage changing to MinnesotaCare

If you get GAMC (except those listed above), you will be moved to MinnesotaCare coverage as soon after Sept. 1, 2006 as you can be enrolled in a MinnesotaCare health plan.

You need to know that:

- Your county office still will handle your case.
- Your county will pay your MinnesotaCare premiums until your first six-month renewal.
- After the first six-month renewal, you will have to meet MinnesotaCare program rules and pay your monthly premium. (Some counties may keep paying premiums. Ask your county worker if they will pay your premiums after renewal.)
- If you lose your MinnesotaCare coverage, you can apply again for GAMC. We will move you to MinnesotaCare again as we explained above.

Questions about the changes on this page? Call your county or MinnesotaCare worker.

Co-pays starting January 1, 2006

The 2005 Legislature passed a law that added co-pays for some services and removed them for other services. A co-pay is an amount that you will be responsible to pay to the provider. This notice shows the co-pays starting Jan. 1, 2006 for each program. Please note that the charts list all co-pays for the programs even if some of the co-pays did not change because of the new law.

Co-pays apply to people who have fee-for-service coverage **and** people in health plans. If you are in a health plan and have questions about co-pays, call your health plan. The health plan will also send you a notice about co-pays before January 1, 2006.

The people listed here do not have to pay co-pays.

- Pregnant women (if you become pregnant, tell your worker right away)
- Children under age 21
- People residing or expecting to reside for more than 30 days in a nursing home or other long-term care facility
- People in the Refugee Medical Assistance Program
- MA enrollees receiving hospice care

Be sure you are reading the co-pay chart for the program in which you are enrolled. **If you don't know which program you are enrolled in, call your worker to find out.**

Medical Assistance (MA)

These are examples of services that do not have co-pays	These services have these co-pays
• Preventive care visits, like physicals • Inpatient hospital stays • Emergency services • Mental health services (counselor, psychiatrist, case manager) • Some mental health drugs (anti-psychotics) • Physical therapy, occupational therapy, and speech therapy • Family planning services • Tests such as blood work, X-rays and ultrasounds • Services at Indian Health Services clinics • Services covered by Medicare • Home care and waiver services • Dental services	• Non-preventive visits — like for a sore throat, high fever, sore back, etc. — provided by a physician, advanced practice nurse, chiropractor, podiatrist (foot doctor), audiologist (hearing), vision care (eye doctors) ..... $3 • Eyeglasses ..... $3 • Emergency room visit when it is not an emergency ..... $6 • Prescriptions Brand name ..... $3 Generic ..... $1 The most you will have to pay in co-pays for prescriptions is $12 per month.

MA with a spenddown: If you are on Medical Assistance with a spenddown, co-pays you pay will be applied to your spenddown. You will need to continue paying co-pays after your spenddown is met.

Questions about co-pays and benefit changes? Call your health plan or the MHCP Recipient Help Desk at (651) 296-7675 or 1(800) 657-3739.

MinnesotaCare Expanded Benefit Set –
There are no co-pays in this benefit set which is only for pregnant women and children.

If you become pregnant while on MinnesotaCare:

As of September 1, 2005, you will have the Expanded Benefit Set going back to the month of conception. You can ask for a refund of any co-pays you paid after conception if the month of conception is September 2005 or later.

MinnesotaCare Basic Plus, Basic Plus One, Basic Plus Two benefit sets	
These are examples of services that do not have co-pays	**These services have these co-pays**
• Preventive care visits, like physicals • Physical therapy, occupational therapy, speech therapy • Tests, such as blood work, X-rays and ultrasounds. • Preventive dental services • Home care	• Non-preventive visits — like for a sore throat, high fever, sore back, etc.— provided by a physician, advanced practice nurse, chiropractor, podiatrist (foot doctor), audiologist (hearing), vision care (eye doctors) ..... $3 • Emergency room visit when it is not an emergency..... $6 • Prescriptions ..... $3 • Eyeglasses..... $25 • Restorative dental (fillings, crowns, etc) for Basic Plus One and Basic Plus Two ..... 50% • Inpatient hospital stays (Basic Plus One only) 10% co-pay up to $1,000 per year

MinnesotaCare Limited Benefit Set	
These are examples of services that do not have co-pays	**These services have these co-pays**
• Preventive care visits, like physicals • Tests, such as blood work, X-rays and ultrasounds	• Non-preventive visits — like for sore throat, high fever, sore back, etc — provided by a physician, advanced practice nurse, chiropractor, eye doctor, psychologist, and licensed independent clinical social worker..... $5 • Emergency room visit..... $50 • Prescriptions ..... $3 The most you will have to pay in co-pays for prescriptions is $20 per month. • Inpatient hospital stay ..... 10% co-pay up to $1,000 per year

Questions about co-pays and benefit changes? Call your health plan or the MHCP Recipient Help Desk at (651) 296-7675 or 1(800) 657-3739.

