Premium Assistance

EARLY INTERVENTION SERVICES TRAINING

Amber Smith

Program Requirements

- Proof of Status
- Proof of Michigan Residence
- Proof of Insurance

- Clients must be ACTIVE on MIDAP
- Premium Assistance & MIDAP are two separate applications.

Accepted Insurance Groups

Marketplace/Afforable Care Act (ACA)

- Platium
- Gold
- Silver
- Bronze
- Catastrophic is not accepted

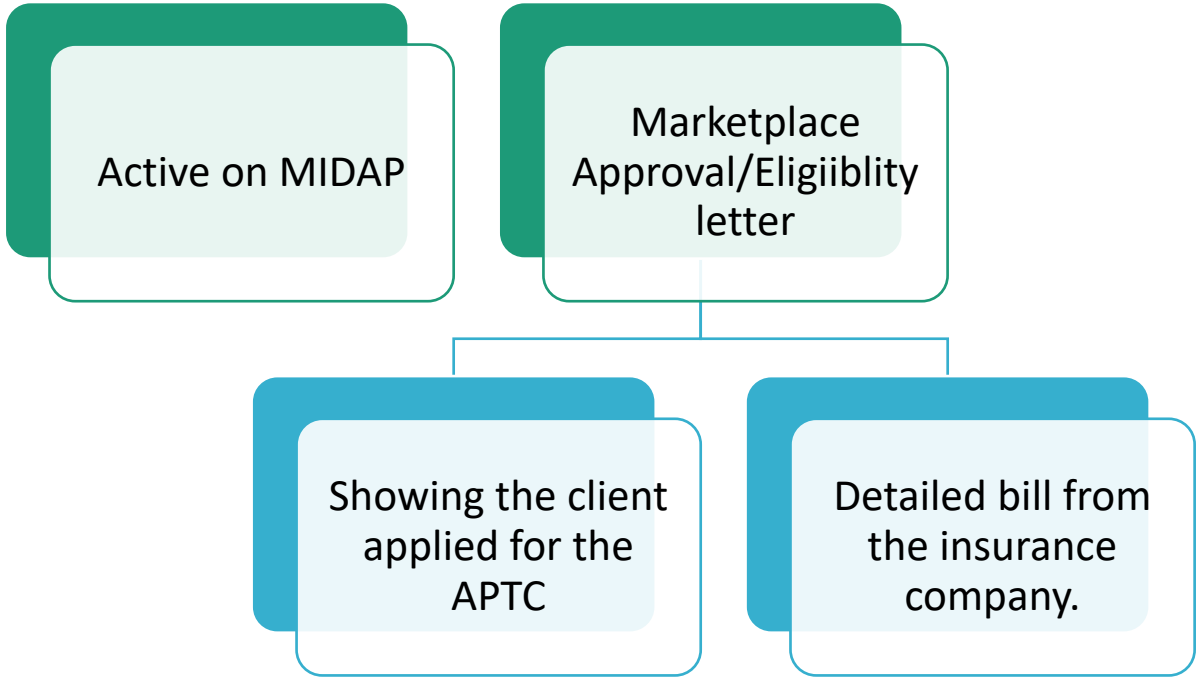
Medicare

- Part C – Advantage plans
- Part D – Prescription Drug plans

COBRA

- Up to 18 Months

Marketplace
MIDAP Premium Assistance Requirements for ACA



Marketplace Eligibility Letter

Application Date: October 19, 2017
2018 Application ID:

Eligibility notice: Important information about health coverage for your household

