FSSA Document Center
PO Box 1810
Marion, IN 46952

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Kayla A Pearson
7820 W County Road 1050 S
Paris Crossing, IN 47270-9485

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Eligibility Notice for Health Coverage

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

Payee Name : Kayla A Pearson

Case Number : 6003607108

AG Number : 20075232

Program : Health Coverage

Mailing Date : DECEMBER 22, 2022

Kayla A Pearson
7820 W County Road 1050 S
Paris Crossing, IN 47270-9485

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

Dear Kayla A Pearson,

The annual redetermination of your eligibility for the Healthy Indiana Plan (HIP) has been completed. You have been redetermined to be eligible through a special auto renewal process for a 12 month period. Your next redetermination is scheduled for JANUARY 2024.

Congratulations! You have been approved for HIP State Plan Plus benefits for your next eligibility period. Under HIP State Plan Plus, by making contributions to your POWER account, you receive comprehensive benefits including coverage for vision and dental services. Other than your monthly POWER account payment, in HIP State Plan Plus you will not be charged anything for visiting the doctor or filling prescriptions. The only other potential cost associated with getting health care in HIP State Plan Plus is a copayment for visits to the Emergency Room if the health condition is not an emergency.

To maintain your HIP State Plan Plus benefits you just need to continue to pay your monthly POWER account contributions. Your POWER Account contribution (PAC) is based on your countable monthly income of $0.00. 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.

The following information on the income, resources and expenses of listed individuals was considered in determining your eligibility.

Kayla A Pearson

Lainey K Bishop

Kynnedi M Bishop

Kayla A Pearson

Total Monthly Medicaid Modified Tax Income	$0

Total Expenses	$0

Lainey K Bishop

Total Monthly Medicaid Modified Tax Income	$0

Total Expenses	$0

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Kynnedi M Bishop

Total Monthly Medicaid Modified Tax Income	$0

Total Expenses	$0

If you have identified yourself and/or your spouse as a tobacco user and are interested in quitting, you can contact your MCE to find out about programs that can help. If you continue to use tobacco and/or do not report to your MCE 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 MCE. If you are not a tobacco user, you will not have a surcharge.

FPL	Monthly Income, Single Individual	Monthly PAC Single Individual	Monthly PAC Spouses	PAC with Tobacco Surcharge	Spouse PAC when one has tobacco surcharge	Spouse PAC when both have tobacco surcharge (each)
<22%	Less than $249.26	$1.00	$1.00	$1.50	$1.00 & $1.50	$1.50
23-50%	$249.27 to $566.50	$5.00	$2.50	$7.50	$2.50 & $3.75	$3.75
51-75%	$566.51 to $849.75	$10.00	$5.00	$15.00	$5.00 & $7.50	$7.50
76-100%	$849.76 to $1,133.00	$15.00	$7.50	$22.50	$7.50 & $11.25	$11.25
101-133%	$1,133.01 to $1,506.23	$20.00	$10.00	$30.00	$10.00 & $15.00	$15.00

If you do not make your POWER account contributions on time you will begin to have copayments charged on doctor visits, prescriptions, and hospital stays. These copayments could end up costing more than your contribution amount.

If you have money remaining in your POWER account at the end of your current eligibility period you may be eligible for rollover. Rollover can reduce the amount of your monthly contributions for HIP State Plan Plus. If you received the recommended preventive care services this year you can double the amount of your rollover and could reduce your HIP State Plan Plus contribution by up to 100 percent. If you enroll in HIP State Plan Plus and qualify for rollover you will receive a discount on your contributions four months after the end of your current eligibility period.

In HIP, your contributions to your POWER account are yours, and you could receive a portion back if you leave the program. Since your contributions are based on a projected annual amount, you may also be responsible for paying the contribution for any remaining months of enrollment if you leave the program early.

INFORMATION ABOUT ELIGIBILITY AND ENROLLMENT IN THE HEALTHY INDIANA PLAN

When you are approved for the Healthy Indiana Plan (HIP), your enrollment period is 12 months. Your benefits may change if you fail to make your POWER Account contributions or if you have a change in circumstances.

Changes You Must Report

You must report the following changes in your circumstances within 10 days of when the change occurs:

- You move. We need to know your current address so that important mailings reach you without delay.
- Your income changes.
- You become pregnant. This will allow you to have additional benefits and will remove the need to make a POWER Account contribution.
- You become insured under other health insurance, either private or Medicare.
- You move out of the State of Indiana to live.

