You can get this information in large print. Call **1-877-623-6765** from Monday to Friday, 8:00 a.m. to 6:00 p.m. **TTY: 1-877-623-7773**

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

[Recipient Name]
[Organization Name]
[Address Line 1]
[Address Line 2]
[City], [State] [Zip]

Date: [Notice Date]
Notice ID: [Notice ID] Notice Name: [Notice Name]
Member ID: [Member ID]

Attn: [ARD Name] Re: Notice sent to [Primary Recipient Name]

Dear [Primary Recipient Name],

Thank you for applying for insurance coverage through the Massachusetts Health Connector. Based on the information that you gave us, the people listed below qualify for the following type(s) of coverage:

Household Member	Member ID	Coverage Type	Eligibility Start Date
[Household Member Name]	[Member ID]	[Coverage Type]	[Effective Date]
[Household Member Name]	[Member ID]	[Coverage Type]	[Effective Date]

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However, we must get more information by [Deadline Date]. We need more proof to confirm that the people listed above qualify for this coverage. You will get another letter telling you more about the information that we need and what you can send us for proof.

If we do not get the information we need by [Deadline Date], the people listed on this notice may not get coverage. If they are already enrolled in a plan, they may lose coverage at the end of [Deadline month].

Comment [FS1]: Dynamic Fragment. Only included if provisional approval.

Comment [FS2]: Dynamic fragment. Only include if AI/AN.

American Indian/Alaska Native

According to our records, you are an American Indian or Alaska Native.

You will not have to pay any out-of-pocket costs when you get services directly from an Indian Health Service (IHS) Center, tribal or Urban Indian organization, or through the Contract Health Service program. See the law at 45 C.F.R . §155.350.

If your income is below 300% of the federal poverty level (for example, $71,550 for a family of 4), you will also not have to pay out-of-pocket costs like deductibles and co-payments when you go to get care.

Choose a plan and pay the first monthly premium bill before coverage can start

Comment [FS3]: Dynamic Fragment. Only include if approval is final (no member of household requires verification).

You must choose a plan and pay the first monthly premium bill before coverage can start.

If you have not chosen a plan, please go to MAhealthconnector.org and follow the steps for choosing a plan.

If you chose a plan already, you must pay the bill by the due date to start being covered.

You can pay your bill after you get it in the mail. Once you pay your bill we will send you a letter telling you about your plan and the date coverage will begin. The insurance company will also contact you with more information about the coverage.

What are ConnectorCare plans?

Comment [FS4]: Dynamic Fragment. Only include if any household member is eligible for ConnectorCare (Wrap).

ConnectorCare plans are a set of plans that offer lower monthly premium bills and lower out-of-pocket costs, because they are partially paid for by the state. If you qualify for a ConnectorCare plan, you will be able to get the most savings possible if you enroll in one of these plans.

What is an Advance Premium Tax Credit?

Comment [FS5]: Dynamic Fragment. Only include if any household member is eligible for subsidy.

An Advance Premium Tax Credit is a tax credit that helps to lower your monthly health insurance premium bill. The tax credit is paid to your insurance company every month by the federal government, so your monthly bill is lower. Your tax credit is based on the income you and the people in your tax household expect to have during the year. If you qualify for a tax credit, you may be able to use some of the tax credit towards the purchase of dental insurance as well.

The maximum amount that your tax household may apply toward your monthly premium is **[$APTC Amount]**

If you end up making more money than you estimated for the year, you may have to pay back some of the credit you received. If you end up making less money than you estimated, you may get the difference at tax time. If you have a change in your income, you should report it to the Health Connector as soon as possible.

Remember that you will need to file taxes and if you are married you must file jointly for the year in which you receive tax credits.

Changing your tax credit amount

You may choose to apply less than the full amount of your tax credit to your monthly premiums. If you choose to take less of a tax credit, your actual health coverage premium will increase by the same amount. For example: if you decide to take $20 *less* per month from your available tax credit, your premium bill will be $20 *more* per month.

If you want to change the amount of tax credit that gets applied to your monthly premium, go to BetterMAhealthconnector.org/tax-credit and download our Change in Tax Credit form. Or call Customer Service to have a copy of the form mailed to you. You will need to fill out the form and mail to us as soon as possible so that your monthly bill can be updated. Any new documents and

payments will be due before the 23rd of the month prior to the month that you want your change in amount to take effect.

Why is my tax credit $0.00?

Comment [FS6]: Dynamic Fragment. Only include if any household member applied for subsidy, but has an APTC amount of Zero or less than zero.

If your tax credit amount is $0.00, it is because there are good, high-quality plans that are available to you through the Health Connector at an affordable premium, without any extra help.

Tax credit amounts are determined by several factors, including your household income and the number of people in your tax household. Using this information, we figure out how much the federal government has said that you should reasonably be able to afford for health insurance each month. Then, we look at the cost of the second least-expensive Silver tier plan available to you, and compare the cost of that plan to the amount that you should be able to afford. The difference between these two numbers will help determine how much money you can get as a premium tax credit. If there is no difference between the amount that the federal government has determined you can afford, and the amount that the second least-expensive Silver plan costs, then your tax credit will be $0.

