MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

MassHealth Buy-In for people who are eligible for Medicare

MHBI-2-LP (Rev. 03/17)

IF your monthly income before taxes and deductions is below…	AND your assets are at or below…	THEN MassHealth Buy-In will pay…
for individuals		
$1,377*	**$7,390****	all of your Medicare Part B premium.
for married couples who live together		
$1,847** (combined)	**$11,090****	all of the Medicare Part B premiums for both you and your spouse.

* These amounts are effective on March 1, 2017.
** These amounts are effective on January 1, 2017.

What is MassHealth Buy-In?

MassHealth Buy-In is a program authorized by Congress for persons who are eligible for Medicare. MassHealth Buy-In allows MassHealth to pay all of the Medicare Part B premium for Massachusetts residents who are not getting other MassHealth benefits. It can also help get Medicare Part B for persons who only have Medicare Part A.

How much can I have in income and assets?

For MassHealth Buy-In, your income and assets (including bank accounts, stocks, bonds, or a second car) must be under certain limits. The chart (at the top right of this page) shows how much you can have and what you will get if your income and assets are within these limits.

If I am eligible for MassHealth Buy-In, how do I get paid?

If MassHealth Buy-In finds that you are eligible for payment of all of your Medicare Part B premium, we will tell Medicare.

If your Medicare Part B premium is deducted from your social security check, your check will be adjusted so that your Medicare premium is no longer deducted. This means that the amount of your social security check will increase based on the amount that had been deducted to pay for your Medicare Part B premium.

If you are eligible for, but not yet getting Medicare Part B, or if you are paying your Medicare Part B premium in some other way, like getting a quarterly bill from Medicare, MassHealth Buy-In will start paying this bill for you.

It will take several months to adjust your social security benefit or to pay your bill. However, you will get a refund for the amount you paid for your Medicare Part B premium back to the month you became eligible for MassHealth Buy-In. You will get this refund in the same way as you now get your social security: either through a check or direct deposit to your bank account.

When does coverage begin?

If you are eligible for MassHealth Buy-In, your coverage begins in the month we get your application. In some cases, it may begin as early as three months before your application month.

You will get a written notice that tells you about your coverage and when it starts. If you are not eligible, the notice will give you the reason(s) you are not eligible. If you think the decision is wrong, you have the right to appeal it. Information about how to appeal is on the back of the written notice.

How we use your social security number (SSN)

We use your SSN to check information you have given us. SSN files may be matched with the files of agencies like: the Internal Revenue Service, Social Security Administration, Systematic Alien Verification for Entitlements (SAVE), Centers for Medicare and Medicaid Services, Registry of Motor Vehicles, Department of Revenue, Department of Transitional Assistance, Department of Industrial Accidents, Division of Unemployment Assistance, Department of Veterans' Services, Human Resource Division, Bureau of Special Investigations, and the Department of Public Health's Bureau of Vital Statistics. Files may also be matched with social service agencies in this state and other states, and computer files of banks and other financial institutions, insurance companies, employers, and managed care organizations.

Estate recovery

MassHealth has the right to get back money from the estates of certain MassHealth members after they die. In general, the money that must be repaid would include Medicare premiums paid by MassHealth for a member after the member turned age 55, and at any age while the member was permanently in a long-term-care facility. Effective with Medicare premiums paid on or after January 1, 2010, MassHealth will not recover premium payments made for members who were aged 55 or older at the time the premiums were paid.

There are also some additional protections and exceptions to this estate recovery rule. If a deceased member leaves behind a spouse, or a child who is blind, permanently and totally disabled, or younger than 21, MassHealth will not require repayment while any of these persons are still living. If real property, like a home, must be sold to get money to repay MassHealth, MassHealth, in limited circumstances, may decide that the estate does not need to repay MassHealth. Also, certain income, resources, and property of American Indians and Alaska Natives may be exempt from recovery.

For more information about estate recovery, see the MassHealth regulations at 130 CMR 515.000, and Chapter 118E of the Massachusetts General Laws.

Privacy and Confidentiality

MassHealth is committed to keeping the personal information we have about you confidential. All personal information we have about any applicant or member, including medical data, health status, and the personal information you give us during your application for and receipt of benefits, is confidential. This information may not be used or released for purposes not related to the administration of MassHealth without your permission unless required by law or a court order.