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 in.gov/fssa/dfr.

If you have changes in your health status, please report them to your health plan. Certain serious health conditions may qualify you for additional benefits appropriate to your condition.

Additional Important Information for HIP:

If the post office returns mail that we sent to you about a change in your benefits and we cannot locate you, we may take action to stop or reduce your benefits. However, if you contact us before the effective date of the action your benefits will continue.

We are required to issue a notice that your benefits are being stopped or reduced at least thirteen (13) days in advance of the effective date. If we do not issue this advance notice to you, your benefits will be reinstated if you appeal within fifteen (15) days of the mailing date of the notice. If you can show you did not receive the notice within fifteen (15) days of the mailing date, your benefits will be reinstated if you appeal within ten (10) days of the date you show you received the notice.

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 (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 percent of your quarterly income or $0.00.

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 percent cost sharing limit.

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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 effective date of the action you are appealing, 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 filed on the date of receipt and not on the postmarked date.

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 and the administrative law judge at the hearing for your appeal rules in your favor, your coverage will be restored back to the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account contributions that accrued during your appeal. You will lose HIP eligibility if you do not repay this 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: Kayla A Pearson

Case Number: 6003607108

Date of Notice: DECEMBER 22, 2022

County: 40

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

JENNINGS COUNTY DFR
2170 North State Hwy 3
North Vernon, IN 47265
PHONE: 1-800-403-0864

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NOTICE REGARDING RIGHTS & RESPONSIBILITIES FOR HEALTH COVERAGE DIVISION OF FAMILY RESOURCES

State Form 55367 (R6 / 11-21) / DFR 0009M / IEDSS

Client Name: Kayla A Pearson	**Case Number:** 6003607108

HEALTH COVERAGE Medicaid; Hoosier Healthwise; the Healthy Indiana Plan (HIP)

Please read this form about the rights and responsibilities for Health Coverage (Medicaid, Hoosier Healthwise, and the Healthy Indiana Plan) for which you have applied for or are being redetermined. When we refer to "you", we mean all persons applying for and receiving benefits in your household. Ask a worker or call toll free at 1-800-403-0864 if you have any questions.