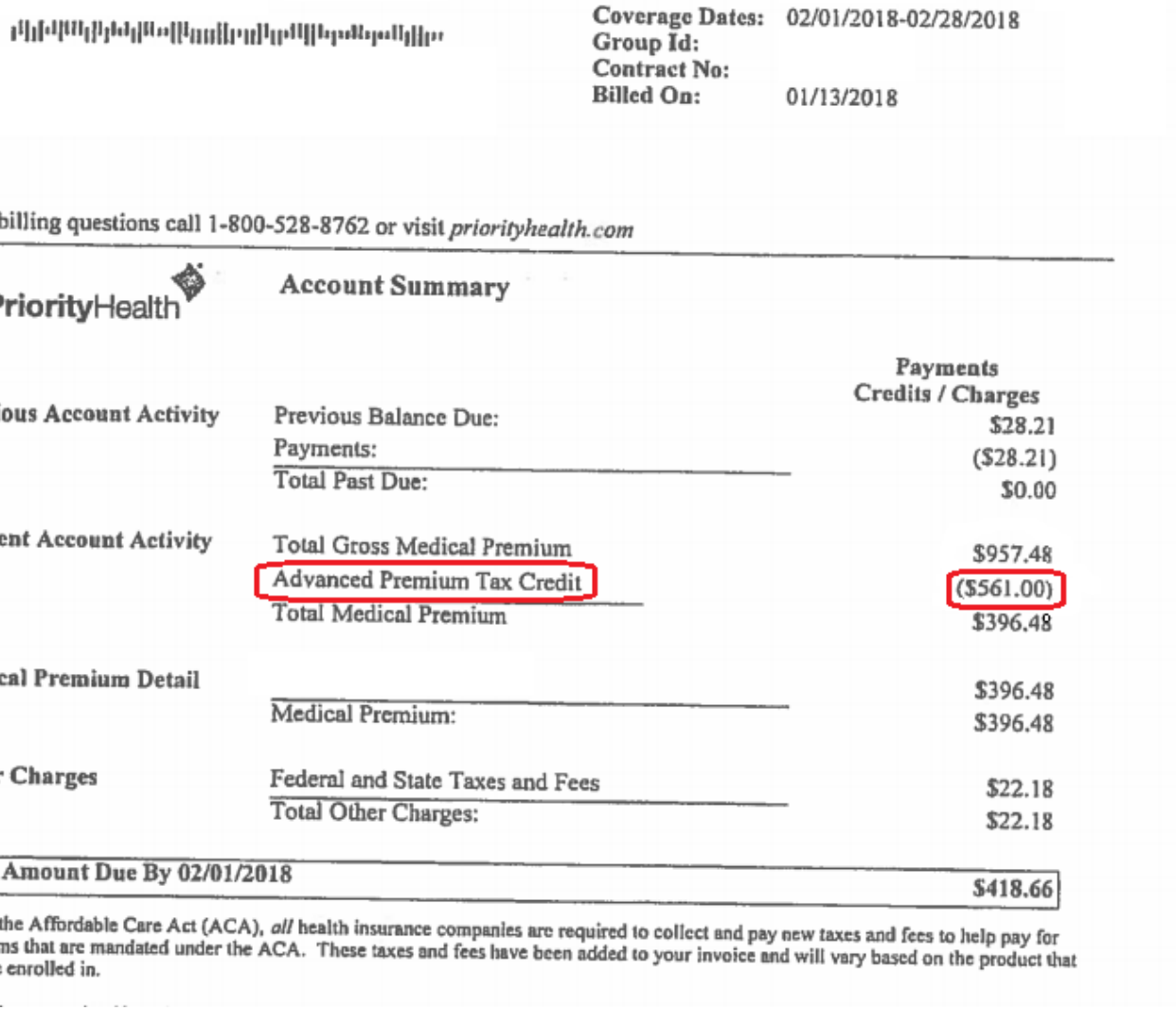
Family member(s)	Results	Next steps
	• Eligible to buy a 2018 Marketplace plan • Eligible for advance payments of the premium tax credit to help pay for a Marketplace plan. You can use up to this much of the tax credit: • $561.00 each month, which is $6,732.00 for the year, for your tax household. • This is based on the yearly household income of $19,490.91 — the amount that you put on your application, or that came from other recent information sources. • Can choose a Silver plan with lower copayments, coinsurance, and deductibles (cost-sharing reductions).	• Not eligible to enroll in a Marketplace plan at this time. • Not eligible for a Special Enrollment Period. • See "What should I do next?" below for more information

Your **Eligibility Results** are based on information including a projection of your household's income for the year you'll need coverage.

If your **"Results"** say you're eligible for advance payments of the premium tax credit or cost-sharing reductions, it means that you don't appear to be eligible for Medicaid based on your application information. However, you could still be eligible for Medicaid if you have a disability or special health care needs that you didn't report on your application. To learn more, visit HealthCare.gov/people-with-disabilities or call your state Medicaid agency to ask about rules for your state.

Detailed Billing Statement

Marketplace invoice from the Insurance company



Coverage Dates: 02/01/2018-02/28/2018
Group Id:
Contract No:
Billed On: 01/13/2018