Find out if you qualify for help paying for coverage

Comment [FS7]: Dynamic Fragment. Only include if any household member did NOT apply for subsidy.

You may be able to qualify for programs that help you pay for health insurance and out-of-pocket costs. You can apply at any time to find out if you qualify. To apply for help paying for coverage, go to **MAhealthconnector.org** and fill out an application online.

How did we make this decision?

The people listed on this notice qualify for coverage for the following reasons:

- [Household Member Name] **Member ID:** [Member ID]
  - You are a resident of Massachusetts 45 C.F.R. §155.305(a)(3)
  - You are a United States citizen or non-citizen who is lawfully present 45 C.F.R. §155.305(a)(1)
  - Our records indicate that you are not serving a prison sentence 45 C.F.R. §155.305(a)(2)
  - You do not have access to health insurance through another source that meets minimum essential coverage standards. 45 C.F.R. §155.305(f)(2)
  - Our records indicate that your annual household income is [MAGI Annual FPL %] of the Federal Poverty Level 45 C.F.R. §155.305(f)(2)(B)

- [Household Member Name] **Member ID:** [Member ID]
  - You are a resident of Massachusetts 45 C.F.R. §155.305(a)(3)
  - You are a United States citizen or non-citizen who is lawfully present 45 C.F.R. §155.305(a)(1)
  - Our records indicate that you are not serving a prison sentence 45 C.F.R. §155.305(a)(2)
  - You do not have access to health insurance through another source that meets minimum essential coverage standards. 45 C.F.R. §155.305(f)(2)

- Our records indicate that your annual household income is [MAGI Annual FPL %] of the Federal Poverty Level 45 C.F.R. §155.305(f)(2)(B)

Comment [FS8]: Dynamic Fragment. Only include if the approval is final (no member of the household has outstanding verification items).

However, the people listed below do not qualify for help paying for coverage though a tax credit or ConnectorCare plan.

- [House hold Member Name] Member ID: [Member ID]
  Does not qualify because of one or both of the following reasons:
  - Your annual income is too high 45 C.F.R. §155.305(f)(i)
  - You have access to health insurance through another source that meets minimum essential coverage standards 45 C.F.R. §155.305(f)(1)(ii)(B) & 26 C.F.R. 1.36B-2(a)(2)
  - You are not an applicable tax filer. In order to qualify, you must: file an income tax return, not be claimed as a dependent on someone else's tax return, or file jointly, if married. 26 C.F.R. 1.36B-2(b)

Comment [FS9]: Dynamic Fragment. Only include if any Household Member applied for a subsidy and was determined eligible for a Health Connector Plan, but ineligible for a subsidy.

If you do not agree with our decision

Comment [FS10]: Dynamic Fragment. Only include if the approval is final (no member of the household has outstanding verification items).

You may appeal to the Health Connector if you do not agree with our decision. Please use the ***Hearing Request Form*** that came with this letter.

If your information changes

Comment [FS11]: Static Fragment. Always include.

Please report changes that may impact coverage to the Health Connector **within 30 days**. These include any changes in address, family size, etc. You must also report income or health insurance access changes if you are receiving a premium tax credit. You can report these changes to Health Connector by calling Customer Service.

It is important that you let us know right away if you have a change of address. We sometimes send important notices affecting coverage, and if you do not receive those notices because we have an old address, you risk losing your health coverage.

You may qualify for certain MassHealth benefits

Comment [FS12]: Dynamic Fragment. Only include if any Household Member applied for a subsidy.

MassHealth will also check to see if the people listed above qualify for health coverage through MassHealth, the Health Safety Net (HSN), or Children's Medical Security Plan (CMSP).

They will get another letter to let them know if they qualify for any of these programs. MassHealth will contact them if they need more information to make a decision. If you have any questions, 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).

If you have questions

Comment [FS13]: Static Fragment.

Call Health Connector Customer Service at 1-877-MA ENROLL (1-877-623-6765) or TTY: 1-877-623-7773, Monday through Friday, 8:00 a.m. to 6:00 p.m. Or visit MAhealthconnector.org.

Thank you,

Massachusetts Health Connector

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If you think our decision is wrong

You may use this **Hearing Request Form** to appeal the Health Connector's decision.

Your Right to Appeal
If you disagree with the action taken by the Massachusetts Health Connector, you have the right to appeal and ask for a hearing before an impartial hearing officer. You can also request a hearing if no one acted on your request in a reasonable time.

How to Appeal
To ask for a hearing, fill out this form and send it to the **Massachusetts Health Connector Appeals Unit, P.O. Box 960189 Boston, MA 02196** or fax it to **1-617-933-3099**. For information about appealing by phone, please call customer service at 1-877-MA-ENROLL (1-877-623-6765). Please keep a copy of your request for hearing form for your information. We must receive your completed, signed request within 30 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 the Health Connector did not take an action on your application, you must send your request 120 days from the date of the intended action.

