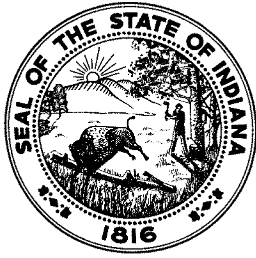

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Notice of Cost Share Restart

Indiana Family and Social Services Administration
PO Box 1810
Marion, IN 46952
Phone/Fax: 1-800-403-0864

Payee Name : Firstname M Lastname
CaseNumber : 2301227803
AG Number : 25824135
Program : Health Coverage
Mailing Date : DECEMBER 13, 2023

Firstname M Lastname
Main Street
Indianapolis, IN 46204-5858

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE AFTER COVID-19 FEDERAL PUBLIC HEALTH EMERGENCY RULES END

Due to the COVID-19 public health emergency, Indiana has not charged premiums, contributions or copays for Medicaid, including the Healthy Indiana Plan or HIP, coverage since March of 2020. Normal rules for cost-sharing will resume effective MAY 01, 2024.

You currently have health coverage through HIP State Plan Plus. HIP State Plan Plus includes coverage for vision and dental benefits and does not require a co-pay for doctor visits, hospitalizations, or prescriptions. The only copayments in HIP State Plan Plus are for using the emergency room for non-emergencies, but if you call your health plan's 24-hour nurse line first and they tell you to go to the emergency room, you will not have to pay this copayment. Medicaid will continue to cover COVID-19 testing and vaccines with no copayments for all members.

The four health plans for HIP are Anthem, CareSource, MHS, and MDwise. If you are not sure who your health plan is or how to contact them, please call 1-877-GET-HIP-9 and the enrollment broker can provide you the information.

In the HIP program, the first $2,500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) Account. The state will pay most of this amount, but in HIP State Plan Plus you will also be responsible for paying a portion of your initial health care costs. Your portion is paid through an affordable, monthly contribution to your POWER Account based on income and could be as low as $1. Preventive services do not get charged to your POWER Account, and you are not responsible for paying any expenses that go beyond the $2,500 in your POWER Account as these will be paid for by your health plan.

YOU NEED TO MAKE YOUR FIRST POWER ACCOUNT CONTRIBUTION IF YOU WANT TO CONTINUE RECEIVING COVERAGE UNDER HIP PLUS.

In a few days, your health plan will send you the bill for your first monthly POWER Account Contribution (PAC) payment. You need to make your payment by the due date that is on the invoice. There is a grace period for paying late, but **if you do not make the payment within the allowed payment period, your coverage will change to HIP State Plan with copays.** Since you have a health condition that makes you medically frail, you will continue to receive benefits but will now owe copayments on most services received. This means that you will be required to make a payment, called a copayment, for most doctors' office visits, hospital stays and prescription drugs. These payments may range from $4 to $8 per doctor visit or prescription filled and may be as high as $75 per hospital stay. Preventive care services never have copays for any category of HIP. Medicaid will continue to cover COVID-19 testing and vaccines with no copayments. You will also continue to owe your monthly POWER account contribution to your health plan. Please contact your health plan for details on your due date and payment period.

Your POWER Account contribution is based on your countable monthly income of $2143.12. **The PAC payment based on your current income is $1.00.** This amount can be paid in monthly installments, or you may choose to pay ahead for multiple months at any time during your eligibility period. If your income increases or decreases, your PAC will be recalculated based on the new income amount.

You will have the option to re-enroll in HIP Plus during your next scheduled annual redetermination. In HIP Plus you would not owe copayments on services. Any unpaid debt you incur through the rest of your current eligibility period will not be used against you to prevent you from being able to re-enroll in HIP Plus at your next annual redetermination.

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If you have identified yourself and/or your spouse as a tobacco user and are interested in quitting, you may contact your health plan to find out about programs that can help. If you continue to use tobacco and/or do not report to your health plan that you have stopped using tobacco, you will be assessed a 50% surcharge after 12 months of HIP coverage. This surcharge will appear on the invoice that you receive from your health plan. If you are not a tobacco user, you will not have a surcharge. For questions on the tobacco surcharge, please contact your health plan.

FPL	Monthly Income, Single Individual	Monthly PAC Single Individual	Monthly PAC Spouses (each)	PAC with Tobacco Surcharge, Individual	Spouse PAC when one has tobacco surcharge	Spouse PAC when both have tobacco surcharge (each)
<22%	Less than $234.08	$1.00	$1.00	$1.50	$1.00 & $1.50	$1.50
23-50%	$244.72 to $532.00	$5.00	$2.50	$7.50	$2.50 & $3.75	$3.75
51-75%	$542.64 to $798.00	$10.00	$5.00	$15.00	$5.00 & $7.50	$7.50
76-100%	$808.64 to $1,064.00	$15.00	$7.50	$22.50	$7.50 & $11.25	$11.25
101-138%	$1,074.64 to $1,468.32	$20.00	$10.00	$30.00	$10.00 & $15.00	$15.00

Your health plan is a managed care entity, which means they have a network of doctors and facilities through which you will receive your Medicaid health benefits and preventive services. This network makes it easier for your primary care physician and other providers to communicate and work together on a personalized plan of care for you. The health plan will send you bills for your POWER Account contributions and will apply the payments that you make. They are also responsible for tracking the balance in your POWER Account and paying the doctors and facilities that provide health care services to you.

