

2017 ACA ASSISTANT TRAINING

October 12, 2016



OPEN ENROLLMENT 4 TRAINING

OCTOBER 12, 2016

9:30 – 10:00	Registration
10:00 – 10:15	Welcome
10:05 – 11:00	Marketplace Insurance Company Presentations
11:00 – 11:15	Break
11:15 – 12:15	Marketplace Plans & Medicare – Group A
11:15 – 12:15	Medicaid & MCOs – Group B
12:15 – 12:45	Lunch
12:45 – 1:45	Marketplace Plan & Medicare – Group B
12:45 – 1:45	Medicaid & MCOs – Group A
1:45 – 2:00	Break
2:00 – 3:00	Q & A Session for Presenters

Contacts

CareSource WV

Highmark WV

Marketplace Plans

Medicare

Medicaid

Managed Care Organizations

Resources

Contacts for ACA, Medicaid and Medicare

WV Offices of the Insurance Commissioner

Benefits Exchange WV website - www.bewv.com
Contains calendar of events, assisters, agents, ACA information and links

Ellen Potter, Director, Health Policy
Ellen.J.Potter@wv.gov
304-558-6279 ext. 1120

Joylynn Fix, Life & Health, Policy and Rate Analyst Supervisor
Joylynn.Fix@wv.gov
304-558-6279 ext. 1170

Consumer Services
Consumer.service@wv.gov
1-800-435-7381
Judy Fling or Dena Wildman

WV DHHR – Bureau of Medical Services

(Please refer to the local county agency directory in section 6)

Rob DeBoard, Senior Medicaid Eligibility Policy Specialist
Robert.G.Deboard@wv.gov
304-356-4622

WV DHHR Managed Care Enrollment Broker – MAXIMUS

(Please refer to their reference guide in section 7)

Region 1- Outreach & Education Specialist
Steve Richardson
StevenPRichardson@Maximus.com
304-844-6148

Region 2- Outreach & Education Specialist
Heather Ray
HealthierRay@Maximus.com
304-707-8501

Region 3- Outreach & Education Specialist
Teresa Long
TeresaLLong@Maximus.com
304-550-1744

(Please refer to the map on slide 10 of the presentation for Regions)

WV Bureau of Senior Services

Marcia Meeks, SHIP & SMP Director

Marcia.D.Meeks@wv.gov

304-558-3317 ext. 107

Rebecca Gouty, SHIP & SMP State Coordinator

Rebecca.A.Gouty@wv.gov

304-558-3317 ext. 103

MarketPlace Health Insurance Companies

CareSource WV

Customer Service

855-202-0622

If you need additional help after working with customer service, you may email:

Michael Ross

Michael.Ross@caresource.com

Or

Tiffany Jones

Tiffany.Jones@caresource.com

Highmark WV

On-Exchange Member Services

888-601-2109

If you need additional help after working with member services, you may email:

Connie Sams

Connie.Sams@Highmark.com

2015-2016 Assister Help Desk Resource Guide

Name of Help Desk	What they Can Help With	Contact Information
<p>Assister Help Resource Center (AHRC)</p> <p>Serving Navigator and non-Navigator assistance personnel [Enrollment Assistance Program (EAP), In-Person Assisters (IPAs)] and certified application counselors (CACs)</p>	<p>Policy related inquiries regarding:</p> <ul style="list-style-type: none"> • Immigration, mixed status households, immigration status • Medicaid and Children's Health Insurance Program (CHIP) as they relate to the states using Healthcare.gov platform • Documents and information needed for ID proofing / verification • Income and eligibility • Enrollment process • Exemptions • Special enrollment periods (SEPs) • Issues with 1095-A • Reporting life changes • Tips for avoiding or resolving data matching issues 	<p>1-855-811-7299</p> <p>Monday through Friday from 9am to 9pm EST and Saturday from 9am to 5pm</p> <p>Closed Thanksgiving, Christmas, and New Year's Day</p> <p>(Hours reflect operating hours during the 2016 Open Enrollment Period for the individual market)</p>
<p>Marketplace Call Center</p>	<ul style="list-style-type: none"> • Completing Marketplace applications • Comparing plans • Enrolling in coverage • Reporting a life change • Resetting passwords/Providing User IDs • Updating consumers' email addresses • Unlocking accounts • Performing prospective SEPs 	<p>1-800-318-2596 (TTY: 1-855-889-4325)</p> <p>Available 24 hours a day, 7 days a week</p> <p>Closed Memorial Day, July 4th, and Labor Day</p>

Name of Help Desk	What they Can Help With	Contact Information
Marketplace Learning Management System (MLMS) Help Desk	<ul style="list-style-type: none"> • MLMS system technical issues • 2016 assister training 	MLMSHelpDesk@cms.hhs.gov Monday through Friday from 8am to 8pm EST and Saturday and Sunday from 9am to 5pm EST
Small Business Health Options Program (SHOP) Call Center	<ul style="list-style-type: none"> • Assists employers and employees with applying for and enrolling in SHOP 	1-800-706-7893 (TTY: 711) Monday through Friday 9am to 7pm EST Closed Veterans Day, Thanksgiving and the day after, Christmas, New Year's Day, Martin Luther King, Jr. Day, Memorial Day, July 3rd, and Labor Day

West Virginia Assistors

County	Assister	Facility	Contact	Main Phone Number	Contact Email	Address	City	State	Zip Code	Organization
State Wide	Navigator	WV Navicare	Stephanie Casto	(844)- WV Cares (844)982-2737	stephanie@1stchs.com	601 Morris Street, Suite 401	Charleston	WV	25301	First Choice Services
State Wide	Navigator	WV Navicare	Jeremy Smith	(304) 675-0628	jeremy@1stchs.com	601 Morris Street, Suite 401	Charleston	WV	25301	First Choice Services
State Wide	CAC	WV Primary Care Association	Ruby Piscopo	(304) 346-0032	Ruby.piscopo@wvpc.org	1700 MacCorkle Avenue, SE	Charleston	WV	25314	WVPCA
State Wide	CAC	WV Primary Care Association	Sherri Ferrell	(304) 346-0032	sherri@wvpc.org	1700 MacCorkle Avenue, SE	Charleston	WV	25314	WVPCA
Barbour	CAC	Belington Medical Clinic	Gwyn Freeman	(304) 853-2175	afreeman@myersclinic.org	70 N. Sturmer Street	Belington	WV	26250	WVPCA
Barbour	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Carol Cain Bush	(304)630-6225	ccbush@hsc.wvu.edu	Randolph Couty Health Dept, 32 Randolph Ave., Ste. 101	Elkins	WV	26241	WV Healthy Start Navigator Project
Barbour	CAC	St. George Medical Clinic	Mary Beth Streets	(304) 478-3339 ext. 125	sgmcrererral@citynet.net	8591 Holly Meadows Road	Parsons	WV	26287	WVPCA
Berkeley	CAC	Shenandoah Valley Medical System, Inc.	Katherine Lluberes	(304) 596-2224 ext. 1506	kluberes@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Berkeley	CAC	Shenandoah Valley Medical System, Inc.	Lillian "Grissel" Anderson	(304) 596-2224 ext. 1510	landerson@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Berkeley	CAC	Shenandoah Valley Medical System, Inc.	Christina Jackson	(304) 596-2224	cjackson@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Berkeley	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Brittany Watts	(304) 851-6737	brittany.watss@hsc.wvu.edu	WVU Neurology Clinic, 156 Health Care Lane	Martinsburg	WV	25401	WV Healthy Start Navigator Project
Boone	CAC	Cabin Creek Health Center	Julie Johnson	(304) 595-5006	jjohnson@cchcwv.com	5722 Cabin Creek Road	Dawes	WV	25054	WVPCA
Boone	CAC	Family Care Health Center	Bambi Huffman	(304) 720-4466	Bambi.huffman@familycarewv.org	116 Hills Plaza	Charleston	WV	25387	WVPCA
Boone	CAC	Family Care Health Center	Gail Parker	(304) 201-1130	gail.parker@familycarewv.org	12 Kanawha Terrace	St. Albans	WV	25177	WVPCA
Boone	CAC	Family Care Health Center	Angela Hughes	(304) 760-6333	Angela.huges@familycarewv.org	97 Great Teays Blvd	Scott Depot	WV	25560	WVPCA
Boone	CAC	Family Care Health Center	Gail Parker	(304) 545-4519 (cell)	gail.parker@familycarewv.org	503 Roosevelt Blvd	Eleanor	WV	25070	WVPCA
Braxton	CAC	Care Xpress - Flatwoods		(304) 765-0351		266 Skidmore Lane	Flatwoods	WV	26601	CCWV
Brooke	CAC	Change, Inc	Amy Arneault	(304) 797-7733	arneault@changeinc.org	3138 West Street	Weirton	WV	26062	WVPCA
Brooke	CAC	Change, Inc/Family Medical Care Hancock County	Barb Urbowicz	(304) 748-2828	burbowicz@changeinc.org	3136 West Street	Weirton	WV	26062	WVPCA
Brooke	CAC	Change, Inc/Family Medical Care Jefferson County	Jackie Reinacher	(304) 748-2828	jreinacher@changeinc.org	200 Luray Drive	Wintersville	OH	43952	WVPCA
Brooke	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project
Cabell	IPA	Valley Health - East Huntington	Jessica Staples	(304) 399-3310	assistors@valleyhealth.org	3377 US Route 60 East	Huntington	WV	25705	Valley
Cabell	IPA	Valley Health - Southside	Brandy Korstanje	(304) 529-0645	assistors@valleyhealth.org	723 Ninth Avenue	Huntington	WV	25701	Valley
Cabell	IPA	Valley Health - Huntington	Jennifer Pepper	(304) 525-0572	assistors@valleyhealth.org	1301 Hal Greer Boulevard	Huntington	WV	25701	Valley
Cabell	IPA	Valley Health - Milton	April Rutherford	(304) 743-1407	assistors@valleyhealth.org	1 Harbour Way	Milton	WV	25541	Valley
Cabell	Navigator	WV Navicare	Jeremy Smith	(304) 675-0628	jeremy@1stchs.com					First Choice Services
Calhoun	CAC	Minnie Hamilton Health Care Center	Janet Heiney	(304) 354-9244 ext. 1409	janet.heiney@mhcc.com	186 Hospital Drive	Grantsville	WV	26147	WVPCA
Clay	CAC	Big Otter Health Clinic		(304) 286-4200		797 Clinic Road	Big Otter	WV	25113	CCWV
Clay	CAC	Cabin Creek/Clendenin Health Center	Maria Shamblin	(304) 548-7272	mshamblin@cchcwv.com	107 Koontz Avenue	Clendenin	WV	25045	WVPCA
Clay	CAC	Primary Care Systems		(304) 587-7301		122 Center Street	Clay	WV	25043	CCWV
Doddridge	CAC	Ritchie Regional Health Center (RRHC)-Doddridge Campus	Felicia Cozatt	(304) 699-0957	feliciadawnh@gmail.com	135 South Penn Avenue	Harrisville	WV	26362	WVPCA
Doddridge	Navigator	WV Healthy Start Navigator Project	Kelly Taylor Allen	(304) 598-5150	ktaylor5@hsc.wvu.edu	453 Van Voorhis Road	Morgantown	WV	26505	WV Healthy Start Navigator Project
Fayette	CAC	Cabin Creek Health Center	Julie Johnson	(304) 595-5006	jjohnson@cchcwv.com	5722 Cabin Creek Road	Dawes	WV	25054	WVPCA
Fayette	CAC	New River Health Association, Inc.	Anthony Canada	(304) 469-2905 ext. 1352	anthony.canada@nrhawv.org	908 Scarbro Road	Scarbro	WV	25917	WVPCA
Fayette	CAC	Rainelle Medical Center, Inc.	Megan Pettrey	(304) 438-6888	mpettrey@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Fayette	CAC	Rainelle Medical Center, Inc.	Deanna Orndorff	(304) 438-6188 ext. 1013	dorndorff@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Gilmer	CAC	Minnie Hamilton Health Care Center - Glenville Office	Janet Heiney	(304) 354-9244 ext. 1409	janet.heiney@mhcc.com	921 Mineral Road, Suite 101	Glenville	WV	26351	WVPCA

West Virginia Assistors

County	Assister	Facility	Contact	Main Phone Number	Contact Email	Address	City	State	Zip Code	Organization
Grant	CAC	Preston Taylor Community Health Centers, Inc.	Kimberly Mitchell	(304)693-7616	kmitchell@ptchc.com	PO Box 277	Mt. Storm	WV	26739	WVPCA
Grant	CAC	Preston Taylor Community Health Centers, Inc.	Kimberly Fridley	(304) 693-7616	kfridley@ptchc.com	PO Box 277	Mt. Storm	WV	26739	WVPCA
Grant	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Brittany Watts	(304)264-0704	brittany.watss@hsc.wvu.edu	WVU Neurology Clinic, 156 Health Care Lane	Martinsburg	WV	25401	WV Healthy Start Navigator Project
Greenbrier	CAC	Monroe Health Center	Katie Erskine	(304)-772-3064 ext. 128	kerskine@monroehealthcenter.com	200 Health Center Drive, PO Box 590	Union	WV	24983	WVPCA
Greenbrier	CAC	Rainelle Medical Center, Inc.	Megan Pettrey	(304) 438-6888	mpettrey@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Greenbrier	CAC	Rainelle Medical Center, Inc.	Deanna Orndorff	(304) 438-6188 ext. 1013	dorndorff@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Hampshire	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Brittany Watts	(304) 851-6737	brittany.watss@hsc.wvu.edu	WVU Neurology Clinic, 156 Health Care Lane	Martinsburg	WV	25401	WV Healthy Start Navigator Project
Hancock	CAC	Change, Inc	Amy Arneault	(304) 797-7733	arneault@changeinc.org	3138 West Street	Weirton	WV	26062	WVPCA
Hancock	CAC	Change, Inc/Family Medical Care Hancock County	Barb Urbowicz	(304) 748-2828	burbowicz@changeinc.org	3136 West Street	Weirton	WV	26062	WVPCA
Hancock	CAC	Change, Inc/Family Medical Care Jefferson County	Jackie Reinacher	(304) 748-2828	jreinacher@changeinc.org	200 Luray Drive	Wintersville	OH	43952	WVPCA
Hancock	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project
Hardy	CAC	E. A. Hawse Health Center, Inc.	Samantha Harman-Mowrey	(304) 897-5915 x229	smowery@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Hardy	CAC	E. A. Hawse Health Center, Inc.	Cindy Howe	(304) 897-5915 x241	chowe@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Hardy	CAC	E. A. Hawse Health Center, Inc.	Kimberly Miller	(304) 897-5915 x272	kmiller@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Hardy	CAC	E. A. Hawse Health Center, Inc.	Brenda Thompson	(304) 897-5915 x235	bthompson@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Hardy	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Brittany Watts	(304) 851-6737	brittany.watss@hsc.wvu.edu	WVU Neurology Clinic, 156 Health Care Lane	Martinsburg	WV	25401	WV Healthy Start Navigator Project
Harrison	CAC	Community Care of West Virginia - West Milford		(304) 745-4568		924 Liberty Street	West Milford	WV	26451	CCWV
Harrison	CAC	Care Xpress - Clarksburg		(304) 623-6330		700 Oak Mound Road	Clarksburg	WV	26301	CCWV
Harrison	IPA	Clarksburg Highland Hospital	Maria Hughes	(304) 969-3105	maria.hughes@highlandhospital.net	3 Hospital Drive	Clarksburg	WV	26301	
Harrison	CAC	Monongahela Valley Association of Health Centers (MVA)	Richard Thony	(304) 367-8759	richard.thony@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Harrison	CAC	Monongahela Valley Association of Health Centers (MVA)	Mina Schultz	(304) 367-8759	mina.schultz@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Harrison	Navigator	WV Healthy Start Navigator Project	Kelly Taylor Allen	(304) 598-5150	ktaylor5@hsc.wvu.edu	453 Van Voorhis Road	Morgantown	WV	26505	WV Healthy Start Navigator Project
Jackson	CAC	Cabin Creek/Clendenin Health Center	Maria Shamblin	(304) 548-7272	mshamblin@cchcwv.com	107 Koontz Avenue	Clendenin	WV	25045	WVPCA
Jackson	CAC	Cabin Creek/Sissionville Health Center	Karen Glazier	(304) 984-1576	kglazier@cchcwv.com	539 Kanawha Two Mile Road, Suite 4	Charleston	WV	25312	WVPCA
Jackson	CAC	Wirt County Health Services Association, Inc. - Coplin Memorial	Casey Jo Lewis	(304) 275- 3301	clewis@wchsa.com	483 Court Street	Elizabeth	WV	26143	WVPCA
Jefferson OH	CAC	Change, Inc	Amy Arneault	(304) 797-7733	arneault@changeinc.org	3138 West Street	Weirton	WV	26062	WVPCA
Jefferson OH	CAC	Change, Inc/Family Medical Care Hancock County	Barb Urbowicz	(304) 748-2828	burbowicz@changeinc.org	3136 West Street	Weirton	WV	26062	WVPCA
Jefferson OH	CAC	Change, Inc/Family Medical Care Jefferson County	Jackie Reinacher	(304) 748-2828	jreinacher@changeinc.org	200 Luray Drive	Wintersville	OH	43952	WVPCA
Jefferson WV	CAC	Shenandoah Valley Medical System, Inc.	Katherine Lluberes	(304) 596-2224 ext. 1506	klluberes@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Jefferson WV	CAC	Shenandoah Valley Medical System, Inc.	Lillian "Grissel" Anderson	(304) 596-2224 ext. 1510	landerson@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Jefferson WV	CAC	Shenandoah Valley Medical System, Inc.	Christina Jackson	(304) 596-2224	cjackson@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA

West Virginia Assistors

County	Assister	Facility	Contact	Main Phone Number	Contact Email	Address	City	State	Zip Code	Organization
Jefferson WV	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Brittany Watts	(304) 851-6737	brittany.watts@hsc.wvu.edu	WVU Neurology Clinic, 156 Health Care Lane	Martinsburg	WV	25401	WV Healthy Start Navigator Project
Kanawha	CAC	Cabin Creek/Kanawha City Health Center	Ashley Falbo	(304) 205-7535	afalbo@cchcww.com	4602 MacCorkle Avenue SE	Charleston	WV	25304	WVPCA
Kanawha	CAC	Cabin Creek Health Center	Julie Johnson	(304) 595-5006	jjohnson@cchcww.com	5722 Cabin Creek Road	Dawes	WV	25054	WVPCA
Kanawha	CAC	Cabin Creek/Sissionville Health Center	Karen Glazier	(304) 984-1576	kglazier@cchcww.com	539 Kanawha Two Mile Road, Suite 4	Charleston	WV	25312	WVPCA
Kanawha	CAC	Family Care Health Center - Patrick Street Plaza	Bambi Huffman	(304) 720-4466	Bambi.huffman@familycarewv.org	116 Hills Plaza	Charleston	WV	25387	WVPCA
Kanawha	CAC	Family Care Health Center - St. Albans	Gail Parker	(304) 201-1130	gail.parker@familycarewv.org	12 Kanawha Terrace	St. Albans	WV	25177	WVPCA
Kanawha	CAC	Family Care Health Center	Angela Hughes	(304) 760-6333	Angela.hughes@familycarewv.org	97 Great Teays Blvd	Scott Depot	WV	25560	WVPCA
Kanawha	CAC	Family Care Health Center	Gail Parker	(304) 545-4519 (cell)	gail.parker@familycarewv.org	503 Roosevelt Blvd	Eleanor	WV	25070	WVPCA
Kanawha	Navigator	WV Navicare	Maricel Bernardo	(304) 558-3317	Maricel@1stchs.com	Town Center Mall, 3rd Level	Charleston	WV	25301	First Choice Services
Kanawha	Navigator	WV Navicare	Amanda Cummings	(844)- WV Cares (844)982-2737	amanda@1stchs.com	601 Morris Street, Suite 401	Charleston	WV	25301	First Choice Services
Lewis	CAC	Camden Family Health	Ann Girod	(304) 872-1663	agirod@cog-wv.org	56 Friends-R-Fun Drive	Summersville	WV	26651	WVPCA
Lewis	CAC	Camden Family Health	April Clenednin	(304) 226-5725	aclendenin@cog-wv.org	10003 Webster Road	Camden on Gauley	WV	26208	WVPCA
Lewis	CAC	Care Xpress - Weston		(304) 269-2022		149 Staunton Drive	Weston	WV	26452	CCWV
Lewis	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Carol Cain Bush	(304)630-6225	ccbush@hsc.wvu.edu	Randolph Couty Health Dept., 32 Randolph Ave., Ste. 101	Elkins	WV	26241	WV Healthy Start Navigator Project
Logan or Lincoln County		Please contact Statewide Assister listed above								
Marion	CAC	Monongahela Valley Association of Health Centers (MVA)	Richard Thony	(304) 367-8759	richard.thony@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Marion	CAC	Monongahela Valley Association of Health Centers (MVA)	Mina Schultz	(304) 367-8759	mina.schultz@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Marion	Navigator	WV Healthy Start Navigator Project	Kelly Taylor Allen	(304) 598-5150	ktaylor5@hsc.wvu.edu	453 Van Voorhis Road	Morgantown	WV	26505	WV Healthy Start Navigator Project
Marshall	CAC	Change, Inc	Amy Arneault	(304) 797-7733	arneault@changeinc.org	3138 West Street	Weirton	WV	26062	WVPCA
Marshall	CAC	Change, Inc/Family Medical Care Hancock County	Barb Urbowicz	(304) 748-2828	burbowicz@changeinc.org	3136 West Street	Weirton	WV	26062	WVPCA
Marshall	CAC	Change, Inc/Family Medical Care Jefferson County	Jackie Reinacher	(304) 748-2828	jreinacher@changeinc.org	200 Luray Drive	Wintersville	OH	43952	WVPCA
Marshall	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project
Mason	IPA	Valley Health - Gallipolis Ferry		(304) 675-5725	assistors@valleyhealth.org	15167 Huntington Road	Gallipolis Ferry	WV	25515	Valley
McDowell	CAC	Tug River Health Association	Sharon Waldron	(304) 448-2101 ext. 225	sharonwaldron52@yahoo.com	PO Box 507	Gary	WV	24836	WVPCA
McDowell	CAC	Tug River Health Association	Kristy Burke	(304) 448-2101	kristy.burke76@yahoo.com	PO Box 507	Gary	WV	24836	WVPCA
McDowell	CAC	Tug River Health Association	Susan Jones	(304) 448-2101	jsjones@citlink.net	PO Box 507	Gary	WV	24836	WVPCA
McDowell	CAC	Tug River Health Association	Stephanie Crutchfield	(304) 448-2101	stephcrutch75@yahoo.com	PO Box 507	Gary	WV	24836	WVPCA
McDowell	CAC	Tug River Health Association	Stephanie Kennedy	304) 448-2101		PO Box 507	Gary	WV	24836	WVPCA
Mercer	CAC	Bluestone Health Association, Inc.	Holly Johnson	(304) 589-3251	holly@bluestonewv.org	3997 Beckley Road	Princeton	WV	24740	WVPCA
Mercer	CAC	Bluestone Health Association, Inc.	Karen Hicks	(304) 431-5499	holly@bluestonewv.org	3997 Beckley Road	Princeton	WV	24740	WVPCA
Mineral	CAC	E. A. Hawse Health Center, Inc.	Samantha Harman-Mowrey	(304) 897-5915 x229	smowery@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Mineral	CAC	E. A. Hawse Health Center, Inc.	Cindy Howe	(304) 897-5915 x241	chowe@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Mineral	CAC	E. A. Hawse Health Center, Inc.	Kimberly Miller	(304) 897-5915 x272	kmiller@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Mineral	CAC	E. A. Hawse Health Center, Inc.	Brenda Thompson	(304) 897-5915 x235	bthompson@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA

West Virginia Assistors

County	Assister	Facility	Contact	Main Phone Number	Contact Email	Address	City	State	Zip Code	Organization
Mineral	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Brittany Watts	(304) 851-6737	brittany.watts@hsc.wvu.edu	WVU Neurology Clinic, 156 Health Care Lane	Martinsburg	WV	25401	WV Healthy Start Navigator Project
Mingo	IPA	Valley Health Steppstown		(304) 393-4090	assistors@valleyhealth.org	# 3 Adena Drive	Kermit	WV	25674	Valley
Monongalia	CAC	Clay-Batelle Community Health Center	Jason Whipkey	(304) 431-8211	Jason.Whipkey@cbhealthwv.org	5861 Mason Dixon Highway	Blacksville	WV	26251	WVPCA
Monongalia	CAC	Clay-Battelle Community Health Center	Rusty Harvilla	(304) 432-8211	rusty.harvilla@cbhealthwv.org	5861 Mason Dixon Highway	Blacksville	WV	26251	WVPCA
Monongalia	CAC	Monongahela Valley Association of Health Centers (MVA)	Richard Thony	(304) 367-8759	richard.thony@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Monongalia	CAC	Monongahela Valley Association of Health Centers (MVA)	Mina Schultz	(304) 367-8759	mina.schultz@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Monongalia	Navigator	WV Healthy Start Navigator Project	Kelly Taylor Allen	(304) 598-5150	ktaylor5@hsc.wvu.edu	453 Van Voorhis Road	Morgantown	WV	26505	WV Healthy Start Navigator Project
Monroe	CAC	Monroe Health Center	Katie Erskine	(304)-772-3064 ext. 128	kerskine@monroehealthcenter.com	200 Health Center Drive, PO Box 590	Union	WV	24983	WVPCA
Monroe	CAC	Monroe Health Center	Stephanie Aliff	(304)-772-3064 ext. 133	saliff@monroehealthcenter.com	200 Health Center Drive, PO Box 590	Union	WV	24983	WVPCA
Monroe	CAC	Monroe Health Center	Jessica Galford	(304)-772-3064 ext. 101	jessicagalford@monroehealthcenter.com	200 Health Center Drive, PO Box 590	Union	WV	24983	WVPCA
Morgan	CAC	Tri-State Community Health Center	Sheila DeShong	(304)678-5187	sdeshong@tschc.com	109 Rayloc Drive	Hancock	MD	27150	WVPCA
Morgan	CAC	Shenandoah Valley Medical System, Inc.	Katherine Lluberes	(304) 596-2224 ext. 1506	klluberes@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Morgan	CAC	Shenandoah Valley Medical System, Inc.	Lillian "Grissel" Anderson	(304) 596-2224 ext. 1510	landerson@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Morgan	CAC	Shenandoah Valley Medical System, Inc.	Christina Jackson	(304) 596-2224	cjackson@svms.net	99 Tavern Road	Martinsburg	WV	25401	WVPCA
Morgan	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Brittany Watts	(304) 851-6737	brittany.watts@hsc.wvu.edu	WVU Neurology Clinic, 156 Health Care Lane	Martinsburg	WV	25401	WV Healthy Start Navigator Project
Nicholas	CAC	Camden Family Health	Ann Girod	(304) 872-1663	agirod@cog-wv.org	55 Friends R Fun Drive	Summersville	WV	26651	WVPCA
Nicholas	CAC	Rainelle Medical Center, Inc.	Megan Pettrey	(304) 438-6888	mpettrey@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Nicholas	CAC	Rainelle Medical Center, Inc.	Deanna Orndorff	(304) 438-6188 ext. 1013	dorndorff@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Ohio	CAC	Change, Inc	Amy Arneault	(304) 797-7733	arneault@changeinc.org	3138 West Street	Weirton	WV	26062	WVPCA
Ohio	CAC	Change, Inc/Family Medical Care Hancock County	Barb Urbowicz	(304) 748-2828	burbowicz@changeinc.org	3136 West Street	Weirton	WV	26062	WVPCA
Ohio	CAC	Change, Inc/Family Medical Care Jefferson County	Jackie Reinacher	(304) 748-2828	jreinacher@changeinc.org	200 Luray Drive	Wintersville	OH	43952	WVPCA
Ohio	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project
Pendleton	CAC	E. A. Hawse Health Center, Inc.	Samantha Harman-Mowrey	(304) 897-5915 x229	smowery@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Pendleton	CAC	E. A. Hawse Health Center, Inc.	Cindy Howe	(304) 897-5915 x241	chowe@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Pendleton	CAC	E. A. Hawse Health Center, Inc.	Kimberly Miller	(304) 897-5915 x272	kmiller@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Pendleton	CAC	E. A. Hawse Health Center, Inc.	Brenda Thompson	(304) 897-5915 x235	bthompson@hawsehealth.com	PO Box 97	Baker	WV	26801	WVPCA
Pendleton	CAC	Pendleton Community Care	Theresa Kimble	(304) 358- 2355 ext. 1166	tkimble@pcc-nfc.org	314 Pine Street	Franklin	WV	26807	WVPCA
Pendleton	CAC	Pendleton Community Care	Chris Judy	(304) 358- 2355	cjudy@pcc-nfc.org	314 Pine Street	Franklin	WV	26807	WVPCA
Pendleton	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Carol Cain Bush	(304)630-6225	ccbush@hsc.wvu.edu	Randolph Couty Health Dept., 32 Randolph Ave., Ste. 101	Elkins	WV	26241	WV Healthy Start Navigator Project
Pleasants	CAC	Ritchie Regional Health Center (RRHC)	Deanna Stanley	(304) 699-0957	deannastanley1153@yahoo.com	135 South Penn Avenue	Harrisville	WV	26362	WVPCA
Pleasants	CAC	Ritchie Regional Health Center (RRHC)	Felicia Cozatt	(304) 699-0957	feliciadawnh@gmail.com	135 South Penn Avenue	Harrisville	WV	26362	WVPCA
Pleasants	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project