If You Are Now Getting Benefits
You may be eligible to keep your benefits while your appeal is decided. If you keep your benefits, and then lose your appeal, you may have to pay back the benefits you received during your appeal. If you do not keep your benefits, and then you win your appeal, we will restore your benefits. Please check one of the lines in the "If You Are Now Getting Benefits" section of the form.

Date of Hearing
At least 15 days before the hearing, we will send you a notice telling you the date and time of the hearing. Your hearing will be conducted by phone, but you may request an in-person hearing for good cause by calling the Health Connector Appeals Unit at 1-617-933-3096 (TTY: 1-877-623-7773). If you need the hearing quickly to avoid harm to your health, please check the line on the back of the form to request an expedited hearing. We will determine if you qualify for an expedited hearing.

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 someone to file a hearing request on your behalf (for example, Power of Attorney, Guardian, or Authorized Representative).

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 or your representative can review your case file before the hearing. If you wish to review your case file, please call the Health Connector Appeals Unit at 1-617-933-3096 (TTY: 1-877-623-7773).

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 ask questions of witnesses at the hearing. 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.

Hearing Request Form

[Primary Recipient Name]

Notice ID: [Notice ID] **Notice Date:** [Notice Date]

First Name	Middle Initial	Last Name	
Mailing address	City [Member ID]	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:_____

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

_____
_____

Keeping benefits during appeal (Check one if you are now getting benefits)
__ I wish to accept, during the appeal process, the proposed change in my coverage in the notice I received. (If you check here and win your appeal, we will restore your original level of benefits)
__ I wish to keep getting the same level of benefits during the appeal process that I was receiving before. (If you check here and lose your appeal, you may have to pay back the cost of the benefits you received during your appeal)

Other information Please check all that may apply. If you need an interpreter, assistive device, or other accommodation, we will provide for you at the hearing. Please describe your needs below.
__ I need an interpreter. My language is_____
__ I need an assistive device to communicate at a hearing. (Describe device)_____
__ I need another accommodation for a disability (Describe accommodation)_____
__ I need an expedited hearing to avoid harm to my health, because _____

Appeal Representative, if any

First Name	Last Name			Title
Mailing Address	City	State	Zip code	Phone Number

Signature The information on this form is true and accurate, to the best of my knowledge. I authorize the Health Connector to provide me and, if I have one, my representative or translator 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 authorized representative form, power of attorney document, or evidence of court appointment as a personal representative).

[FPL]%

Important! This has important information about your health insurance. If you want the information translated into your own language, call **1-877-623-6765**.

¡Importante! Esto tiene información importante sobre su seguro de salud. Si usted quiere la información traducida a su propio idioma, llame al **1-877-623-6765**.

Spanish

សំខាន់! ក្នុងនេះមានព័ត៌មានសំខាន់អំពី ជានារ៉ាប់រងសុខភាពរបស់អ្នក។ ប្រសិនបើអ្នកចង់បានព័ត៌មាននេះបកប្រែជាភាសារបស់ អ្នក សូមទូរស័ព្ទមកលេខ **1-877-623-6765**។

Cambodian

重要提示：該文件載有關於您的醫療保險的重要資訊。如果您想要將相關資訊翻譯為您的母語，請致電 1-877-623-6765。

Traditional Chinese (Cantonese)

重要提示：该文件载有关于您的医疗保险的重要信息。如果您想要将相关信息翻译为您的母语，请致电 1-877-623-6765。

Simplified Chinese (Mandarin)

Enpòtan! Sa a gen enfòmasyon enpòtan ou asirans sante ou. Si w vle nou tradwi enfòmasyon an nan pwòp lang ou rele **1-877-623-6765**.

Haitian Creole

ສິ່ງສຳຄັນ! ນີ້ມີຂໍ້ມູນທສຳຄັນກ່ຽວກັບການປະກັນໄພສຸຂະພາບຂອງທ່ານ. ຖ້າຫາກທ່ານຕ້ອງການຂໍ້ມູນຂ່າວສານເຂົ້າໃນການແປພາສາໂທຫາ **1-877-623-6765** ຂອງຕົນເອງຂອງທ່ານ.

Laotian

Importante! Neste pacote há informações importantes sobre o seu seguro-saúde. Se quiser que as informações sejam traduzidas para o seu idioma, ligue para **1-877-623-6765**.

Brazilian Portuguese

Importante! Contém informações importantes sobre o seu seguro de saúde. Se desejar a tradução das informações para a sua língua, contacte-nos pelo telefone **1-877-623-6765**.

European Portuguese

Важная информация! Здесь содержится важная информация о Вашем медицинском страховании. Если Вы хотите, чтобы информация была переведена на Ваш родной язык, позвоните по номеру: **1-877-623-6765**.

Russian

Lưu ý quan trọng! Đây là thông tin quan trọng về bảo hiểm y tế của quý vị. Nếu quý vị muốn có bản dịch thông tin này bằng ngôn ngữ của quý vị, hãy gọi số **1-877-623-6765**.

Vietnamese