For billing questions call 1-800-528-8762 or visit *priorityhealth.com*

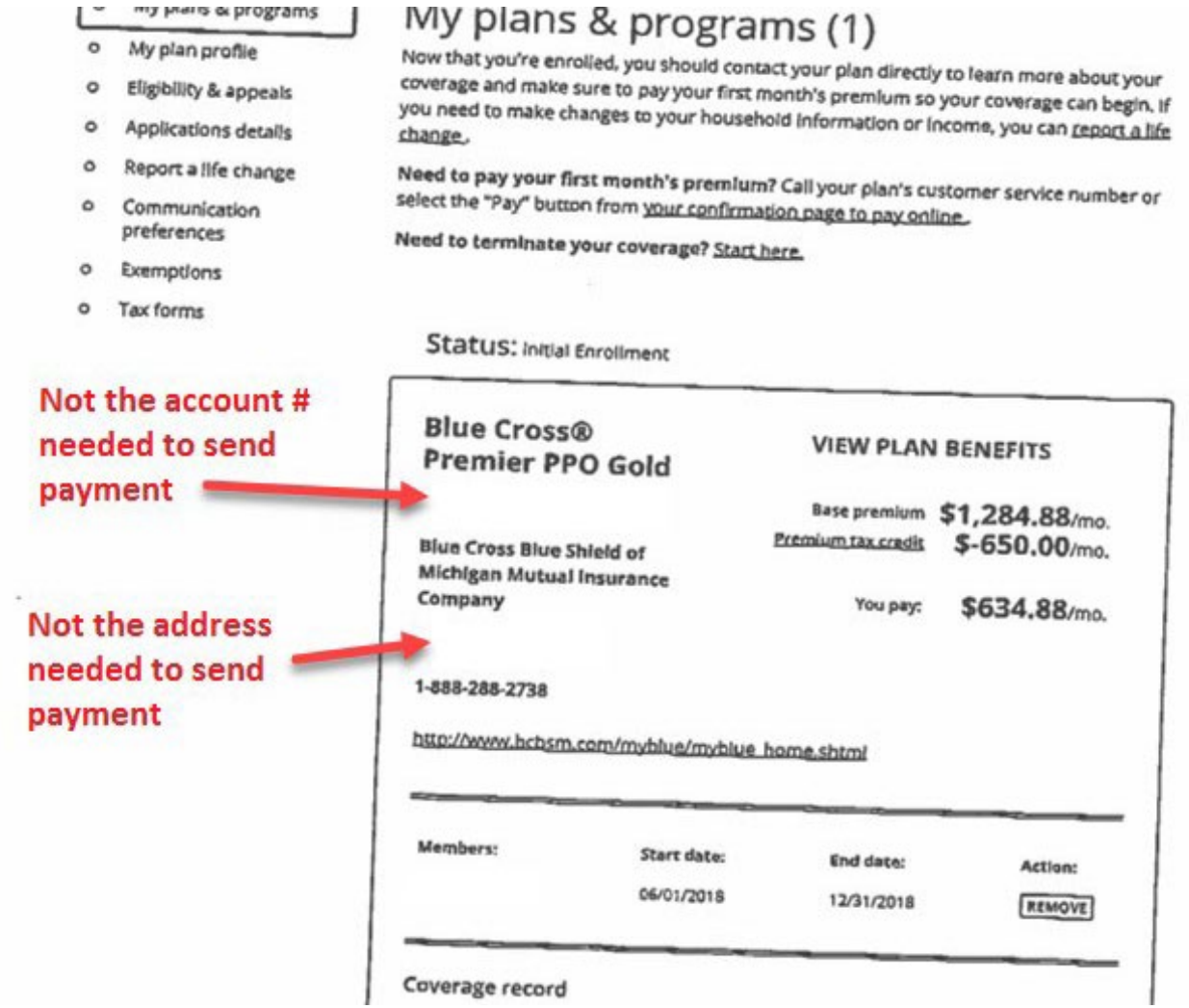
PriorityHealth

Account Summary

		Payments / Credits / Charges
Previous Account Activity	Previous Balance Due:	$28.21
	Payments:	($28.21)
	Total Past Due:	$0.00
Current Account Activity	Total Gross Medical Premium	$957.48
	Advanced Premium Tax Credit	($561.00)
	Total Medical Premium	$396.48
Medical Premium Detail		$396.48
	Medical Premium:	$396.48
Other Charges	Federal and State Taxes and Fees	$22.18
	Total Other Charges:	$22.18
Total Amount Due By 02/01/2018		**$418.66**

Under the Affordable Care Act (ACA), *all* health insurance companies are required to collect and pay new taxes and fees to help pay for programs that are mandated under the ACA. These taxes and fees have been added to your invoice and will vary based on the product that you are enrolled in.

Marketplace bill that is NOT excepted



Medicare

- Premium Assistance Requirements for Medicare Part C and D
  - Active On MIDAP
  - Detail Bill (Medicare Invoice)
  - Proof of Low Income Subsidy (LIS)
    - Medicare Part D only
    - Clients under 150% of the FPL

Detailed Bill for Medicare PART D

Basic Blue® Rx (PDP)
A Medicare Prescription Drug Plan

PREMIUM NOTICE

Invoice #
Invoice Date
Member ID

For inquiries concerning this invoice or your enrollment status, please call Basic Blue Rx Customer Service at 1-877-376-2185. for TTY call 711. Our service hours are 8:00 a.m. to 8:00 p.m., daily, Local Time.

COVERAGE PERIOD

FROM	TO	GROUP ID	DUE DATE	AMOUNT DUE
05/01/2018	05/31/2018		05/01/2018	$136.30

Prior Balance	$117.60
Current Premium	$24.90
Current Low Income Subsidy	($6.20)
Current Late Enrollment Penalty	$0.00
Retroactive Late Enrollment Penalty	$0.00
Retroactive Premium and Low Income Subsidy	$0.00
Total Amount Due	$136.30
This notice does not reflect payments received after 04/05/2018.	

Return the portion below with your payment in full in the envelope we provided. Keep the top section for your records. Include your Member ID on all payments and make payable to Basic Blue Rx.