1. You have the right to apply for benefits at any time during normal office hours. The date you submit your application determines the date your benefits begin if you are eligible. You have the opportunity to submit the application online, by mail, fax, over the telephone, or in-person. You can also apply for health coverage through the Federally Facilitated Marketplace. **Don't delay in filing your application.**
2. You may appoint someone to apply for benefits on your behalf.
3. A decision must be made on your application within the following time frames: forty-five (45) days for all categories of Health Coverage, except Medicaid under the Disability category which is ninety (90) days.
4. Privacy Statement:
   - ∑ We are authorized to collect your information (on the application and other supporting documentation) under state and federal laws and regulations, including but not limited to IC 4-22-2 and 42 CFR 435.907.
   - ∑ All personal information you provide is kept confidential and will only be used to determine your eligibility for benefits, and to communicate with you or your authorized representative. Your personal information is protected by both state and federal law. The Division of Family Resources takes the privacy of your information seriously and employs numerous privacy and security controls to safeguard your information.
   - ∑ If you believe that we have violated the privacy of your information, please contact the Division of Family Services, either by visiting your local office or calling 1-800-403-0864. You may also contact the Family & Social Services Administration Privacy Officer by phone (1-877-690-0010) or email (FSSA.PrivacyOffice@fssa.IN.gov).
   - ∑ The information you provide will be entered into our eligibility computer system. You have the right to review that information and to request corrections or amendments to that information, and may do so by visiting your local Division of Family Resources office or calling 1-800-403-0864 (please note that requested corrections or amendments are subject to verification by our staff as required by state and federal regulations).
   - ∑ You will also be provided with a copy of the agency's Notice of Privacy Practices for Health Coverage that provides additional information about how your personal health care information is used and protected, and your health coverage privacy rights.
5. You will need to answer all questions that are required to determine eligibility.
6. Eligibility for benefits is determined without any regard to race, color, creed, sex, age, disability, national origin, or political belief. Information is requested about your racial-ethnic heritage to comply with the Federal Civil Rights Law. However, you do not have to provide this information. If you choose not to give us this information, we will indicate a race/ethnicity classification for you for data collection purposes.
7. A Social Security number (SSN) must be given for each applicant who can legally have a number. If you don't have an SSN you must apply for one. This requirement does not apply to certain immigrants who cannot legally have a number and therefore can be eligible for emergency services only under Medicaid/Hoosier Healthwise. Your SSN will be used to check the records of other State and Federal agencies such as the Social Security Administration, Bureau of Motor Vehicles, Internal Revenue Service, Department of Homeland Security, Department of Workforce Development, and other states' public assistance records. If you are applying for assistance on the basis of being aged (sixty-five (65) or older) or disabled, we utilize an Asset Verification System (AVS) to electronically attempt to verify assets which could affect your eligibility determination. You will be notified of any action taken based upon information received from the Asset Verification System. Further, under the Fair Credit Reporting Act (FCRA) you have the right to request the information obtained from the AVS as well as dispute any information you believe to be incomplete or inaccurate. Any information we receive about you from these sources is kept strictly confidential, and used only to determine your eligibility for benefits. We may ask for the Social Security numbers of family members who are not applying; however, you do not have to provide these numbers as a condition of eligibility. Determination of eligibility will not be delayed, denied, or discontinued due to waiting on a Social Security number to be issued.
8. If you are an immigrant, you must provide the document showing your immigration status if we are unable to verify the information electronically. A person who does not provide immigration documents or has no documentation can only be eligible for health coverage for medical emergencies. The immigration status of lawful immigrants who are applying for or receiving benefits is subject to verification by the U.S. Citizenship and Immigration Services (USCIS).
9. You will need to verify certain information you provide, if not able to be done so electronically, based on the requirements of the programs you have chosen or may be eligible for. If you have tried to get the documentation, but are unable to do so, you can sign a release of information and the worker will assist in obtaining the information. Any release of information form that you sign must have the name of the person, agency, or organization that the worker will be contacting.
10. Certain persons must be included in the application and/or have their income, resources, needs and/or expenses counted in determining eligibility for benefits. For this reason you must report everyone who lives with you. In certain instances, a limited amount of your personal information may be disclosed to another household member or their authorized representative in order to complete the required eligibility processes.

NOTICE REGARDING RIGHTS & RESPONSIBILITIES FOR HEALTH COVERAGE DIVISION OF FAMILY RESOURCES

State Form 55367 (R6 / 11-21) / DFR 0009M / IEDSS

11. You are required to report changes in your circumstances to the Division of Family Resources. The changes that you must report include your new address if you move, increases or decreases in your household's income, resources, or any change in your family circumstances that may affect your eligibility for benefits. You must report changes within ten (10) days of the date on which you are aware of the change. Also, there are certain circumstances in which resources are not counted and income of parents is exempt and therefore changes do not have to be reported. You will be given a form describing your reporting requirements.
12. If you move, please tell us your new address so that important mail about your application and health plan membership will reach you without delay. Also, you must tell us if you or your child(ren) becomes covered under other health insurance such as Medicare or employer-sponsored health insurance.
13. You are required to provide complete and correct information to the best of your knowledge. A person who receives benefits by intentionally giving false information or by failing to report information may be criminally prosecuted under State and Federal law.
14. You have the right to receive a written notice about any action taken on your application or on the benefits you receive.
15. You may request a fair hearing in writing if you disagree with any action taken on your case, including the late processing of your application. Your case may be presented at the hearing by any person you choose.
16. In accordance with Federal Law and United States Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. If you believe that you have been discriminated against and wish to file a complaint, you may do so by contacting the Department of Health and Human Services, Regional Manager, Region V, Office for Civil Rights, 233 N. Michigan Ave, Suite 240, Chicago, Illinois 60601. You may call them at (800) 368-1019 or for TDD calls, (800) 537-7697.
17. The category you qualify for will be chosen for you. Some categories provide limited coverage. You will be approved for the most benefits you are eligible to receive based upon the information you have provided. However, if you want your eligibility determined under a different category, you have the right to choose your category.
18. You must file for any benefits which you may be eligible for, such as Social Security or pensions, or disability benefits.
19. Benefits paid on your behalf after you become fifty-five (55) years of age become a preferred claim against your estate. This includes all benefits paid and/or monthly capitation payments made to a Managed Care Entity for your healthcare coverage. This claim has priority over all claims except prior recorded claims and taxes.
20. You may be required to pay back health coverage benefits that have been paid on your behalf, including capitation fees paid to a health plan or provider, if you had been incorrectly determined eligible whether by agency or client error or through providing fraudulent information.
21. We will not report undocumented immigrants to the United States Citizenship and Immigration Service. Applying for health coverage benefits will not affect your immigration status or chances of becoming a permanent resident or U.S. citizen.
22. Your rights to payments for medical care are assigned to the State of Indiana if you are found eligible for benefits. This includes rights to medical support and payment for medical care that you have on behalf of yourself and your dependents who are approved for benefits under this application. However, the assignment does not include Medicare payments.