West Virginia Assistors

County	Assistor	Facility	Contact	Main Phone Number	Contact Email	Address	City	State	Zip Code	Organization
Pocahontas	IPA	Community Care of West Virginia - Greenbank		(304) 456-5115		4498 Potomac Highland Trail	Green Bank	WV	24944	CCWV
Pocahontas	IPA	Community Care of West Virginia - Marlinton		(304) 799-4404		821 3rd Avenue	Marlinton	WV	24954	CCWV
Pocahontas	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Carol Cain Bush	(304)630-6225	ccbush@hsc.wvu.edu	Randolph Couty Health Dept., 32 Randolph Ave., Ste. 101	Elkins	WV	26241	WV Healthy Start Navigator Project
Preston	CAC	Newburg Clinic	Sarah Maxwell	(304) 892-2828	smaxwell@ptchc.com	2060 M. Mountaineer Hwy	Newburg	WV	26410	WVPCA
Preston	CAC	St. George Medical Clinic	Mary Beth Streets	(304) 478-3339 ext. 125	sgmcreferral@citynet.net	8591 Holly Meadows Road	Parsons	WV	26287	WVPCA
Preston	CAC	Rowlesburg Clinic	Sara Maxwell	(304) 892-2828	smaxwell@ptchc.com	1 Renaissance Square	Rowlesburg	WV	26425	WVPCA
Preston	CAC	Egion Clinic	Sarah Maxwell	(304) 892-2828	smaxwell@ptchc.com	2604 Grange Hall Road	Egion	WV	26716	WVPCA
Preston	Navigator	WV Healthy Start Navigator Project	Kelly Taylor Allen	(304) 598-5150	ktaylor5@hsc.wvu.edu	453 Van Voorhis Road	Morgantown	WV	26505	WV Healthy Start Navigator Project
Putnam	CAC	Family Care Health Center	Bambi Huffman	(304) 720-4466	Bambi.huffman@familycarewv.org	116 Hills Plaza	Charleston	WV	25387	WVPCA
Putnam	CAC	Family Care Health Center	Angela Hughes	(304) 760-6333	Angela.hughes@familycarewv.org	97 Great Teays Blvd	Scott Depot	WV	25560	WVPCA
Putnam	CAC	Family Care Health Center	Gail Parker	(304) 545-4519 (cell)	gail.parker@familycarewv.org	503 Roosevelt Blvd	Eleanor	WV	25070	WVPCA
Putnam	CAC	Family Care Health Center	Gail Parker	(304) 201-1130	gail.parker@familycarewv.org	12 Kanawha Terrace	St. Albans	WV	25177	WVPCA
Raleigh	CAC	New River Health Association, Inc.	Anthony Canada	(304) 469-2905 ext. 1352	anthony.canada@nrhawv.org	908 Scarbro Road	Scarbro	WV	25917	WVPCA
Raleigh	CAC	AccessHealth	Lolita Jones	(304) 252-8324 ext. 153	ljones@accesshealthwv.com	252 Rural Acres Drive	Beckley	WV	25801	WVPCA
Raleigh	Navigator	WV Navicare	Amanda Cummings	(844)- WV Cares (844)982-2737	amanda@1stchs.com					First Choice Services
Randolph	CAC	Belington Medical Clinic	Connie Williams	(304) 853-2175	cwilliams@BCMSA.ORG	70 N. Sturmer Street	Belington	WV	26250	WVPCA
Randolph	CAC	Valley Health Care, Inc.	Robert Haddix	(304) 335-2050	vhc@wv.net	Polling Street	Mill Creek	WV	26280	WVPCA
Randolph	CAC	Valley Health Care, Inc.	Jennifer McLaughlin	(304) 335-2050	vhc@wv.net	Polling Street	Mill Creek	WV	26280	WVPCA
Randolph	CAC	Valley Health Care, Inc.	Danielle Findley	(304) 335-2050	vhc@wv.net	Polling Street	Mill Creek	WV	26280	WVPCA
Randolph	CAC	St. George Medical Clinic	Mary Beth Streets	(304) 478-3339 ext. 125	sgmcrererral@citynet.net	8591 Holly Meadows Road	Parsons	WV	26287	WVPCA
Randolph	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Carol Cain Bush	(304)630-6225	ccbush@hsc.wvu.edu	Randolph Couty Health Dept., 32 Randolph Ave., Ste. 101	Elkins	WV	26241	WV Healthy Start Navigator Project
Ritchie	CAC	Ritchie Regional Health Center (RRHC)	Deanna Stanley	(304) 699-0957	rcpcastanely@gmail.com	135 South Penn Avenue	Harrisville	WV	26362	WVPCA
Ritchie	CAC	Ritchie Regional Health Center (RRHC)	Felicia Cozatt	(304) 699-0957	feliciadawnh@gmail.com	135 South Penn Avenue	Harrisville	WV	26362	WVPCA
Ritchie	Navigator	WV Healthy Start Navigator Project	Kelly Taylor Allen	(304) 598-5150	ktaylor5@hsc.wvu.edu	453 Van Voorhis Road	Morgantown	WV	26505	WV Healthy Start Navigator Project
Roane	CAC	Cabin Creek/Clendenin Health Center	Maria Shamblin	(304) 548-7272	mshamblin@cchcwv.com	107 Koontz Avenue	Clendenin	WV	25045	WVPCA
Roane	CAC	Roane County Family Health Center, Inc.	Amy Landis	(304) 927-8185	alandis@rcfhc.org	146 Williams Drive	Spencer	WV	25276	WVPCA
Summers	CAC	Monroe Health Center	Katie Erskine	(304)-772-3064 ext. 128	kerskine@monroehealthcenter.com	200 Health Center Drive, PO Box 590	Union	WV	24983	WVPCA
Summers	CAC	Rainelle Medical Center, Inc.	Megan Pettrey	(304) 438-6888	mpettrey@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Summers	CAC	Rainelle Medical Center, Inc.	Deanna Orndorff	(304) 438-6188 ext. 1013	dorndorff@rmchealth.org	645 Kanawha Avenue	Rainelle	WV	25962	WVPCA
Taylor	CAC	Belington Medical Clinic	Connie Williams	(304) 853-2175	cwilliams@BCMSA.ORG	70 N. Sturmer Street	Belington	WV	26250	WVPCA
Taylor	CAC	Monongahela Valley Association of Health Centers (MVA)	Richard Thony	(304) 367-8759	richard.thony@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Taylor	CAC	Monongahela Valley Association of Health Centers (MVA)	Mina Schultz	(304) 367-8759	mina.schultz@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Taylor	CAC	Preston-Taylor Community Health Centers, Inc.	Kim Mitchell	(304) 265-4909	kmitchell@ptchc.com	725 North Pike Street	Grafton	WV	26354	WVPCA
Taylor	Navigator	WV Healthy Start Navigator Project	Kelly Taylor Allen	(304) 598-5150	ktaylor5@hsc.wvu.edu	453 Van Voorhis Road	Morgantown	WV	26505	WV Healthy Start Navigator Project
Tucker	CAC	Belington Medical Clinic	Connie Williams	(304) 853-2175	cwilliams@BCMSA.ORG	70 N. Sturmer Street	Belington	WV	26250	WVPCA
Tucker	CAC	Preston Taylor Community Health Centers, Inc.	Terry White	(304) 463-3331	twhite@ptchc.com	30 Cortland Acres Lane	Thomas	WV	26292	WVPCA
Tucker	CAC	Mountaintop Health Center	Terry White	(304) 463-3331	twhite@ptchc.com	HC 60 Box 99	Thomas	WV	26292	WVPCA

West Virginia Assistors

County	Assister	Facility	Contact	Main Phone Number	Contact Email	Address	City	State	Zip Code	Organization
Tucker	CAC	St. George Medical Clinic	Mary Beth Streets	(304) 478-3339 ext. 125	sgmcrererral@citynet.net	8591 Holly Meadows Road	Parsons	WV	26287	WVPCA
Tucker	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Carol Cain Bush	(304)630-6225	ccbush@hsc.wvu.edu	Randolph County Health Dept., 32 Randolph Ave., Ste. 101	Elkins	WV	26241	WV Healthy Start Navigator Project
Tyler	CAC	Clay-Battelle Community Health Center	Rusty Harvilla	(304) 432-8211	rusty.harvilla@cbhealthwv.org	5861 Mason Dixon Highway	Blacksville	WV	26251	WVPCA
Tyler	IPA	Sisterville General Hospital	Luanne Beard	(304)447-2519	lbeard@sistersvillegeneral.com	314 South Wells Street	Sisterville	WV	25175	PIHN
Tyler	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project
Upshur	CAC	Community Care of West Virginia -Tri County Health		(304) 924-6262		PO Box 217, Intersection of Rt 4 & 20 South	Rock Cave	WV	26234	CCWV
Upshur	CAC	Care Xpress - Buckhannon		(304) 473-1440		11 N. Locust Street	Buckhannon	WV	26201	CCWV
Upshur	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Carol Cain Bush	(304)630-6225	ccbush@hsc.wvu.edu	Randolph County Health Dept., 32 Randolph Ave., Ste. 101	Elkins	WV	26241	WV Healthy Start Navigator Project
Wayne	IPA	Valley Health - Westmoreland	Amber Caldwell	(304) 781-5800	assisters@valleyhealth.org	2908 Auburn Road	Huntington	WV	25704	Valley
Wayne	IPA	Valley Health - Fort Gay	Rhonda Damron	(304) 648-5544	assisters@valleyhealth.org	71 Wayne Street	Fort Gay	WV	25514	Valley
Wayne	IPA	Valley Health - Wayne	Rhonda Hinkle	(304) 272-5136	assisters@valleyhealth.org	203 Kenova Avenuenue	Wayne	WV	25570	Valley
Webster	CAC	Camden Family Health	Ann Girod	(304) 226-5725	agirod@cog-wv.org	10003 Webster Road	Camden on Gauley	WV	26208	WVPCA
Webster	CAC	Camden Family Health	April Clenednin	(304) 226-5725	aclendenin@cog-wv.org	10003 Webster Road	Camden on Gauley	WV	26208	WVPCA
Wetzel	CAC	Clay-Battelle Community Health Center of NE Wetzel County	Rusty Harvilla	(304) 432-8211	rusty.harvilla@cbhealthwv.org	60 May Lane, Suite 102	Burton	WV	26562	WVPCA
Wetzel	CAC	Monongahela Valley Association of Health Centers (MVA)	Richard Thony	(304) 367-8759	richard.thony@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Wetzel	CAC	Monongahela Valley Association of Health Centers (MVA)	Mina Schultz	(304) 367-8759	mina.schultz@mvahealth.org	1322 Locust Avenue	Fairmont	WV	26554	WVPCA
Wetzel	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project
Wirt	CAC	Minnie Hamilton Health Care Center	Janet Heiney	(304) 354-9244 ext. 1409	janet.heiney@mhcc.com	186 Hospital Drive	Grantsville	WV	26147	WVPCA
Wirt	CAC	Wirt County Health Services Association, Inc. - Coplin Memorial	Casey Jo Lewis	(304) 275- 3301	clewis@wchsa.com	483 Court Street	Elizabeth	WV	26143	WVPCA
Wood	CAC	Ritchie Regional Health Center (RRHC)	Deanna Stanley	(304) 699-0957	rcpcastaney@gmail.com	135 South Penn Avenue	Harrisville	WV	26362	WVPCA
Wood	CAC	Ritchie Regional Health Center (RRHC)	Felicia Cozatt	(304) 699-0957	feliciadawnh@gmail.com	135 South Penn Avenue	Harrisville	WV	26362	WVPCA
Wood	CAC	Wirt County Health Services Association, Inc. - Coplin Memorial	Casey Jo Lewis	(304) 275- 3301	clewis@wchsa.com	483 Court Street	Elizabeth	WV	26143	WVPCA
Wood	Navigator	WV Navicare	Stephanie Casto	(844)- WV Cares (844)982-2737	stephanie@1stchs.com					First Choice Services
Wood	Navigator	West Virginia Healthy Start/WV Healthy Start Navigator Project	Jim Adams	(304)218-2894	james.adams1@hsc.wvu.edu	87 15th Street, Suite 124	Wheeling	WV	26003	WV Healthy Start Navigator Project
Wyoming	CAC	Tug River Health Association	Donna Musgrave	(304) 732-7069	dlnusgrave@aim.com	585 Appalachian Highway	Pineville	WV	24874	WVPCA

Updated October 28, 2016



CareSource and the Health Insurance Marketplace

CareSource

ADV-SP(WV2016)-95 WV-EXCM-0095a
WVOIC Approved XX/XX/2016

CareSource

*It's not just about making a change.
It's about making a difference.*

Every number on a spreadsheet and every digit that moves a graph up or down is a living, breathing human being who deserves our attention.

We made the decision 27 years ago that health care reform is not as much about laws and legislation as it is about caring and compassion; not as much about policies and politics as it is about principle and practice; not as much about process and profit as it is about purpose and people.

Source: 2016 Annual Report



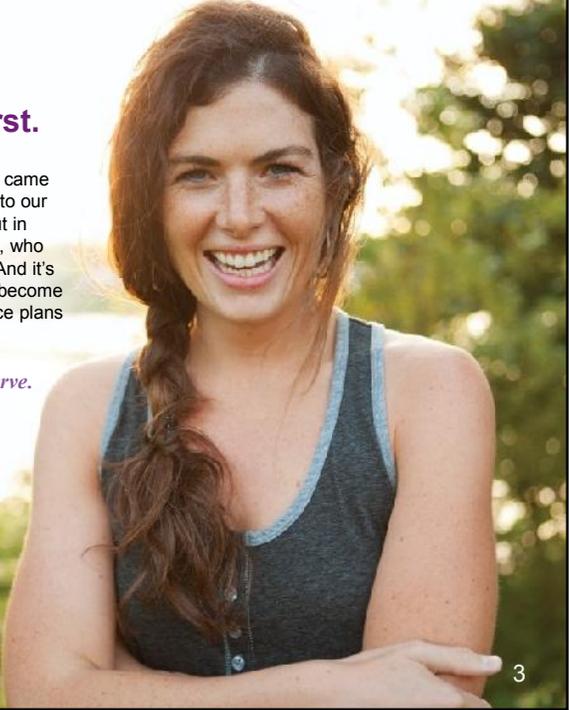


Face-to-face.

Hand-in-hand.

Heart-to-heart.

2



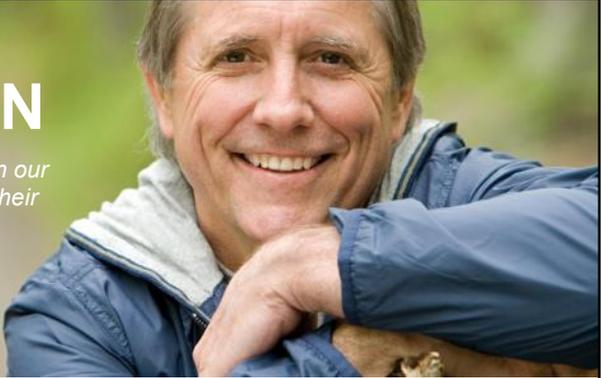
CareSource is and will always be members first.

Last year, nearly **94%** of the revenue that came in to our organization went right back out to our members. That's a statistic that stands out in stark contrast to our for-profit competitors, who typically measure between 85% to 90%. And it's one of the reasons why CareSource has become one of the fastest growing health insurance plans in America.

Our profits go back to the people we serve.

Source: 2016 Annual Report

CareSource 3



Our MISSION

To make a lasting difference in our members' lives by improving their health and well-being.

CareSource

CARESOURCE

- A nonprofit health plan and national leader in Managed Care
- 27-year history of serving the low-income populations across multiple states and insurance products
- Currently serving over 1.5 million members in Kentucky, Ohio, Indiana, West Virginia
- Preparing to serve Indiana and Georgia Medicaid members in 2017



1.52M
members



4



Marketplace

CareSource provides low-cost coverage for young people, those who aren't offered employer-based insurance, those with pre-existing conditions and many others.

Our Marketplace plans have optional vision and dental coverage as well as subsidized options through the Health Insurance Marketplace.

Focusing on what's possible.



5 Confidential & Proprietary

Marketplace



You may hear it called “Obamacare” “The Affordable Care Act (ACA)” or “Health Insurance Marketplace.”

In 2010 the Patient Protection and Affordable Care Act became law. Now *all people in the United States are required to have health care coverage or pay a tax penalty* to the Internal Revenue Service (IRS) at tax time.



6

Marketplace: TAX PENALTY

If you can afford health insurance but choose not to buy it, you must pay a fee called the *individual shared responsibility payment*.

(The fee is sometimes called the "penalty," "fine," or "individual mandate.")

- You owe the fee for any month above three that you, your spouse, or your tax dependents don't have qualifying health coverage (sometimes called "minimum essential coverage").
- You pay the fee when you file your federal tax return for the year you don't have coverage.



(Source: HealthCare.gov)

7

Marketplace: TAX PENALTY

The fee is calculated 2 different ways – as a percentage of your household income, and per person.

2016 Penalties (2017 penalties will be adjusted for inflation):

Percentage of Income
2.5%
of household income

Maximum: Total yearly premium for the national average price of a Bronze plan sold through the Marketplace.

or

Per Person
\$695 per adult
\$347.50 per child under 18

Maximum: \$2,085

You'll pay whichever is higher.



(Source: HealthCare.gov)

8

Consider This...

THE COST OF A BROKEN LEG

If it isn't broke, you don't have to fix it.

But if it is, it could cost you a lot of money.

A broken leg can cost up to **\$7,500** to correct.

If you have to stay in the hospital for three days, you'll pay an average of **\$30,000**.

(Source: HealthCare.gov)





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Marketplace:

PREMIUM TAX CREDITS AND COST SHARING

Premium Tax Credits

A tax credit you can use to lower your monthly insurance payment (called your "premium") when you enroll in a plan through the Health Insurance Marketplace. Your tax credit is based on the income estimate and household information you put on your Marketplace application.



86%

of all people who received coverage in West Virginia received premium tax credits.

>

The average premium tax credit in West Virginia for 2016 was

\$311

per month.



(Source: HealthCare.gov)

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Marketplace: PREMIUM TAX CREDITS AND COST SHARING

Cost Sharing

The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

You can only receive cost sharing benefits when you're enrolled in a Silver level plan.



(Source: HealthCare.gov)

11

Marketplace: PREMIUM TAX CREDITS AND COST SHARING

Income Guidelines

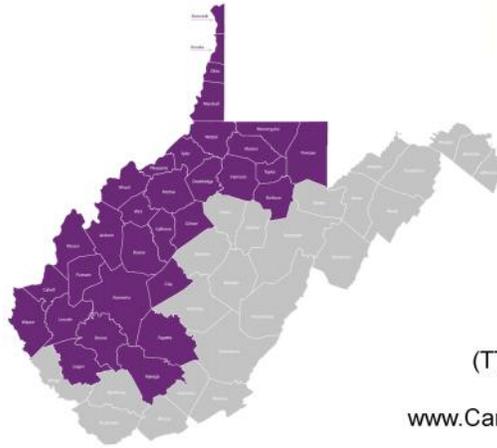
Number of People in Your Household					
1	2	3	4	5	6
\$16,243 - \$47,080	\$21,983 - \$63,720	\$27,724 - \$80,360	\$33,465 - \$97,000	\$39,2016 - \$113,640	\$44,947 - \$130,280
Yearly Income					

Source: HHS – Office of the Assistant Secretary for Planning and Evaluation (ASPE)



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CareSource Coverage Area: WEST VIRGINIA



Member Services

1-855-202-0622
(TTY 1-800-982-8771 or 711)

www.CareSource.com/marketplace



CareSource Plans: GOLD, SILVER AND BRONZE

Pediatric Dental (including Orthodontia)

Dental coverage for children is included in our CareSource Gold, Silver, and Bronze plans and our CareSource Gold, Silver, and Bronze Dental & Vision plans.

Plan	Deductible	Preventive Services	Coinsurance/Copay Comprehensive Services, Implants & Prosthetics	Orthodontia Copay/Coinsurance	Annual Limits	Age Limit
CareSource Gold	\$0	\$0	25%	20%	\$3,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver	\$0	\$0	30%	40%	\$2,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver (Silver 1 level)	\$0	\$0	30%	40%	\$2,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver (Silver 2 level)	\$0	\$0	15%	20%	\$2,500 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver (Silver 3 level)	\$0	\$0	5%	20%	\$3,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Bronze	\$0	\$20	40%	50%	\$1,700 lifetime limit* (Orthodontia)	Until age 19

*Lifetime limit only applies to cosmetic orthodontia. There is no limit for medically necessary orthodontia.



CareSource Plans: GOLD, SILVER AND BRONZE

Gold plan

A good choice for you if you expect to have a lot of doctor appointments, need many prescription medicines, or need other health services.

- **Higher premiums.**
You pay more each month for a gold plan than you would for another metal level.
- **Lower out-of-pocket costs.**
With a gold plan, the amount you pay each time you get a health service, such as seeing a doctor or filling a prescription, is less than what you'd pay if you have a bronze or silver plan.

Silver plans

This is the best plan for most people.

- **Offer the best value** if you qualify to save on out-of-pocket costs.
- **Lower deductible and lower out-of-pocket costs** for those who qualify for cost sharing reductions.

Silver plan costs are calculated based on your income. So there are multiple levels of coverage (Silver, Silver 1, Silver 2, and Silver 3).

The amount of tax credits and cost sharing is determined by the Health Insurance Marketplace (www.healthcare.gov).

Bronze plans

Highest deductibles and out-of-pocket costs but lowest premiums.



CareSource Plans: GOLD, SILVER AND BRONZE DENTAL & VISION

If you need dental and vision coverage our Dental & Vision plans offer benefits for adult over the age of 19.

You'll pay *one premium* for health, dental and vision coverage.



**CareSource Plans:
GOLD, SILVER AND BRONZE
DENTAL & VISION**

**Now includes optional
Fitness Benefit**

\$100 annual membership
(a little more than \$8 a month)

Pay one fitness center,
visit any in the network

or a Home Fitness Kit for \$10
annually includes 2 kits
(choose from over 17)

Program connects to more than
50 popular fitness devices



**CareSource Plans:
Simple Choice Gold,
Silver and Bronze**

Our Federal Standard plans.

The benefits of these plans are the same for every health insurer, but the provider networks, monthly premiums, and medications covered vary.





CareSource Plans: Low Premium

This plan was designed for the cost-conscious. You can compare it to our Bronze plans from a cost perspective, but you can still qualify for tax credits and cost sharing.

You pay a little more for services than our other silver plans, but less each month for your premium.

CareSource 19

CareSource Plans: *How to Enroll*



1. Go to CareSource.com/marketplace
2. Click on "Enroll."
3. Follow the prompts and you will be routed to the Marketplace to determine your eligibility for cost savings.
4. Complete the eligibility form using the personal financial information you've collected. Allow 20–40 minutes to complete this process. The Marketplace will determine your eligibility and if you qualify for a subsidy. It will also let you know if you or your family members qualify for health care coverage through Medicaid, Medicare or CHIP (Children's Health Insurance Program).
5. Once complete, the Marketplace will automatically return you to CareSource to apply any subsidies, calculate your costs and compare plans.
6. You can then select your plan and choose your payment method

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**CareSource Plans:
Open Enrollment**

November 1, 2016
through January 31, 2017



CareSource



CareSource[®]



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Confidential & Proprietary

September 2016

CareSource

Expanded Availability in 2017

- Barbour
- Boone
- Brooke
- Cabell
- Calhoun
- Clay
- Doddridge
- Fayette
- Gilmer
- Hancock
- Harrison
- Jackson
- Kanawha
- Lincoln
- Logan
- Marion
- Marshall
- Mason
- Monongalia
- Ohio
- Pleasants
- Preston
- Putnam
- Raleigh
- Ritchie
- Roane
- Taylor
- Tyler
- Wayne
- Wetzel
- Wirt
- Wood





HIGHMARK
West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

WEST VIRGINIA 2017
Open Enrollment

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COMPANY BACKGROUND

HIGHMARK HEALTH IS THE THIRD LARGEST INTEGRATED HEALTH CARE DELIVERY SYSTEM IN THE NATION.

35,000 

Our more than **35,000** employees are dedicated to helping your clients get the health care and peace of mind they deserve

3rd largest 

The Highmark Health enterprise is the **3rd largest** integrated health care delivery & financing system in America

150 years 

The **Highmark Health enterprise** includes affiliates with legacies of more than 150 years of providing health care in the community

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HEALTH CARE REFORM

IMPACT TO HIGHMARK

- Impacts have been financially significant
- In 2015, we paid \$1.19 in claims for every \$1 in premiums.
- Large uninsured population now have coverage
 - 85% more likely to have cancer
 - Our ACA population is 7 years older than the average commercial member.
 - Our ACA population is 34 percent more costly than a comparable commercial population, particularly for Inpatient Services.
 - Our ACA population is 37 percent more costly for Rx, 35 percent more costly for Outpatient Services and 17 percent more costly for Professional Services.
- Two of the ACA programs designed to help stabilize the market — reinsurance and risk corridor — are going away in 2017.

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OPEN ENROLLMENT 2017

WHO DO I CONTACT?

Highmark Member Services Vs. Marketplace

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OPEN ENROLLMENT 2017

CONTACT THE MARKETPLACE TO:

- Address Changes
- Add or remove a spouse, domestic partner or dependent
- Cancel your coverage (Contact the Marketplace at least 14 days prior to the date of the requested cancellation)
- Terminate membership because you are enroll in Medicare (Contact the Marketplace at least 14 days prior to the date of the requested cancellation)
- Discuss or determine status of member data matching issues (DMI) that may affect the Advanced Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR).
- Establishing a retroactive effective date of coverage after resolving citizenship, immigration issues, or DMI issues.

Marketplace – 1.800.318.2596



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OPEN ENROLLMENT 2017

CONTACT HIGHMARK TO:

- Check contract benefits
- Inquire about claims payment
- Premiums – paid to dates or premium amounts
- Make premium payment
- Provider Network

The following changes are required in writing via change form

- Spelling corrections to names
- Email corrections or additions
- Phone number corrections
- Correspondence/ mailing address change or addition
- Permanent address changes within the same city, zip code, and county
- Spelling corrections to permanent address street or city name
- Contact method preference change
- Authorized representative change

Highmark Member Services – 888-809-9121

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OPEN ENROLLMENT 2017

WHY CHOOSE HIGHMARK

My Care Navigator
A guide to help members understand and Manage their care costs

BlueCard Highmark
members have access to thousands of hospitals and physicians across the country

Online Provider Directory
Find the provider that is right for you is as easy as www.highmarkcboswv.com and Find a Doctor or Rx tab

Care Cost Estimator
Online tool that helps you find and compare costs for services when you're sick or injured

Blues On Call
24/7 hotline to a team of registered nurses to help with personal health questions

Telemedicine
Highmark provides access to a network of doctors that can assist with certain issues over the phone or internet video

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OPEN ENROLLMENT 2017



- Member Portal – access through computer or smart phone

- **TRACK AND REVIEW CLAIMS** - View up to two years of claims and sort them by member, provider, date and member responsibility.
- **TAKE THE WELLNESS PROFILE** -This self-health assessment covers all aspects of your health. It gives you an in-depth health status report and recommends online wellness programs that can help you stay healthy, enhance your health or better manage a health condition.
- **IMPROVE YOUR HEALTH** - Learn how to reduce stress, eat sensibly, manage your weight, quit tobacco or get more active with personalized online digital health assistants.
- **RESEARCH HEALTH TOPICS** -Get information on a specific health topic or emerging health trends with news articles, a health library, condition guides, e-newsletters, videos and links to relevant health resources across the web.
- **VIEW THE PREVENTIVE SCHEDULE** - Based on recommendations from the American Academy of Family Physicians, the online preventive schedule is a handy reference for your family's health screening and immunizations. Stay up-to-date on required shots, recommended exams and routine screenings.