Basic Blue® Rx (PDP)
A Medicare Prescription Drug Plan

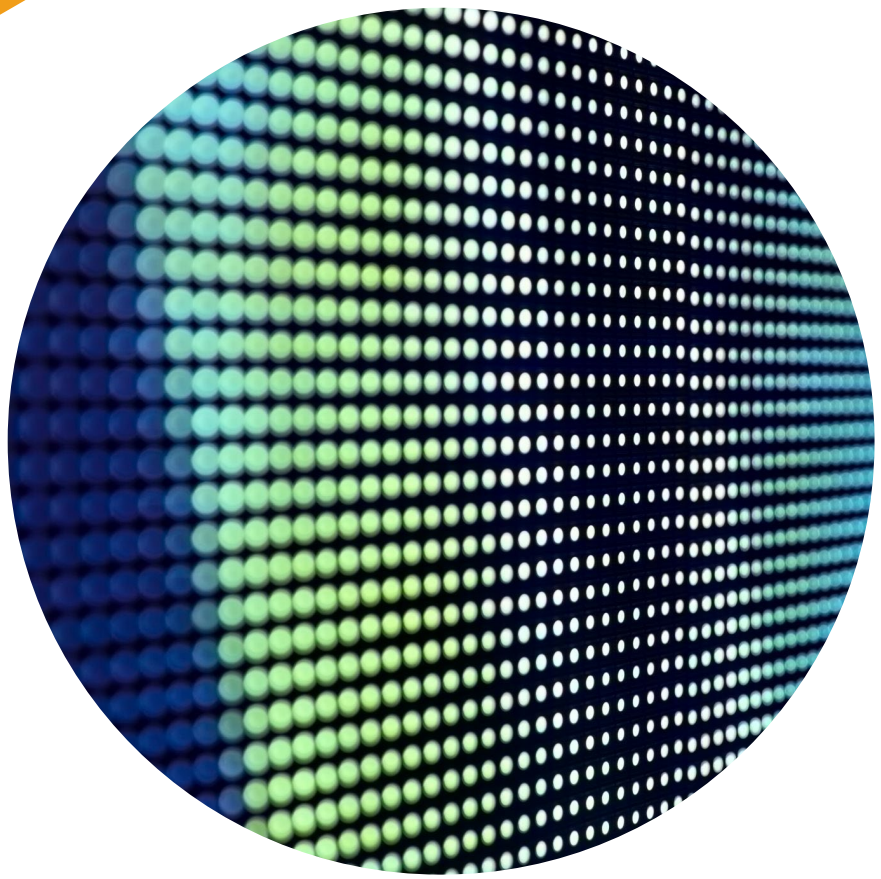
Name: Little, Hosea.		
Address Change: ☐ Permanent ☐ Mailing ☐ Both		
Street		
City		
State Zip		
Phone ( )		
Move Date:		
Invoice #	Member ID	Amount Due $136.30

