



Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780-0419

MassHealth HIX Notice

You can get this information in large print and braille. Call 1-800-841-2900 from Monday to Friday, 8:00 A.M. to 5:00 P.M. TTY: 1-800-497-4648



000020

[REDACTED]

Date: November 27, 2018
Notice ID: 965318722/570/APPR-LIM-271118
Member ID: Not Available
SSN: Not Available

Dear [REDACTED]

MassHealth has approved the person listed below for MassHealth Limited. The Health Safety Net may be able to help pay for health care at Massachusetts acute hospitals or community health centers.

Members of your family who applied for health benefits but are not listed below may get another letter about their eligibility.

> Name: [REDACTED], Member ID: Not Available, Date of Birth: [REDACTED]
[REDACTED] Starting on November 01, 2018

If the person listed above is younger than the age of 19 and she or he is not approved for the Children's Medical Security Plan (CMSP) they do not qualify because they have access to other health insurance.

We have approved the person listed above for a limited time only! We need more information to decide if they can keep these benefits. You will also get a *Request for More Information* letter and the *List of Acceptable Documents* for you and your family. Read this to find out what information we need, the due date and how you can send it to us. This will help you keep the benefits that you have now.

If we do not receive the information by the due date, we will use available federal and state data sources to decide if person listed above still qualifies. This means that the health coverage of the people listed below may decrease or end.

If you have previously received an approval and a Request for More Information letter, you will still need to provide information requested in that letter or your benefits may change or end.

MassHealth Limited covers emergency services such as ambulance transportation, pharmacy services, visits to emergency rooms, emergency treatment of cancer, outpatient and inpatient hospital services, and labor and delivery. Organ transplants are not covered. There is no monthly premium (fee).

Qualifying American Indians do not have copays or premiums. More information can be found in the MassHealth regulations at 130 CMR 506.015 and 130 CMR 506.011.

Why doesn't the person on this letter qualify for more MassHealth benefits?

The listed person does not qualify for more MassHealth benefits because of one or more of the following reasons:

- The person does not meet citizenship and immigration requirements. 130 CMR 504.000
- The person does not have a special circumstance such as pregnancy or disability. 130 CMR 505.002(A) and (E) and 130 CMR 505.004

To find out which of these reasons apply or if you think they may qualify for more benefits based on pregnancy, disability or a change in immigration status, call MassHealth Customer Service at 1-800-841-2900 (TTY:1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

The person listed above may qualify for health insurance through the Massachusetts Health Connector. The Health Connector will send another notice to let you know if you qualify. If you want to know more, go to MAhealthconnector.org or call Health Connector Customer Service at 1-877 MA ENROLL (1-877-623-6765) or TTY 1-877-623-7773 if you are deaf, hard of hearing or speech disabled.

MassHealth Limited provides limited benefits. It does not satisfy either federal or state law that requires most people to have health insurance.

How did we make our decision?



MassHealth uses the rules for household size and income to make a decision. We also consider pregnancy, disability, immigration status, and breast or cervical cancer or HIV.

Household size is based on how you and your dependents are claimed on your tax return and who you are related to and live with. If you do not file taxes, household size is based on who you are related to and live with.

We used this information to make our decision.

- ❖ Household size: 1
- ❖ Monthly household income: 0.00% of the federal poverty level (FPL)

To decide your income, we mostly count income taxable by the IRS.

The person approved on this letter can get MassHealth Limited and the Health Safety Net according to the MassHealth regulations 130 CMR 505.006 and the Health Safety Net regulations at 101 CMR 613.00.

If indicated above, the person listed on this letter may get CMSP benefits according to MassHealth regulations 130 CMR 522.004. Go to www.mass.gov/eohhs/gov/laws-regs/masshealth/regulations/member-eligibility-regulations.html to find these regulations.

What happens next?

New members will get their MassHealth cards in the mail. Show this card to the doctor or pharmacy when getting medical services.

How does the Health Safety Net work?