Please contact your health plan if you have questions about:
- What benefits are covered by HIP,
- How much services will cost,
- What preventive services are recommended for you,
- Reporting a medical condition that might qualify you as Medically frail, or
- How to find a doctor.

The four health plans for HIP are Anthem, CareSource, MHS, and MDwise. If you are not sure who your health plan is or how to contact them, please call 1-877-GET-HIP-9 and the enrollment broker can provide you the information.

For questions about your eligibility, please contact the Family and Social Services Administration at 1-800-403-0864.

LIMITATIONS ON COST SHARING
SSA 1916A(c); 42 CFR 447.56; 405 IAC 10-10-3

Your health plan tracks your cost sharing (copayments and contributions that your family pays for Medicaid-covered services) based on the bills that are submitted by your providers within each calendar quarter, which is three months.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
January 1st to March 31st	April 1st to June 30th	July 1st to September 30th	October 1st to December 31st

Your cost sharing is limited to 5% of your quarterly income or $321.47.

Your health plan will stop your copayments and may adjust your POWER account contribution amount if you hit this limit and will send you a notice that you do not have cost sharing for the remainder of that calendar quarter. Please contact your health plan if you think you have met your 5% cost sharing limit.

If you think your POWER Account contribution amount is incorrect
If you disagree with the amount of your contribution, you may need to update your income with us. If you have a change to report, please call or fax information to the FSSA Document Center at 800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at https://fssabenefits.in.gov.

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You can appeal the amount of your PAC payment (see instructions below), but you cannot appeal that premiums and copayments are restarting because the public health emergency has ended.

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If you disagree with our decision

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. This notice includes instructions for filing an appeal. Please read this information carefully.

Timelines and process for appealing

You must file your appeal in writing by close of business within thirty-three (33) days of the date of the notice or the adverse action, whichever is later. Please note that close of business means 4:30 PM local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. If you mail your appeal, your appeal will be considered received on the date of receipt and not on the postmarked date.

You should expect a short interruption in coverage if we receive your appeal request near the deadline.

An FSSA representative will notify you of the next steps. If FSSA schedules a hearing we will notify you in writing of the date, time, and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

How will the appeal impact my benefits?

If you submit your request for appeal prior to the effective date of the change in your coverage listed in this notice, you will be able to receive the same level of benefits you are currently receiving while your appeal is pending. However, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contribution during your appeal in order to continue receiving HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you will lose access to HIP Plus or HIP State Plan Plus benefits and you may lose your HIP eligibility.

You should expect a short delay in having your current coverage continue if we receive your appeal request near the deadline, but we will restore the benefits retroactively so that you have no break in coverage.

If you submit your request for appeal after the effective date of the change in your coverage listed in this notice, you will receive your new benefits while your appeal is pending.

Can I maintain my current benefits during the appeal?

As indicated in this notice, you will maintain your current HIP benefits while your appeal is pending if you submit your request for appeal prior to the effective date of the discontinuation of benefits listed in this notice. However, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contribution during your appeal in order to continue receiving HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you will lose access to HIP Plus or HIP State Plan Plus benefits and you may lose your HIP eligibility.

Back payments for HIP POWER account

If you become ineligible for any HIP services during your appeal and the ALJ rules in your favor, your coverage will be restored back to the date of discontinuance or the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account payments that accrued during your appeal. You will lose HIP eligibility or access to HIP Plus benefits if you do not repay this entire amount timely.

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How to file an appeal

You can mail, fax, or hand deliver your written appeal request.

To appeal, please send a signed letter with as much information as possible including your Name, Case Number, and Reason for the appeal, along with a copy of this entire notice to one of the following locations listed below. For your case, this information is provided below for your convenience.

Name: Firstname M Lastname

Case Number: 2301227803

Date of Notice: DECEMBER 13, 2023

County: 49

1. Mail your written appeal to:

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or,

2. Fax your written appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

FOR MORE INFORMATION ABOUT THE FAIR HEARING PROCESS

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

Local Office of Family Resources
MARION COUNTY DFR
FSSA Service Center
Ste 400
Indianapolis, IN 46208-5839
PHONE: 1-800-403-0864

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