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Open Enrollment 2017 Questions?

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Member Name (Please print): _____

Member ID: _____

Please indicate the changes you are requesting:

Spelling correction to name: _____

Email correction or addition: _____

Phone number correction: _____

Correspondence/Mailing address change or addition:

Permanent Address change within the same city, zip code and county:

Spelling correction to permanent address street or city name:

Contact method preference change: _____

Authorized representative change: _____

Signature _____ **Date** _____

Please return to P.O. Box 890118 Camp Hill, PA 17089-0118 or fax to 1-877-332-2299

MY CONNECT BLUE WV PPO 4750S BASE
Individual / Direct pay

Benefit Provision	Template Number:			PPO Out-of-Network
	PPO In-Network PREFERRED	PPO In-Network ENHANCED	PPO In-Network STANDARD	
Effective Date	General Provisions			PPO Out-of-Network
Group Number	01-Jan-17 [12345678]			
Plan Year	Plan-Wide Provisions			
Out-of-Pocket (OOP) Maximum - INDIVIDUAL	Calendar			
Out-of-Pocket (OOP) Maximum - FAMILY	\$7,150 Combined All Tiers			N/A
Coinsurance - Plan Payment Level	\$14,300 Combined All Tiers			N/A
Medical Deductible - Individual	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Medical Deductible - Family	\$4,750 \$9,500	\$5,250 \$10,500	\$5,750 \$11,500	\$11,500 \$23,000
Inpatient Hospital Facility Services	Inpatient Facility Services			
Skilled Nursing Facility	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Maternity - State Mandates Apply	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Maternity for Dependent Daughter	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Nursery Care	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Short Term Inpatient Rehabilitation	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Inpatient Occupational Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Inpatient Speech Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Inpatient Physical Medicine	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Inpatient Respiratory Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Emergency Room Care (includes Emergency medical / Emergency Accident) One copay per visit	Outpatient Facility			
Outpatient Surgery	80% after deductible	60% after deductible	50% after deductible	40% after deductible

MY CONNECT BLUE WV PPO 4750S BASE
Individual / Direct pay

Template Number:				
Benefit Provision	PPO In-Network PREFERRED	PPO In-Network ENHANCED	PPO In-Network STANDARD	PPO Out-of-Network
Outpatient Diagnostic				
Advanced Imaging	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Standard Imaging	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Pathology/Lab	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Diagnostic Medical	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Allergy Testing	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Mammograms (Routine)	100% (deductible does not apply)	100% (deductible does not apply)	100% (deductible does not apply)	Not Covered
Mammograms (Medically Necessary)	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Outpatient Therapy, Rehabilitation, and Habilitation Services				
Occupational Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Speech Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Physical Medicine	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Respiratory Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Dialysis	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Chemotherapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Radiation Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Infusion Therapy	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Clinic	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Professional Services				
Inpatient Medical Care (Includes Intensive Medical Care)	80% after preferred deductible	80% after preferred deductible	80% after preferred deductible	40% after deductible
Skilled Nursing Facility Care	80% after preferred deductible	80% after preferred deductible	80% after preferred deductible	40% after deductible
Concurrent Care	80% after preferred deductible	80% after preferred deductible	80% after preferred deductible	40% after deductible
Consultations (Inpatient)	80% after preferred deductible	80% after preferred deductible	80% after preferred deductible	40% after deductible
Benefit Maximum: 1 Consultation, per Consultant, per Admission				
Voluntary Second Surgical Opinion	80% after preferred deductible	80% after preferred deductible	80% after preferred deductible	40% after deductible
Emergency Medical / Emergency Accident	80% (deductible does not apply)	80% (deductible does not apply)	80% (deductible does not apply)	80% (deductible does not apply)
Specialist Office/Outpatient Visit/ Consultation	100% after \$60 copay, no deductible	100% after \$60 copay, no deductible	100% after \$60 copay, no deductible	40% after deductible

MY CONNECT BLUE WV PPO 4750S BASE
Individual / Direct pay

Benefit Provision	Template Number:			PPO Out-of-Network
	PPO In-Network PREFERRED	PPO In-Network ENHANCED	PPO In-Network STANDARD	
Physician Office/Outpatient Visit/ Consultation	100% after \$45 copay, no deductible			40% after deductible
Telemedicine Service	100% after \$20 copay, no deductible			Not covered
Virtual Visit Origination Fee Site	80% after preferred deductible			40% after deductible
Origination Fee	80% after preferred deductible			40% after deductible
Surgery	80% after preferred deductible			40% after deductible
Tubal Ligation	80% after preferred deductible			40% after deductible
Vasectomy	80% after preferred deductible			40% after deductible
Sterilization Reversal	Not Covered			Not Covered
Transsexual Surgery	80% after preferred deductible			40% after deductible
Assistant at Surgery	80% after preferred deductible			40% after deductible
Anesthesia	80% after preferred deductible			40% after deductible
Outpatient Diagnostic				
Advanced Imaging	60% after deductible			40% after deductible
Standard Imaging	80% after preferred deductible			40% after deductible
Pathology/Lab	80% after preferred deductible			40% after deductible
Diagnostic Medical	80% after preferred deductible			40% after deductible
Allergy Testing	80% after preferred deductible			40% after deductible
Mammograms (Routine)	100% (deductible does not apply)			Not Covered
Mammograms (Medically Necessary)	80% after preferred deductible			40% after deductible
Maternity - State Mandated Benefits Apply	80% after preferred deductible			40% after deductible
Maternity for Dependent Daughter	80% after preferred deductible			40% after deductible
Newborn Care	80% after preferred deductible			40% after deductible
State Mandated Benefits Apply				
Professional Therapy, Rehabilitation, and Habilitation Services				
Occupational Therapy	80% after preferred deductible			40% after deductible
	Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period			
Speech Therapy	80% after preferred deductible			40% after deductible
	Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period			
Physical Medicine	80% after preferred deductible			40% after deductible
	Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period			
Respiratory Therapy	80% after preferred deductible			40% after deductible
Cardiac Rehabilitation Therapy	80% after preferred deductible			40% after deductible

MY CONNECT BLUE WV PPO 4750S BASE
Individual / Direct pay

Template Number:				
Benefit Provision	PPO In-Network PREFERRED	PPO In-Network ENHANCED	PPO In-Network STANDARD	PPO Out-of-Network
Dialysis		80% after preferred deductible		40% after deductible
Chemotherapy		80% after preferred deductible		40% after deductible
Radiation Therapy		80% after preferred deductible		40% after deductible
Infusion Therapy		60% after deductible		40% after deductible
Spinal Manipulations		80% after preferred deductible		40% after deductible
		Limit: 30 visits/benefit period		
Allergy Extracts		80% after preferred deductible		40% after deductible
Retail Clinic		100% after \$45 copay, no deductible		40% after deductible
Allergy Injections		80% after preferred deductible		40% after deductible
Urgent Care		100% after \$65 copay, no deductible		40% after deductible
Preventive Care				
Preventive Schedule		Highmark Preventive Schedule		
Routine Physical Exam		100% (deductible does not apply)		Not Covered
State / Federal Mandates Apply		Number of visits: See Preventive Schedule / Women's Health Schedule		
Routine Gynecological Exam -		100% (deductible does not apply)		Not Covered
State / Federal Mandates Apply		Number of visits: See Preventive Schedule / Women's Health Schedule		
Routine Pap Smear -		100% (deductible does not apply)		Not Covered
State / Federal Mandates Apply		Number of visits: See Preventive Schedule / Women's Health Schedule		
Routine Mammogram -		100% (deductible does not apply)		Not Covered
State / Federal Mandates Apply		Number of visits: See Preventive Schedule / Women's Health Schedule		
Adult Immunizations		100% (deductible does not apply)		Not Covered
Travel Immunizations		Not Covered		Not Covered
Pediatric Immunizations		100% (deductible does not apply)		Not Covered
Well Baby Care		100% (deductible does not apply)		100% (deductible does not apply)
Neonatal Circumcision		100% after deductible		100% after deductible
Adult Care		100% (deductible does not apply)		Not Covered
Routine Foot Care		Not Covered		Not Covered
Hearing Care		100% (deductible does not apply)		Not Covered
Routine Hearing Screening		100% (deductible does not apply)		100% (deductible does not apply)
Hearing Aid		Not Covered		Not Covered
Hearing Aid Exam		100% (deductible does not apply)		100% (deductible does not apply)
Routine Diagnostic Services and Procedures Limited - Highmark WV Preventive Schedule Only		100% (deductible does not apply)		Not Covered

MY CONNECT BLUE WV PPO 4750S BASE
Individual / Direct pay

Benefit Provision	Template Number:			PPO Out-of-Network
	PPO In-Network PREFERRED	PPO In-Network ENHANCED	PPO In-Network STANDARD	
	Other Services			
Emergency Ambulance		80% after preferred deductible		80% after preferred deductible
Non-Emergency Ambulance		60% after deductible		40% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Prosthetic Devices	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Orthotics	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Home Infusion Therapy		80% after preferred deductible		40% after deductible
Blood / Blood Components		80% after preferred deductible		40% after deductible
Private Duty Nursing		80% after preferred deductible	Limit: 35 Visits/benefit period	40% after deductible
Home Health		80% after preferred deductible		40% after deductible
		Limit: 100 visits/benefit period - aggregate with Visiting Nurse		
Visiting Nurse		80% after preferred deductible		40% after deductible
		Limit: 100 visits/benefit period - aggregate with Home Health		
Hospice		80% after preferred deductible		40% after deductible
Experimental /Investigational		Not Covered		Not Covered
Nicotine Cessation Programs		Not Covered		Not Covered
Assisted Fertilization		Not Covered		Not Covered
Elective Abortion		Not Covered		Not Covered
Non-Elective Abortion(Limited to those necessary to avert the death of the member or to terminate pregnancies by rape or incest)		80% after deductible	50% after deductible	40% after deductible
Transplant Services	80% after deductible	60% after deductible		40% after deductible
Oral Surgery	80% after deductible	60% after preferred deductible	50% after deductible	40% after deductible
Impacted Teeth Services Limited: Impacted third molars when Partially or Totally covered by bone.		80% after preferred deductible		40% after deductible
Surgery to Mouth Services Limited to Maxillary or Mandibular Frenectomy and Mandibular Staples - when not for dentures)		80% after preferred deductible		40% after deductible

MY CONNECT BLUE WV PPO 4750S BASE
Individual / Direct pay

Template Number:				
Benefit Provision	PPO In-Network PREFERRED	PPO In-Network ENHANCED	PPO In-Network STANDARD	PPO Out-of-Network
Mastectomy and Breast Cancer Reconstruction <i>State Mandates Apply</i>	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Dental Accident	80% after preferred deductible	80% after preferred deductible	50% after deductible	40% after deductible
Enteral Formulae	80% after preferred deductible	80% after preferred deductible	50% after deductible	40% after deductible
Prescription Drugs		IMWV RX11		Not Covered
Contraceptives		80% after preferred deductible		40% after deductible
		See Preventive Schedule / Women's Health Schedule		
Injectables		80% after preferred deductible		40% after deductible
		See Preventive Schedule / Women's Health Schedule		
Devices/Implants		80% after preferred deductible		40% after deductible
		See Preventive Schedule / Women's Health Schedule		
Injections	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Acupuncture		Not Covered		Not Covered
Dean Ornish Program		Not Covered		Not Covered
Bariatric Surgery	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Health Education Services		80% after deductible		40% after deductible
Blues on Call		Covered		Not Covered
Disease State Management		Covered		Not Covered
Complementary Wellness Discount Program		Covered		Not Covered
Maternity Program		Covered		Not Covered
Case Management		Covered		Not Covered
Conditions				
Inpatient Mental Health Services		80% after preferred deductible		40% after deductible
Outpatient Mental Health Services		100% after \$45 copay, no deductible		40% after deductible
Inpatient Substance Abuse Rehabilitation		80% after preferred deductible		40% after deductible
Inpatient Substance Abuse Detoxification		80% after preferred deductible		40% after deductible
Outpatient Substance Abuse Services		100% after \$45 copay, no deductible		40% after deductible
TMJ				
		80% after preferred deductible		40% after deductible
<i>Limit: Orthotics/splints/appliances limited to 1 every 36 months</i>				
Cleft Palate <i>**Includes orthodontic treatment</i>	80% after deductible	60% after deductible	50% after deductible	40% after deductible

MY CONNECT BLUE WV PPO 4750S BASE
Individual / Direct pay

Benefit Provision	Template Number:			
	PPO In-Network PREFERRED	PPO In-Network ENHANCED	PPO In-Network STANDARD	PPO Out-of-Network
Morbid Obesity	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Diabetes - State Mandates Apply	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Infertility <i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on the group's prescription drug program</i>	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Cosmetic Surgery <i>Limited to reconstruction to restore body function or malformation caused by disease, trauma, birth defects, growth defects, prior therapeutic processes or as a result for an act of family violence.</i>	80% after deductible	60% after deductible	50% after deductible	40% after deductible
Autism Mandate Benefits	80% after preferred deductible			
				40% after deductible

Highmark WV Hospital List*

	Preferred	Enhanced	Standard
Barbour		Broadus Hospital	
Berkeley		Berkeley Medical Center	VA Medical Center of Martinsburg
Boone		Boone Memorial	
Braxton		Braxton Memorial	
Brooke		No hospitals in this county	
Cabell	St. Mary's Hospital		Cabell Huntington Hospital Dept of Veterans Affairs Medical Center - Huntington
Calhoun		Minnie Hamilton Health Center	
Clay		No hospitals in this county	
Doddridge		No hospitals in this county	
Fayette		Montgomery General	Plateau Medical Center
Gilmer		No hospitals in this county	
Grant		Grant Memorial Hospital	
Greenbrier		Greenbrier Valley Medical Center	
Hampshire		Hampshire Memorial Hospital	
Hancock	Weirton Medical Center	Trinity Medical Center, Ohio	
Hardy		No hospitals in this county	
Harrison		United Hospital Center	Louis A Johnson VA Medical Center
Jackson		Jackson General Hospital	
Jefferson		Jefferson Medical Center	
		Thomas Memorial Hospital	
Kanawha		St. Francis Hospital	
		Charleston Area Medical Center	
		Charleston Surgical Hospital	
Lewis		Stonewall Jackson Memorial Hospital	
Lincoln		No hospitals in this county	
Logan			Logan General
Marion		Fairmont Regiona	
Marshall	Reynolds Memorial		
Mason		Pleasant Valley Hospital	
McDowell		Welch Community Hospital	
Mercer	Princeton Community Hospital	Bluefield Regional Medical Center	
Mineral		Potomac Valley Hospital	
Mingo		Tug Valley ARH, Kentucky Hospital	Williamson Memorial Hospital
Monongalia	Monongalia Gen Hospital		West Virginia University Hospital
Monroe		No hospitals in this county	
Morgan		War Memorial Hospital	
Nicholas		Summersville Regional Medical Center	
Ohio	Ohio Vallye Medical Center	Wheeling Hospital	
Pleasants			
Pocahontas		Pocahontas Memoral Hospital	
Preston		Preston Memorial Hospital	
Putnam		CAMC Teays Valley	
Raleigh		Beckley ARH	Raleigh General Hospital Beckley Veteran Affairs Medical Center
Randolph	Davis Medical Center		
Ritchie		No hospitals in this county	
Roane		Roane General Hospital	
Summers		Summers County ARH	
Taylor		Grafton City Hospital	
Tucker		No hospitals in this county	
Tyler		Sistersville General Hospital	
Upshur		St. Joseph's Hospital of Buckhannon	
Wayne		No hospitals in this county	
Webster		Webster County Memorial Hospital	
Wetzel		Wetzel County Hospital	
Wirt		No hospitals in this county	
Wood		Camden Clark Memorial Hospital	
Wyoming		No hospitals in this county	

*List is as of October 6, 2016, and is subject to change

How to Read Your Plan Activity Statement: This is a sample of a Plan Activity Statement

Key Document Benefits: Modern design, easy to read terminology . Plan for future care, make decisions about timing, cost and other choices, keep records of health care, manage health care budgets and understand what money may be owed to whom.

Location Name
123 Any Avenue - City, ST 12345-6789

1 DEC. 12, 2011

2  NEED HELP? CALL 1 (800) 555-1212
8AM - 8PM EST | MONDAY - FRIDAY
OR GO TO WEBSITE.COM
OR CALL TTY AT 1 (800) 555-2222

3

Member Name	SCOTT CUSTOMER
Member ID	XXXXXXXXXXXX
Group Name	ABC COMPANY

Scott Customer
123 A Street
Anytown, PA 17011

YOUR PLAN ACTIVITY STATEMENT

THIS IS NOT A BILL.
PROVIDED FOR YOUR REFERENCE.

4 :CHECK ENCLOSED

5 **SPENDING ACCOUNTS SUMMARY**

ACCOUNT TYPE	PLAN PERIOD START	PLAN PERIOD END	TOTAL ACCT. TRANSACTIONS
Health Reimbursement Account (HRA)	01/01/2011	12/31/2011	\$15.80
Flexible Spending Account (FSA)	01/01/2011	12/31/2011	\$7.40

The values in the Spending Accounts Summary only represent payment information. Check your account online for all the details.

6 **PLAN ACTIVITY SUMMARY**

Amount Billed	\$175.00	This is the total amount of all claims submitted.
Discounts	- \$47.50	Your negotiated discounts saved you this amount.
What Your Plan Paid	- \$104.30	This amount was covered by your plan.
What Your Spending Account(s) Paid	- \$23.20	This amount was paid by your spending account(s) for medical claims.
WHAT YOU OWE OR MAY HAVE PAID	= \$0.00	This is the amount you owe on services after we subtracted your discount, what your plan paid, and what your account(s) paid. Any amount you paid at the time of service may reduce the amount you owe.

PAGE 1 OF 4 An independent licensee of the Blue Cross and Blue Shield Association.

1 Statement date : Shows the date the statement was created.

2 How to Reach Us: Shows information on how to contact us.

3 Member information: Lists the primary Member Name, It also shows the Member ID number, the same number printed on the health care coverage card. If covered by more than one company's benefits plan, information for all of the Groups will be listed.

4 Check Enclosed: If there's a check included with the statement, there will be a message here. The check will be printed on a separate page. Towards the end of your statement, we'll include a Payment Summary section that explains how we calculated the amount.

5 Spending Account Summary: Shows the total amount spent out of the spending account(s) during this statement period. If the spending account activity spans more than one plan period, all of the periods will be listed.

6 Plan Activity Summary: Summarizes all the medical claims that were submitted, how much was paid, and the amount that may be owed.

7 YOUR DETAILED CLAIMS ACTIVITY

SCOTT CUSTOMER

8

DATE AND PROCEDURE	EXPLANATION	YOUR MEDICAL COSTS
<p>9</p> <p>Date of Service: 10/31/2011 Claim No. XXXXXXXXXXXXX Procedure Code: XXXXX</p> <p>Status: <input checked="" type="radio"/> Approved</p>	<p>Your provider (Allentown Medicine) charged you \$80.00 for this service. Your discount was \$26.00. This is the difference between the provider's charge and our allowance. Since this provider is preferred you are not responsible for this amount. Your plan allowance was \$54.00. Your coinsurance was \$5.40. Your health plan paid \$48.60.</p> <p>You are responsible for \$5.40.</p>	<p>\$5.40</p> <p>13</p>
<p>11</p> <p>FSA 12/08/2011 Status: <input checked="" type="radio"/> Paid Plan Period Start: 01/01/2011 Plan Period End: 12/31/2011</p>	<p>\$5.40 was submitted to your account. Payment was issued to you.</p>	<p>WHAT YOUR ACCOUNT(S) PAID \$5.40</p> <p>WHAT YOU OWE OR MAY HAVE PAID \$0.00</p>
<p>Date of Service: 10/31/2011 Claim No. XXXXXXXXXXXXX Procedure Code: XXXXX</p> <p>Status: <input checked="" type="radio"/> Approved</p>	<p>Your provider (Allentown Medicine) charged you \$40.00 for this service. Your discount was \$12.00. This is the difference between the provider's charge and our allowance. Since this provider is preferred you are not responsible for this amount. Your plan allowance was \$28.00. Your coinsurance was \$2.80. Your health plan paid \$25.20.</p> <p>You are responsible for \$2.80.</p>	<p>YOUR MEDICAL COSTS \$2.80</p>
<p>FSA 12/08/2011 Status: <input checked="" type="radio"/> Paid Plan Period Start: 01/01/2011 Plan Period End: 12/31/2011</p>	<p>\$2.80 was submitted to your account. Payment was issued to you.</p>	<p>WHAT YOUR ACCOUNT(S) PAID \$2.00</p> <p>WHAT YOU OWE OR MAY HAVE PAID \$0.80</p>
<p>HRA 12/08/2011 Status: <input checked="" type="radio"/> Paid Plan Period Start: 01/01/2011 Plan Period End: 12/31/2011</p>	<p>\$0.80 was submitted to your account. Payment was issued to you.</p>	<p>WHAT YOUR ACCOUNT(S) PAID \$0.80</p> <p>WHAT YOU OWE OR MAY HAVE PAID \$0.00</p>
<p>Date of Service: 11/30/2011 Claim No. XXXXXXXXXXXXX Procedure Code: XXXXX</p> <p>Status: <input checked="" type="radio"/> Paid</p>	<p>Your provider (D Gerhart) charged you \$35.00 for this service. Your discount was \$4.50. This is the difference between the provider's charge and our allowance. Since this provider is preferred you are not responsible for this amount. Your plan allowance was \$30.50. Your coinsurance was \$15.50. Your copayment was \$15.00.</p> <p>You are responsible for \$15.00.</p>	<p>YOUR MEDICAL COSTS \$15.00</p>
<p>FSA 12/08/2011 Status: <input type="radio"/> Denied Plan Period Start: 01/01/2011 Plan Period End: 12/31/2011</p>	<p>\$15.00 was submitted to your account. Due to insufficient funds no payment has been made.</p>	<p>WHAT YOUR ACCOUNT(S) PAID \$0.00</p> <p>WHAT YOU OWE OR MAY HAVE PAID \$15.00</p>
<p>HRA 12/08/2011 Status: <input checked="" type="radio"/> Paid Plan Period Start: 01/01/2011 Plan Period End: 12/31/2011</p>	<p>\$15.00 was submitted to your account. Payment was issued to your provider.</p>	<p>WHAT YOUR ACCOUNT(S) PAID \$15.00</p> <p>WHAT YOU OWE OR MAY HAVE PAID \$0.00</p>

PAGE 2 OF 4

7 Your Detailed Claims Activity:

Breaks down each medical claim in detail.

8 Whose Claim it is:

Claims for each person in the household are grouped together by name.

9 Individual Claim Status:

Lists the specifics of a medical claim line-by-line, starting with the date the service was performed. The Claim No. identifies this particular claim in our computer system. The doctor's name, or the place of service, is also listed. The Status line says whether the claim is approved, denied or still waiting for a final decision.

10 Explanation of Status:

Explains our decision about this item within the claim. Starting with how much the doctor or place of service charged, we walk through the math to show members how we figured the amount they may be responsible to pay, if anything at all.

11 Spending Account Information:

Shows which health spending account paid the medical claim, and the date payment was made.

12 Explanation of Payment:

Tells exactly how much was paid out of the spending account, or why payment was not made.

13 Your Medical Costs:

Shows the approved amount they are responsible for, how much was paid, and what they still may owe.

YOUR DETAILED CLAIMS ACTIVITY (CONT.)

DATE AND PROCEDURE	EXPLANATION	YOUR MEDICAL COSTS
Date of Service: 11/29/2011 Claim No. [REDACTED] Procedure Code: [REDACTED] Status: <input checked="" type="radio"/> Paid	Your provider (D Gerhart, DC) charged you \$26.00 for this service. Your discount was \$5.00. This is the difference between the provider's charge and our allowance. Since the provider is preferred you are not responsible for this amount. Your plan allowance was \$15.00. Your health plan paid \$15.00. You are responsible for \$6.00.	\$6.00

ADVERSE MEDICAL SERVICE DETERMINATION INFORMATION

If you have questions regarding your medical benefits, please contact:

Human Resources
Email: tax.com
Telephone: 1 800 [REDACTED]
Fax: 1 800 [REDACTED]

If you suspect fraud or abuse involving your health insurance, please call the toll-free fraud or abuse hotline at 1 (800) 535-5335.

SPENDING ACCOUNT TRANSACTIONS SUMMARY

Plan Period 01/01/2011 - 12/31/2011

PAYMENT AMOUNT	PAYMENT #	PAYMENT DATE	PAYMENT TO	DATE OF SERVICE	ACCOUNT TYPE	CLAIM NUMBER	CATEGORY	TYPE
\$16.80	000000	12/05/2011	Pharmacy Name	12/05/2011	HRA	N/A	PHARM	Debit Card

The values in the Spending Account Transactions Summary only represent payment information. Check your account online for all the details.

PAYMENT SUMMARY

PAYMENT TO	CHECK NUMBER #	CLAIM NUMBER	CHECK AMOUNT	ORIGINAL AMOUNT	OFFSET QP	PAYMENT AMOUNT
<Scott	<XXXXXXXX>	<XXXX>	<XXXX.YY>	<N/A>	<N/A>	<XXXX.YY>
<Scott	<XXXXXXXX>	<XXXX>	<XXXX.YY>	<XXXX.YY>	-	<XXXX.YY>

BENEFITS-AT-A-GLANCE (YEAR-TO-DATE)

Plan Period 01/01/2011 - 12/31/2011

DEDUCTIBLE				OUT OF POCKET			
IN NETWORK				IN NETWORK			
Program	\$100.00	Remaining		Program	\$1,000.00	Remaining	
Individual	Deductible	Applied	Remaining	Individual	Maximum	Applied	Remaining
Scott	\$100.00	\$100.00	\$0.00	Scott	\$1,000.00	\$48.28	\$951.72
OUT OF NETWORK				OUT OF NETWORK			
Program	\$500.00	Remaining		Program	\$2,000.00	Remaining	
Individual	Deductible	Applied	Remaining	Individual	Deductible	Applied	Remaining
Scott	\$500.00	\$0.00	\$500.00	Scott	\$2,000.00	\$0.00	\$2,000.00

14 Denied Claims, Explanation of Denial, and Adjustments:

If there are adjustments to previously processed claims, we'll tell you about it here.

15 Adverse Medical Service Determination Information:

If the claim was denied, they may get additional contact or plan-specific information here.

16 Spending Account Transactions:

Lists spending account transactions not associated to a medical claim shown on that statement.

17 Payment Summary:

If we're sending you checks as payment, a summary of how the amount of the check was calculated will appear in this area.

18 Benefits-at-a-Glance (Year-to-date):

See how much of the deductible and out-of-pocket expenses are left, and other information related to their specific plan benefits.

Healthcare coverage
wherever you go.

When you're a BlueSM member, you take your healthcare benefits with you – across the country and around the world. The BlueCard Program gives you access to doctors and hospitals almost everywhere, giving you the peace of mind that you'll be able to find the healthcare provider you need.



To learn more about the BlueCard Program, call your local Blue Plan or visit www.BCBS.com.

Important

Visit the BlueSM National Doctor & Hospital Finder at www.BCBS.com or call BlueCard Access at 1.800.810.BLUE (2583) to locate doctors and hospitals outside of your Blue Plan's service area in the United States.