General Assistance Medical Care (GAMC)	
These are examples of services that do not have co-pays	**These services have these co-pays**
• Preventive and non-preventive visits provided by a physician, advanced practice nurse, chiropractor, podiatrist (foot doctor), audiologist (hearing), eye doctor. • Inpatient hospital stay • Emergency services • Mental health services (counselor, psychiatrist) • Some mental health drugs (anti-psychotics) • Physical therapy, occupational therapy, and speech therapy • Family planning services • Tests such as blood work, X-rays and ultrasounds • Preventive dental services	• Eyeglasses.....$25 • Emergency room visit when it is not an emergency .....$25 • Prescriptions Brand name.....$3 Generic.....$1 The most you will have to pay in co-pays for prescriptions is $12 per month. Co-pays will not be charged for some mental health drugs. • Restorative dental services.....50%

General Assistance Medical Care (GAMC) – Hospital Only coverage
This program pays for inpatient hospital and physician care while in the hospital. Enrollees have a $1,000 co-pay for each inpatient stay. There is no co-pay on inpatient physician services.

Paying your co-pays

You must pay your co-pay to your provider. Most providers require that you pay the co-pay when you arrive for your appointment. If you see the same doctor more than once in a day, you only have to pay one co-pay to that doctor.

If you are unable to pay the co-pay, the provider must still provide services. Providers must take your word that you cannot pay. Providers cannot ask for documentation to prove that you cannot pay.

When you are unable to pay a co-pay, the provider must give you time to pay it. If the co-pay remains unpaid, the provider can then stop serving you. Providers may only stop serving you if they regularly refuse to serve people with unpaid bills. They must tell you in advance if they will no longer serve you.

Questions about co-pays and benefit changes? Call your health plan or the MHCP Recipient Help Desk at (651) 296-7675 or 1(800) 657-3739.

Changes in what Minnesota Health Care Programs Cover

$500 limit on dental services removed

Starting January 1, 2006

MA, MinnesotaCare and GAMC now have a $500 limit per year for dental services for many people. If you have dental coverage, there will be no limit starting January 1, 2006.

More mental health services covered

Starting January 1, 2006

MA, MinnesotaCare and GAMC will pay for:

- mental health services provided over interactive television.
- meetings (in person or other means) between your primary care doctor and a psychiatrist to improve your care for mental health problems.

Starting July 1, 2006

MA and MinnesotaCare will pay for:

- mental health treatment services for emotionally disturbed children in licensed treatment foster care homes.
- intensive community treatment team services for older adolescents with severe emotional disturbance.

Services no longer covered

MA, MinnesotaCare and GAMC will no longer pay for:

- sex reassignment surgery (starting August 1, 2005*)
- circumcision (starting September 1, 2005*), unless it is medically necessary or required by religious practice.

* If you are in a health plan, the effective date may be later. Your health plan will send you a notice telling you when these services will no longer be paid for.

MinnesotaCare Limited Benefit Set

$5,000 limit removed starting January 1, 2006

MinnesotaCare's Limited Benefit Set now has a $5,000 limit per year for health services (other than inpatient hospital). Starting January 1, 2006, there will be no limit on these services. This includes services such as:

- outpatient hospital care
- physician visits
- prescription drugs
- lab and other tests
- chiropractic care

You may still have a co-pay for these services. Please see page 4 for information about co-pays. The $10,000 limit on inpatient hospital services has not been changed.

New benefits starting January 1, 2006

MinnesotaCare Limited Benefit Set will pay for:

- diabetic supplies
- psychologists
- licensed clinical social workers

Change affecting people with Medicare and MA

Starting September 1, 2005

People on MA will be enrolled in a health plan when they have a private non-HMO Medicare plan. This applies even if the private plan is cost effective.

Questions about co-pays and benefit changes? Call your health plan or the MHCP Recipient Help Desk at (651) 296-7675 or 1(800) 657-3739.

Prescription Drug Coverage Changes

The information below does not apply to health plan members unless noted. If you are in a health plan, the health plan decides the covered drugs, where you get them, prices, and if prior approval is needed.

