HEALTHSOURCE RI/EOHHS
HZD MAILROOM
74 WEST ROAD STE 500
CRANSTON RI 02920-8409

Date : 01/23/2015
Account Number : 221183

HEALTHSOURCE RI/EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES/DEPARTMENT OF HUMAN SERVICES

Arumugam Jeganathan
110 Victory St
Apt/Unit # A
Cumberland, RI 02864

How to Contact Us

Please contact us if you have any questions about this letter. You can contact us in any of the following ways:

Online : Visit www.healthsourceri.com www.eohhs.ri.gov

By phone : Call (855) 712-9158

By mail : HEALTHSOURCE RI/EOHHS
HZD MAILROOM
74 WEST ROAD STE 500
CRANSTON RI 02920-8409

In person : To find an office near you, go to http://www.dhs.ri.gov/tabid/835/Default.aspx or call us at (855) 712-9158

Eligibility Decision Notice

Dear Arumugam Jeganathan :

You have successfully enrolled in medical coverage with UnitedHealthcare and dental coverage with Delta Dental of Rhode Island. You will receive letters from your insurance companies with your member ID card and information about how to use your coverage. Your monthly bill will be $270.29.

Summary of Coverage

Name	SSN	Health Plan	Effective Date
Arumugam Jeganathan	XXX-XX-3404	UnitedHealthcare (UnitedHealthcare Gold Compass HSA 1300)	02/01/2015
Arumugam Jeganathan	XXX-XX-3404	Delta Dental of Rhode Island (Delta Dental Individual and Family - Starter Plan) (Dental)	02/01/2015

How do I pay my bill?

You will receive a bill in the mail or by email with instructions. You can also find instructions or pay your bill at www.healthsourceri.com.

Questions? Call (855) 712-9158 You can call Monday to Saturday, 8 a.m to 9 p.m and Sunday 12 p.m to 6 p.m. Or, go to www.healthsourceri.com www.eohhs.ri.gov

Si usted necesita ayuda en espanol para entender esta informacion, llame a (855) 712-9158
Se precisar de ajuda em Português para entender essas informações, ligue para (855) 712-9158

What if my household income or other information about my household changes?

You must inform us immediately:

- if your household income changes (goes up or down);
- if you move;
- if citizenship or immigration status changes for any household member;
- if your family size changes, for example because of marriage, divorce, birth, adoption, or death.

Some changes will make you eligible for better coverage or lower prices. Some changes, if you do not report them, will make you owe more in your taxes next year. Please see the attached rights and responsibilities sheet for a complete list of changes you must report to us.

You are not eligible for Medicaid.

We determined that you are not eligible for Medicaid because of the following reason(s). This decision is based on Code R.I. Section 1300-1315, Access to Medicaid Coverage Under the Affordable Care Act.

Your application for Medicaid has been denied because your household income exceeds the eligibility criteria. See OHHS Code R.I. Section 1305.4, Overview of MACC Groups.

You are not eligible for premium credits.

We determined that you are not eligible for premium credits because of the following reason(s):

- Household income is greater than requirements and not eligible to receive premium tax credits

What if I disagree?

You can appeal decisions that we made about eligibility for Medicaid Coverage and other programs. For example, if you disagree with us regarding your eligibility for a Qualified Health Plan or the amount of premium tax credits you are determined eligible to receive, you may file an appeal. See the attached information about your appeal rights. There are deadlines for filing an appeal, so you should act quickly. You must request your appeal within 30 days of the receipt of your eligibility determination notice.

Rights and Responsibilities

Information about your coverage, rights and responsibilities:

Change Reporting Requirements

HealthSource RI requires you to report changes that may affect the eligibility and enrollment of you or any member of your household. You must report any of the following changes affecting you or any member of your household within 30 days:

- Residential address;
- Mailing address;
- Incarceration or institutional status;
- Immigration or citizenship status.

Regulatory Basis for Decision

This eligibility decision is based on the rules outlined in 45 C.F.R. § 155.305, 42 C.F.R. § 435.119 and 26 C.F.R. Part 1.36(B) 1-4.

Non-Discrimination

In accordance with Federal and State laws, the Rhode Island Department of Human Services and HealthSource RI do not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion, gender, or sexual orientation. If you believe you or any member of your household have been wrongfully discriminated against, call us at (855) 712-9158 for information on how to file a complaint.