You can give us your written permission to use your personal health information for a specific purpose or to share it with a specific person or organization. You can also give us your permission to share your personal information with your authorized representative, Certified Application Counselor (CAC), or Navigator, if you have one, by filling out an Authorized Representative Designation Form, a Certified Application Counselor Designation Form, or a Navigator Designation Form.

For more information about how MassHealth may use and share your information and what your rights are about your information, please review the MassHealth Notice of Privacy Practices. You can get a copy by calling 1-800-841-2900 (TTY: 1-800-497-4648) or by visiting www.mass.gov/masshealt.

Authorized Representative

An authorized representative is someone you choose to help you get health care coverage through programs offered by MassHealth and the Massachusetts Health Connector. You can do this by filling out the Authorized Representative Designation Form (ARD) or a similar designation form. An authorized representative may fill out your application or eligibility review forms, give proof of information given on these eligibility forms, report changes in your income, address, or other circumstances, get copies of all MassHealth or Health Connector eligibility or enrollment notices sent to you, and act on your behalf in all other matters with MassHealth or the Health Connector.

An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to

help you. It is up to you to choose an authorized representative, if you want one. MassHealth or the Health Connector will not choose an authorized representative for you.

You must designate in writing on the Authorized Representative Designation Form or a similar designation document or authorization document the person or organization you want to be your authorized representative. In most cases, your authorized representative must also fill out this form or a similar designation document or authorization document. This form is included in the application packet, or you can call us or visit www.mass.gov/masshealth to get one. Please see the instructions on the form for more details.

An authorized representative can also be someone who is acting responsibly on your behalf if you cannot designate an authorized representative in writing because of a mental or physical condition, or has been appointed by law to act on your behalf or on behalf of your estate. This person must fill out the applicable parts of the Authorized Representative Designation Form or provide a similar designation document. If this person has been appointed by law to represent

you, either you or this person must also submit to MassHealth or the Health Connector a copy of the applicable legal document stating that this person is lawfully representing you or your estate. This person may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or if the applicant or member has died, the estate's administrator or executor.

Permission to Share Information

If you want us to share your personal health information, including sending copies of your eligibility notices, with someone who is not your authorized representative, you can do this by giving us written permission. We have forms you can use to do this. You can call us or visit www.mass.gov/masshealth to get a copy of the appropriate form.

Reporting Changes

If there are any changes in your income, assets, address, health insurance, immigration status, or disability status, you must tell us within 10 calendar days of the changes or as soon as possible. If you do not tell us about these changes, you may lose your benefits. You can tell

us about any changes by calling 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled.

Other benefits

MassHealth offers other health care benefits that either pay for medical services directly, or pay your Medicare copayments and deductibles. You may be eligible for these benefits if your income and assets are under certain amounts, or if you are disabled and younger than 65. Call us at 1-800-841-2900 (TTY: 1-800-497-4648) to learn about these benefits. You should also call this number if you have any questions about MassHealth Buy-In.

Medicare recipients can get help with prescription drug costs through Medicare. To get more information, call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048), or visit www.medicare.gov.

Prescription Advantage offers help with prescription drug costs. To learn more about these benefits, call the Executive Office of Elder Affairs toll free at 1-800-AGE-INFO (1-800-243-4636) (TTY: 1-877-610-0241).

How do I apply for MassHealth Buy-In?

1. To apply for MassHealth Buy-In, fill out the attached application. Include information about your spouse too, if he or she lives with you.

2. Sign the filled-out application, include proof of your income (except for social security income), and

   send it to: MassHealth Enrollment Center
   Central Processing Unit
   P.O. Box 290794
   Charlestown, MA 02129-0214

   or fax it to: 1-857-323-8300

3. When we get the application, we will review it for completeness. If we need more information, we will write to you or call. Once we get all information, we will decide if you are eligible. We will also decide if your spouse is eligible.

4. A voter registration form is included with your application. (You do not need to register to vote to get MassHealth Buy-In.)

5. If you want someone to act on your behalf as your authorized representative, use the enclosed Authorized Representative Designation Form to tell us.

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

MassHealth Buy-In Application for people who are eligible for Medicare

This is an application for payment of your Medicare Part B premium. It can also help you get Medicare Part B if you are getting only Medicare Part A. If you want to apply for other MassHealth benefits, call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled) for a different application. Please print clearly and fill out all sections.