Changes that began July 1, 2005

Your doctor may have to get approval before prescribing a new drug. A new drug means a drug approved by the U.S. Food and Drug Administration after June 30, 2005. You may have to try another drug first, unless your doctor has a good reason for giving you the new drug.

Brand name drugs for treating mental illness. Normally, you must try the generic version of a drug before we will pay for the brand name version. If you are taking a brand name drug to treat mental illness and a generic becomes available, you can keep getting the brand name for up to 60 days. During that 60 days, your doctor can either switch you to the generic or try to get approval to keep giving you the brand name drug.

Changes that began August 1, 2005

Payment to pharmacies for some products used to treat hemophilia will go down. Pharmacies have been told of this change. If you have hemophilia, your pharmacy should continue to provide you with these products. Please call the Minnesota Health Care Program Recipient Help Desk if your pharmacy will not provide these products to you.

Changes starting September 1, 2005

Drugs used to treat impotence will no longer be covered. Viagra, Cialis, Levitra, Muse, Caverject, Edex and alprostadil will not be covered when used to treat impotence. Viagra, Cialis and Levitra may be covered when used to treat a lung problem called pulmonary hypertension. However, your doctor will have to get approval before those drugs will be covered for that problem. This change also applies to health plan enrollees.

Changes starting January 1, 2006

You may have to get some "specialty" drugs from a different pharmacy. The state may lower what we pay pharmacies for "specialty" drugs. These are very expensive drugs and many of them must be injected. They are used for multiple sclerosis, transplants, rheumatoid arthritis, liver disease and other serious and chronic problems. This may mean some pharmacies will stop providing specialty drugs to you. However, the state is working with other "specialty" pharmacies to make sure you can get the drugs you need. To find out if this affects you, ask your pharmacist whether they will continue providing specialty drugs or call the Minnesota Health Care Program help desk.

MA and GAMC enrollees may be able to get extra help from your pharmacists if you take four or more medicines. Pharmacists who have special training can provide a new service called medication therapy management. The pharmacist will work with you and your doctor to find and correct problems with your medications. To get this service, you usually must have at least two chronic health problems. Usually, you also must be taking at least four different medications. If you want this service, ask your pharmacist if they are enrolled with MHCP or your health plan to provide this service.

General Assistance Medical Care (GAMC) may cover fewer drugs. GAMC will no longer cover a drug if its manufacturer does not offer a discounted price. The state is trying to get all manufacturers to agree to provide discounts, but some might not agree. Pharmacists and doctors will get information later this year if GAMC will no longer pay for some drugs. They can help you switch to another drug that will be paid for.

Questions about co-pays and benefit changes? Call your health plan or the MHCP Recipient Help Desk at (651) 296-7675 or 1(800) 657-3739.

Appeal Rights

You have the right to appeal a reduction in benefits. An appeal is a legal process where a state referee reviews a decision made by the county agency or the Minnesota Department of Human Services. You may request the help of the county agency to file an appeal or you may appeal directly to the appeals unit of the Department of Human Services or to your health plan.

Appeals must be submitted within 30 days from the date of this Notice of Action, or 90 days if you can show good cause for failing to appeal within the 30-day limit. "Good cause" is when you have a good reason for not appealing on time. The State Appeals Office will decide if your reason is a good cause reason. You can send a letter appealing a decision to the county agency, or directly to the State Appeals Office.

If you appeal, you may represent yourself or ask an attorney, relative, friend or spokesperson to assist you.

Send your appeal request to:

Minnesota Department of Human Services
Appeals Unit
444 Lafayette Road
St. Paul, MN 55155-3813

If you file an appeal, keep paying your co-pays while your appeal is pending.

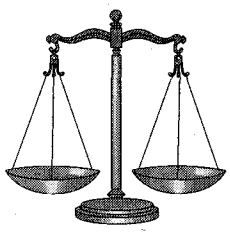
Notice of Action: August 10, 2005

This information is available in other forms to people with disabilities by calling us at (651) 296-7675 (voice) or toll free at 1 (800) 657-3739. TDD users can call the Minnesota Relay at 711 or 1 (800) 627-3529. For the Speech-to-Speech Relay, call 1 (877) 627-3848.

Minnesota Department of **Human Services**

DHS-4173-ENG 8-05
(was MS-2049)

Attachment D



Notice About Your Rights
for Minnesota's Managed Health Care Programs

You have the right to change your health plan.