Please Do Not Write Below this Area

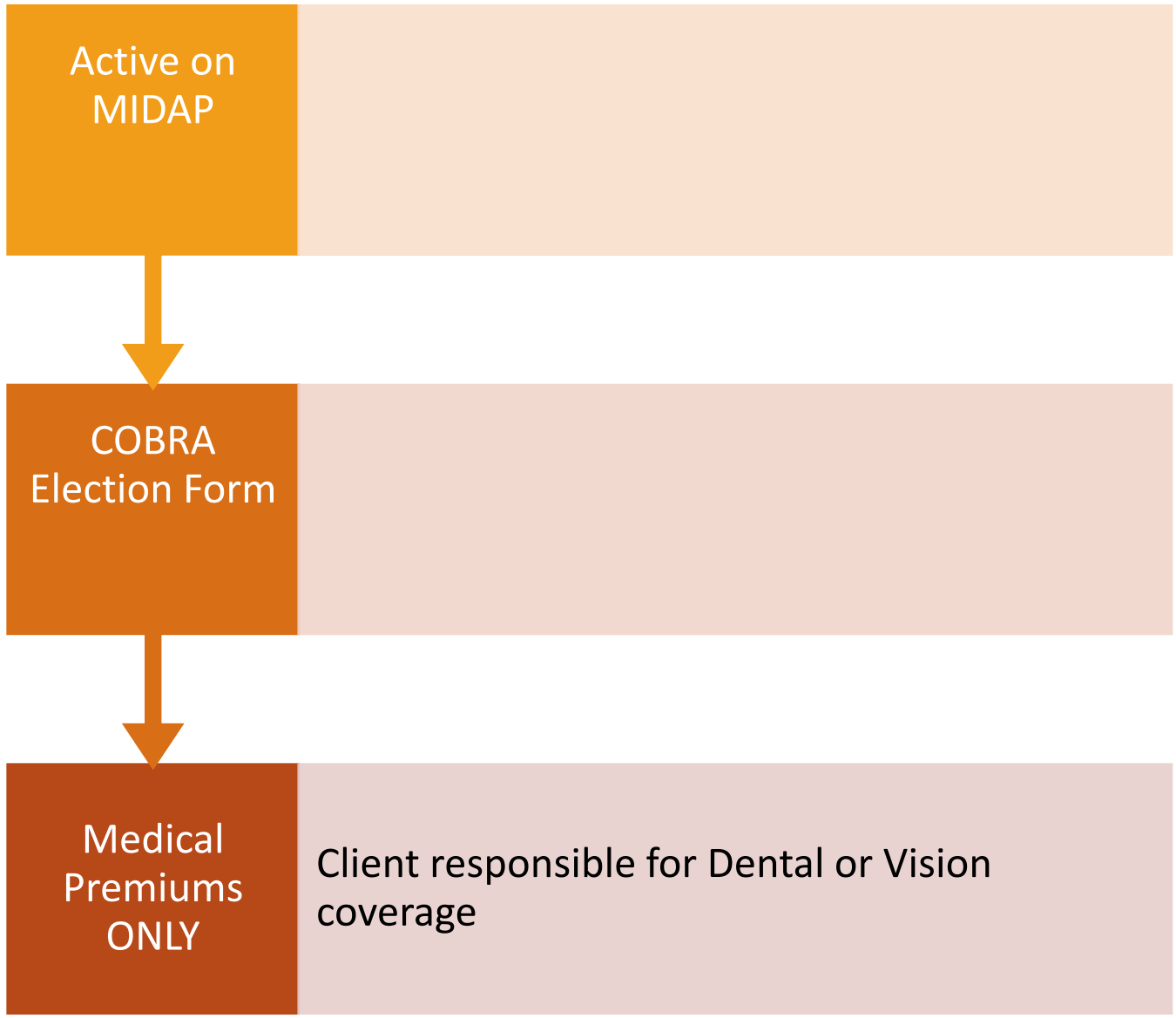
Premium Assistance Requirements

Ways to Apply for Low Income Subsidy

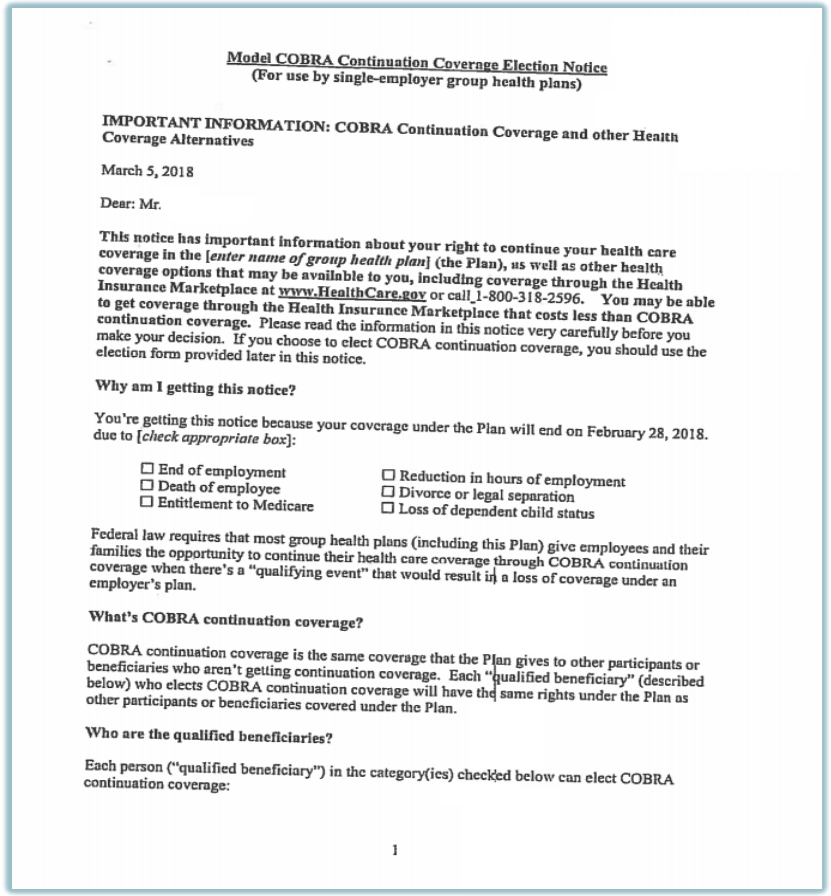
- Online – www.socialsecurity.gov
- Phone 1800-772-1213 or 1800-325-0778
- In person at your local Social Security Office



COBRA


Active on MIDAP
COBRA Election Form
Medical Premiums ONLY
Client responsible for Dental or Vision coverage

COBRA Election Form



Model COBRA Continuation Coverage Election Notice
(For use by single-employer group health plans)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

March 5, 2018

Dear: Mr.

This notice has important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on February 28, 2018. due to [*check appropriate box*]:

- ☐ End of employment
- ☐ Death of employee
- ☐ Entitlement to Medicare
- ☐ Reduction in hours of employment
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