MHBI-1-LP (Rev. 03/17)

General Information

Who is applying? ☐ you ☐ you and your spouse

If you and your spouse live together, you must also give us information about your spouse even if he or she is not applying for benefits.

You

Last name _____

First name _____ MI ____

Street address _____

☐ own ☐ rent

City _____ State ____ Zip _____

Mailing address (if different from above)

_____

City _____ State ____ Zip _____

Date of birth ___ /___ /_____ Gender ☐ M ☐ F

Preferred written language _____

Telephone number (____) _____

Social security number _____

For office use only

Medicare claim number _____

For office use only

Your Spouse

Last name _____

First name _____ MI ____

Date of birth ___ /___ /_____ Gender ☐ M ☐ F

Preferred written language _____

Social security number _____

For office use only

Medicare claim number _____

For office use only

Income

Fill out this section for you and your spouse. List the gross monthly income (before taxes and other deductions, such as the Medicare Part B premium).

Send proof of your income, like a copy of two recent paystubs or copies of pension check stubs. (You do not have to send proof of social security income.)

Your and your spouse's gross monthly income before taxes and deductions

Your gross monthly income from social security before taxes and deductions $ _____

For office use only

Your spouse's gross monthly income from social security before taxes and deductions $ _____

For office use only

Your gross monthly income from pensions before taxes and deductions $ _____

Your spouse's gross monthly income from pensions before taxes and deductions $ _____

Your gross monthly income from Veterans' benefits before taxes and deductions $ _____

Your spouse's gross monthly income from Veterans' benefits before taxes and deductions $ _____

Your gross monthly income from annuities or trusts before taxes and deductions $ _____

Your spouse's gross monthly income from annuities or trusts before taxes and deductions $ _____

Your gross monthly income from dividends and/or interest before taxes and deductions $ _____

Your spouse's gross monthly income from dividends and/or interest before taxes and deductions $ _____

Your gross monthly income from a job (before deductions) $ _____

Your spouse's gross monthly income from a job (before deductions) $ _____

Your gross monthly income from rent (after expenses) before taxes and deductions $ _____

Your spouse's gross monthly income from rent (after expenses) before taxes and deductions $ _____

Your gross monthly income from other sources (please specify) _____ before taxes and deductions $ _____

Your spouse's gross monthly income from other sources (please specify) _____ before taxes and deductions $ _____

Assets

Fill out this section for you and your spouse. List the value of all assets you and/or your spouse own. Do not list your primary home or car.

Your savings accounts $ _____
Your spouse's savings accounts $ _____
Your and your spouse's savings accounts $ _____

Your checking accounts $ _____
Your spouse's checking accounts $ _____
Your and your spouse's checking accounts $ _____

Your second car $ _____
Your spouse's second car $ _____
Your and your spouse's second car $ _____

Your certificates of deposits $ _____
Your spouse's certificates of deposits $ _____
Your and your spouse's certificates of deposits $ _____

Your stocks $ _____
Your spouse's stocks $ _____
Your and your spouse's stocks $ _____

Your bonds $ _____
Your spouse's bonds $ _____
Your and your spouse's bonds $ _____

Your mutual funds $ _____
Your spouse's mutual funds $ _____
Your and your spouse's mutual funds $ _____

Your other assets (please specify)
_____ $ _____
Your spouse's other assets (please specify)
_____ $ _____
Your and your spouse's other assets (please specify)
_____ $ _____

Total value of all assets listed in this section for you $ _____

For office use only

Total value of all assets listed in this section for your spouse $ _____

For office use only

Total value of all assets listed in this section for you and your spouse $ _____

For office use only

Signature

Please read the following carefully. Then sign and date the bottom of this page. Both you and your spouse must sign if your spouse lives with you.

I give permission to MassHealth to get any records or data to prove any information given on this application. I understand that I must tell MassHealth of any changes in information I gave on this application. I further certify under the penalty of perjury that the information on this application is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this application, the enclosed MassHealth Authorized Representative Designation Form must also be filled out and sent back with this application. Your signature on this application as an authorized representative certifies that the information on this application is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal. If you are denied benefits, you will get information on how to appeal.

X _____
Signature of applicant or authorized representative
Print name _____
Date ___ /___ /_____

X _____
Signature of applicant's spouse or authorized representative
Print name _____
Date ___ /___ /_____

Voter registration information is enclosed in this packet.

Once you have filled out and signed this form, send it to

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214

OR

fax it to:
1-857-323-8300