If there is more than one health plan available in your county.

- You may change your health plan once during the first year after you are enrolled in managed care.
- There is an open enrollment 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 request to change your health plan *For Cause*, (including, but not limited to: lack of access to services and providers, 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 fair hearing.
- Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MnDHO) enrollees can disenroll at anytime.
- You may change your primary care clinic every 30 days upon request to the health plan.

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 who is part of the health plan network.
- 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, you can keep getting the service if you file a health plan appeal or request a State fair hearing **within ten days** after your health plan sends you the notice, or before the service is stopped or reduced, whichever is later. Your treating provider must agree the service should be continued. If you lose the appeal, you may have to pay for the health care services you received.

This information is available in other forms to people with disabilities by contacting us at (651) 296-1256 (voice) or toll free at (800) 657-3729. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

If you have a problem with your health plan, you can do any of these things:

You must appeal to the health plan **within 90 days** of receiving a notice that the health plan is decreasing or denying services or payment.

- Call your health plan. The phone number is on your health plan ID card. The health plan must answer you within 10 days.
- Write a letter to your health plan. Include your name, address and telephone number. The health plan must answer your letter within 30 days.
- Call your county Managed Health Care Unit, your MinnesotaCare enrollment representative or your Care Coordinator and ask for help.
- Call the Ombudsman Office for State Managed Health Care at (651) 296-1256 or toll free at (800) 657-3729. They can help you appeal to the health plan or request a State fair hearing. If you have a complaint that needs a decision quickly, tell the Ombudsman.
- Request a State fair hearing.

How to request a State fair hearing.

You must request a State fair hearing in writing **within 30 days** of receiving a notice that the health plan is decreasing or denying services or payment.

Write or Fax to:

Appeals Unit
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, MN 55155-3813 • Fax: (651) 297-3173

- You will get a letter telling you the date and time of the hearing.
- You may bring an attorney, relative, friend or advocate to the hearing.
- A State referee will make a decision about your case. The referee is not part of your health plan.

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼືໂທຣ໌ຫາ ຕາມເລກໂທຣ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

Attachment E DHS-2810-ENG 6-05

Minnesota Department of **Human Services**

Your Notice About Third-Party Liability

Minnesota Health Care Programs (MHCP) include Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare and the Prescription Drug Program.

What is third-party liability?

Third-party liability (TPL) means any other person, program, or company that must pay your medical bills or provide your medical care before MHCP. Examples of TPL include health insurance and private Health Maintenance Organization (HMO) coverage, Medicare, workers' compensation, accident benefits, car and home owner insurance and court-ordered insurance.

What must I do about TPL?

- You must report to your worker within 10 days:
  - health or accident insurance you have to cover medical bills;
  - changes in your insurance;
  - claims or lawsuits you file because you are injured;
  - workers' compensation claims you file;
  - health insurance you could have through your employment or your spouse's employment.
- You must follow the rules of your insurance plan or HMO to get care that they cover.
- If you currently are enrolled in a health plan through MHCP you must get your medical care through doctors in that plan. Even if you apply for another program, such as MA, GAMC or MinnesotaCare you still may have to continue using your health plan for one more month.
- When you get medical assistance from any MHCP, you have signed over your rights to payment of medical care from any third party. You have agreed to "Assignment of Benefits."
- You must help us get back any grant money or medical payments made for or to you by any liable person, program, or company.
- If you are paid by the insurance company, you must pay that money to your medical provider. ***You are not allowed to keep money paid to you for medical bills.***
- You must follow the rules of any health insurance or HMO plan that covers you or your children. You must always get the highest level of benefits you can.

How do I know if I can get insurance through my employer?

You must ask your employer if you could get health insurance from the employer's group plan.

It is important that you tell your worker about coverage you could get through your or your spouse's job. The worker needs to get this information and refer it to the state. The state will decide if it will pay your premium in order to get coverage or keep it in effect. This is called a "Cost Effective Review."

Federal laws (known as COBRA) require employers with 20 or more people to offer continuation coverage in certain cases.

Some examples:

- With termination, lay-off, or reduction in hours below 20 hours, employees can continue coverage up to 18 months.
- Widows, divorced spouses, spouses of Medicare-eligible employees, dependent children of any of these persons, and dependent children who lose eligibility due to age can continue coverage up to three years.

What happens if I file a lawsuit because of an injury?