TheBlueCard[®]

Now, Home Is Where The Card Is[®]

Blue Cross, Blue Shield, the Blue Cross and Blue Shield symbols, BlueCard and BlueCard Worldwide are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

N-11-183



The BlueCard[®] Program

Across the country
and around the world...
we've got
you covered.





The BlueCard[®] Program



As a BlueSM member, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your membership gives you a world of choices. Within the United States, you're covered whether you need care in urban or rural areas. Outside of the United States, you have access to doctors and hospitals in more than 200 countries and territories around the world through the BlueCard Worldwide[®] Program.

With the BlueCard Program, you can locate doctors and hospitals quickly and easily. With your Blue Plan ID card handy, follow these steps:

- Visit the Blue National Doctor & Hospital Finder at www.BCBS.com to locate doctors and hospitals, along with maps and directions to find them.
- Blue Cross and Blue Shield Association launched a Blue National Doctor and Hospital Finder app for iPhone, iPad and iPod Touch, allowing you to quickly search for healthcare providers nationwide. There is no charge to download the app from the App Store, but rates from your wireless provider may apply.
- Call BlueCard Access at 1.800.810.BLUE (2583) for the names and addresses of doctors and hospitals in the area where you or a covered dependent need care.

If you're a PPO member, always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits.

Designed to save you money.

In most cases, when you travel or live outside your Blue Plan's service area, you can take advantage of savings the local Blue Plan has negotiated with its doctors and hospitals. For covered services, you should not have to pay any amount above these negotiated rates and any applicable out-of-pocket expenses.

Take charge of your health, wherever you are.

Within the United States

1. Always carry your current Blue ID card.
2. To find nearby doctors and hospitals, call BlueCard Access at 1.800.810.BLUE (2583) or visit the Blue National Doctor & Hospital Finder at www.BCBS.com.
3. Call your Blue Plan for precertification or prior authorization, if necessary. Refer to the phone number located on your Blue ID card. *Note: This phone number is different from the BlueCard Access number mentioned above.*
4. When you arrive at the participating doctor's office or hospital, show the provider your ID card. The provider will identify your benefit level through one of these symbols:



Traditional/
Indemnity
Benefits



PPO
Benefits

After you receive care, you should:

- Not have to complete any claim forms.
- Not have to pay upfront for medical services, except for the usual out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance).
- Receive an explanation of benefits from your Blue Plan.

In an emergency, go directly to the nearest hospital.

Around the world

1. Verify your international benefits with your Blue Plan before leaving the United States as coverage may be different outside the country.
2. Always carry your current Blue ID card.
3. If you need to locate a doctor or hospital, or need medical assistance services, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
4. Please see below for the steps that should be taken for inpatient and professional services.

Inpatient claim: Call the BlueCard Worldwide Service Center at 1.800.810.2583 or collect at 1.804.673.1177 when you need inpatient care. In most cases, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket expenses (non covered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf. In addition to contacting the BlueCard Worldwide Service Center, call your Blue Plan for precertification or preauthorization. Refer to the the phone number on your Blue ID card. *Note: this number is different from the phone number listed above.*

Professional claim: You pay upfront for care received from a doctor and/or non-participating hospital. Complete a BlueCard Worldwide International claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The claim form is available from your Blue Plan, the BlueCard Worldwide Service Center, or online at www.BCBS.com/bluecardworldwide.

Open Enrollment 4

Medical Plans

Information provided is current as of today. Please join the OIC listserv to keep up to date on federal and state updates.

Objectives

- Upon completion of this module, participants will be able to:
 - Help consumers compare health plans based on cost, provider network, and availability of services
 - Assist consumers in selecting a plan, and giving them the right information in following up with that plan
 - Inform consumers regarding how to pay for their plans, including application of any available tax breaks/subsidies.
 - Assist consumers in completing attestation

Comparing Plans

- Healthcare.gov allows consumers to compare plans so you get an **ESTIMATE** of what premiums you'd pay and what benefits and protections you'd get before you enroll.
- Standardized Plans

The screenshot shows the '14 Health Plans' comparison tool on Healthcare.gov. The sidebar on the left includes filters for Premium (Monthly: \$300-\$700, Annual: \$3,600-\$8,400), Coverage categories (HSA plans (3), Silver plans (2), Gold plans (2)), Plan types (PPO (14)), Insurance companies (Highmark WV (14)), and Medical management programs (None (14), Chronic Care (14), Depression (14), Diabetes (14), High blood pressure & cholesterol (14), Low back pain (14), Pregnancy (14)). The main content area displays details for 'Highmark WV - Health Savings Blue PPO 3000', including an estimated monthly premium of \$218, a \$3,000 deductible, and a \$6,350 out-of-pocket maximum. A second plan, 'Highmark WV - Comprehensive Care Blue PPO 4000', is partially visible below.

Factors to Consider when Selecting a Plan

Cost (*premium, copay, deductible, out-of-pocket max*)

Expected Number of Doctor Visits

Benefits and Prescriptions Offered

Provider Network

Marketplace Plans Offered in WV



32 Counties



Statewide

**21 Individual Medical Insurance Plans through
2 Insurance Carriers**

Health Plans on the FFE

Ambulatory patient services	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance use disorder services, including behavioral health treatment	Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)

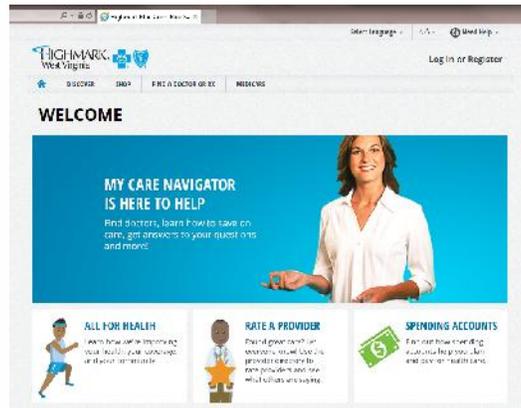
Preventive Coverage

- The US Preventive Services Task Force is tasked with grading preventive medical services
- A or B graded services must be covered with no cost sharing as a part of the ACA
- See the complete [list](#)

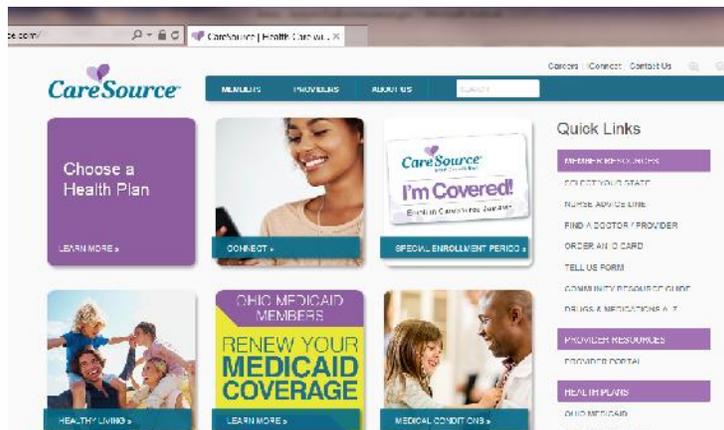
Health Plans on the FFE: Metal Tiers

	 Gold	 Silver	 Bronze
Monthly Cost	\$\$\$	\$\$	\$
Cost When You Get Care	\$\$	\$\$\$	\$\$\$\$
Good Option If You...	want to pay higher monthly premiums while keeping your out-of-pocket cost low	need to balance your monthly premium with your out-of-pocket costs premium	don't plan to need a lot of health care services

Network



Network





Highmark

- 1 Product, Multiple Deductibles
 - MyConnect Blue
- Catastrophic
 - Major Events
- Hospital Tiering
- Rx restructure



Highmark

- Network Tiering
 - Hospital Claims only
 - Preferred
 - Enhanced
 - Standard
 - Professional Services
 - Stand Alone Facilities paid at preferred





Highmark

- Prescription Restructure
 - Tier 1: 15% with \$3 minimum and \$10 max
 - Tier 2: 25% with \$20 minimum and \$75 max
 - Tier 3: 35% with \$70 minimum and \$250 max
 - Tier 4: 50% with \$150 minimum and \$1000 max



Highmark West Virginia

MyConnect Blue 1000

- \$1000/\$2000 Deductible OR \$1500/\$3000 OR \$2500/\$5000
- \$4500/\$9000 OOP Max
- 10% OR 30% OR 50% Co-Insurance
- \$20 Primary/\$40 Specialist
- \$200 Copay**, then 100% ER
- Rx 15%/25%/35%/50%

**ER Copay waived if admitted.

GOLD



Highmark West Virginia

MyConnect Blue 1000

- \$1500/\$3000 Deductible OR \$2000/\$4000 OR \$3000/\$6000
- \$4200/\$8400 OOP Max
- 20% OR 40% OR 50% Co-Insurance
- \$35 Primary/\$45 Specialist
- \$150 Copay**, then 20% ER (for all hospital tiers)
- Rx 15%/25%/35%/50%

**ER Copay waived if admitted.

GOLD





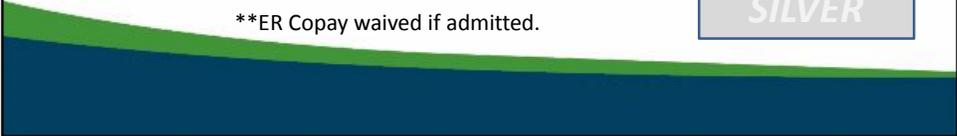
Highmark West Virginia

MyConnect Blue 750

- \$750/\$1500 Deductible OR \$4000/\$8000 OR \$6000/\$12,000
- \$7150/\$14,300 OOP Max
- 30% OR 40% OR 50% Co-Insurance
- \$65 Primary/\$115 Specialist
- \$500 Copay**, then 100% ER
- Rx 15%/25%/35%/50%

**ER Copay waived if admitted.

SILVER





Highmark West Virginia

MyConnect Blue 2800

- \$2800/\$5600 Deductible
- \$5700/\$11,400 OOP Max
- 20% OR 40% OR 50% Co-Insurance
- Deductible, then 20% for all Office Visits
- Deductible, then 20% ER (for all hospital tiers)
- Rx Deductible, 20%

SILVER





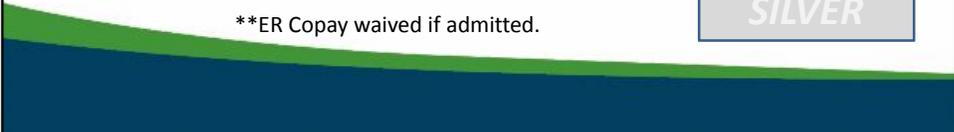
Highmark West Virginia

MyConnect Blue 4750

- \$4750/\$9500 Deductible OR \$5250/\$10,500 OR \$5750/\$11,500
- \$7150/\$14,300 OOP Max
- 20% OR 40% OR 50% Co-Insurance
- \$45 Primary/ \$60 Specialist
- \$150 Copay**, then 20% ER (for all hospital tiers)
- Rx 15%/25%/35%/50%

**ER Copay waived if admitted.

SILVER





Highmark West Virginia

MyConnect Blue \$6500

- \$6500/\$13,000 Deductible OR \$6800/\$13,600 OR \$7000/\$14,000
- \$7150/\$14,300 OOP Max
- 30% OR 40% OR 50% Co-Insurance
- \$100 Primary/ \$140 Specialist
- Deductible then 30% ER (all hospital tiers)
- Rx 15%/25%/35%/50%

BRONZE



Highmark West Virginia

Major Events Catastrophic Plan

- \$7150/\$14,300 Deductible
- \$7150/\$14,300 OOP Max
- 100% Co-Insurance
- 3 PCP Visits no cost sharing

MultiState Plans

- West Virginia has no MultiState Plans for 2017



CareSource

Expanded Availability in 2017

- Barbour
- Boone
- Brooke
- Cabell
- Calhoun
- Clay
- Doddridge
- Fayette
- Gilmer
- Hancock
- Harrison
- Jackson
- Kanawha
- Lincoln
- Logan
- Marion
- Marshall
- Mason
- Monongalia
- Ohio
- Pleasants
- Preston
- Putnam
- Raleigh
- Ritchie
- Roane
- Taylor
- Tyler
- Wayne
- Wetzel
- Wirt
- Wood



CareSource

Gold

- \$1000/\$2000 Deductible
- \$4500/\$9000 OOP Max
 - \$2500 Medical/\$2000 Pharmacy
 - \$5000 Medical/\$4000 Pharmacy
- 20% Co-Insurance
- \$0 Primary/\$40 Specialist
- \$250 Copay, then Deductible ER
- Rx \$0/\$120/\$160/40%/50%
 - Tier 4 and 5 capped at \$300 per script

**ER Copay waived if admitted.

GOLD



CareSource

Gold Enhanced

<ul style="list-style-type: none"> • \$1000/\$2000 Deductible • \$4500/\$9000 OOP Max <ul style="list-style-type: none"> • \$2500 Medical/\$2000 Pharmacy • \$5000 Medical/\$4000 Pharmacy • 20% Co-Insurance • \$0 Primary/\$40 Specialist • \$250 Copay, then Deductible ER • Rx \$0/\$120/\$160/40%/50% <ul style="list-style-type: none"> • Tier 4 and 5 capped at \$300 per script 	<ul style="list-style-type: none"> • \$25 Copay after deductible for Adult Vision (\$150 Limit) • \$0 Preventive Dental • 25% Major Services • 20% Ortho (\$3000 Lifetime Max)
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**ER Copay waived if admitted.

GOLD



CareSource

Gold Simple Choice

- \$1250/\$2500 Deductible
- \$6250/\$12,500 OOP Max
 - \$4750 Medical/\$1500 Pharmacy
 - \$9500 Medical/\$3000 Pharmacy
- 20% Co-Insurance
- \$20 Primary/\$50 Specialist
- \$250 Copay, then Deductible ER
- Rx \$10/\$30/\$75/30%

**ER Copay waived if admitted.

GOLD



CareSource

Silver

- \$3300/\$6600 Deductible
- \$6400/\$12,800 OOP Max
- 30% Co-Insurance
- \$0 Primary/\$50 Specialist
- \$500 Copay**, then Deductible ER
- Rx \$0/\$60/\$130/40%/50%
 - Tier 4 and 5 capped at \$300 per script

**ER Copay waived if admitted.

SILVER



CareSource

Silver Enhanced

- \$3300/\$6600 Deductible
- \$6400/\$12,800 OOP Max
- 30% Co-Insurance
- \$0 Primary/\$50 Specialist
- \$500 Copay**, then Deductible ER
- Rx \$0/\$60/\$130/40%/50%
 - Tier 4 and 5 capped at \$300 per script
- \$25 Copay after deductible for Adult Vision (\$150 Limit)
- \$0 Preventive Dental
- 25% Major Services
- 20% Ortho (\$3000 Lifetime Max)

**ER Copay waived if admitted.

SILVER



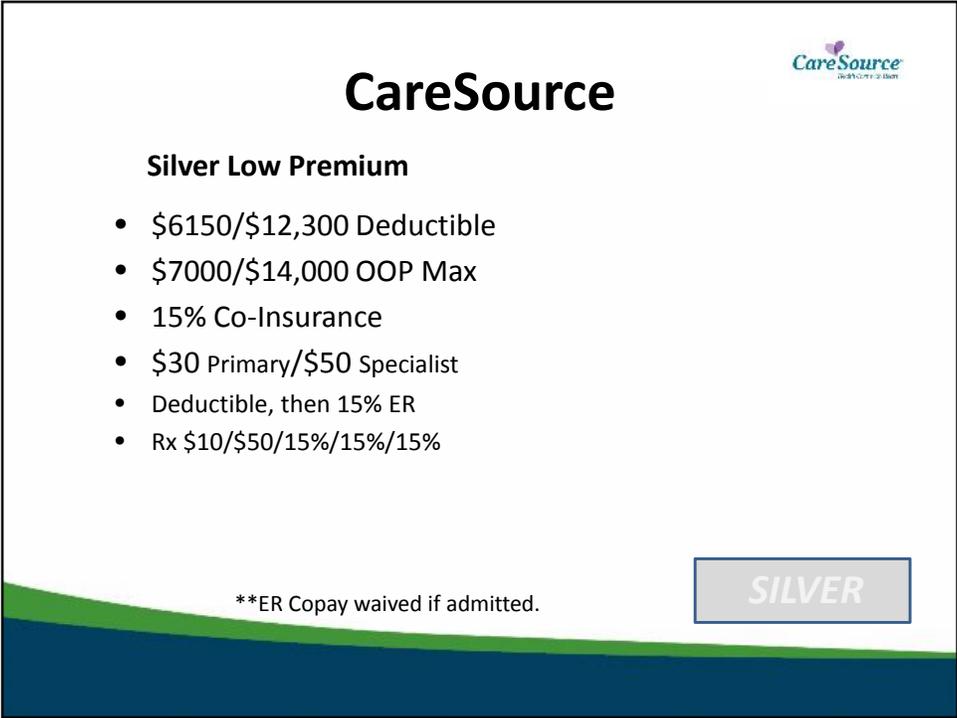
CareSource

Silver Simple Choice

- \$3500/\$7000 Deductible
- \$7150/\$14,300 OOP Max
- 20% Co-Insurance
- \$30 Primary/\$65 Specialist
- \$400 Copay**, then Deductible ER
- Rx \$15/\$50/\$100/40%

**ER Copay waived if admitted.

SILVER



CareSource

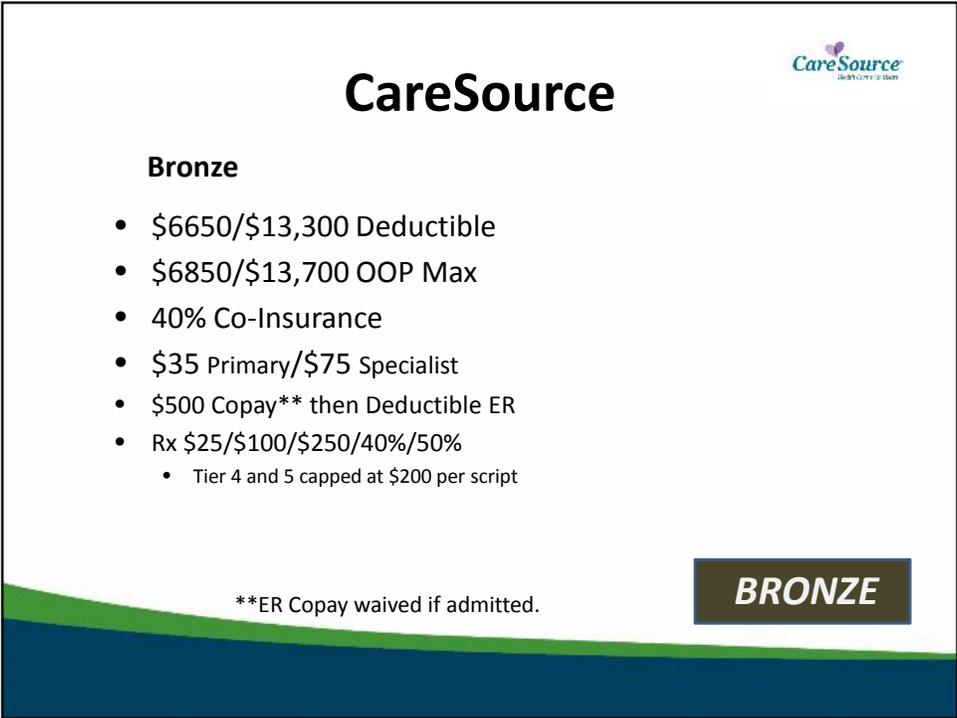
Silver Low Premium

- \$6150/\$12,300 Deductible
- \$7000/\$14,000 OOP Max
- 15% Co-Insurance
- \$30 Primary/\$50 Specialist
- Deductible, then 15% ER
- Rx \$10/\$50/15%/15%/15%

**ER Copay waived if admitted.

SILVER

The slide features the CareSource logo in the top right corner. The main title is 'CareSource' in a large, bold, black font. Below it is the sub-title 'Silver Low Premium'. A bulleted list of plan details is centered on the page. At the bottom right, there is a grey rectangular box with the word 'SILVER' in white, bold, uppercase letters. A decorative footer at the bottom consists of a dark blue base with a green wave-like shape on top.



CareSource

Bronze

- \$6650/\$13,300 Deductible
- \$6850/\$13,700 OOP Max
- 40% Co-Insurance
- \$35 Primary/\$75 Specialist
- \$500 Copay** then Deductible ER
- Rx \$25/\$100/\$250/40%/50%
 - Tier 4 and 5 capped at \$200 per script

**ER Copay waived if admitted.

BRONZE

The slide features the CareSource logo in the top right corner. The main title is 'CareSource' in a large, bold, black font. Below it is the sub-title 'Bronze'. A bulleted list of plan details is centered on the page. At the bottom right, there is a dark grey rectangular box with the word 'BRONZE' in white, bold, uppercase letters. A decorative footer at the bottom consists of a dark blue base with a green wave-like shape on top.



CareSource

Bronze Enhanced

- \$6650/\$13,300 Deductible
- \$6850/\$13,700 OOP Max
- 40% Co-Insurance
- \$35 Primary/\$75 Specialist
- \$500 Copay** then Deductible ER
- Rx \$25/\$100/\$250/40%/50%
 - Tier 4 and 5 capped at \$200 per script
- \$25 Copay after deductible for Adult Vision (\$150 Limit)
- \$0 Preventive Dental
- 25% Major Services
- 20% Ortho (\$3000 Lifetime Max)

**ER Copay waived if admitted.

BRONZE



CareSource

Bronze Simple Choice

- \$6650/\$13,300 Deductible
- \$7150/\$14,300 OOP Max
- 50% Co-Insurance
- \$45 Primary/50% Specialist
- Deductible, then 50% ER
- Rx \$35/35%/40%/45%/no coverage

**ER Copay waived if admitted.

BRONZE

Gold Comparison

CareSource

- \$1000/\$2000 Deductible
- \$4500/\$9000 OOP Max
 - \$2500 Medical/\$2000 Pharmacy
 - \$5000 Medical/\$4000 Pharmacy
- 20% Co-Insurance
- \$0 Primary/\$40 Specialist
- \$250 Copay, then Deductible ER
- Rx \$0/\$120/\$160/40%/50%

HighmarkWV

- \$1000/\$2000 Deductible
- \$4500/\$9000 OOP Max
- 90% Co-Insurance
- \$20 Primary/\$40 Specialist
- \$200 Copay**, then 100% ER
- Rx 15%/25%/35%/50%

GOLD

Silver Comparison

CareSource

- \$3300/\$6600 Deductible
- \$6400/\$12,800 OOP Max
- 30% Co-Insurance
- \$0 Primary/\$50 Specialist
- \$500 Copay**, then Deductible ER
- Rx \$0/\$60/\$130/40%/50%

HighmarkWV

- \$2800/\$5600 Deductible
- \$5700/\$11,400 OOP Max
- 80% Co-Insurance
- Deductible, then 80% for all Office Visits
- Deductible, then 80% ER (for all hospital tiers)
- Rx Deductible, 20%

SILVER

Bronze Comparison

CareSource

- \$6650/\$13,300 Deductible
- \$6850/\$13,700 OOP Max
- 40% Co-Insurance
- \$35 Primary/\$75 Specialist
- \$500 Copay** then Deductible ER
- Rx \$25/\$100/\$250/40%/50%

HighmarkWV

- \$6500/\$13,000 Deductible
- \$7150/\$14,300 OOP Max
- 30% Co-Insurance
- \$100 Primary/ \$140 Specialist
- Deductible then 30% ER (all hospital tiers)
- Rx 15%/25%/35%/50%

BRONZE

Summary of Benefits and Coverage

- Federally mandated layout
- Limited to the information provided
- Will look different in 2017

CareSource SBC

CareSource: Just4Me Silver 1

Coverage Period: 01/01/16 – 12/31/16

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.caresource.com/just4me or by calling 855-202-0622.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$3,500 Individual / \$7,000 Family per Benefit Year. Deductible does not apply to Copayments, Physician, Home and Office Services for Primary Care, Physician Home and Office Services for Specialty Care, Prescription Drugs, Preventive Health Services, Urgent Care Services, and Vision Services – Pediatric.	You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the Deductible.
Are there other Deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$1,850 Individual \$9,700 Family.	The Out-of-Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services. Copayments and coinsurance are applied toward the out-of-pocket limit. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges and health care services that are not covered by this plan.	Even though you pay these expenses, they don't count toward the Out-of-Pocket Limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes how the plan and you will pay for specific covered services.

Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me.

OMB Control Number: 1548-2225, 12100-0141, and 0938-1146 (revised) | Revised on April 21, 2015 | 1 of 12 | WV-FXCM-73

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.caresource.com/just4me or call 855-202-0622 to request a copy. ADVSBC-WV001(2016)-B-Silver 1

CareSource: Just4Me Silver 1

Coverage Period: 01/01/16 – 12/31/16

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: HMO

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of network providers, see www.caresource.com/just4me or call 855-202-0622.	If you use an in-network doctor or other health care Provider, this plan will pay some or all of the costs for covered services. Be aware, your in-network doctor or hospital may use an out-of-network Provider for some services. Plans use the term Preferred or participating for Providers in their networks. See the chart starting below for how this plan pays different kinds of Providers.
Do I need a referral to see a specialist?	No.	You can see the Network Specialist you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about Excluded Services.

- Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 30% would be \$300. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,300 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$300 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office	Primary care visit to treat an injury or illness	\$0/visit	Not covered.	No Deductible. You only pay the Copay.

Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me.

OMB Control Number: 1548-2225, 12100-0141, and 0938-1146 (revised) | Revised on April 21, 2015 | 2 of 12 | WV-FXCM-73

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.caresource.com/just4me or call 855-202-0622 to request a copy. ADVSBC-WV001(2016)-B-Silver 1

CareSource: Just4Me Silver 1 Coverage Period: 01/01/16 – 12/31/16
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
or clinic	Specialist visit	\$80/visit	Not covered.	Plan covers 100% of Allowed Amount in excess of the Copay. Copayment waived when the only charge is for allergy injections/serum. If you receive services in addition to office visit, additional Copays, Deductibles, or Coinsurance may apply.
	Other practitioner office visit	20% Coinsurance after Deductible	Not covered.	
	Preventive care/screening/immunization	\$0/visit	Not covered.	
If you have a test	Diagnostic tests (x-ray, blood work)	30% Coinsurance after Deductible	Not covered.	Prior Authorization Required.
	Imaging (CT/PET scans, MRIs)	\$150/procedure after Deductible	Not covered.	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caresource.com/just4me .	Generic drugs	Retail: \$0 Copay Mail-Order: \$0 Copay	Not covered.	There is no Deductible for prescription drug coverage. You only pay the Copay / Coinsurance. Retail: Up to a 31 day supply. Mail-Order: Up to a 90-day supply. Certain drugs may require a Prior Authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Preferred brand drugs	Retail: \$10 Copay Mail-Order: \$100 Copay	Not covered.	
	Non-preferred brand drugs	Retail: \$125 Copay Mail-Order: \$312.50 Copay	Not covered.	

Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me OMB Control Number: 1548-2203, 1210-0147, and 7530-1146 (03/2014)
Revised on April 15, 2015
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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.caresource.com/just4me or call 855-202-0622 to request a copy.
ADVSBC-WV001(2016)-B-Silver 1

CareSource: Just4Me Silver 1 Coverage Period: 01/01/16 – 12/31/16
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	40% (up to \$300) Coinsurance (Retail and Mail-Order)	Not covered.	\$300 maximum Coinsurance.
	Specialty drugs Non-Preferred	50% (up to \$300) Coinsurance (Retail and Mail-Order)	Not covered.	\$300 maximum Coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	Not covered.	Prior Authorization Required.
	Physician/surgeon fees	30% Coinsurance after Deductible	Not covered.	
If you need immediate medical attention	Emergency room services	\$300/visit after Deductible	\$300/visit after Deductible	Copay waived if you are admitted to the hospital directly from the Emergency Department. If you receive services in addition to urgent care, additional Copays, Deductibles, or Coinsurance may apply.
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	
	Urgent care	\$50/visit	Not covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300/stay after Deductible	Not covered.	Prior Authorization Required.
	Physician/surgeon fee	30% Coinsurance after Deductible	Not covered.	

Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me OMB Control Number: 1548-2203, 1210-0147, and 7530-1146 (03/2014)
Revised on April 15, 2015
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ADVSBC-WV001(2016)-B-Silver 1

CareSource: Just4Me Silver 1 Coverage Period: 01/01/16 – 12/31/16
Summary of Benefits and Coverage: What this Plan Covers & What It Costs Coverage for: Individual | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	\$0/visit for office visits and 30% Coinsurance after Deductible for other outpatient services	Not covered.	Prior Authorization required for all inpatient stays, partial hospitalization programs, and intensive outpatient services.
	Mental/behavioral health inpatient services	\$0/cost share after Deductible	Not covered.	
	Substance use disorder outpatient services	\$0/visit for office visits and 30% Coinsurance after Deductible for other outpatient services	Not covered.	
	Substance use disorder inpatient services	\$0/cost share after Deductible	Not covered.	
If you are pregnant	Prenatal and postnatal care	\$0 Copay	Not covered.	Copay covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional Copays, Deductibles, or Coinsurance may apply depending on services rendered in addition to the Global Maternity Fee. Your cost for inpatient services only. See above for physician delivery charges.

Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.caresource.com/just4me or call 855-202-0622 to request a copy. ADVSBC-WV001(2016)-B-Silver 1

OMB Control Number 1545-2226, 1210-0147, and 0930-1149 (continued)
Revised on April 23, 2015
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CareSource: Just4Me Silver 1 Coverage Period: 01/01/16 – 12/31/16
Summary of Benefits and Coverage: What this Plan Covers & What It Costs Coverage for: Individual | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Not covered.	Limited to 100 combined visits per benefit year after Deductible. Physical therapy, occupational therapy, speech therapy, and pulmonary rehab limited to 20 visits.
	Rehabilitation services	30% Coinsurance after Deductible	Not covered.	Cardiac rehab is limited to 36 visits. Spinal manipulations are limited to 12 visits.
	Habilitation services	30% Coinsurance after Deductible	Not covered.	Home health care limits apply when services are rendered in the home. Habilitation services are subject to the visit limits described in "Rehabilitation Services," which is a combined limit for Habilitation and Rehabilitation services.
	Skilled nursing care	\$0/cost share after Deductible	Not covered.	Any combination of benefits for skilled nursing facility, inpatient rehabilitation services is limited to 90 days per calendar year.
	Durable medical equipment	30% Coinsurance after Deductible	Not covered.	May require Prior Authorization.
	Hospice services	30% Coinsurance after Deductible	Not covered.	
If your child needs dental or eye care	Eye exam	\$0/visit	Not covered.	Limit of one routine eye exam per benefit year.

Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.caresource.com/just4me or call 855-202-0622 to request a copy. ADVSBC-WV001 (2016)-B-Silver 1

OMB Control Number 1545-2226, 1210-0147, and 0930-1149 (continued)
Revised on April 23, 2015
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WV-ENCM-73

CareSource: Just4Me Silver 1 Coverage Period: 01/01/16 – 12/31/16
 Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Glasses	30% Coinsurance after Deductible	Not covered.	Limit to 1 pair per benefit year and 1 replacement pair if medically necessary.
	Dental check-up	Not covered.	Not covered.	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Dental Care (Adult)
- Hearing Aids for Adults
- Long-term care
- Routine foot care
- Weight loss programs
- Non-Emergency care when traveling outside the U.S.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Routine Eye Care
- Private Duty Nursing
- Bariatric Surgery
- Cosmetic Surgery
- Infertility treatment

Your Rights to Continue Coverage:
 Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at 855-202-0622 or contact 304-558-3386. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me

OMB Control Number: 4510-0047 and 0938-1146 (corrected) Released on April 21, 2011 8 of 12 WV-EXCM-73

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.caresource.com/just4me or call 855-202-0622 to request a copy. ADVSBC-WV001(2016)-H-Silver 1

CareSource: Just4Me Silver 1 Coverage Period: 01/01/16 – 12/31/16
 Coverage Examples Coverage for: Individual | Plan Type: HMO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby <small>(normal delivery)</small>	Managing type 2 diabetes <small>(routine maintenance of a well-controlled condition)</small>																																
<ul style="list-style-type: none"> Amount owed to providers: \$7,040 Plan pays \$6,340 Patient pays \$1,200 	<ul style="list-style-type: none"> Amount owed to providers: \$5,400 Plan pays \$3,790 Patient pays \$1,610 																																
Sample care costs: <table border="1"> <tr><td>Hospital charges (mother)</td><td>\$2,700</td></tr> <tr><td>Routine obstetric care</td><td>\$2,100</td></tr> <tr><td>Hospital charges (baby)</td><td>\$900</td></tr> <tr><td>Anesthesia</td><td>\$900</td></tr> <tr><td>Laboratory tests</td><td>\$500</td></tr> <tr><td>Prescriptions</td><td>\$200</td></tr> <tr><td>Radiology</td><td>\$200</td></tr> <tr><td>Vaccines, other preventive</td><td>\$40</td></tr> <tr><td>Total</td><td>\$7,040</td></tr> </table>	Hospital charges (mother)	\$2,700	Routine obstetric care	\$2,100	Hospital charges (baby)	\$900	Anesthesia	\$900	Laboratory tests	\$500	Prescriptions	\$200	Radiology	\$200	Vaccines, other preventive	\$40	Total	\$7,040	Sample care costs: <table border="1"> <tr><td>Prescriptions</td><td>\$2,900</td></tr> <tr><td>Medical Equipment and Supplies</td><td>\$1,300</td></tr> <tr><td>Office Visits and Procedures</td><td>\$700</td></tr> <tr><td>Education</td><td>\$300</td></tr> <tr><td>Laboratory tests</td><td>\$100</td></tr> <tr><td>Vaccines, other preventive</td><td>\$100</td></tr> <tr><td>Total</td><td>\$5,400</td></tr> </table>	Prescriptions	\$2,900	Medical Equipment and Supplies	\$1,300	Office Visits and Procedures	\$700	Education	\$300	Laboratory tests	\$100	Vaccines, other preventive	\$100	Total	\$5,400
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Patient pays: <table border="1"> <tr><td>Deductibles</td><td>\$700</td></tr> <tr><td>Copays</td><td>\$350</td></tr> <tr><td>Coinsurance</td><td>\$90</td></tr> <tr><td>Limits or exclusions</td><td>\$150</td></tr> <tr><td>Total</td><td>\$1,200</td></tr> </table>	Deductibles	\$700	Copays	\$350	Coinsurance	\$90	Limits or exclusions	\$150	Total	\$1,200	Patient pays: <table border="1"> <tr><td>Deductibles</td><td>\$1,150</td></tr> <tr><td>Copays</td><td>\$0</td></tr> <tr><td>Coinsurance</td><td>\$380</td></tr> <tr><td>Limits or exclusions</td><td>\$80</td></tr> <tr><td>Total</td><td>\$1,610</td></tr> </table>	Deductibles	\$1,150	Copays	\$0	Coinsurance	\$380	Limits or exclusions	\$80	Total	\$1,610												
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Questions: Call 855-202-0622 or visit us at www.caresource.com/just4me

OMB Control Number: 4510-0047 and 0938-1146 (corrected) Released on April 21, 2011 8 of 12 WV-EXCM-73

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Highmark SBC

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

 This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.highmarkbcbswv.com or by calling 1-888-601-2109.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 individual/\$1,000 family network, \$1,000 individual/\$2,000 family out-of-network. Network deductible does not apply to primary care visits, specialist visits, preventive care services, emergency room services, urgent care, outpatient mental health, outpatient substance use disorder, podiatric dental and vision. Coinsurance amounts don't count toward the network deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, \$3,000 individual/\$6,000 family network, \$6,000 individual/\$12,000 family out-of-network.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcbswv.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.doi.gov/ebsa/healthreform and www.HealthCare.gov or call 1-888-601-2109 to request a copy.

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WVHMC Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.highmarkbcbswv.com or call 1-888-601-2109.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out of network provider for some services. Plans use the term in-network, preferred or participating for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about excluded services.

-  **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcbswv.com.
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WVHMC Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 -12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 copay/visit	40% coinsurance	none
	Specialist visit	\$50 copay/visit	40% coinsurance	none
	Other practitioner office visit	\$50 copay/visit for chiropractor	40% coinsurance for chiropractor	Combined network and out-of-network limit: 30 visits per benefit period. Combined network and out-of-network: Habilitation and rehabilitation services.
	Preventive care Screening Immunization	No charge for preventive care services	No coverage for preventive care services	Please refer to your preventive schedule for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	\$50 copay/visit	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	\$100 copay/visit	40% coinsurance	none

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcbswv.com.

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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 -12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at 1-888-601-2109.	Generic drugs	\$3 / \$6 /\$12 copay (retail) \$6 copay (mail order)	Not covered	Up to 31 /60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Formulary Brand drugs	\$50 /\$100 / \$0 copay (retail) \$100 copay (mail order)	Not covered	Up to 31 /60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Non-Formulary Brand drugs	\$100 /\$200/\$300 copay (retail) \$200 copay (mail order)	Not covered	Up to 31 /60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Formulary Specialty drugs	40% coinsurance with a \$300 maximum per prescription (retail) 40% coinsurance with a \$600 maximum per prescription (mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcbswv.com.

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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 -12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Non-Formulary Specialty drugs	50% coinsurance with a \$500 maximum per prescription (retail) 50% coinsurance with a \$1,000 maximum per prescription (mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply mail-order prescription drugs through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	none
If you need immediate medical attention	Emergency room services	20% coinsurance after \$150 copay/visit	20% coinsurance after \$150 copay/visit	Copay waived if admitted as an inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
If you have a hospital stay	Urgent care	\$50 copay/visit	40% coinsurance	none
	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	none

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcbsw.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.HealthCare.gov or call 1-888-601-2109 to request a copy.

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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 -12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40 copay/visit	40% coinsurance	none
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
	Substance use disorder outpatient services	\$40 copay/visit	40% coinsurance	none
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.

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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 -12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Combined network and cut-of-network: 100 visits per benefit period.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined network and cut-of-network: 30 physical medicine visits and 30 occupational therapy visits per benefit period.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Combined network and cut-of-network: 120 days per benefit period. Precertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	none
If your child needs dental or eye care	Hospice service	20% coinsurance	40% coinsurance	none
	Eye exam	No charge	Not covered	Maximum one exam per 12 month period.
	Glasses	No charge	Not covered	Maximum one pair of eyeglass lenses (including frames) per 12 month period.
	Dental check-up	No charge	Not covered	Maximum two exams per 12 month period.

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcbswv.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.HealthCare.gov or call 1-888-601-2109 to request a copy.

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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

Coverage Period: 01/01/2016 -12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
• Acupuncture	• Hearing aids	• Routine foot care
• Cosmetic surgery	• Long-term care	• Termination of pregnancy, except in limited circumstances
• Dental care (Adult)		• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Coverage provided outside the United States. See www.bcbsva.com	• Private-duty nursing
• Chiropractic care	• Infertility treatment	• Routine eye care (Adult)
	• Non-emergency care when traveling outside the U.S.	

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcbswv.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.HealthCare.gov or call 1-888-601-2109 to request a copy.

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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500 Coverage Period: 01/01/2016 - 12/31/2016
 Coverage Examples Coverage for: Individual/Family | Plan Type: PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
<ul style="list-style-type: none"> ■ Amount owed to providers: \$7,540 ■ Plan pays: \$5,730 ■ Patient pays \$1,810 		<ul style="list-style-type: none"> ■ Amount owed to providers: \$5,400 ■ Plan pays \$4,300 ■ Patient pays \$1,100 	
Sample care costs:		Sample care costs:	
Hospital charges (mother)	\$2,700	Prescriptions	\$2,900
Routine obstetric care	\$2,100	Medical Equipment and Supplies	\$1,300
Hospital charges (baby)	\$900	Office Visits and Procedures	\$700
Anesthesia	\$900	Education	\$300
Laboratory tests	\$500	Laboratory tests	\$100
Prescriptions	\$200	Vaccines, other preventive	\$100
Radiology	\$200	Total	\$5,400
Vaccines, other preventive	\$40		
Total	\$7,540		
Patient pays:		Patient pays:	
Deductibles	\$500	Deductibles	\$500
Copays	\$10	Copays	\$400
Coinsurance	\$1,300	Coinsurance	\$200
Limits or exclusions	\$0	Limits or exclusions	\$0
Total	\$1,810	Total	\$1,100

You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-888-601-2109 or visit us at www.highmarkbcswv.com.
 If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.HealthCare.gov or call 1-888-601-2109 to request a copy.

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WVHMK Balance Blue PPO500

Key Marketplace Dates for 2017

- Open Enrollment Begins – November 1, 2016
- Coverage Begins – January 1, 2017 (If enrolled before December 15)
- Open Enrollment Ends – January 31, 2017



When a Consumer Wishes to Enroll with an Assister...

1. Assess Consumer's Knowledge of ACA and Marketplace
2. Ask if the consumer has completed an application and received an eligibility determination from the FFE
 - If yes, they are ready to enroll
3. Recite the disclaimer:

I'm happy to assist you in the enrollment process, however please know that I can't offer any specific guidance on plan selection or directly recommend that you chose one health plan over another. I can offer general enrollment guidance and help you decide which factors to consider when choosing a plan that fits your needs and budget. If you would like to talk to somebody who can help you select a plan, I can refer you to a Marketplace-certified agent in your local area.
4. Assist the consumer in the enrollment process
5. Have the consumer to sign the Enrollment Agreement Form

How Would the Consumer like to Enroll?



Online at
healthcare.gov



By phone

1-800-318-2596



By mail to

Health Insurance Marketplace
Dept. of Health and Human Services
4750 Reservoir Blvd.
London, KY

Enroll by completing the following sections:

On healthcare.gov...

Set discount usage by applying tax credit, if applicable

Answer questions about the household

Select a health insurance plan

Review and confirm health insurance plan

After a Consumer has Enrolled..

- **Enrollment Receipt:** Provide the consumer with a document which includes a summary of transaction information including plan name, insurance carrier contact information, premium amount and due date.
- **Payment:** Refer the consumer to the insurance carrier to arrange the first month's premium payment.



Enrollment Receipt

West Virginia IPA Consumer Reference Card

Exchange Website: www.healthcare.gov
Exchange Phone Number: 1-800-318-2596
My Account Username: _____
My Account Password: _____
My health plan: _____
My policy number: _____
My payment date: _____
Highmark Insurance Phone Number: 1-800-385-1985
West Virginia OIC Phone Number: 1-888-879-9842

**KEEP
ME!!!!**



Questions?

Open Enrollment 4

Dental Plans

Information provided is current as of today. Please join the OIC listserv to keep up to date on federal and state updates.

Objectives

- **Upon completion of this module, participants will be able to:**
 - Help consumers compare dental plans based on cost, provider network, and availability of services
 - Assist consumers in selecting a plan, and giving them the right information in following up with that plan
 - Inform consumers regarding how to pay for their plans.

Comparing Plans

- Healthcare.gov allows consumers to compare plans so you get an ESTIMATE of what premiums you'd pay and what benefits and protections you'd get before you enroll.

The screenshot displays a comparison page for dental plans. The main focus is on the 'Delta Dental - Delta Dental PPO Basic Plan for Families'. The estimated monthly premium is \$12, the deductible is \$45, and the out-of-pocket maximum is \$350. The page also includes a sidebar with navigation options and a 'People Covered' section showing 1 adult and 2 children.

Factors to Consider when Selecting a Plan

Cost (premium, copay, deductible, out-of-pocket max)

Expected Work Needed

Services and Benefits Offered

Provider Network

Marketplace Plans Offered in WV



**6 Individual Dental Insurance Plans through
3 Insurance Carriers**

Delta Dental Preferred Plan for Families

Adult Benefits

- \$50 Deductible
- \$1000 Annual Limit
- 100/80/50

Pediatric Benefits

- \$40 Deductible
- No Annual Limit
- 100/80/50
- 50% Medically Necessary Ortho
 - 12 month waiting period

- 3 Deductibles Maximum Per Family
- All Benefits Run on a Calendar Year
- \$350 Max Out of Pocket for Pediatric Enrollee
 - \$700 Max for multiple children

Delta Dental Basic Plan for Families

Adult Benefits

- \$50 Deductible
- \$1000 Annual Max
- 100/50
- No Major Coverage

Pediatric Benefits

- \$50 Deductible
- No Annual Max
- 100/50/50
- 50% Medically Necessary Ortho
 - 12 month waiting period

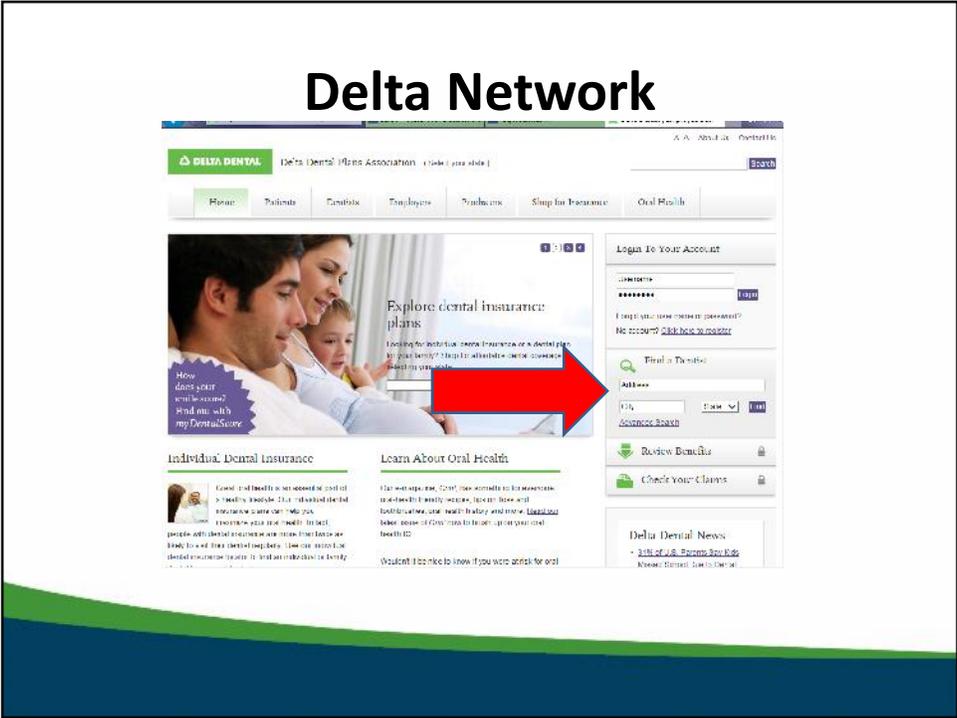
- 3 Deductibles Maximum Per Family
- All Benefits Run on a Calendar Year
- \$350 Max Out of Pocket for Pediatric Enrollee
 - \$700 Max for multiple children

Delta Dental Basic Plan for Families

New for 2017

- Delta will sell a high and low pediatric only plan off of the Marketplace





Dentegra Dental Family Preferred

<p>Adult Benefits</p> <ul style="list-style-type: none"> • \$50 Deductible • \$1000 Annual Max • 100/80/50 	<p>Pediatric Benefits</p> <ul style="list-style-type: none"> • \$55 Deductible • No Annual Max • 100/80/50 • 50% Medically Necessary Ortho <ul style="list-style-type: none"> – 12 month waiting period
----------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

- 3 Deductibles Maximum Per Family
- All Benefits Run on a Calendar Year
- \$350 Max Out of Pocket for Pediatric Enrollee
 - \$700 Max for multiple children

Dentegra Dental Family Basic

Adult Benefits

- \$50 Deductible
- \$1000 Annual Max
- 100/50
- No Major Coverage

Pediatric Benefits

- \$50 Deductible
- No Annual Max
- 100/50/50
- 50% Medically Necessary Ortho
 - 12 month waiting period

- 3 Deductibles Maximum Per Family
- All Benefits Run on a Calendar Year
- \$350 Max Out of Pocket for Pediatric Enrollee
 - \$700 Max for multiple children

Delta Dental Basic Plan for Families

New for 2017

- Dentegra will sell a low pediatric only plan off of the Marketplace



Dentegra Network

The screenshot shows the Dentegra Network website. At the top, there is a navigation menu with links for 'Dental Insurance Plans', 'Health and Wellness', 'My Account', 'For Providers', and 'About Dentegra'. A search bar is located on the right. The main content area features a coffee cup on the left and a central message: 'We come to Dentegra. A dental plan that's as fresh as your morning coffee. (And probably costs a lot less.)' Below this is a 'Get a Quote' button. To the right, there are three blue buttons: 'Dental Plans', 'Find a Dentist', and 'Who We Are'. A red arrow points to the 'Find a Dentist' button. At the bottom, there is a footer with links for 'Terms and Conditions', 'Privacy Policy', 'About Us', 'Customer Login', 'Register', 'Help & Support', 'Feedback', and 'Facebook'.

TruAssure Dental Preferred Plan

Adult Benefits

- \$50 Deductible
- \$2000 Annual Max
- 100/70/50

Pediatric Benefits

- \$25 Deductible
- No Annual Max
- 100/70/50
- 50% Medically Necessary Ortho
 - 12 month waiting period

- All Benefits Run on a Calendar Year
- \$350 Max Out of Pocket for Pediatric Enrollee
 - \$700 Max for multiple children

TruAssure Dental Basic Plan

Adult Benefits

- \$50 Deductible
- \$2000 Annual Max
- 100/50 (6 month wait for Basic)
- No Major Coverage

Pediatric Benefits

- \$85 Deductible
- No Annual Max
- 100/50/50
- 50% Medically Necessary Ortho
 - 12 month waiting period

- 3 Deductibles Maximum Per Family
- All Benefits Run on a Calendar Year
- \$350 Max Out of Pocket for Pediatric Enrollee
 - \$700 Max for multiple children

TruAssure Network

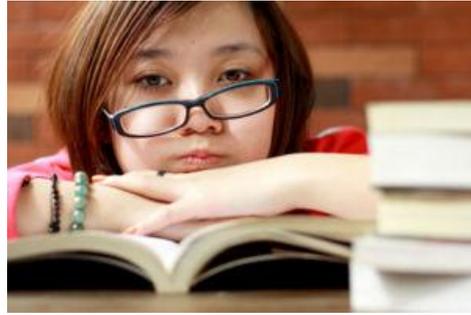
The screenshot shows the TruAssure Insurance Company website. At the top, there is a navigation bar with links for 'Home', 'About Us', 'Sign In', 'Contact Us', and a phone number '888 559 0781'. Below the navigation bar, there are several menu items: 'Shop for Plans', 'Learn More', 'Find a Provider', 'Members', 'Providers', 'Groups', and 'Products'. The main content area features a large banner with the text 'Find Affordable Dental Plans Near You' and a red arrow pointing to the 'Find a Provider' link. Below the banner, there is a search box with the text 'Enter Zip Code' and a button labeled 'VIEW AVAILABLE PLANS NOW'. A 'Learn More' link is also visible at the bottom left of the banner area.

Pediatric EHBs

- Dental Exam every 6 months with Fluoride
- Full Mouth X-Ray every 36 months
- Sealants and Fillings as needed
- Simple Extractions
- Treatment of abscesses
- Root canal therapy
- Removal of cysts under tooth or gums
- Space maintainers
- Bitewings every 6 months

Pediatric Dental Requirement

In order to receive APTC, ALL children under the age of 19 must have qualified dental coverage



Questions?

Medicare and the Marketplace

Marcia Meeks – Director
 Rebecca Gouty – State Coordinator
 Medicare Programs
 WV Bureau of Senior Services

If You Have a Marketplace Plan First and Then Get Medicare Coverage

- You lose eligibility for any premium tax credits and/or reduced cost sharing for your Marketplace plan
- If you choose to drop your Marketplace plan, pay special attention to the timing
 - If a consumer is the only member of their household enrolled on their Marketplace plan, they should visit the Marketplace at least 15 days before the date they want their Marketplace coverage to end
 - If a consumer is enrolled in the same Marketplace plan with other members of their household, in most cases, their coverage will end immediately when they request termination of their coverage for only some people on their application
 - In some cases, coverage won't end immediately, including when the people staying on the Marketplace plan qualify for a Special Enrollment Period
 - If Marketplace coverage doesn't end immediately for the person being removed from the plan:
 - **If the request to remove the person is made on or before the 15th of the month:** Coverage ends on the last day of the current month
 - **If the request to remove the person is made after the 15th of the month:** Coverage ends on the last day of the next following month

Terminating Medicare for Marketplace Plan

- If you're enrolled in premium Part A (meaning you pay monthly for Part A) and Part B, or Part B only
 - You can disenroll from Medicare and choose a Marketplace plan
 - You can qualify for advanced payments of the premium tax credit (APTC) or cost sharing reductions (CSRs) if you meet eligibility requirements
 - If you delay enrolling in Medicare after your Initial Enrollment Period (IEP) ends, a late enrollment penalty may apply
 - You would **only** be able to enroll during the Medicare GEP, January 1 to March 31, with coverage starting July 1
- Enrolled in Medicare premium free Part A
 - Must withdraw the application for Social Security benefits
 - Pay back all Social Security and Medicare benefits received
 - Lose APTC and CSR

July 2016

Medicare and the Marketplace

3

Medicare and Coverage through the Small Business Health Options Program (SHOP)

- Medicare Secondary Payer rules apply
- You may delay your Part B enrollment while covered by the Marketplace through your or your spouse's current employment
- You'll have a Special Enrollment Period (SEP) to sign up for Part B
 - Any time you're still covered by a group plan through your/your spouse's current employment
 - During 8-month period after current employment/coverage ends

July 2016

Medicare and the Marketplace

4

Medicare Periodic Data Matching (PDM): Background

- Marketplaces must:
 - Periodically examine available data sources to determine whether consumers who are enrolled in Marketplace coverage with financial assistance (i.e., advance payments of the premium tax credit (APTC) or income-based cost sharing reductions (CSRs)) have been determined eligible for Medicare
 - Notify these consumers, and if the consumer doesn't respond to the notice, end APTC/CSRs

- Medicare PDM identifies consumers who are enrolled in both:
 - Federally-facilitated Marketplace (Marketplace) coverage with financial assistance, and
 - Medicare that qualifies as minimum essential coverage (Part A).

IMPORTANT: In this first round of Medicare PDM, the Marketplace will not take action to end consumers' financial assistance as a result of Medicare PDM. Consumers are responsible to follow the instructions in their Medicare PDM notice and take appropriate action if they have been determined eligible for or are enrolled in MEC Medicare.

Medicare Periodic Data Matching (PDM): Notifying Dually-Enrolled Consumers

- The Marketplace is mailing paper Medicare PDM notices* to the household contact for consumers aged 65 and older who may be dually-enrolled in Medicare *and* a Marketplace plan with financial assistance
- If a consumer has been determined eligible for or is enrolled in Medicare, he or she is *not* eligible to receive financial assistance to help pay for a Marketplace plan premium or other covered services. Consumers should be encouraged to follow instructions listed on their Medicare PDM notice
 - If a consumer still wants a Marketplace plan without financial assistance after he or she has been determined eligible for MEC Medicare, he or she will have to pay full price for their share of the Marketplace plan premium and covered services

Medicare PDM Notices will Include:

- Names of consumers who were found to be dually-enrolled
- A warning that individuals who are found to be enrolled in MEC Medicare are not eligible for financial assistance to help pay for Marketplace coverage
- Instructions on how to end Marketplace coverage with APTC (for consumers enrolled in MEC Medicare)
- Where to find Medicare contact information to confirm if they are enrolled or if they have any questions about Medicare

* *Note:* Paper Medicare PDM notices will be sent via the United State Postal Service, and will *not* be posted electronically to consumers' Marketplace accounts.

Medicare PDM: Sample Notice

09/01/2016

Application date: 11/16/2015
Application ID: 557890321

Dear Mary:

You're getting this notice because our records show that the people listed below are enrolled in both Medicare and a Marketplace health plan with advance payments of the premium tax credit. If you have Medicare Part A (Hospital Insurance) (including if you receive benefits through a Medicare Advantage plan, also called Medicare Part C), you aren't eligible to receive advance payments of the premium tax credit or cost-sharing reductions to help pay for Marketplace plan premiums and covered services. If this is the case for you, you may have to pay back some or all of the advance premium tax credits you received during the months you also had Medicare Part A or Medicare Advantage.

Our records show that the following people are enrolled in both Medicare and a Marketplace plan with advance premium tax credits:

- Mary Smith
- Robert Smith

What should I do next?