The Health Safety Net is not insurance. It pays for certain care at Massachusetts community health centers and acute hospitals. There is no Health Safety Net membership card. You may want to bring this notice to your appointments. Ask your health-care provider what the Health Safety Net can pay for.

Go to www.mass.gov/masshealth/healthsafetynet/patients to find more information about Health Safety Net provider locations, what the Health Safety Net pays for, and to read other frequently asked questions.

IMPORTANT: In many hospitals, the doctors work for private groups. They are not hospital employees. The Health Safety Net does not pay for private doctor services or private lab or radiology tests even when you get those services in a hospital. Check to see if your provider accepts the Health Safety Net before you get services.

If the person approved on this letter has other health insurance, they must use that health insurance first, before the Health Safety Net can pay for their services. There may be copays and deductibles. Pay these charges directly to the health care provider. Keep a copy of all medical bills and payments.

Go to www.mass.gov/eohhs/gov/laws-regs/masshealth/regulations/member-eligibility-regulations.html to find the MassHealth regulations and www.mass.gov/eohhs/gov/laws-regs/hhs/health-safety-net-regulations.html to find the Health Safety Net regulations.

Children's Medical Security Plan

If listed above, the person in this letter may qualify for CMSP. CMSP pays for outpatient services including preventive and sick visits, eye exams and hearing tests, dental services and prescription medicines. There may be some co-payments and yearly (\$) limits on certain types of covered services. There is no monthly premium (fee).

If the person listed on this letter gets CMSP, they need to pick a doctor. For a list of all CMSP doctors, go to www.cmspkids.com or call CMSP Customer Service at 1-800-909-2677. When you make an appointment, make sure the doctor accepts CMSP. They will also get their CMSP card in the mail. Show this card to the doctor or pharmacy when getting medical services.

What else do you need to know?

- The **Member Booklet** explains income rules, premiums, and covered services for MassHealth. To get a copy, go to www.mass.gov/masshealth and click "Member Library" or call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

You must report changes. How can you give us this information?

You must report any change in your information to MassHealth as soon as possible, but **no later than 10 days**, from the date of the change. This includes any changes to your income, address, phone number, family size, job, or health insurance.

You can give us this information in the following ways.

1. **Online (*Recommended*)**: The fastest way to update your information for your household is online through our website at MAhealthconnector.org.
 - Go to <https://mahealthconnector.optum.com/individual/code/MWvyfa> where you will be able to create an account and see your information.
2. **Fax: 1-857-323-8300**
3. **Mail**: Commonwealth of Massachusetts
Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780-0419
4. **Call: 1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

What if you do not agree with our decision?

You can ask for a fair hearing if you do not agree with our decision.

- Read *How to Ask for a Fair Hearing* that came with this letter.

What other assistance is available to you?

For free good foods and help with healthy eating, call the Women, Infants and Children (WIC) nutrition program. WIC serves pregnant women, children under five, and new mothers. One or more members of your family may be eligible for WIC services. Call the WIC Hotline at 1-800-942-1007.

What if you have questions?

- If you have questions about CMSP, call CMSP at 1-800-909-2677.
- If you have questions about the Health Safety Net go to www.mass.gov/MassHealth/healthsafetynet/patients or call 1-877-910-2100.
- If you have questions about MassHealth, go to www.mass.gov/masshealth or call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Thank you.

MassHealth

How to Ask for a Fair Hearing

Your Right to Appeal. If you disagree with the action taken by MassHealth, you have the right to appeal and ask for a hearing before an impartial hearing officer. You can also request a hearing if MassHealth did not act on your request in a reasonable time.

How to Appeal. To ask for a hearing, fill out this hearing request form and send it to the Appeal Processing Center, P.O. Box 4405, Taunton, MA 02780-0419 or fax it to 1-857-323-8300. If you have a question about your hearing call 617-847-1200 or 1-800-655-0338.

The Board of Hearings must receive your completed, signed request within 30 calendar days from the date you received the notice of our action. If you did not receive a written notice of the action to be taken, or MassHealth did not take an action on your application, you must send your request no later than 120 calendar days from the date the action takes place.