    You must tell us about health insurance that you have. You must tell us about any legal or administrative actions you take to get payment for medical care, such as a personal injury settlement.

    The establishment of paternity is an important service for Medicaid/Hoosier Healthwise members that benefits children who do not have legal fathers. We encourage you to contact your local child support office in your County Prosecutor's office when your children are enrolled in Medicaid/Hoosier Healthwise. Except for children enrolled in Package C, there is no cost for this service or other child support services.
23. For children who are enrolled under Hoosier Healthwise Package C, there is a cap on the amount of cost-sharing that you will have to pay. This amount is 5% of your annual income before taxes. It is your responsibility to keep track of the amount of premiums and co-payments you pay. If you reach the cap, you will need to contact the Division of Family Resources and provide your receipts so that you will no longer have to make payments. If your children are approved for Package C, the approval notice you receive will tell you the cost-share cap.
24. American Indians and Alaskan Natives who are members of a federally recognized tribe are exempt from some premiums, copayments and other cost sharing requirements. You will need to provide your tribal identification in order to receive this exemption.
25. Certain income received by American Indians and Alaskan Natives who are members of a federally recognized tribe is exempt. The exempt income includes: distributions from Alaska Native Corporations and Settlement Trusts, distributions from any property held in trust located within a former Federal reservation or under the supervision of the Secretary of the Interior, distributions and payments from rents, leases, royalties, rights of way, or natural resource extraction and harvest, distributions from real property ownership interests or usage rights to items that have unique religious, spiritual, or cultural significance, and student financial assistance provided under the Bureau of Indiana Affairs educational programs.
26. Preventative health care services are available for children under age twenty-one (21). You may request assistance with appointment scheduling and arranging transportation for the Health Watch services by contacting a worker.
27. If you are applying for Medicaid long term care services (Medicaid facility or waiver services), you are specifically required by federal law to provide all information about annuities which you or your spouse own. For annuities purchased on or after November 1, 2009, the State of Indiana will become a preferred remainder beneficiary under the annuity for the total amount of medical assistance paid on your behalf.
28. If you are eligible for the Medicare Savings Program, it will take at least 3-4 months for the Social Security Administration to stop withholding the Part B premium from your check. However, you will receive a refund for the full amount of premiums that we owe you.

NOTICE REGARDING RIGHTS & RESPONSIBILITIES FOR HEALTH COVERAGE DIVISION OF FAMILY RESOURCES

State Form 55367 (R6 / 11-21) / DFR 0009M / IEDSS

29. Family Planning Services are available under Indiana's Medicaid program. Men and Women who do not qualify for full coverage Medicaid can qualify for these services if they meet the income requirements. If you are enrolled in Hoosier Healthwise for pregnancy, we will determine your eligibility for Family Planning Services when your pregnancy ends.

30. If you are found eligible for the Children's Health Insurance Plan (CHIP) or the Healthy Indiana Plan (HIP) and are required to make premiums or contributions to a POWER Account, you must make such payments in order to become and remain eligible.

31. If you have a CHIP or HIP appeal which allows benefits to be maintained during the administrative appeal process, you must continue to pay your premium or POWER Account contribution in order to maintain coverage. If the Administrative Law Judge (ALJ) rules in your favor by deciding your CHIP or HIP benefits should not have been discontinued or denied, your coverage will be restored back to the date of discontinuance or denial. You will be responsible for paying the amount of premiums or contributions to the POWER Account back to the date of discontinuance or denial. Plan on saving money to pay back your premiums or contributions to your POWER Account back to the date of discontinuance or denial.