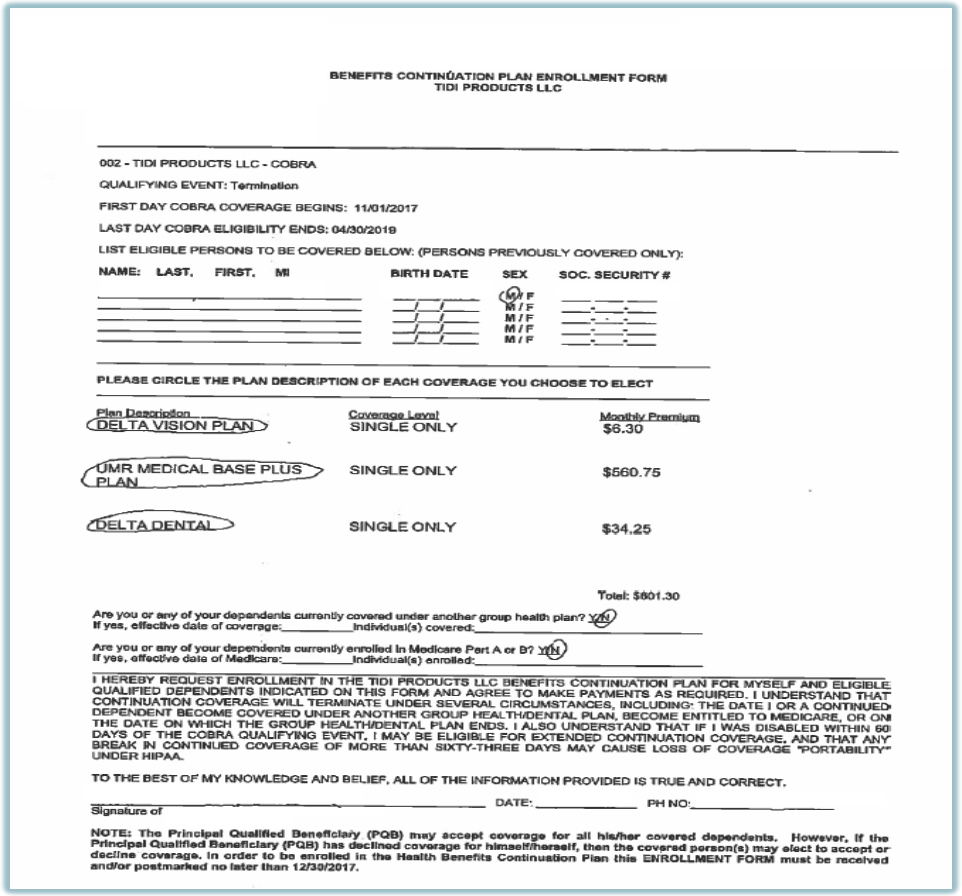
What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

1



BENEFITS CONTINUATION PLAN ENROLLMENT FORM
TIDI PRODUCTS LLC

002 - TIDI PRODUCTS LLC - COBRA

QUALIFYING EVENT: Termination

FIRST DAY COBRA COVERAGE BEGINS: 11/01/2017

LAST DAY COBRA ELIGIBILITY ENDS: 04/30/2019

LIST ELIGIBLE PERSONS TO BE COVERED BELOW: (PERSONS PREVIOUSLY COVERED ONLY):

NAME: LAST, FIRST, MI	BIRTH DATE	SEX	SOC. SECURITY #
	/ /	(M) / F	- -
	/ /	M / F	- -
	/ /	M / F	- -
	/ /	M / F	- -

PLEASE CIRCLE THE PLAN DESCRIPTION OF EACH COVERAGE YOU CHOOSE TO ELECT

Plan Description	Coverage Level	Monthly Premium
DELTA VISION PLAN	SINGLE ONLY	$6.30
UMR MEDICAL BASE PLUS PLAN	SINGLE ONLY	$560.75
DELTA DENTAL	SINGLE ONLY	$34.25

Total: $601.30

Are you or any of your dependents currently covered under another group health plan? Y(N)
If yes, effective date of coverage:_____ Individual(s) covered:_____

Are you or any of your dependents currently enrolled in Medicare Part A or B? Y(N)
If yes, effective date of Medicare:_____ Individual(s) enrolled:_____