If You Are Now Getting MassHealth Benefits. You may be eligible to keep your benefits between the time you appeal and the time that the Board of Hearings makes a decision to approve or deny your appeal. If you decide to keep your benefits between the time the appeal is pending, and then you lose your appeal, you may have to pay back the cost of the benefits you received. If you do not get benefits, and then you win your appeal, we will restore your benefits. You will keep your benefits if the hearing form is received either before the benefit stops or within 10 calendar days from the date of the MassHealth notice, whichever is later. Please mark your choice in the "If You Are Now Getting Benefits" section of the form.

Date of Hearing. At least 10 days before the hearing, we will send you a notice telling you the date, time and place of the hearing. Your hearing may be conducted by phone. You can ask us to reschedule a hearing, but you must have good cause. If you do not reschedule or appear on time to the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing. At the hearing, you may have a lawyer or other person represent you, or you may represent yourself. We will not pay for anyone to represent you. You may contact a local legal aid service or community agency to see if you can receive advice or representation at no cost. A hearing request can also be filed on your behalf by an individual authorized to act on your behalf. If someone other than a lawyer is acting on your behalf, please attach a copy of the document authorizing that person to file a hearing request on your behalf (for example, Power of Attorney, Guardian, Health Care Proxy).

If You Need an Interpreter, Assistive Device, or Other Accommodation. If you do not understand English or if you are hearing or sight impaired, we will provide an interpreter or assistive device at the hearing at no cost to you. We will also make other reasonable accommodations a person with a disability may need to participate in the hearing. Please tell us what you need in the "Other Information" section of the form.

Your Right to Review Your Case File. You and/or your representative can review your case file before the hearing. If you wish to review your case file, call 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Your Right to Ask to Subpoena Witnesses and Your Right to Question. You or your representative may write to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and cross-examine witnesses at the hearing. This means you can ask questions of witnesses. The hearing officer will make a decision based on all evidence presented at the hearing.

Impact on Other Household Members. Please note that an appeal decision for one household member may result in a change in eligibility for other household members. If that happens, any affected household members will receive a new eligibility notice explaining the changes.

HOH: [REDACTED]

Member ID: Not Available

Fair Hearing Request Form

[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
First Name	Middle Initial	Last Name	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Mailing Address	City	State	Zip
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Phone Number	Member ID	Date of Birth	

Reason For Your Appeal (Circle any reason(s) that may apply.)

- | | | |
|-------------|--------------------------------|---------------------------|
| Income | Citizenship/Immigration Status | Access to Other Insurance |
| Family Size | Residency | Incarceration Status |

Other: _____

Please explain why you are appealing. Attach any documents that support your reason.

Other Information (Check one if you are now getting MassHealth.)

- I accept the proposed change in my coverage during the appeal process. If you check this line and you win your appeal, we will restore your original level of benefits.
- I want to keep the benefits during the appeal process that I was receiving before. If you check this line, and you lose your appeal, you may have to pay back the cost of the benefits you received during your appeal.
- I need an interpreter. My language is _____ (We will provide the interpreter for the hearing.)
- I need an assistive device to communicate at a hearing. _____ (Describe what type of device you need, and we will provide an assistive device for the hearing.)
- I need another accommodation for a disability. (Describe the accommodation needed.) _____

I need an expedited hearing

Name of Appeal Representative, if you have one:

_____	_____
Appeal Representative name	Phone number

_____	_____	_____	_____
Mailing Address	City	State	Zip

Signature

The information on this form is true and accurate, to the best of my knowledge. I authorize MassHealth to provide me and my representative, if I have one, with my individual information, including federal and state tax information used in the determination of my eligibility, for purposes of this appeal process.

_____	_____	_____
Signature (Sign)	Date	First and Last Name (Print)

If this is signed by someone other than an appellant 18 years of age or older who has authority to file, please attach a copy of your authority to file the appeal on behalf of the appellant (for example, a copy of your power of attorney document or evidence of court appointment as a personal representative).