The Commonwealth of Massachusetts
Executive Office of Health and Human Services
MassHealth Premium Assistance Program
PO Box 120068, Boston, MA 02112

6/28/19

MassHealth ID#: 100010001000 Case ID: SHP111

Jane Doe
10 Smith Lane
Orange, MA 01010

Dear Jane Doe

Good News! MassHealth has determined that you are enrolled in an acceptable student health insurance plan (SHIP) and has approved you for the MassHealth SHIP Premium Assistance Program (Program). This means that MassHealth will cover the premiums for your student health insurance plan beginning on ***9/1/19*** , either for the entire plan year or by semester depending on how your school administers their SHIP program. MassHealth will send premium payment directly to your school or insurance carrier on your behalf.

MassHealth may also cover services that are not covered by your student health plan, such as doctor and clinic visits, hospital stays, prescription medicines, personal care attendant services, dental services, and transportation to medical appointments, even if it is not an emergency. This may include copays and deductibles. **Always show both your MassHealth and your student health insurance card when getting medical services.**

Enrollment in SHIP Premium Assistance Program is mandatory if you qualify for it.
Please be aware that if you qualify for the Program, MassHealth requires that you enroll in and stay on a SHIP plan if you have access to one. This will not cost you more than you may currently pay for MassHealth. If you do not enroll in the SHIP plan, you may lose your MassHealth benefits. If you receive coordination services through the Department of Children and Families (DCF) or receive services through the Children's Behavioral Health Initiative (CBHI), or if you have complex medical needs and are concerned about your ability to continue a current treatment, you may have additional options. Please contact SHIP PA customer service at 1-855-273-5903 to learn more.

The member approved to receive Premium Assistance is:

- Jane Doe,
  MassHealth ID#: 100010001000

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Your MassHealth coverage will continue without interruption until your SHIP policy ends.
This program allows for you to have continuous MassHealth eligibility without interruption while you are covered on your SHIP plan. You must be active on MassHealth as of the start date of the SHIP policy shown above for this to happen. Please be sure to still respond to all requests for information from MassHealth during this period.

You must report changes. How can you send us 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 changes to your income, address, phone number, family size, job, health insurance coverage or health insurance premiums.

- To report changes to **your health insurance (coverage or premium cost)** you can contact the Premium Assistance Unit in the following ways:

  Call: 1-855-273-5903 TTY: 1-617-886-8102 (For people who are deaf, hard of hearing or speech disabled.)

  Fax: 1-617-886-8400

  Mail: MassHealth Premium Assistance Unit - SHIP
  PO Box 120068
  Boston, MA 02112

- To report **all other changes**, you can contact MassHealth in the following ways:

  Call: 1-800-841-2900
  TTY: 1-800-497-4648 (For people who are deaf, hard of hearing or speech disabled.)

  Fax: 1-857-323-8300

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

How did we make this decision?
MassHealth has determined that the health insurance meets MassHealth rules for Premium Assistance. This is according to MassHealth regulations at 130 CMR 506.012.

What if you think our decision is wrong?
You can ask for a fair hearing if you do not agree with our decision.

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

The Premium Assistance Unit looks forward to working with you. Please do not hesitate to call if you have any further questions. The Premium Assistance Unit can be reached by calling 855-273-5903.

Sincerely,
MassHealth Premium Assistance Unit

Name: Jane Doe **SSN:** xxx-xx-0000
Date: June 28, 2019 **SHIP Premium Assistance**

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 **Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171 or fax it to (617) 847-1204.** If you have a question about your hearing call (617) 847-1200 or (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 mailing date of the MassHealth notice, whichever is later. Please mark your choice in the Other Information section of the form.

Date of Fair 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 (800) 841-2900, TTY: (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.

FHR-1 (Rev. 04-19)

FAIR HEARING REQUEST FORM

First Name: _____

Middle Initial: _____

Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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 (see below)

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: _____ Date: _____

First & 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).