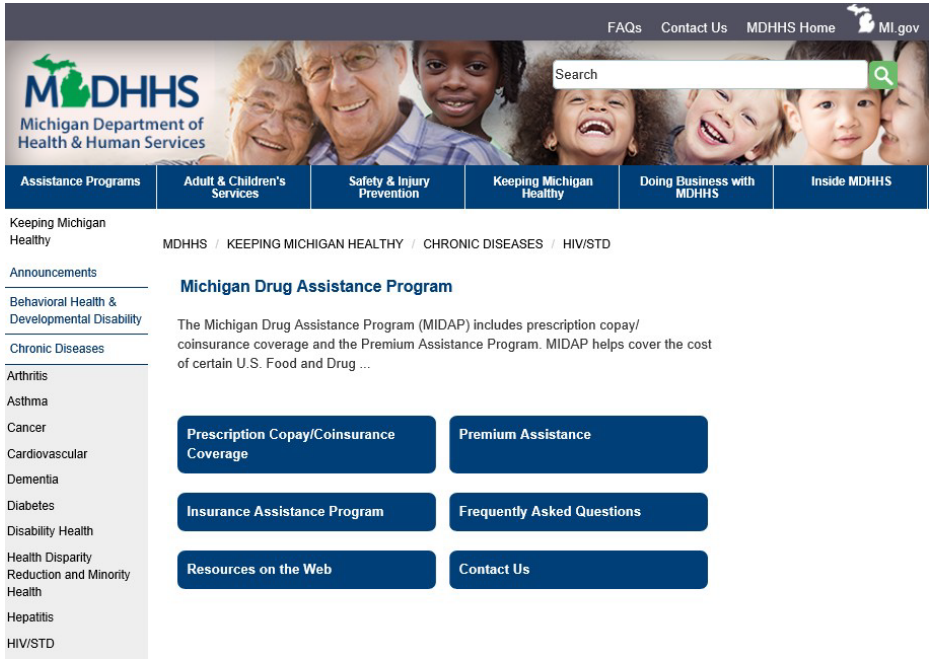
I HEREBY REQUEST ENROLLMENT IN THE TIDI PRODUCTS LLC BENEFITS CONTINUATION PLAN FOR MYSELF AND ELIGIBLE QUALIFIED DEPENDENTS INDICATED ON THIS FORM AND AGREE TO MAKE PAYMENTS AS REQUIRED. I UNDERSTAND THAT CONTINUATION COVERAGE WILL TERMINATE UNDER SEVERAL CIRCUMSTANCES, INCLUDING: THE DATE I OR A CONTINUED DEPENDENT BECOME COVERED UNDER ANOTHER GROUP HEALTH/DENTAL PLAN, BECOME ENTITLED TO MEDICARE, OR ON THE DATE ON WHICH THE GROUP HEALTH/DENTAL PLAN ENDS. I ALSO UNDERSTAND THAT IF I WAS DISABLED WITHIN 60 DAYS OF THE COBRA QUALIFYING EVENT, I MAY BE ELIGIBLE FOR EXTENDED CONTINUATION COVERAGE, AND THAT ANY BREAK IN CONTINUED COVERAGE OF MORE THAN SIXTY-THREE DAYS MAY CAUSE LOSS OF COVERAGE "PORTABILITY" UNDER HIPAA.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF THE INFORMATION PROVIDED IS TRUE AND CORRECT.

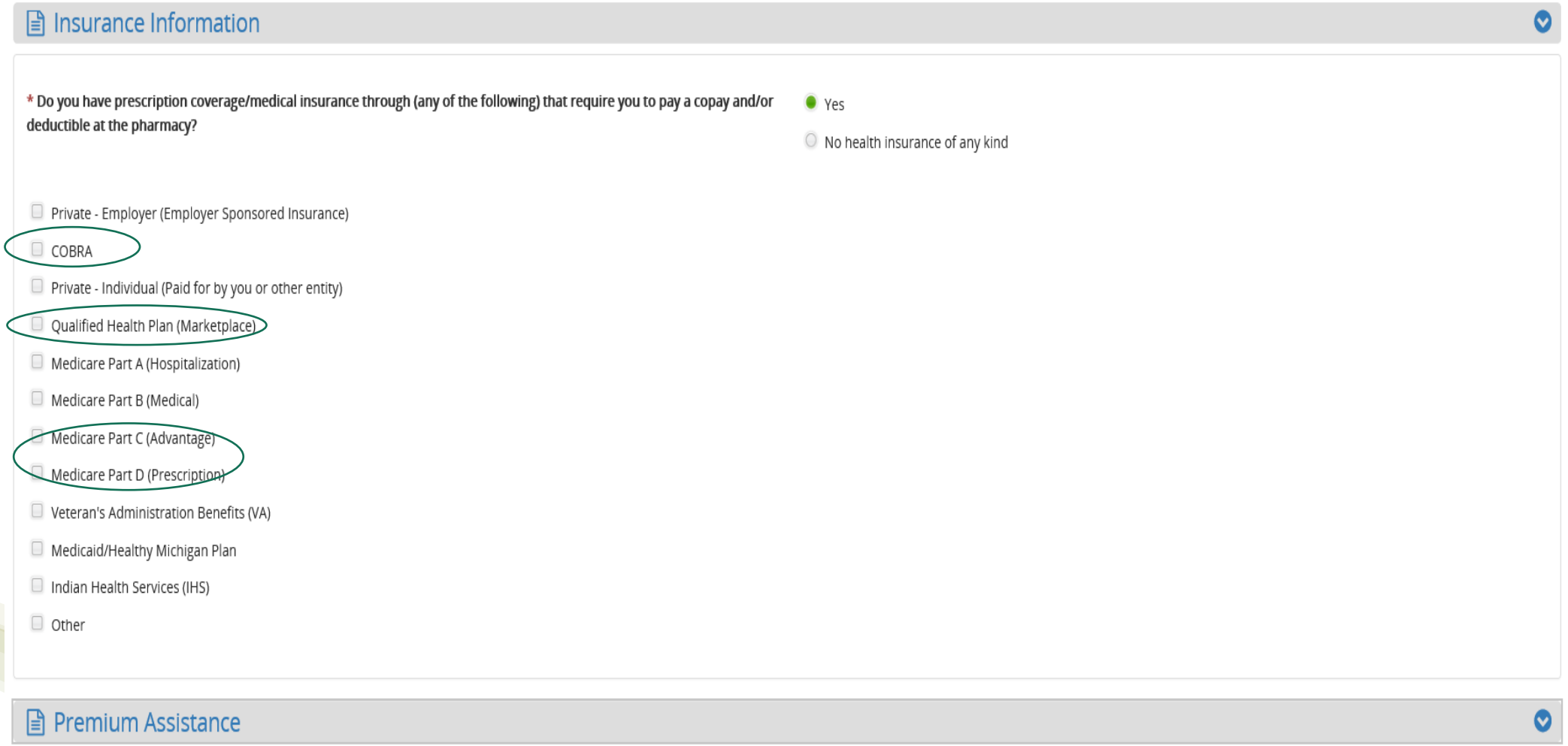
_____ DATE: _____ PH NO:_____
Signature of