You can contact Medicare to confirm if you (or the people listed above) have Medicare coverage or what type of Medicare coverage you have. You can call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2018.

If you (or the people listed above) have Medicare, the action you need to take will depend on your Medicare coverage:

7

Next Steps for Consumers Who Have Premium-free Medicare Part A and Part B

- **If consumers have premium-free Medicare Part A and Part B, they should end their Marketplace coverage with APTC.**
 - Although consumers can keep both their Marketplace coverage without APTC and Medicare Parts A and B, Marketplace coverage duplicates benefits they already have through Medicare.
 - And because they are not eligible to receive APTC, ending their Marketplace coverage with APTC now will help them avoid having to pay back some or all of the APTC received during months they also had Medicare when they file their federal income tax return.

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Next Steps for Consumers Who Have Premium-free Medicare Part A but not Part B

- If consumers have premium-free Medicare Part A but don't have Part B, they should end any APTC that they may be receiving for a Marketplace plan immediately. They may have to pay back some or all of the APTC for the months they had both Marketplace coverage with APTC and Medicare Part A. Consumers may want to stay in their Marketplace plan temporarily without APTC or CSRs, depending on when they turned 65.
- If consumers' 65th birthdays were **less than** 3 months ago, many people will want to enroll in Medicare Part B now and end Marketplace coverage.
 - If consumers want to enroll in Medicare Part B and end Marketplace coverage, they should contact the Marketplace at least 15 days before the date they want their Marketplace coverage to end.
 - Usually, consumers' Marketplace coverage should end the day before their Medicare Part B coverage starts. To enroll in Part B, direct consumers to contact the Social Security Administration
- If consumers' 65th birthdays were **more than** 3 months ago, many people will want to enroll in Medicare Part B during the next general enrollment period (January – March 2017; coverage starts July 1) and then end their Marketplace coverage.
 - If consumers want to enroll in Medicare Part B and end Marketplace coverage, they should contact the Marketplace at least 15 days before their Medicare Part B coverage starts to end their Marketplace coverage.
 - Usually consumers' Marketplace coverage should end the day before their Medicare Part B coverage starts.

9



Medicare Open Enrollment



- October 15th – December 7th
- Time to review 2017 prescription drug plans and/or Medicare Advantage plans
- ~4,300 Medicare beneficiaries Medicare Advantage plans are terminating
- Going from 27 prescription drug plans to 22 prescription drug plans in 2017
- Refer to WV SHIP at Bureau of Senior Services
 - 304-558-3317 or 877-987-3646



Contact Information



- Marcia Meeks – SHIP and SMP Director
 - Marcia.D.Meeks@wv.gov
 - 304-558-3317 ext 107
- Rebecca Gouty – SHIP and SMP State Coordinator
 - Rebecca.A.Gouty@wv.gov
 - 304-558-3317 ext 103
- WV Bureau of Senior Services 1900 Kanawha Blvd East, Charleston, WV 25305 (Mailing)
- 3rd Floor Charleston Town Center Mall (Physical)

**WV Department of Health & Human Resources
Bureau for Children and Families
Local County Office Directory**

The WV Department of Health and Human Resources (WV DHHR) comprises the central offices of Client Services; Family Support; and Social Services and the following county offices where clients may seek assistance.

COUNTY	PHONE	FAX	MAILING ADDRESS	PHYSICAL ADDRESS
Barbour	457-9030	457-4094	49 Mattaliano Drive Philippi, WV 26416	
Berkeley	267-0100	267-0123	P.O. Box 1247 Martinsburg, WV 25402	433 Mid-Atlantic Parkway Martinsburg, WV 25404
Boone	369-7802	369-7816	P.O. Box 970 Danville, WV 25053	156 Resource Lane Foster, WV 25081
Braxton	765-7344	765-3694	3708 Sutton Lane Sutton, WV 26601	
Brooke (see Hancock)				
Cabell	528-5800	528-5523	2699 Park Avenue, Suite 100 Huntington, WV 25704	
Calhoun	354-6118	354-7076	P.O. Box 280 Grantsville, WV 26147	85 Industrial Park Road
Clay	587-4268	587-2567	P.O. Box 969 Clay, WV 25043	94 Main Street
Doddridge	873-2031	873-3078	PO Box 207 Smithburg, WV 26436	22 Herbert Avenue Smithburg, WV 26436
Fayette	465-9613	465-7288	1400 Virginia Street Oak Hill, WV 25901	
Gilmer	462-0412	462-0416	1493 WV Highway 5, East Glennville, WV 26351	
Grant	257-4211	257-1569	53 Kiess Drive Petersburg, WV 26847	
Greenbrier	647-7476	647-7486	150 Maplewood Ave. Lewisburg, WV 24901	
Hampshire	822-6900	822-7571	P.O. Box 1736 Romney, WV 26757	24954 Northwestern Pike
Hancock	794-3060	794-4169	100 Municipal Plaza, Suite 600 Weirton, WV 26062	
Hardy	538-2391	538-2476	149 Robert C. Byrd Industrial Park, Moorefield, WV 26836	
Harrison	627-2295	627-2171	P.O. Box 1877 Clarksburg, WV 26302	153 West Main Street, 2 nd Floor
Jackson	373-2560	372-7888	4285 Cedar Lakes Drive Ripley, WV 25271	
Jefferson	724-2600	728-0529	P.O. Box 984 Charles Town, WV 25414	239 Willow Spring Drive
Kanawha	746-2360	558-1801	4190 W. Washington Street Charleston, WV 25313	
Lewis	269-6820	269-0544	P.O. Box 1268 Weston, WV 26452	91 Arnold Avenue
Lincoln	824-5811	824-7811	P.O. Box 468 Hamlin, WV 25523	8209 Court Avenue
Logan	792-7095	792-7003	130 Stratton Street Logan, WV 25601	
McDowell	436-8302	436-3248	840 Virginia Avenue Welch, WV 24801	
Marion	368-4420	368-4191	416 Adams Street, Suite 307 Fairmont, WV 26554	
Marshall	843-4120	843-4127	400 Teletech Drive, Suite 2 Moundsville, WV 26041	
Mason	675-0880	675-0883	1406 Kanawha Street Pt. Pleasant, WV 25550	

COUNTY	PHONE	FAX	MAILING ADDRESS	PHYSICAL ADDRESS
Mercer	425-8738	487-3589	200 Davis Street Princeton, WV 27439	
Mineral	788-4150	788-5363	18 N. Tornado Way Keyser, WV 26726	
Mingo	235-4680	235-4667	203 E. Third Avenue Williamson, WV 25661	
Monongalia	285-3175	285-3174	P.O. Box 800 Morgantown, WV 26507	114 S. High Street
Monroe	772-3013	772-4372	P.O. Box 678 Union, WV 24983	#174 Route 3, East Union, WV 24983
Morgan	258-1350	258-3794	P.O. Box 597 Berkeley Springs, WV 25411	62 Regal Court
Nicholas	872-0803	872-0832	707 Professional Park Drive Summersville, WV 26651	
Ohio	232-4411	232-4773	P.O. Box 6165 Wheeling, WV 26003	69-16 th Street
Pendleton	358-2305	358-7163	100 Thorn Creek Road Suite 200 Franklin, WV 26807	
Pleasants	684-9244	684-9245	201 Second Street St. Marys, WV 26170	
Pocahontas	799-2540	799-2560	211 Valhalla Lane Marlinton, WV 24954-5520	
Preston	329-4340	329-6082	P.O. Box 100 Kingwood, WV 26537	18351 Veteran's Mem Hwy Kingwood, WV 26537
Putnam	586-1520	586-0300	3405 Winfield Road Winfield, WV 25213	
Raleigh	256-6930	256-6932	407 Neville St. Beckley, WV 25801	
Randolph	637-5560	637-0391	1027 N. Randolph Avenue Elkins, WV 26241	
Ritchie	643-2934	643-4098	220 W. Main Street Harrisville, WV 26362	
Roane	927-0956	927-0970	677 Ripley Road, Suite 3 Spencer, WV 25276	
Summers	466-2807	466-2814	320 Summers St., Suite A Hinton, WV 25951	
Taylor	265-6103	265-6107	P.O. Box 29 Grafton, WV 26354	235 Barrett Street
Tucker	478-3212	478-4514	9346 Seneca Trl Parsons, WV 26287-9575	
Tyler	758-2127	758-2587	P.O. Box 563 Middlebourne, WV 26149	210 Main Street
Upshur	473-4230	473-4207	P.O. Box 460 Buckhannon, WV 26201	Route 3, Box 376-A
Wayne	272-6311	272-5183	26452 East Lynn Road Wayne, WV 25570-5103	
Webster	847-2861	847-7244	110 N. Main St., Suite 201 Webster Springs, WV 26288	
Wetzel	455-0920	455-0928	1236 North State Route 2 New Martinsville, WV 26155	
Wirt	275-6551	275-1126	P.O. Box 310 Elizabeth, WV 26143	Court Street
Wood	420-2560	420-4884	P.O. Box 1547 Parkersburg, WV 26102	400 5 th Street
Wyoming	732-6900	732-8223	HC 72, Box 300 Pineville, WV 24874	1767 Bearhole Road Pineville, WV 24874-8113

West Virginia Medicaid and WVCHIP

Eligibility and Enrollment

Rob DeBoard
Senior Medicaid Eligibility Policy Specialist
October 12, 2016
2017 Affordable Care Act (ACA) Assister Training
Flatwoods, WV



WEST VIRGINIA
Department of
**Health &
Human
Resources**
BUREAU FOR
MEDICAL SERVICES

Agenda

- **Submitting Your Application**
- **Medicaid Reviews**
- **Annual vs Monthly Income**
- **Federally-Facilitated Marketplace (FFM) and State Communications**
- **West Virginia Department of Health and Human Resources (DHHR) Direct Contact, Incarcerated Individuals**
- **Homeless Consumers**
- **1095-B Tax Document**
- **Adult Children Tax Filing**
- **Non-Citizen Pregnant Women and Children Under Age 19**

Submitting Your Application

Paper applications:

- Are submitted to a local West Virginia Department of Health and Human Resources (DHHR) office.
- Are generally processed within 30 days.
- For pregnant women and children under age 19, are generally processed in 13 days.

inROADS and Community Partner Portal applications:

- Are submitted electronically in a nightly batch to the inbox of an economic service worker for processing the next day.
- Have the same processing time limits as paper applications, 30 days.
- Are checked daily for pregnancy and children's applications for special 13 day processing requirements.

Potential delays in processing:

- If the application is completely filled out, then no additional information is required from the consumer.
- However, when the application is completely entered into our data system and matched against our electronic data sources, one of the following results can be expected:
 - Results verified
 - Results discrepant
- If the consumer does not return the requested information, they will receive a notice of denial.
- The application will not be transferred to the Federally Facilitated Marketplace (FFM), as no eligibility was determined.
- If the consumer returns the information within 60 days of the original application, then the case can be reopened without a new application being submitted.

Submitting Your Application (Cont.)

- If the results come back as verified, then no further information will be requested from the consumer.
- If the results come back as discrepant, then the worker will hold the case in a “pending status.”
 - The worker will contact the consumer either by phone or a letter to determine why the information on the application is discrepant with our electronic data sources.
 - The consumer generally has 10 days to return this information. If the consumer does not return the requested information, then the application will be denied.

Medicaid Reviews

- Generally, Medicaid reviews occur every 12 months.
- If the consumer is receiving another program of assistance through DHHR, the time frame can vary.
- Supplemental Nutrition Assistance Program (SNAP) has a 12-month review schedule for non-aged/disabled consumers with a six-month interim contact in the middle of their review cycle.
 - Information gathered during these review cycles will affect Medicaid benefits.
 - If the consumer has a SNAP review that still maintains Medicaid eligibility, then the consumer will have a rolling-renewal.

Rolling renewals:

- The consumer's review cycle for Medicaid will be extended an additional 12 months.
- This process also aligns the SNAP and Medicaid review cycles so the consumer is only reviewed every 12 months.

Medicaid Reviews (Cont.)

- Current Modified Adjusted Gross Income (MAGI) methodology for Medicaid and WVCHIP utilizes monthly income to determine eligibility.
- DHHR does not determine eligibility using Advanced Premium Tax Credit (APTC) methodology.

Annual vs. Monthly Income

- If the consumer is currently a Medicaid recipient that goes over the income limit for Medicaid benefits, we will transfer the case to the FFM.
- If they are under 100% of the Federal Poverty Level (FPL) using Advanced Premium Tax Credit (APTC) rules, the case will be transferred back to the state. This is known as the gap-filling rule. This was operationalized by Centers for Medicare and Medicaid Services (CMS) and the FFM this year.
- The most expedient method for the client to obtain benefits if they have changed income within the year is to complete the application via healthcare.gov.
- When the FFM processes the application for eligibility, the consumer will obtain Medicaid benefits through the deterministic account transfer process.

- The current communication process between the marketplace and DHHR is improving.
- There are still some mismatching data sets and very few unspent file records being processed at this time.
- CMS continues to improve defects in the transfer process.

- The consumer can call their local DHHR office, or the Customer Service Center at 1-877-716-1212, to check on the status of their application.
- Due to Health Insurance Portability and Accountability (HIPAA) regulations, the consumer or their authorized representative would have to call and check on their own application.
- If the consumer disagrees with the decision that is made on their application, every notice comes with an explanation of the fair hearing process and how to proceed with it.

Incarcerated Individuals

- Consumers who are incarcerated may qualify for Medicaid, if financially eligible.
- However, payment is limited to Medicaid covered services when admitted as an inpatient in a medical institution for at least 24 hours.
- Medicaid does not cover any other service while the consumer is incarcerated; a restriction is placed on their coverage.

Incarcerated Individuals (Cont.)

- The Bureau for Medical Services (BMS) collaborates with the West Virginia Division of Corrections (DOC) to ensure incarcerated individuals, ready to be paroled, are released with Medicaid coverage, if eligible.
- The DOC assists the incarcerated individual with submitting an application 30-60 days prior to their release date.
- BMS is currently evaluating the incarceration status and developing the process for individuals in certain work release centers to obtain Medicaid eligibility.

- The application process for a homeless consumer is the same as for any other consumer.
- If the applicant does not have a permanent physical address, they must at least include a mailing address.
- All applications must have, at the minimum, a mailing address, name and signature.
- The Medicaid card must be mailed to the consumer. There is no requirement for an individual to maintain a permanent residence or a physical address. They must intend to reside in West Virginia to be eligible.

Homeless Consumers (Cont.)

- They can choose any location to pick up their mail to receive notifications.
- They can also choose to have all of their notices be sent electronically via inROADS, if they choose to set up an account.

1095-B Tax Document

- There is no requirement for a consumer to submit a 1095-B form to file their taxes. Some local tax preparation firms do require it.
- The 1095-B will be issued by Medicaid and WVCHIP to consumers by January 31 each year.
- If the consumer feels their 1095-B is incorrect, they need to call their case worker, or the Customer Service Center at 1-877-716-1212, to make needed corrections or address changes.
- For more information refer to [irs.gov](https://www.irs.gov).

Adult Children Tax Filing

- Adult children living with their parents can file their own tax returns.
- If the consumer applies for their own Medicaid or WVCHIP benefit, they will be approved, if otherwise eligible, without counting the parents' income if they are not claimed as a dependent by the parent(s).
- The consumer has to state that they file their own taxes and are not claimed as a dependent on anyone else's taxes.
- The parents can still file separately or jointly as long as the tax household relationships state they do not claim the adult child.

Conditions for Medicaid and/or WVCHIP eligibility:

- Lawfully residing pregnant women or children under age 19 can be approved for Medicaid or WVCHIP if they are otherwise financially eligible.
 - They must be in West Virginia legally.
 - They must intend to reside in West Virginia.

- Current functionality in our data system automatically refers pregnant women that were denied Medicaid and/or WVCHIP to the Office of Maternal Family and Child Health.
- The ineligible pregnant woman will receive a denial notice from our system for the pregnancy application.
- Non-citizens, that do not qualify for Medicaid or WVCHIP, may receive emergency medical coverage only, if otherwise financially eligible. A pregnant woman may qualify for the delivery only.

Questions?

Contact

For information contact:

Bureau for Medical Services

350 Capitol Street, Room 251

Charleston, WV 25301

Phone: 304-356-4622

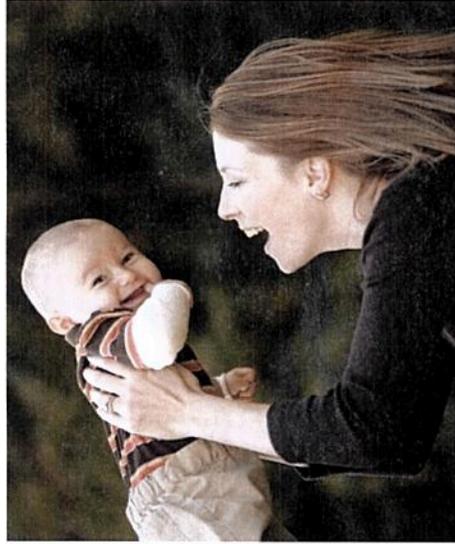
Email: Robert.G.Deboard@wv.gov

What type of information will I need to apply?

- Your approximate income for the coming year and the sources of that income.
- How many people you can claim as a dependent in your household or if you will be claimed as a dependent by someone else.
- Employer and income information for every member of your household who needs coverage.
- Your Social Security number.



West Virginia has expanded Medicaid coverage.



See if you qualify today!

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
MEDICAL SERVICES
350 Capitol Street
Room 251
Charleston, WV 25301

February 2016



You may now qualify for Medicaid...



even if you were denied in the past.

Am I eligible?

The Affordable Care Act of 2010 gave states the option to expand their Medicaid program to include individuals between the ages of 19 and 64. In 2013, West Virginia chose to expand Medicaid coverage.

Your eligibility for Medicaid coverage will depend on two factors: modified adjusted income and the size of your household.

What is Modified Adjusted Gross Income (MAGI)?

MAGI is based on federal tax rules for determining adjusted gross income with some modifications.

Income of all adults, parents and spouses in the household is counted. Income of children or other tax dependents is counted only if they are required to file taxes. Income that is not counted includes:

- Scholarships, grants, and awards used for educational purposes
- Child support income
- Workers compensation benefits
- Veteran's benefits
- Non-recurring lump sum payments
- Certain American Indian and Alaska Native income

How is household size determined?

Household size is determined based on who you may claim as a dependent on your federal tax return. This may include:

- You
- Your spouse
- Your dependent children (biological, adopted or stepchildren)
- Other relatives and even non-relatives who qualify as dependents

The chart below provides general guidance on whether you and your family may qualify for Medicaid based on household size and income.

Number of people in household	Your 2016 Modified Adjusted Gross (Yearly) Income is no more than:
1	\$16,242
2	\$21,983
3	\$27,724
4	\$33,465



What type of coverage will I have with Medicaid?

As a Medicaid member, you will have access to physicians, diagnostic testing, in-patient and out-patient hospital care, prescription drugs, durable medical equipment, behavioral health services, and other services as may be appropriate to your health care needs.

If your child is under the age of 21, he or she will have access to the same services as adults plus early periodic diagnosis and treatment, eye and dental care. More information on Medicaid services can be found at www.dhhr.wv.gov/bms.

How do I apply for Medicaid?

- On-line at www.wvinRoads.org.
- By phoning the federal call center at 1-800-318-2596.
- In person at your local WV Department of Health and Human Resources office. A list of offices can be found at <http://www.dhhr.wv.gov/bcf/>.
- Many community agencies have navigators and/or in-person assisters to help you apply. You can find a list of these organizations at www.bewv.com.

Do I have to pick one doctor to be my regular doctor?

You do not have to pick one doctor to be your regular doctor, unless you are in a Managed Care Organization (MCO).

Is there a limit on the number of times I can go to the doctor?

No.



Learn how Medicaid coverage works for you!



Your medical card is your ticket to health care!



350 Capitol Street
Room 251
Charleston, WV 25301

West Virginia Department of
Health and Human Resources

Bureau For Medical Services



I Qualify For Medicaid
What's Next?

What Happens first?

You will receive a medical card around the first of each month as long as you are eligible. It is important to keep your appointments with the local Department of Health and Human Resources office so your Medicaid eligibility will continue with no interruptions.

If you are a member of Mountain Health Trust, the Bureau for Medical Services managed care program, you will also receive an insurance card from them.

When will my coverage start?

Medicaid coverage is effective the first day of the month in which you applied.

Do all providers accept Medicaid?

No. You should contact the provider to find out if they accept the card and if the medical service is covered before receiving services. To receive a complete list of providers, please contact Molina Medicaid Solutions Member Services at 1(888)783-0797 or (304) 348-3365.



What is a Medicaid Managed Care Organization (MCO)?

West Virginia Medicaid works with certain managed care plans to serve some Medicaid enrollees who, once enrolled, become “members” of that MCO. The WV Medicaid Managed Care Plan is Mountain Health Trust.

The MCO arranges health care for its members through a network of providers. You must get your medical treatment from a doctor who has agreed to work with your MCO or is in the MCO’s network. You will need to choose one doctor or a group of doctors. This allows you to develop a close relationship with your primary care physician.

If you or your children need services of a specialist, your physician will make the referral at no cost to you. There is no limit to the number of times a MCO member can see a doctor.

What do I need to bring with me to my doctor’s appointment?

When you visit a doctor, you need to present your most recent Medicaid card along with any other private or public medical insurance cards you have, such as your Medicaid managed care card, your red, white and blue



Medicare card or your private insurance card.

I cannot drive or take the bus, and there is no one who can take me to the doctor. Can Medicaid help?

Yes. Non-Emergency Medical Transportation (NEMT) is available to Medicaid members who need assistance in order to keep scheduled appointments and treatments. In order to be eligible for NEMT, a person must be a Medicaid member and have an appointment for treatment that is approved under Medicaid guidelines.

Reference Guide for Medicaid Managed Care

Department of Health and Human Resources (DHHR)

Apply and Change Medicaid Benefits

- First Time Applicants
- Report Changes and Updates – (*Income, Address, and Newborn Children*)

Customer Service Center: 1-877-716-1212

Apply online for Medicaid Website: www.wvinroads.org

- Third Party Liability (TPL) Customer Service Center: 1-877-598-5820

Mountain Health Trust (MHT)

Enroll in a Medicaid Managed Care Organization (MCO)

- Enroll in an MCO or transfer MCOs

Customer Service Center Phone: 1-800-449-8466

Website: www.MountainHealthTrust.com

Managed Care Organizations (MCOs)

- This is your Health Plan
- Member Claims and Benefits
- Member Appeals



Member Services: 1-888-348-2922

Provider Services: 1-800-348-2922

Website: www.aetnabetterhealth.com/wv



Member Services: 1-888-613-8385

Provider Services: 1-877-847-7901

Website: www.healthplan.org



Member Services: 1-800-782-0095

Provider Services: 1-800-782-0095

Website: www.unicare.com/Medicaid



Member Services: 1-855-412-8001

Provider Services: 1-855-412-8002

Website: www.wvfh.com

Molina Medicaid Solutions

For questions about covered services and billing:

Member Customer Service Center Phone: 1-888-483-0797

Provider Helpline: 1-888-483-0793

Website: www.wvmmis.com

Helping Government **Serve the People**[®]



WV Medicaid Managed Care



Agenda

Medicaid Overview

Managed Care Updates

Member Enrollment

Services & Benefits

Medicaid Verification

Outreach & Education

Medicaid Overview

- On average there is approximately 580,000 of West Virginia's Population covered by Medicaid.
 - Medicaid Managed Care – 70%
 - Medicaid Fee-for-Service – 30%

Medicaid Overview

- Fee-for-Service (MOLINA) - All Medicaid members who are exempt from managed care are served through a Fee-for-Service delivery system administered by Molina.
- Mountain Health Trust (MHT) – West Virginia Medicaid managed care program.
- Enrollment Broker (MAXIMUS) – Coordinates member enrollment into managed care organizations.
- Managed Care Organization's (MCOs) – Often referred to as “a” health plan the coordinates the provision of health services through networks and case management.



Managed Care Updates

- As of February 1, 2017, approximately 50,000 SSI Medicaid members will be transitioned from Medicaid Fee-for-Service to Medicaid managed care.
- As of September 26, 2016, Coventry Cares of WV will be known as AETNA Better Health of WV.
- As of March 1, 2016, all 4 MCOs are available in all WV counties.
- As of July 1, 2016, the Physician Assured Access System (PAAS) program ended. All former PAAS members are now members of an MCO.

MAXIMUS™

5

Helping Government Serve the People®

Member Enrollment



Call us at 1-800-449-8466. We are here Monday through Friday from 8:00 a.m. to 6:00 p.m. For hearing Impaired (TTY) please call 1-304-344-0015.



You can use our website to find answers to your questions, compare your health plan options, search for your provider, or enroll in a health plan at www.MountainHealthTrust.com



You can mail your completed enrollment form to us at: West Virginia Mountain Health Trust
231 Capitol Street, Suite 310 Charleston, WV 25301.

MAXIMUS™

6

Helping Government Serve the People®

Member Enrollment

Managed Care

- Who must enroll:
 - Medicaid expansion (Adults)
 - Children
 - Most parents
 - Most caretakers

Fee-for-Service

- Exempt from managed care:
 - Aged/Disabled Waiver
 - I/DD Waiver
 - SSI* - Transitioning to managed care as of 2/1/2017
 - TBI Waiver
 - Medicare
 - Live in a long term care facility
 - Foster Care
 - Spend down program

Service & Benefits

Alternative Benefit Plan

- Only Medicaid Expansion members, also known as WV Health Bridge, qualify for ABP.
- <http://www.dhhr.wv.gov/bms/Pages/default.asp>



Traditional Benefit Plan

- Specific types of basic health services a State must provide beneficiaries in order to have a valid Medicaid program.
- <http://www.dhhr.wv.gov/bms/Pages/default.aspx>



Medicaid Verification

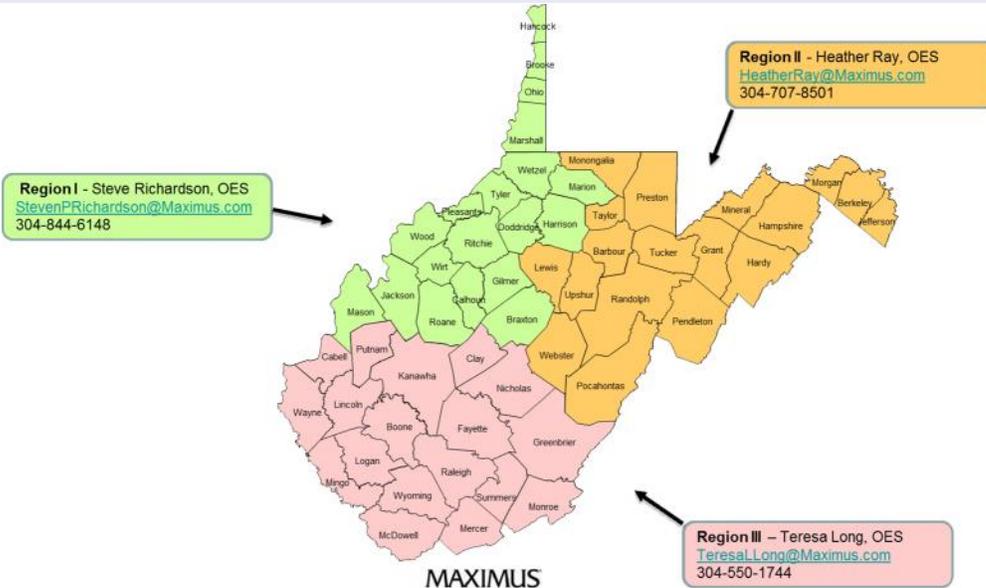
Managed Care

- Members should utilize their MCO health plan benefit when receiving healthcare services.
- Members should provide both their annual State Medicaid card and their MCO health plan membership card.
- Providers should bill the members MCO health plan for health services provided and bill Fee-for-Service (Molina) for “carved out services like personal care.

Fee-for-Service

- Members who are exempt from managed care should utilize their Fee-for-Service benefit when receiving healthcare services.
- Members should have their annual State Medicaid Card.
- Providers should bill Fee-for-Service (Molina) for health services provided.