Private Qualified Health Plan: Termination by You

The following member(s) of your household are enrolled in a private Qualified Health Plan:

Name	SSN
Arumugam Jeganathan	XXX-XX-3404

You may terminate enrollment of any member of your household in their health plan at any time. Their termination will be effective as of the date you request, so long as the request is made at least two weeks in advance.

Private Qualified Health Plan: Termination by Your Carrier or by HealthSource RI

The following member(s) of your household are enrolled in a private Qualified Health Plan:

Name	SSN
Arumugam Jeganathan	XXX-XX-3404

Your coverage, or the coverage for any member of your household in a private Qualified Health Plan can be cancelled only if the following things happen:

- if you or your household member are no longer eligible for coverage through HealthSource RI,
- if you or your household member does not pay premiums and your grace period ends,
- if you or your household member's coverage is ended due to fraudulent information in your application,

- if you or your household member's insurer goes out of business, loses its license or certification under state law, and
- If you or your household member changes to another plan offered on HealthSource RI during an open or special enrollment period.

Private Qualified Health Plan: Annual Renewal

The following member(s) of your household are enrolled in a private Qualified Health Plan:

Name	SSN
Arumugam Jeganathan	XXX-XX-3404

You will receive a notice next September about renewing the private Qualified Health Plan of your household members. To renew their health insurance coverage, you must either return the form that will be sent to you, visit our website, or call our contact center. If you do not respond, their coverage will continue based on the latest information we have about them. Your monthly bill and coverage may change. Failure to respond may also result in increased tax liability or may prevent you or members of your household from receiving full benefits.

If you have special health care needs

You and members of your household might qualify for more services through Medicaid if anyone in your household has special health care needs.

- Does anyone in your household have a disability?
- Does anyone in your household need nursing home care or other long term care services?
- Does anyone in your household have high or frequent medical bills?

If so, find out if they qualify based on special health care needs. Call (855) 712-9158 or visit www.healthsourceri.com for more information.

Appeal Rights and Deadlines

You and every member of your household have the right to a hearing, if you disagree with a decision we have made. You have 30 days from the date you receive this letter to request an appeal. If you do not request an appeal, you may lose the right to a hearing. Please see the enclosed appeal form for complete instructions.

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Appeal Form
Form Number: OHHS 121

Appeal Request Process

You may request an appeal (a review of our decision) by doing one of the following below. If you submit this form, the state will complete a review of your case to try to resolve the issue.

- **Online.** Visit www.healthsourceri.com;
- **By phone.** Call (855) 712-9158;
- **In person.** To find an office near you, go to http://www.dhs.ri.gov/tabid/835/Default.aspx or call us at (855) 712-9158
- **By mail or fax.** Complete this form and mail it to HZD MAILROOM, 74 WEST ROAD STE 500, CRANSTON RI 02920-8409 or fax it to 1-401-223-6317

Name (required): _____

Date of Birth (required): _____

Account Number : _____

Address (required): _____

Phone number: _____

Email: _____

Do you need help speaking, reading or writing English? ☐ No ☐ Yes:

If yes, what is your primary language? _____

Preferred method of contact (circle one): email / paper mail

Please explain the reason for your appeal:

_____

_____

_____

_____

Do you need important health services immediately? If so, would you like an expedited (fast) appeal?

Yes / No. If yes, please explain:

_____

_____

Would you like your coverage and benefits to continue unchanged while you wait for a hearing? Yes /No

☐ Check this box if someone is going to help you with the appeal or represent you during the appeals process. This can be an attorney, friend, or family member. Please provide this person's contact information:

Name: _____

Phone: _____

Address: _____

Email: _____

Preferred method of contact (circle one): email / paper mail

Appeal Instructions

Deadlines

You must request your appeal within 30 days of the receipt of your eligibility determination notice . If you miss this deadline, you may lose your right to appeal. After you have filed your appeal, we must schedule your hearing and issue a decision within 90 days.

Expedited Appeals

You have the right to an expedited appeal if you have an immediate need for health services and waiting for a standard appeal could seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function. We must decide expedited appeals as quickly as possible, given the circumstances. If we deny your request for an expedited appeal, we must inform you quickly, and we must handle your appeal through our standard process.