If you file a claim to get money because of an injury, the Department of Human Services may file a claim in your lawsuit or workers' compensation claim. We may file a claim for the cost of medical care or grant money paid to you or your family because of the injury. Grant money means General Assistance (GA), Minnesota Family Investment Program (MFIP), and other cash payments.

What will happen if I do not cooperate with TPL rules?

You must cooperate to get MA, MinnesotaCare, or GAMC. If someone else is responsible to pay, you must help get medical care payments. You must give us information to help get third-party payments for you and your dependents.

If you do not cooperate, you may lose your MA, MinnesotaCare and GAMC. To get MA, you must cooperate by giving information about group health insurance you could enroll in through employment. If we decide the premium can be paid by MA or GAMC or there is no cost to you, you must enroll in the group insurance plan at the first open enrollment.

Who bills my health insurance or HMO?

Medical providers usually must bill your insurance plan or HMO before they bill MHCP. A federal law gives some exceptions to the rule that providers must bill insurance first. Your medical providers will have information about this.

You should not be asked to bill your insurance or to pay money for services covered by your insurance or MHCP unless you have a spenddown or MHCP co-pays. You must help your provider by completing insurance forms, giving needed information, etc. Have your insurance card or other information with you when you get medical care. Be sure to show all ID cards when you get care.

How should I use my private HMO or health insurance plan?

Private HMO or health insurance must pay first before MHCP. For care that your HMO or insurance plan pays for, you must follow the rules of the plan to get the care. Your plan may have some or all of these rules:

- You may need to go to certain medical providers. Some plans pay a different rate (100 percent vs. 80 percent) if you go to "preferred providers." **You must use providers who will get the highest rate of coverage for your care.**
- You may need to go to a provider with a certain type of license or education. This may be true for mental health services where services may be done by a nurse, a social worker, a psychologist, etc. Find out what your insurance plan will cover.
- You may need to get permission from the HMO or insurance plan first for some services.
- Your plan may have "managed" mental health or medical care. This may limit where you must go to get services.
- You may need a referral for some care or some providers.

Get a copy of your HMO or insurance plan to know the rules you must follow. You may need to get a denial from your HMO or insurance plan or have a copy of your policy. This will show the provider if a service is covered by the plan.

You must ask providers if they are MHCP providers and if they are approved under your HMO or private health insurance plan. This is important to ensure that you are not charged for services.

MHCP will not pay for care which could have been paid by an HMO or insurance plan. MHCP will pay for care not covered by the plan (if it is covered by MHCP) and for insurance co-payment fees up to the MHCP allowable.

What happens if I am enrolled in a prepaid health plan through MHCP?

If you are enrolled in a Prepaid Health Plan through MHCP, you need to know the following:

- Contact your MHCP Prepaid Health Plan before receiving health care. Tell them you have other insurance. Your prepaid health plan will tell you what to do.
- Use the providers that your MHCP Prepaid Health Plan tells you to use. Your MHCP Health Plan will coordinate with your private insurance plan.
- Follow your MHCP Prepaid Health Plan's rules. Otherwise, you may be responsible for all or part of your bills.
- If you currently are enrolled in a health plan through MHCP you must get your medical care through doctors in that plan. Even if you apply for a different program, such as MA, GAMC or MinnesotaCare you still may have to continue using your health plan for one more month.
- If you are able to get health insurance at work, tell your financial worker. You may be exempt from a MHCP Prepaid Health Plan if that premium is cost effective. The state will decide if it will pay the premium for your employer plan.
- Contact your MHCP Prepaid Health Plan's member services if you have questions about how to use your other insurance.

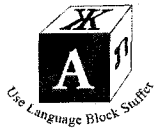
Information we must get about you

By federal law, we must check for health insurance or other third-party benefits you may be able to get. We must check data about you with other agencies or third-party payers. We will use your Social Security number to check data with:

- Minnesota Department of Labor and Industry workers' compensation records.
- Minnesota Department of Public Safety licensing and accident records.
- Minnesota Department of Employment and Economic Development wages and earnings.
- Private health insurance and HMO plan records of insured persons.
- United States Social Security Administration (SSA) Medicare.
- Other sources of TPL information

For more information contact your worker at the county agency. For MinnesotaCare enrollees call the MinnesotaCare Phone Center at (651) 297-3862 (metro) or (800) 657-3672 (toll free).

This information is available in other forms to people with disabilities by calling your county worker. For TTY/TDD users, contact your county worker through the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.



Benefit Recovery Section
Department of Human Services