Outreach & Education



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2017 Individual ACA Compliant Medical Plans

Marketplace Plans

CareSource – 3 Gold
3 Silver
3 Bronze

Highmark WV- 2 Gold
3 Silver
1 Bronze
1 Catastrophic

Off Marketplace Plans

Aetna- 1 Bronze

CareSource - 3 Gold
3 Silver
3 Bronze

Freedom Life* - 2 Silver
3 Bronze

Highmark WV- 2 Gold
3 Silver
1 Bronze
1 Catastrophic

The Health Plan of WV
1 Bronze
1 Catastrophic

Must purchase plans on the Marketplace to be eligible to receive APTC &/or Cost Sharing.

*Freedom Life is the only company listed that also offers “Limited Benefit Plans”. Consumers need to be certain they are purchasing the ACA compliant plan.



HOW HEALTH INSURANCE PLANS WORK

Most health insurance plans have three different stages that determine how much you and your health insurance company pay for health care services:

- 1 Before you meet your deductible
- 2 After you meet your deductible
- 3 When you reach your out-of-pocket maximum

Before you meet your deductible

Each plan year begins with a new deductible. You personally pay out of pocket for your medical services until your expenses total the amount of your deductible. Then, your plan pays for its share of covered services. Remember that your insurance company pays 100% of many preventive care services, which are not subject to your deductible as long as you visit an in-network provider. And many plans have copays for common services in advance of the deductible.

After you meet your deductible

Once you have paid your deductible, you only pay for part of your care. During this stage, you pay a percentage (coinsurance) of some medical costs and/or a flat fee (copay) for others. Your health insurance company pays for 100% of the plan allowance for covered in-network care. You'll continue to pay coinsurance and copays until you reach your out-of-pocket maximum for the year.

When you reach your out-of-pocket maximum

Your out-of-pocket maximum is the most you will be asked to pay from your own pocket during any given plan year. After that, your health insurance company pays 100% of the plan allowance for covered in-network care. **Your deductible, coinsurance and copays all go toward meeting your out-of-pocket maximum.**

\$1,000 DEDUCTIBLE

	YOU PAY:	100% (+ copays)
	PLAN PAYS:	0%

For example: If your plan has a \$1,000 deductible and you pay \$800 in covered medical costs, you must spend \$200 more in medical fees to meet your \$1,000 deductible (copays do not go toward meeting your deductible).

20% COINSURANCE

	YOU PAY:	20% (+ copays)
	PLAN PAYS:	80%

For example: Let's say you visit the doctor after you've met your deductible, and your plan has a \$20 office visit copay and 20% coinsurance. That means you pay a fixed \$20 fee (your copay) for your appointment. If your doctor performs a special service, such as a blood test, you may also pay 20% of that cost (your coinsurance).

OUT-OF-POCKET MAXIMUM

	YOU PAY:	\$0
	PLAN PAYS:	100%

For example: If your plan has a \$6,350 out-of-pocket maximum and you spend \$6,350 in covered medical services, your plan pays for 100% of your covered in-network care for the rest of the plan year. You'll still need to keep paying your monthly premium after you meet your out-of-pocket maximum.

Glossary of Health Insurance Terms

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. When making decisions about health coverage, consumers should know the specific meanings of terms used to discuss health insurance. Below are definitions for some of the more commonly used terms and how PPACA impacts their use.

-A-

Actuarial justification — The demonstration by an insurer that the premiums collected are reasonable, given the benefits provided under the plan or that the distribution of *premiums* among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. PPACA requires insurers to publicly disclose the actuarial justifications behind unreasonable premium increases.

Adjusted community rating — A way of pricing insurance where *premiums* are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location. PPACA requires the use of adjusted community rating, with maximum variation for age of 3:1 and for tobacco use of 1.5:1.

Annual limit — Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for *essential benefits* for plan years beginning after Sept. 23, 2010.

-B-

Balance billing — When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount. This is known as "balance billing."

-C-

CHIP — The Children's Health Insurance Program (CHIP) provides coverage to low- and moderate-income children. Like *Medicaid*, it is jointly funded and administered by the states and the federal government. It was originally called the State Children's Health Insurance Program (SCHIP).

COBRA coverage — Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

Coinsurance — A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

Community rating — A way of pricing insurance, where every policyholder pays the same premium, regardless of health status, age or other factors.

Co-Op Plan — A health insurance plan that will be sold by member-owned and operated non-profit organizations through *Exchanges* when they open in 2014. PPACA provides grants and loans to help Co-Op plans enter the marketplace.

Co-payment — A flat-dollar amount which a patient must pay when visiting a health care provider.

Cost-sharing — Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include *deductibles*, *coinsurance* and *co-payments*. *Balance-billed* charges from *out-of-network physicians* are not considered cost-sharing. PPACA prohibits total cost-sharing exceed \$5,950 for an individual and \$11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

-D-

Deductible — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small group policies to \$2,000 for policies that cover an individual, and \$4,000 for other policies. These amounts will be adjusted annually to reflect the growth of premiums.

Disease management — A broad approach to appropriate coordination of the entire disease treatment process that often involves shifting away from more expensive inpatient and acute care to areas such as preventive medicine, patient counseling and education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

-E-

ERISA — The Employee Retirement Income Security Act of 1974 (ERISA) is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.

Essential Benefits — PPACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits. It also places restrictions on the amount of *cost-sharing* that patients must pay for these services.

Exchange — PPACA creates new “American Health Benefit Exchanges” in each state to assist individuals and small businesses in comparing and purchasing *qualified health insurance plans*. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them. They will also accept applications for other health coverage programs such as *Medicaid* and *CHIP*.

External review — The review of a health plan’s determination that a requested or provided health care service or treatment is not or was not medically necessary by a person or entity with no affiliation or connection to the health plan. PPACA requires all health plans to provide an external review process that meets minimum standards.

-F-

Formulary — The list of drugs covered fully or in part by a health plan.

-G-

Grandfathered plan — A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by PPACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans.

Group health plan — An employee welfare benefit plan that is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise.

Guaranteed issue — A requirement that health insurers sell a health insurance policy to any person who requests coverage. PPACA requires that all health insurance be sold on a guaranteed-issue basis beginning in 2014.

Guaranteed renewability — A requirement that health insurers renew coverage under a health plan except for failure to pay premium or fraud. *HIPAA* requires that all health insurance be guaranteed renewable.

-H-

Health Maintenance Organization (HMO) — A type of managed care organization (health plan) that provides health care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from an *in-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

Health Savings Account (HSA) — The Medicare bill signed by President Bush on Dec. 8, 2003 created HSAs. Individuals covered by a *qualified high deductible health plan (HDHP)* (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses. Additional information about HSAs can be found on the U.S. Treasury Web site: <http://www.treas.gov/offices/public-affairs/hsa/>.

High Deductible Health Plan (HDHP) — A type of health insurance plan that, compared to traditional health insurance plans, requires greater *out-of-pocket spending*, although *premiums* may be lower. In 2010, an HSA-qualifying HDHP must have a deductible of at least \$1,200 for single coverage and \$2,400 for family coverage. The plan must also limit the total amount of out-of-pocket *cost-sharing* for covered benefits each year to \$5,950 for single coverage and \$11,900 for families.

High risk pool — A state-subsidized health plan that provides coverage for individuals *with pre-existing health care conditions* who cannot purchase it in the private market. PPACA creates a temporary federal high risk pool program, which may be administered by the states, to provide coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months.

HIPAA (Health Insurance Portability and Accountability Act of 1996) — The federal law enacted in 1996 which eased the “job lock” problem by making it easier for individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to *pre-existing medical conditions*.

-I-

In-Network provider — A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an *HMO* or *PPO*). The provider agrees to the managed care organization’s rules and fee schedules in order to be part of the network and agrees not to *balance bill* patients for amounts beyond the agreed upon fee.

Individual mandate — A requirement that everyone maintain health insurance coverage. PPACA requires that everyone who can purchase health insurance for less than 8% of their household income do so or pay a tax penalty.

Individual market — The market for health insurance coverage offered to individuals other than in connection with a *group health plan*. PPACA makes numerous changes to the rules governing insurers in the individual market.

Internal review — The review of the health plan’s determination that a requested or provided health care service or treatment health care service is not or was not medically necessary by an individual(s) associated with the health plan. PPACA requires all plans to conduct an internal review upon request of the patient or the patient’s representative.

Interstate compact — An agreement between two or more states. PPACA provides guidelines for states to enter into interstate compacts to allow health insurance policies to be sold in multiple states.

-J-

Job Lock — The situation where individuals remain in their current job because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave that job. PPACA would eliminate job lock by prohibiting insurers from refusing to cover individuals due to health status.

-L-

Lifetime limit — Many health insurance plans place dollar limits upon the claims that the insurer will pay over the course of an individual’s life. PPACA prohibits lifetime limits on benefits beginning with on Sept. 23, 2010.

Limited Benefits Plan — A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

-M-

Mandated benefit — A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service.

Medicaid — A joint state and federal program that provides health care coverage to eligible categories of low-income individuals. Rules for eligible categories (such as children, pregnant women, people with disabilities, etc), and for income and asset requirements, vary by state. Coverage is generally available to all individuals who meet these state eligibility requirements. Medicaid often pays for long-term care (such as nursing home care). PPACA extends eligibility for Medicaid to all individuals earning up to \$29,326 for a family of four.

Medical loss ratio — The percentage of health insurance *premiums* that are spent by the insurance company on health care services. PPACA requires that large group plans spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. *Small group* and *individual market* plans must devote 80% of premiums to these purposes.

Medicare — A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Benefits can also be provided through a *Medicare Advantage* plan (Medicare Part C).

Medicare Advantage — An option *Medicare* beneficiaries can choose to receive most or all of their Medicare benefits through a private insurance company. Also known as Medicare Part C. Plans contract with the federal government and are required to offer at least the same benefits as original Medicare, but may follow different rules and may offer additional benefits. Unlike original Medicare, enrollees may not be covered at any health care provider that accepts Medicare, and may be required to pay higher costs if they choose an *out-of-network provider* or one outside of the plan’s service area.

Medicare Supplement (Medigap) Insurance — Private insurance policies that can be purchased to “fill-in the gaps” and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original *Medicare* (Part A and Part B).

Multi-state plan — A plan, created by PPACA and overseen by the U.S. Office of Personnel Management (OPM), that will be available in every state through *Exchanges* beginning in 2014.

-O-

Open enrollment period — A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

Out-of-network provider — A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization’s network (such as an *HMO* or *PPO*). Depending on the managed care organization’s rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

Out-of-pocket limit — An annual limitation on all *cost-sharing* for which patients are responsible under a health insurance plan. This limit does not apply to *premiums*, *balance-billed* charges from out of network health care providers or services that are not covered by the plan. PPACA requires out-of-pocket limits of \$5,950 per individual and \$11,900 per family, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance *premiums*.

-P-

Patient Protection and Affordable Care Act (PPACA) — Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.

Pre-existing condition exclusion — The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

Preferred Provider Organization (PPO) — A type of managed care organization (health plan) that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay higher costs when they seek care from an *out-of-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

Premium — The periodic payment required to keep a policy in force.

Preventive benefits — Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. PPACA requires insurers to provide coverage for preventive benefits without *deductibles*, *co-payments* or *coinsurance*.

-Q-

Qualified health plan — A health insurance policy that is sold through an *Exchange*. PPACA requires Exchanges to certify that qualified health plans meet minimum standards contained in the law.

-R-

Rate review — Review by insurance regulators of proposed *premiums* and premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims, that they are not unreasonably high in relation to the benefits being provided, and that they are not unfairly discriminatory to any individual or group of individuals.

Reinsurance — Insurance purchased by insurers from other insurers to limit the total loss an insurer would experience in case of a disaster or unexpectedly high claims. PPACA directs states to create temporary reinsurance programs to stabilize their *individual markets* during the implementation of health reform.

Rescission — The process of voiding a health plan from its inception usually based on the grounds of material misrepresentation or omission on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. PPACA prohibits rescissions except in cases of fraud or intentional misrepresentation of a relevant fact.

Risk adjustment — A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans who enroll a disproportionate number of healthy individuals. PPACA requires states to conduct risk adjustment for all non-*grandfathered* health insurance plans.

Risk corridor — A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

-S-

Self-insured — *Group health plans* may be self-insured or fully insured. A plan is self-insured (or self-funded), when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer.

Small group market — The market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states. PPACA will broaden the market to those with between 1 and 100 employees.

Solvency — The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

-U-

Usual, Customary and Reasonable charge (UCR) —

The cost associated with a health care service that is consistent with the going rate for identical or similar services within a particular geographic area.

Reimbursement for *out-of-network providers* is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

-W-

Waiting period — A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. *Premiums* are not collected during this period.

2016 Federal Poverty Level Chart

Household Size	100%	138%	150%	200%	250%	300%	400%
1	\$11,880	\$16,394	\$17,820	\$23,760	\$29,700	\$35,640	\$47,520
2	\$16,020	\$22,108	\$24,030	\$32,040	\$40,050	\$48,060	\$64,080
3	\$20,160	\$27,821	\$30,240	\$40,320	\$50,400	\$60,480	\$80,640
4	\$24,300	\$33,534	\$36,450	\$48,600	\$60,750	\$72,900	\$97,200
5	\$28,440	\$39,247	\$42,660	\$56,880	\$71,100	\$85,320	\$113,760
6	\$32,580	\$44,960	\$48,870	\$65,160	\$81,450	\$97,740	\$130,320
7	\$36,730	\$50,687	\$55,095	\$73,460	\$91,825	\$110,190	\$146,920
8	\$40,890	\$56,428	\$61,335	\$81,780	\$102,225	\$122,670	\$163,560

The Federally-facilitated Marketplaces will use the 2016 guidelines when making calculations for the insurance affordability programs starting November 1, 2016.

Cost-Sharing Chart

Household Size	100%		250%
1	\$11,880	to	\$29,700
2	\$16,020	to	\$40,050
3	\$20,160	to	\$50,400
4	\$24,300	to	\$60,750
5	\$28,440	to	\$71,100
6	\$32,580	to	\$81,450
7	\$36,730	to	\$91,825
8	\$40,890	to	\$102,225

To qualify for Cost-Sharing, one must be enrolled in a Silver level plan through a Marketplace plan.

Individuals and families with household incomes generally up to 250% of the FPL may be eligible to receive cost-sharing reductions. Household income is determined by calculating a consumer's adjusted gross income (MAGI).

Short-Term or Limited Benefit Health Insurance Policies

People needing to fill a gap in health coverage (if they missed open enrollment and don't qualify for a special enrollment period) may look at short-term policies to protect their assets in case of a medical emergency. While short-term health insurance policies have their place, they also have some drawbacks:

- They are not required to provide the full range of benefits offered by ACA compliant policies
- They can use pre-existing condition exclusions and refuse enrollment
- They can rate premiums based on health status or gender
- They may include higher out-of-pocket costs
- They cannot be renewed
- They are **not** considered minimum essential coverage for tax purposes

Please refer to the list of Insurance Companies writing ACA compliant plans. If a company is not on this list, then it is most likely a limited benefit plan. Please feel free to contact the WV OIC with any questions.

Marketplace Application Checklist

When you apply for or renew your coverage in the Health Insurance Marketplace, you'll need to provide some information about you and your household, including income, any coverage you currently have, and some additional items.

Use the checklist below to help you gather what you need to apply for coverage.

- Information about your household size. Figure out who in your household should apply before you start your application. Visit [HealthCare.gov/income-and-household-information/household-size](https://www.healthcare.gov/income-and-household-information/household-size) for help figuring out who needs coverage.
- Home and/or mailing addresses for everyone applying for coverage.
- Information about everyone applying for coverage, like addresses and birth dates.
- Social Security Numbers.
- Information about the professional helping you apply (if you're getting help completing your application). Visit [HealthCare.gov/help/whos-helping-me-complete-my-application](https://www.healthcare.gov/help/whos-helping-me-complete-my-application) for more information.
- Document information for legal immigrants. Visit [HealthCare.gov/help/immigration-document-types](https://www.healthcare.gov/help/immigration-document-types) for more information.
- Information on how you file your taxes.
- Employer and income information for every member of your household (for example, from pay stubs or W-2 forms—Wage and Tax Statements). Visit [HealthCare.gov/income-and-household-information/income](https://www.healthcare.gov/income-and-household-information/income) to learn more about what types of income to include and not include.
- Your best estimate of what your household income will be in 2017. Visit [HealthCare.gov/income-and-household-information/how-to-report](https://www.healthcare.gov/income-and-household-information/how-to-report) for help estimating your income.
- Policy numbers for any current health insurance plans covering members of your household.
- A completed “**Employer Coverage Tool**” for every job-based plan you or someone in your household is eligible for. (You'll need to fill out this form even for coverage you're eligible for but don't enroll in.) Visit [HealthCare.gov/downloads/employer-coverage-tool.pdf](https://www.healthcare.gov/downloads/employer-coverage-tool.pdf) to view or print the tool.
- Notices from your current plan that include your plan ID, if you have or had health coverage in 2016.

Stay up-to-date about the Marketplace. Visit [HealthCare.gov](https://www.healthcare.gov) to get email or text updates that will help you get ready to apply or renew.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit <https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice.html>, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users should call 1-855-889-4325.



Who to include in your household

Relationship	Include in household?	Notes
Dependent children, including adopted and foster children	Yes	Include any child you'll claim as a tax dependent, regardless of age.
Children, shared custody	Sometimes	Include children whose custody you share only during years you claim them as tax dependents.
Non-dependent child under 26	Sometimes	Include them only if you want to cover them on your Marketplace plan.
Children under 21 you take care of	Yes	Include any child under 21 you take care of and who lives with you, even if not your tax dependent.
Unborn children	No	Don't include a baby until it's born. You have up to 60 days after the birth to enroll your baby.
Dependent parents	Yes	Include parents only if you'll claim them as tax dependents .
Dependent siblings and other relatives	Yes	Include them only if you'll claim them as tax dependents .
Spouse	Yes	Include your legally married spouse, whether opposite sex or same sex . In most cases,

Who to include in your household

Relationship	Include in household?	Notes
		married couples must file taxes jointly to qualify for savings.
Legally separated spouse	No	Don't include a legally separated spouse, even if you live together.
Divorced spouse	No	Don't include a former spouse, even if you live together.
Spouse, living apart	Yes	Include your spouse unless you're legally separated or divorced. (See next row for an important exception.)
Spouse, if you're a victim of domestic abuse, domestic violence, or spousal abandonment	Not required	In these cases, you don't have to include your spouse. See rules for victims of domestic abuse, domestic violence, or spousal abandonment.
Unmarried domestic partner	Sometimes	Include an unmarried domestic partner only if you have a child together or you'll claim your partner as a tax dependent.
Roommate	No	Don't include people you just live with — unless they're a spouse, tax dependent, or covered by another exception in this chart.



What counts as income on my Marketplace application?

When applying for or updating your Marketplace application on HealthCare.gov, we'll ask you to enter your income.

- If you have income below a certain amount, you may qualify for different programs or get help paying for health coverage. We need to know about your income to see what you qualify for.
- Your application may be pre-filled and show your income for the year. We get this information from a consumer reporting agency, and we'll ask if you'll make the same amount next year. Or, we may ask you to estimate what you think you'll make.
- If you think your income will be different than previous years, we'll ask if you expect changes or a different kind of income that you didn't get before.
- If you're not sure about your income or how it will change, enter your best guess or select "I don't know." You'll need to update your application if something changes later. It's important to update your income because changes may affect the coverage or savings you're eligible for.

When adding your income, include income from:

- Jobs. Visit [HealthCare.gov/help/income-from-your-job](https://www.healthcare.gov/help/income-from-your-job).
- Self-employment. Self-employment income is the net income a person earns from their own trade or business. Net income is the amount left after you've subtracted your business expenses. For more information, or to find out what expenses you can deduct, visit [HealthCare.gov/help/add-other-income](https://www.healthcare.gov/help/add-other-income) and see the "Self employment income" section.
- Social Security (taxable and non-taxable).
- Retirement.
- Pensions.

- Unemployment.
- Capital gains.
- Investments.
- Rental or royalty.
- Farming or fishing.
- Alimony.
- Other taxable income, including canceled debts, court awards, jury duty pay, cash support, and income from gambling, prizes, or awards.

When you're adding your income, don't include money you get from:

- Child support.
- Gifts.
- Supplemental Security Income (SSI).
- Veterans' disability payments.
- Workers' compensation.

You'll also answer questions about deductions. You should include:

- Alimony you pay.
- Student loan interest you pay.
- Educator expenses if you're a teacher and pay for supplies out-of-pocket.
- Moving expenses if you're moving to live much closer to your job.
- Contributions to your individual retirement account if you don't have a retirement account through a job.
- Tuition costs for school if you pay for the costs out-of-pocket and deduct them on your tax return.
- Other deductions you can take on the front of your IRS form 1040.

You shouldn't include these deductions:

- Charitable donations.
- Home mortgage interest.

For more information:

- Visit [HealthCare.gov/help/add-other-income](https://www.healthcare.gov/help/add-other-income).
- Visit [HealthCare.gov/help/income-deductions](https://www.healthcare.gov/help/income-deductions).
- Call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit <https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice.html>, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users should call 1-855-889-4325.



How to Obtain a Consumer's Authorization before Gaining Access to Personally Identifiable Information (PII)

Some of the first steps that Navigators, non-Navigator assistance personnel (in-person assisters), and certified application counselors (CACs) in Federally-facilitated Marketplaces and State Partnership Marketplaces (collectively referred to as “assisters” or “you” in this document) must take when providing application and enrollment assistance involve informing the consumer about the assister’s roles and responsibilities and obtaining that consumer’s authorization, which is sometimes referred to as getting the consumer’s consent. Assisters are required to:

- ensure that applicants are informed of the functions and responsibilities of the assister;
- ensure that applicants provide authorization in a form and manner as determined by the Marketplace prior to an assister obtaining access to a consumer’s PII, and that applicants can revoke that authorization at any time; and
- maintain a record of the authorization in a form and manner determined by the Marketplace. In Federally-facilitated Marketplaces, this period is no less than six years, unless a different and longer retention period has already been provided under other applicable Federal law.¹

If you are one of the types of assisters listed above, this tip sheet addresses this consumer authorization requirement and how assisters may meet this requirement in various scenarios. This tip sheet also contains information about the model authorization form and the recent revisions by CMS.

What is Personally Identifiable Information (PII)?

Personally Identifiable Information (PII) is information which can be used to distinguish or trace an individual’s identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information that is linked or linkable

¹ 45 CFR 155.210(e)(6), 155.215(g), and 155.225(f).

to a specific individual, such as date and place of birth, mother's maiden name, etc. (OMB Memorandum M-07-16 (May 22, 2007)).

A more comprehensive list of examples of PII that you might encounter is included in the Navigator grant terms and conditions, or in the agreements between CMS and CAC designated organizations. These lists explain that the PII Navigators and CACs are expected to encounter when carrying out their required duties includes an applicant's spoken and written language preferences, pregnancy status, cost-sharing reduction level, tobacco use, Marketplace applicant ID, and the reason for an applicant's special enrollment period eligibility.

Ways to Obtain Consumer Authorization

Consumers may give their authorization themselves or choose to have a legal or authorized representative provide authorization on their behalf, provided this is consistent with the scope of the representative's authority to act on the consumer's behalf. In addition, assisters may obtain a consumer's authorization orally (such as over the phone), in writing, or both.

What the Authorization and Record of Authorization Should Include

I. Consumer's Authorization

At a minimum, a consumer's authorization should include the following:

- (1) An acknowledgment that you informed the consumer of the functions and responsibilities that apply to your specific assister role (e.g., Navigator, CAC) (including all the consumer protection standards that apply through CMS regulations to your assister type, such as conflict of interest requirements, rules about accepting payment and providing gifts, etc.);
- (2) Consent for you to access and use the consumer's PII to carry out your Marketplace functions and responsibilities; and
- (3) An acknowledgment that the consumer may revoke any part of the authorization at any time, as well as a description of any limitations that the consumer wants to place on your access or use of the consumer's PII.

We also recommend that the authorization include:

- (1) An explanation of what PII includes, and examples of the kinds of PII you might request from the consumer;
- (2) An acknowledgment that the consumer is not required to provide you with any PII;
- (3) An explanation that the help you provide is based only on the information the consumer provides, and that if the information given is inaccurate or incomplete, you might not be

- able to offer all the help that is available for the consumer's situation;
- (4) An acknowledgment that you will ask only for the minimum amount of PII necessary for you to carry out your functions and responsibilities; and
 - (5) Any applicable specific consents to obtain access to consumer PII for CMS-approved purposes that are not already captured in the list of purposes set forth in your agreement with CMS.

Please note that express CMS approval for any activities requiring a consumer's specific consent that are not already captured in the list of purposes set forth in your agreement with CMS or your grant terms and conditions is required in order for an assister organization to use grant or contract funds on those activities.

II. Record of Authorization

At a minimum, the record of the authorization should include the following:

- (1) The consumer's name and (if applicable) the name of the legal or Marketplace authorized representative who provides authorization on the consumer's behalf;
- (2) The date the authorization was given;
- (3) Your name, or the name of the assister to whom authorization was given. Note that this could include additional names of assisters if the consumer authorized multiple assisters within the same assister organization to obtain access to his or her PII;
- (4) Notes regarding any limitations placed by the consumer on the scope of the authorization;
- (5) Notes recording all acknowledgments and consents obtained from the consumer, including any applicable specific consents to access consumer PII for CMS-approved purposes that are not already captured in the list of purposes set forth in your agreement with CMS; and
- (6) If any changes are later made to the authorization, including if and when a consumer revoked the authorization, or any part thereof, this should be included with the original record.

Examples of How to Fulfill the Consumer Authorization Requirement

The following scenarios illustrate some of the ways in which an assister might fulfill the consumer authorization requirement.²

² This is not an exhaustive list. If you have questions about how the consumer authorization requirement applies to a specific situation, you should direct your questions to:

Example 1—Assisting a Homebound Consumer over the Telephone

Scenario: You are assisting a consumer for the first time. The consumer is homebound, and you are providing assistance over the telephone.

Authorization: You may obtain the consumer’s authorization by reading them your organization’s standard written authorization form or a script that contains, at a minimum, the required elements of the authorization that are summarized above. You must record in writing that the consumer’s authorization was obtained. The record of the authorization must include, at a minimum, the required elements summarized above. Be sure to make special notations documenting all consents provided by the consumer and any limitations placed by the consumer on their consents. We strongly recommend that you create a record of the authorization as it is being provided, and then read back the content of the record to the consumer once it is complete, so that the consumer can confirm that the record is accurate and complete, and correct it if it is not. We also recommend that you provide a copy of the record to the consumer at the earliest available opportunity.

Example 2—Outreach Events with Sign-up Sheets for Follow-up

Scenario: Your assister organization is participating in an outreach or enrollment event. The organizers would like to create a sign-up sheet so that consumers who desire to receive a follow-up contact from a participating assister organization can leave their names and contact information. However, the organizers are concerned about collecting this PII without first having the consumer sign a standard written authorization form in advance.

Authorization: Please be assured that you or your organization may use a sign-up sheet to collect a consumer’s name and contact information, provided that you make clear to consumers in writing (and orally, if appropriate) that by providing their name and contact information, they are consenting to be contacted for application and enrollment assistance (for example, you could say, “By signing up, you agree that it is okay for an assister to contact you to help you with health care coverage and/or the Marketplace”). Any PII collected on the sign-up sheet should be maintained privately and securely and access to it should be given only to staff who need to access it to carry out required duties. Unless this authorization contains the minimum elements summarized above, it does **not** meet the regulatory requirements, and should be followed up with a more complete authorization if and when you follow up with the consumer. Even if this authorization does include all the required minimum elements, we strongly encourage you to obtain the consumer’s authorization again when you follow up with them, following your organization’s standard authorization procedures.

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- Certified Application Counselors and Non-Navigator Assistance Personnel: CACQuestions@cms.hhs.gov
 - Navigators: NavigatorGrants@cms.hhs.gov

Example 3—Consumer makes initial contact and shares PII

Scenario: You or your assister organization may receive a direct phone call, voicemail, or email from a consumer requesting your services as an assister. This communication likely contains the consumer's PII.