32. The goal of the Healthy Indiana Plan is to assist you in maintaining health care coverage until you can obtain employment that will allow you to obtain health insurance on your own. To assist you in getting better employment, we have developed a partnership with the Indiana Department of Workforce Development called the Gateway to Work program. By signing the application, you acknowledge that your application will be screened for eligibility to the HIP Gateway to Work program, and if found eligible, your contact and employment information will be shared with the Indiana Department of Workforce Development, so that you may receive information about the State's job search and training programs.

33. We will use electronic sources to verify income, citizenship, alien status, and other eligibility factors whenever possible; if certain eligibility factors cannot be verified electronically, you may be asked to provide paper documentation.

34. If you are not eligible for Medicaid/Hoosier Healthwise/Healthy Indiana Plan, you may be eligible for other health insurance coverage through the health insurance marketplace. If your application is denied or discontinued (for non-procedural reasons), your application will be submitted to the health insurance marketplace for a determination of other insurance affordability programs. If your family income is under 400% of the federal poverty level, you may be eligible for Advance Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR) through the marketplace.

35. Beginning in 2014, most individuals will be required to have health insurance coverage. Such coverage may be obtained through employer-sponsored health insurance, qualified health plans through the marketplace, or through Medicaid/Hoosier Healthwise/Healthy Indiana Plan.

36. The Affordable Care Act (ACA) mandates the use of the Modified Adjusted Gross Income (MAGI) financial methodology when determining Medicaid income eligibility for most parents and other caretakers, children, pregnant women, and adults aged 19-64 who are **not** blind, disabled, or in need of long term care services.

37. The Indiana Application for Health Coverage meets the requirements of an alternative single, streamlined application for all insurance affordability programs.

38. Redeterminations will be completed every twelve (12) months to determine if you still meet the eligibility requirements. We will first attempt to complete your annual redetermination using available electronic data sources and will automatically continue your enrollment for another twelve (12) months if found eligible. If we are unable to do this, you will receive a pre-populated reenrollment form in the mail that must be completed and returned.

39. The following individuals are exempt from cost sharing (copayments, contributions, and premiums) in Medicaid or HIP: Children under age eighteen (18) who are not in CHIP coverage, pregnant individuals, former foster children, Native Americans and Alaskan Natives who have ever received a service or referral from an Indian health care provider, members living in a Medicaid-approved institution, members approved for Home-and-Community-Based waiver services, and those receiving hospice care.

    For other approved Medicaid and HIP members, cost sharing imposed by the Medicaid program is limited to five percent (5%) of your quarterly countable income. This is separate from any Medicare cost sharing you may have, and does not apply to patient/waiver liability amounts or spend down. Your health plan or Indiana Medicaid will track your cost sharing and stop charging you premiums and copayments for the remainder of any calendar quarter in which you meet the five percent (5%) limit. If you have questions or think you have met your limit, please contact your health plan. If you do not have a health plan, you can contact Indiana Medicaid at (800) 457-4584.

    Your health plan will notify you or the amount of any copayments you must pay. If you are not covered by a health plan in managed care, the following copayments for Medicaid-covered services may apply.

Transportation costing $10 or less:	$0.50	Transportation costing $50.01 or more	$2
Transportation costing $10.01 to $50:	$1	Prescription Drugs:	$3

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NOTICE REGARDING RIGHTS & RESPONSIBILITIES FOR HEALTH COVERAGE DIVISION OF FAMILY RESOURCES

State Form 55367 (R6 / 11-21) / DFR 0009M / IEDSS

40. If you applied at the Federal Marketplace (www.healthcare.gov), your application has been transferred to Indiana Medicaid for consideration. As a result, we are evaluating your potential eligibility for Health Coverage through Indiana Medicaid. For some categories of coverage, you will receive services through a health plan, also called a Managed Care Entity or MCE (e.g., Anthem, CareSource, MHS, MDwise, or UnitedHealthcare). To find out about which health plan may be best for you and choose the health plan you prefer, you can contact the Indiana Enrollment Broker at (800) 438-4479. If you do not select a health plan, you will be auto assigned to one.

    If you applied directly with the State, and your application did not identify a health plan selection, you will be auto assigned to one. If you prefer to select your health plan, you can contact the Indiana Enrollment Broker at (800) 438-4479 to learn more about the health plans offered and select the one that is best for you. This option is only available if you have not already made a Fast-Track payment for this application.

    Members approved for HIP or Medicaid will have the opportunity to change health plans annually. Your current health plan will notify you of the dates of your open enrollment period and how to change health plans if you wish to do so.