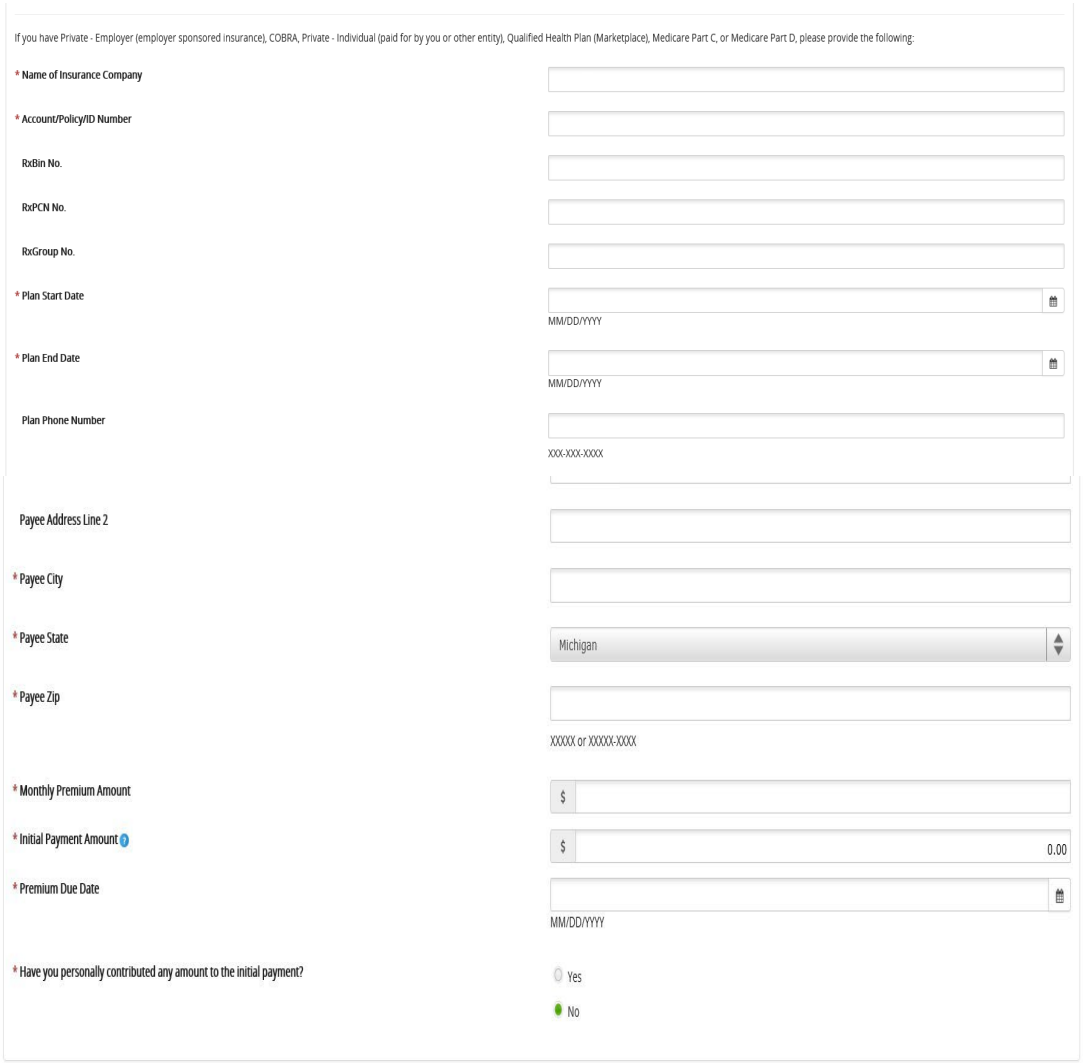
NOTE: The Principal Qualified Beneficiary (PQB) may accept coverage for all his/her covered dependents. However, if the Principal Qualified Beneficiary (PQB) has declined coverage for himself/herself, then the covered person(s) may elect to accept or decline coverage. In order to be enrolled in the Health Benefits Continuation Plan this ENROLLMENT FORM must be received and/or postmarked no later than 12/30/2017.

Premium Assistance Online



Checking one of the Qualifying Insurance plans





Insurance Payee Information

Ways to Apply for Premium Assistance

- MIDAP Online System
  - Case Managers are required to submit all applications online
  - All Approval/Denial/Modification Required notifications will be sent via email
- Paper Application
  - Only clients will be able to submit paper applications via mail or fax.
  - Due to working from Home a MIDAP reviewer is calling paper clients as well.
  - The Online System is preferred.

Questions

Contact Information

- Rachael Feher
- feherr1@michigan.gov