Right to Continue Benefits While Awaiting Hearing

You may have the right to have your benefits continue unchanged while you wait for your hearing (this is called "Aid-Pending"). You can only request Aid-Pending if you appeal within 10 days after you receive the notice you are challenging. Unless you can show otherwise, we will assume that you received the notice 5 days after the date on the notice. If you pay monthly premiums, you must still pay those premiums during the Aid-Pending period. If you have Medicaid and you receive Aid-Pending, and then you lose your appeal, the State may make you pay back its costs for covering you during the Aid-Pending period. If you are receiving tax credits to help pay for your premiums and you receive Aid-Pending, and then you lose your appeal, then you may owe extra money in your federal taxes next year.

Right to Represent Yourself and Right to be Represented

You have the right to represent yourself at the hearing, or to be represented by anyone you choose, including an attorney, advocate, friend, or relative.

Legal advice is available from Rhode Island Legal Services, Inc. at 274-2652 or 1-800-662-5034. If you choose to have Legal representation, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the Legal representative access to the Agency case record. It is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

Eligibility of Other Household Members May be Effected

Our appeal decision may result in changes to the eligibility of another member of your household.

Access to Your Case Record

You have the right to see your case record, including any evidence the State will use at your hearing. To receive a copy of your case record, call us at (855) 712-9158 or visit www.healthsourceri.com.

Informal Resolution

We may be able to fix your problem quickly without a hearing. Please call (855) 712-9158 so that we can review your case informally. We may also reach out to you in an effort to resolve your appeal informally. Your right to a hearing will not be impacted by efforts to resolve your issue informally.

This letter includes important information about your health insurance. If you need an interpreter, call (855) 712-9158 Monday - Saturday 8am-9pm or Sunday 12pm-6pm.

Esta carta incluye información importante acerca de su seguro de salud. Si necesita un intérprete, llame al (855) 712-9158 de lunes a sabado de 8 a.m. a 9 p.m. o el domingo de 12 p.m. a 6 p.m.

Esta carta inclui informações importantes sobre o seu seguro de saúde. Se precisar de um intérprete, contacte-nos através do número (855) 712-9158 de Segunda a Sábado das 8h às 21h ou aos Domingos das 12h às 18h.

លិខិតនេះមានព័ត៌មានសំខាន់អំពីធានារ៉ាប់រងសុខភាពរបស់អ្នក។ ប្រសិនបើអ្នកត្រូវការអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់ សូមទូរស័ព្ទមក (855) 712-9158 ពីថ្ងៃច័ន្ទ ដល់ថ្ងៃសៅរ៍ ពីម៉ោង 8 ព្រឹក ដល់ 9 ល្ងាច ឬ ថ្ងៃអាទិត្យ ពីម៉ោង 12 ថ្ងៃ ដល់ 6 ល្ងាច។

ເອກະສານນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບປະກັນສຸຂະພາບຂອງທ່ານ. ຖ້າທ່ານຕ້ອງການຜູ້ແປພາສາ, ໃຫ້ໂທຫາເບີ (855) 712-9158 ວັນຈັນ - ວັນເສົາ 8 ໂມງເຊົ້າ - 9 ໂມງແລງ ຫຼືວັນອາທິດ 12 ໂມງທ່ຽງ - 6 ໂມງແລງ

В настоящем письме приведена важная информация о вашем полисе медицинского страхования. Услугами переводчика при необходимости можно воспользоваться, позвонив по номеру: (855) 712-9158 с 8.00 до 21.00 с понедельника по субботу или с 12.00 до 18.00 по воскресеньям.

這封信包括你的健康保險有關的重要信息。 如果你需要一個翻譯員，請週一至週六上午8時-9時或週日12時-下午6時致電(855) 712-9158。

这信包括有关您的医疗保险的重要信息。 如果您需要一名口译译员，请与周一至周六上午 8 点 9 点者周日中午 12 点下午 6 点(855) 712-9158。

Cette lettre comprend des renseignements importants sur votre assurance santé. Si vous avez besoin d'un interprète, appelez le (855) 712-9158 du lundi au samedi de 8 h à 21 h ou le dimanche de 12 h à 18 h.

Cette lettre contient des informations importantes sur votre assurance santé. Si vous avez besoin d'un interprète, appelez le (855) 712-9158 du lundi au samedi de 8 h à 21 h ou le dimanche de 12 h à 18 h.