Authorization: If a consumer directly contacts you or your organization, the consumer is providing his or her implicit authorization for you or your organization to obtain access to the PII shared with you during the contact. This implicit authorization most likely does not contain all the elements listed as minimum required elements above, and therefore you must obtain a complete authorization from the consumer either during the first contact, or the next time you follow up with or meet in-person with the consumer, as appropriate. Any PII collected during or by means of the initial contact should be maintained privately and securely and access to it should be given only to staff who need to access it to carry out required duties.

Example 4—Third party makes initial contact and shares consumer's PII

Scenario: You might obtain access to a consumer's PII through a third party (for example, someone who is neither you, nor your assister organization, nor the consumer, nor his or her legal or authorized representative) when a third party contacts you directly. The third party might share the consumer's PII without the consumer being present, which would raise concerns that the consumer had not authorized the third party to share his or her PII with you.

Authorization: Generally speaking, you are permitted to follow up with the consumer so long as you can confirm that the third party has obtained the consumer's consent to share his or her PII with you or your organization so you can contact the consumer. Examples of scenarios in which this type of consumer consent may occur are the following:

- A third party operates a phone bank event, informs the consumer about the availability of application and enrollment assistance in the area, and obtains the consumer's consent over the phone to share his or her contact information with an assister organization for follow-up. To prove that the third party obtained the consumer's consent, the third party shares documentation of the consumer's consent to a follow-up contact with the assister organization, and the assister organization retains this documentation for its records.
- A third party holds an outreach and education event about the Marketplace. At the event, the third party hands out postcards that consumers may fill out with their contact information to leave with the third party. To document that the third party obtained the consumer's consent, the form language on the postcard clearly indicates that by filling out the postcard, the consumer agrees to be contacted by an assister organization for follow-up. The third party shares these cards with the assister organization, and the assister organization keeps the completed cards on file as

documentation that consumer authorization for the follow-up contact has been obtained.

Please note: In any case in which a third party has obtained a consumer's authorization to receive a follow-up contact from an assister, it will nearly always be the case that this preliminary authorization does not contain all the minimum required elements under the rules applicable to Marketplace assisters. Therefore, you must obtain a complete authorization from the consumer when you follow up with the consumer or meet in-person with the consumer, as appropriate. Additionally, any PII collected from the third-party organization should be maintained privately and securely and access to it should be given only to staff who need to access it to carry out required duties.

Maintaining a Record of Consumer Authorization

You and your organization are required by federal regulations to maintain a record of each consumer authorization obtained. The regulations do not prescribe a standard format or process for obtaining the authorization or for maintaining its record, so assisters have flexibility to determine how they will maintain such a record. For example, a record could be maintained in hard copy or electronic format. If in hard copy, we recommend that the authorization be kept in a locked file cabinet that may only be accessed by authorized individuals. If in electronic format, we recommend that the authorization be kept in a password-protected computer and/or a file that is kept securely at all times. Only those personnel who need to access the records to carry out their duties and responsibilities should be given access to them. In addition, CMS expects that each assister organization establish internal policies and procedures to keep each record of authorization secure and organized in a way that allows a consumer to request access to his or her authorization and make corrections, as needed. For example, CMS recommends that each assister service location maintain a central repository that contains each record of authorization collected from each consumer seeking services at that location.

Regardless of the specific format for each written record of consumer authorization, you or your organization must maintain that record for at least six years. If you or your organization is required under federal law to maintain a record of authorization for a period that is longer than six years, the longer retention period must be followed.

Model Authorization Form

CMS has developed model consumer authorization forms that Navigators and CACs may adopt or modify to obtain and keep a record of consumer authorizations, as appropriate. We note that, for Navigators, a model form is included in the grant award materials, and for CACs, a model form is among the documents provided to CAC designated organizations upon designation by CMS; in both cases, these forms are provided in both English and Spanish versions.

In Fall 2014, CMS has updated both the model Navigator and CAC authorization forms. These forms are drafts and subject to OMB approval. However, assisters may use the draft forms immediately if they wish. Please note that the Spanish version of the revised draft model forms will be published after the publication of the English version (as soon as possible).

To allow assisters to understand what has changed from last year's model authorization form, here is a general summary of updates to the Navigator and CAC draft model authorization forms:

1. Restructured the forms into four parts:
 - an acknowledgement that consumer received information about the assister's roles and responsibilities, consistent with the requirement under 45 CFR 155.210(e)(6)(i) and 45 CFR 155.225(f)(1);
 - definitions of terms used in the form;
 - consents provided by the consumer, including: a **general consent** to let the assister create, collect, disclose, access, maintain, store, and/or use PII to carry out all assister required duties that might require the assister to access, etc. PII; **specific consents** for other purposes as approved by CMS, such as to follow-up with the consumer for the annual redetermination and reenrollment processes; **exceptions/limitations** to consents; and **additional information** about the assister's use of PII;
 - a signature section where consumer may provide contact information for follow-up.
2. For each form, created an attachment to summarize the functions and responsibilities of assisters, including requirements that were finalized in regulations in summer 2014.
3. For Navigators, removed the "cover sheet."
4. Under **general consent**, clarified that by signing the form, consumer agrees to allow the assister organization, including individual assisters who are a part of the organization, to create, collect, disclose, access, maintain, store, and/or use his or her PII and/or the PII of his or her authorized representative to carry out their responsibilities, unless the consumer has limited that consent.
5. Under **additional information**, added a space where assisters inform a consumer if they are required under state law or regulation to collect, handle, disclose, access, maintain, store, and/or use consumer PII to carry out other activities.
6. For Navigators, under **additional information**, clarified that if the Navigator cannot help the consumer right away due to a lack of resources or skills, the Navigator will refer the consumer to another Navigator or in-person assister, or to the federal Marketplace Call

Center, who can meet the consumer's specific needs sooner. Added that if the Navigator needs to refer that consumer to another source of help, the Navigator will contact the source that is easiest for the consumer to access, and that the consumer acknowledges that the Navigator might need to share consumer's contact information and information about the consumer's needs with possible referral sources in order to help.³

7. Revised language throughout to be more plainly worded. For example, added examples of PII at the beginning of the form.
8. At the bottom of the form, added information where consumer can specify his or her preferred method of contact for follow-up.

Consumer Authorization FAQs:

Q1: *Does a consumer's authorization expire? Do consumers need to sign a new authorization form for next open enrollment?*

A1: The regulations do not specify an automatic expiration date for the consumer's authorization because it could become burdensome for a consumer consistently seeking services from the same assister to have to repeatedly renew the authorization, and for the assister to have to maintain a record of each new authorization for a minimum of six years.⁴ The regulations do not however, prevent assister organizations from setting an expiration date for authorizations or requiring their periodic renewal. Unless the organization does so, the authorization may last indefinitely, unless the consumer revokes it. Under the CMS regulations, consumers are allowed to revoke their authorization at any time, and may also place a time restriction on the authorization at any time, if they desire.

Q2: *As an assister operating in a Federally-facilitated Marketplace, I had previously obtained a consumer's consent to retain his or her name and contact information so that I could follow up with the consumer "on applying for or enrolling in coverage," (as stated on the first versions of the Navigator and CAC model authorization forms, as examples). Based on this language, am I permitted to re-contact that consumer regarding the annual Marketplace redetermination and re-enrollment process?*

A2: Yes. CMS considers that if a consumer already provided his or her consent to an assister to follow up with the consumer on applying for or enrolling in coverage, the assister would be permitted (but not required) to contact the consumer to offer his or her assistance with the annual Marketplace eligibility redetermination and re-enrollment processes. To make it more clear that the consumer's consent would also apply to this activity, we included additional language providing a specific consent covering this activity in the updated draft Navigator and

³ This is based on the guidance provided at 78 FR 42830 and 42839 (July 17, 2013).

⁴ 79 FR 30286 (May 27, 2014).

CAC model authorization forms.

Q3: *Does CMS review any modifications that assisters and assister organizations make to the CMS model authorization form to verify that the modifications are consistent with applicable assister regulations and privacy and security standards?*

A3: CMS does not review modifications to its model authorization form to verify that the modifications are consistent with applicable requirements, and CMS approval is not required to modify the model form. Nor is CMS approval required if your organization would like to create its own authorization form instead of using the CMS-provided model forms.

CMS suggests, however, that the assister consult with CMS where an assister would like to obtain specific consumer authorization to access or use the consumer's PII for reasons **not** clearly directly related to the assister's regulatory duties, especially if the assister is a Navigator who intends to use CMS grant funding on activities that involve accessing or using PII for reasons not clearly directly related to the assister's regulatory duties. If a Navigator or CAC organization has specific questions regarding whether a particular consumer authorization it plans to request is permitted by federal law or the agreement(s) that the assister organization or its assisters are subject to, including the privacy and security standards specified in those agreements or grant terms and conditions, then it may contact CMS for technical assistance. As always, Navigator grantees should contact their project officer and CACs or in-person assisters should contact CACquestions@cms.hhs.gov.

Q4: *My assister organization provides other services, such as health care or social services, that are separate and apart from its federal duties as a Federally-facilitated or State Partnership Marketplace (FFM/SPM) consumer assistance entity. If an assister organization would like to obtain a consumer's consent to create, collect, disclose, access, maintain, store, or use their PII for purposes other than what is in the scope of their regular assister duties (listed as "Authorized Functions" in the Navigator and CAC privacy and security agreements, for example), is this permitted? Can that consent be included in the same document the assister uses to satisfy the consumer authorization requirement under federal regulations?*

A4: Participating in an assister program does not generally preclude an organization or individual from obtaining a consumer's consent to create, collect, disclose, access, maintain, store, or use PII for a legally permissible purpose that is not within the scope of your work as an assister in the FFM or in an SPM.⁵ We also recognize that some states might require an assister entity to

⁵ For Navigators and CMS contractors in the Enrollment Assistance Program (EAP), keep in mind, however, that you cannot claim as allowable costs any costs that are not related to the scope of work under your contract or grant. If costs are not attributable to work performed under the scope of work under your contract or grant, they would generally be unallowable costs unless the organization receives express, written permission obtained consistent with HHS grants regulations and policies for claiming them. HHS expects that it will generally permit Navigator grant or EAP contract

report to a state agency the names of consumers that an assister has assisted and other information, such as the dates on which the assister provided services to a particular consumer. To this end, we have added language to the draft model authorization forms we provide Navigators and CACs to provide notice of any applicable state disclosure requirements to consumers.

We recommend as a best practice that assisters use a document separate from any record of the authorization requirement related to FFM or SPM assister duties to obtain a consumer's consent if either: 1.) the purpose is outside of the scope of your assister work; or 2.) is not related to a state reporting requirement related to your role as assisters. This separate consent will make it easier for consumers to understand the scope of FFM/SPM assister duties and how their PII will be used in the context of the organization's FFM/SPM assister-related services. In addition, maintaining this consent in a separate document will make it easier for the organization to comply with any different retention periods, revocations or limitations, and expiration dates that may apply to different types of activities and the consumer consents related to those other activities. Maintaining this consent separately will also make it easier for the organization to properly allocate the costs associated with obtaining and storing consents for activities that are not within the scope of the organization's assister work.

Q5: *If the help of an additional assister or assisters in the same organization is necessary to assist with a particular consumer's access needs, Marketplace application, enrollment, or some other Marketplace coverage-related issue, are the additional assisters required to obtain the consumer's authorization separately?*

A5: It is not necessary for a consumer to provide a separate authorization for each individual assister. That is, additional assisters at the same organization may access a consumer's PII (as may be necessary to provide assistance) without having to obtain a separate authorization. To make it clearer that, generally speaking, the consumer's consent includes having any assister affiliated with a particular organization access his or her PII if needed to carry out required assister duties, we have provided a clarification in the "general consent" section in the draft model forms we provide to Navigators and CACs, as highlighted above.

Please note that a consumer's ability to provide limitations or exceptions to his or her consent includes the ability to limit his or her consent to cover only assisters expressly identified on the authorization form, or only assisters at a particular service location. Any such limitation or exception should be documented, and there is a space on the model form to do so. In addition, if a consumer seeks assistance from a different assister organization, even if it is for the same

funds to be used for costs that are not in the assister's scope of work, but are related to the regulatory duties and functions of these assister programs, so long as extending that permission is within HHS's legal authority under the statutes and regulations governing each assister program.

application or enrollment period, then the new assister or new assister organization, as applicable, must obtain a new authorization from the consumer before assisting that consumer.



**Health Insurance Marketplace
Client Agreement and Authorization**



The following understandings and assurances have been explained to me and I agree to counseling under provisions and guidelines of the Health Insurance Marketplace

Organization Name: _____

Assister Name: _____

- J This program is intended to provide information regarding insurance affordability programs (Marketplace, CHIP, Medicaid, and other health insurance programs) and health options to empower the client(s) to: be informed of viable choices; exercise his/her individual right and protections; and become a pro-active partner in his/her own health care insurance decisions.
- J Services are provided by trained assisters who are acting in good faith, and information given shall not be construed to be legal advice.
- J Assisters do not sell, recommend, or endorse any specific insurance product, agency, or company, nor may they be actively affiliated with an insurance company as a health agent. Any potential conflict of interest will be clearly disclosed to the client.
- J Assisters will seek from the client(s) any and all information necessary to provide comprehensive counseling assistance, and the client(s) acknowledge(s) that the counseling information provided by the ASSISTER will be based upon the accuracy and completeness of the information provided by the client(s).
- J Assisters will use information collected only in pursuit of assisting the client(s) and will not divulge confidential data to external sources other than CMS and the Federally-Facilitated Marketplace (“hub”) in conjunction with counseling or assistance duties.
- J Upon the client’s request, the ASSISTER will assist a client with applications for eligibility determination and enrollment into a Qualified Health Plan, or will provide the client with a referral if eligible for an alternative affordability plan. The decision to enroll in or apply for a specific health care insurance plan is solely the choice of the client. Assistance provided by the ASSISTER will be to follow the application/enrollment instructions and fill in the application/enrollment form with information provided directly by the client(s). Any information provided by the client during the process is assumed to be complete, truthful and accurate
- J Assisters assume no responsibility for decisions made or actions taken by the client(s) and the client agrees to hold harmless _____ and the ASSISTER for any liability arising out of services provided within the program guidelines.

I hereby authorize the program and/or the below named individual, to receive and transmit information as necessary to the Federally-Facilitated Marketplace. Unless restricted below, this authorization shall remain valid for 365 days from the date of signature.

Client has been advised by ASSISTER that tax credit subsidies calculated by the Marketplace website are only estimates. Due to the complexities of applicable tax return information, actual tax credit subsidies awarded may differ. Clients should seek the advice of a tax professional to verify available tax subsidies.

Client Name: _____ Counselor Name: _____

Counselor ID Number: _____

Client Signature: _____ Counselor Signature: _____

Date: _____ Date: _____

Health Insurance Appeals

Marketplace Eligibility Appeals

Marketplace Appeals Center 1-855-231-1751

- Eligible to buy a Marketplace plan
- Enroll outside of Open Enrollment
- Eligible for APTC
- Eligible for Cost Sharing
- Eligible for Medicaid or CHIP
- Exempt from fee for not having insurance

Insurance Company Decision Appeals

(Claim denial, coverage cancellation)

Contact Insurance Company

WVOIC Consumer Services Division

- Internal Appeal- if your claim is denied or your health insurance coverage cancelled, you have the right for an internal appeal.
 - Must file it within 180 days of getting denial notice.
 - Complete all forms your insurance company requires.
 - Submit any other information that you feel is important to evaluating your appeal
 - Once you receive a decision, they process your claim or uphold the denial you will receive instructions to request an external review if it is denied.
- External Review – Your right to have your appeal reviewed by an independent third party.
 - To request an external review, you must receive a denial from the internal review process.
 - The paperwork for an External Review can be found on the WVOIC website.
www.wvinsurance.gov “External Review Request Form” found on the landing page.

If you are not sure of what steps to take you may contact WVOIC Consumer Services Division for assistance at 800-435-7381 or Consumer.Services@wv.gov



Appealing eligibility decisions in the Health Insurance Marketplace

You can appeal these kinds of Marketplace eligibility determinations:

- Whether you're eligible to buy a Marketplace plan.
- Whether you can enroll in a Marketplace plan outside of Open Enrollment.
- Whether you're eligible for an advanced premium tax credit to lower your monthly Marketplace plan premium.
- The amount of savings you're eligible for (sometimes called cost-sharing reductions) when you get services through your Marketplace plan.
- Whether you're eligible for Medicaid or the Children's Health Insurance Program (CHIP) (only if your state allows the Marketplace to determine Medicaid eligibility and if your state allows the Marketplace to consider these appeals).
- Whether you're exempt from having to pay a fee because you don't have health coverage:
 - **Important:** You must request an exemption from the requirement to have health coverage by filing an exemption request with the Marketplace or the IRS (depending on the type of exemption). If the Marketplace denies your request, you can appeal the denial by using the process described below under the heading "How do I file a Marketplace eligibility appeal?" If the IRS denies your request, you must appeal through them.
 - Visit [IRS.gov](https://www.irs.gov) for more information about what to do if you disagree with an IRS exemption denial or want to file an appeal with the IRS. For more information about exemptions, visit [HealthCare.gov/exemptions](https://www.healthcare.gov/exemptions).

Keep copies of all information related to your appeal. This includes paperwork, notes from phone calls, and any other documentation that's sent to you, or that you sent to the Marketplace or the insurance company. Visit [HealthCare.gov](https://www.healthcare.gov) to learn more about Marketplace eligibility decisions.

How do I file a Marketplace eligibility appeal?

You can file a Marketplace eligibility appeal in one of 3 ways:

1. Visit [HealthCare.gov/marketplace-appeals/appeal-forms/](https://www.healthcare.gov/marketplace-appeals/appeal-forms/) and download an appeal request form. Complete the form, then mail to the address on the form.
2. Write a letter to:
Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061
3. Fax your appeal request to our secure fax line: 1-877-369-0129.

What happens after I file a Marketplace eligibility appeal?

After you file an appeal, you'll get a letter that states that the Marketplace got your appeal.

If we accept your appeal, you'll get an acknowledgement letter that describes the next steps in the appeals process and includes instructions for submitting additional material for consideration, if necessary.

While we process your appeal, we may call you, or you may get a letter from us asking for more information or documentation (like a copy of your passport). If you send this information to us, we may be able to informally resolve your case fairly quickly. We'll call you to explain your informal resolution and will then send you a notice in the mail explaining it.

In general, we must tell you our decision and mail our response to you within 90 days of when we received your appeal.

Note: If your appeal isn't accepted because it wasn't filed in a timely manner, you'll get a notice that your appeal was dismissed. If your appeal isn't accepted for any other reason, a company that handles Marketplace appeals will mail you a letter explaining why your appeal wasn't accepted and what you need to do to fix the appeal.

What if my health situation is urgent?

You can ask for an expedited (faster) appeal if the time needed for the standard appeal process would jeopardize your life, health, or your ability to attain, maintain, or regain maximum function.

Write on the appeal request form that you need an expedited appeal and explain why. Your request to expedite your appeal should explain how a standard appeal would jeopardize your life, health, or your ability to attain, maintain, or regain maximum function.

Your request to expedite your appeal will be processed and a decision will be made as quickly as possible.

Getting help with my appeal

There are many resources available to help you with your appeal:

- **Your state's Consumer Assistance Program (CAP)** (where available), Department of Insurance, or other local organizations. Visit LocalHelp.HealthCare.gov to find help in your area.
- **The Marketplace Appeals Center.** You can call them at 1-855-231-1751. TTY users should call 1-855-739-2231.
- **An authorized representative.** You can designate a representative to help you file your appeal. Your authorized representative can file an appeal on your behalf (with your consent) or just help you with your appeal. Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you.

You can designate an authorized representative one of 2 ways:

1. Complete this form:
HealthCare.gov/downloads/marketplace-authorize-appeal-representative-form.pdf.
 2. Submit a written request with your appeal, and mail it to:
Marketplace Appeals Center
P.O. Box 311
Pittston, PA 18640
- If you submit a written request, be sure to include:
 - Your name, address, and phone number
 - Your (case/record/request/file) number
 - A statement appointing someone as your representative
 - The name, address, and phone number of your representative
 - The professional status of your representative or their relationship to you
 - A statement authorizing the release of your personal and identifiable information to your representative
 - A statement explaining why you're being represented
 - Your representative's signature and the date they signed the request

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit <https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice.html>, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users should call 1-855-889-4325.



Appealing Your Insurer's Decision Not To Pay

If your health insurance company ends your coverage or refuses to pay a claim that you filed, you may have the right to appeal the decision and have it reviewed by a third party. Directions for filing an appeal are listed in the information your insurance company sent you when they denied your claim. For prescription drugs, an "exceptions" process is also available. To learn more about the exceptions process, visit <https://marketplace.cms.gov/outreach-and-education/know-your-rights.pdf> to read "Know Your Rights."

Steps for appealing your insurance company's decision

Your plan must notify you of their decision about your claim and explain why you were denied within a set amount of time (based on the type of claim you filed). They also have to let you know how you can appeal their decision. In most cases, you must submit your appeal request in writing.

You can request an urgent internal appeal or an expedited external appeal if the time needed for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function.

1. Request an internal appeal

An internal appeal is the first action you can take. To ask for an internal appeal, you must file it within 180 days (about 6 months) of getting notice that your claim was denied or your coverage was ended. To file an internal appeal you must:

- Complete all forms your health insurance company requires or write to your insurance company with your name, claim number, and health insurance ID number.
- Submit any other information that you want the insurance company to consider when evaluating your appeal, like a letter from your doctor.

Important: You may also file an urgent internal appeal in cases where you would be subject to severe pain that can't be managed without the care requested by a doctor who knows about your condition. Appeals involving urgent care claims can be made by phone to your insurance company.

2. Review your insurance company's decision about your internal appeal

Your insurance company must provide you with a written decision at the end of the internal appeals process. In most cases, if your insurance company still denies you the service or payment for a service, or ends your coverage, you can ask for an external review. Directions for asking for an external review are on the insurance company's final decision letter.

3. Request an external review, if needed

If you decide to ask for an external review, you usually must file a written request within 4 months, but in some cases within 60 days, of the date your insurance company sent you a written decision. The notice your health insurance company sends you should tell you the specific timeframe in which you must make your request. You may appoint a representative (like your doctor or another medical professional) who knows about your medical condition to file an external review on your behalf.

- The information on your “Explanation of Benefits” (EOB) or on the final denial of the internal appeal by your health insurance company will tell you how and where to send your external review request.
- The external reviewer will issue a final decision. An external review either upholds your insurance company’s decision or decides in your favor.
- You may also request an expedited external review if the decision involves a case concerning the admission, availability of care, continued stay, or health care service for which you got emergency services, but haven’t been discharged from a facility.
- Your insurance company can’t delay payment for the service if the decision’s in your favor, even if it intends to seek judicial review or another remedy that may be available in some states.
- Standard external reviews are decided no later than 60 days after the request was received, and in most cases within 45 days.

Insurance companies in all states must participate in an external review process that meets the consumer protection standards of the health care law. Your state may have an external review process that meets or goes beyond these standards. If so, insurance companies in your state will follow your state’s external review processes. If your state doesn’t have an external review process that meets the minimum consumer protection standards, the state’s plans and insurers must choose between one of two options for a federally administered external review. The external review can be conducted by an independent review that’s contracted by the insurance company or by an external review program contractor administered by the Department of Health and Human Services (HHS).

More about urgent and expedited requests

You can file your internal appeal and external review at the same time if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. A final decision about your appeal must come as quickly as your medical condition requires. In most cases this will happen within 72 hours or less, but it won’t take longer than 4 business days.

Getting help with your appeal

There are many resources available to help you with your appeal.

- Visit [HealthCare.gov/appeal-insurance-company-decision/](https://www.healthcare.gov/appeal-insurance-company-decision/).
- Visit [LocalHelp.HealthCare.gov](https://www.localhelp.healthcare.gov) to find help in your area. Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help you, along with other local organizations.
- Call your insurance company's consumer hotline. A list of hotlines is available at [HealthCare.gov](https://www.healthcare.gov).
- Get help and information about appeals and other Marketplace issues in your preferred language at no cost. To talk to an interpreter, call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- Appoint an authorized representative to help you. Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you. This can be done several ways, depending on the type of appeal you're filing. In the case of an urgent care claim, a health care professional with knowledge of your condition may serve as your authorized representative.



How do you appeal a decision?

How you appeal a decision depends on who makes the decision: either your health insurance company or the Marketplace. The chart below lists the decisions you can appeal, who to appeal those decisions to, and the appeals process.

How to appeal a decision by the Marketplace

If you don't agree with...	You can...	File an expedited (faster) appeal if...
<p>One of these kinds of decisions made by the Marketplace:</p> <ul style="list-style-type: none"> ▪ Whether you're eligible to buy a Marketplace plan, including a Catastrophic health insurance plan ▪ Whether you can enroll in a Marketplace plan outside the regular open enrollment period ▪ Whether you're eligible for lower costs based on your income ▪ The amount of savings you're eligible for ▪ Whether you're eligible for Medicaid or the Children's Health Insurance Program (CHIP). Note: contact the Marketplace to confirm where to file a Medicaid or CHIP eligibility appeal; the Marketplace may direct you to file this appeal directly with the state Medicaid or CHIP agency. ▪ Whether you're eligible for certain exemptions from the requirement to have health insurance ▪ Whether the Marketplace made a timely determination about your eligibility after you applied 	<p>File a standard appeal with the Marketplace within 90 days of the date of your final eligibility determination from the Marketplace or if you are appealing a decision about Medicaid eligibility, you can choose to have your appeal heard by the Medicaid agency instead.</p> <p>If your appeal is to the Marketplace, we may contact you to discuss your appeal and agree to an informal resolution. If you do not agree with the outcome of the informal resolution, you can request a hearing. We will provide more information on the process if you request an appeal. At the end of the appeal process, we will mail you our decision as soon as possible.</p> <p>Marketplace appeal decisions are final and binding. But judicial review may be available.</p>	<p>The time needed for the standard appeal process would jeopardize your life, health, or your ability to attain, maintain, or regain maximum function.</p> <p>Your request to expedite your appeal will be processed as quickly as possible.</p>

For more information, go to: www.healthcare.gov/marketplace-appeals/

How to appeal a decision made by your health insurance plan

If you don't agree with...	You can...	File an expedited (faster) appeal if...
<p>One of these kinds of decisions made by your health insurance plan:</p> <ul style="list-style-type: none"> ▪ Refusing to pay a claim for a benefit, (like a health service, treatment, or prescription drug) you believe should be covered in whole or in part based on the terms of your plan ▪ Ending your coverage ▪ Saying you aren't eligible for coverage after you file a claim 	<p>File an appeal with your health insurance plan.</p> <p>Your insurance company must first notify you in writing to explain why they denied coverage. They also must let you know how you can appeal their decision.</p> <p>You have at least 180 days from the time your insurance company notified you in writing of their decision to file an internal coverage appeal.</p> <p>In general, your insurance plan must tell you their decision and mail you their response within:</p> <ul style="list-style-type: none"> ▪ 30 days if your appeal is for a service that you have not yet received ▪ 60 days if your appeal is for a service that has already been rendered <p>If you don't agree with the decision, you may be able to receive an external review by an independent third party.</p>	<p>The time needed for the standard appeal process would jeopardize your life, health, or your ability to attain, maintain, or regain maximum function.</p> <p>You can file an internal appeal and an external review request at the same time.</p> <p>A final decision about your appeal must come as quickly as your medical condition requires, but within no more than 72 hours after your request is received.</p>
<p>One of these kinds of decisions made by your health insurance plan after an internal review conducted by the plan:</p> <ul style="list-style-type: none"> ▪ Any plan's denial of payment for a benefit (like a health service, treatment, or prescription drug) that you think should be covered based on the terms of your plan ▪ Cancellation of coverage, effective back to the date the coverage started (also called a "rescission") <p>Note: If you have an urgent health situation, you can ask for an external review at the same time as your internal appeal.</p>	<p>Request an external review by an independent third party. See your health plan documents for instructions on how to request an external review.</p> <p>You have at least 60 days from the receipt of an adverse benefit determination notice or a final internal adverse benefit determination notice to file a request for external review. Some plans may allow you more than 60 days to file your request. The notice sent to you by your health insurance issuer or health plan should tell you the timeframe in which you must make your request.</p> <p>Standard external reviews are decided within no more than 60 days after the request was received. Some states may require a decision to be made within less than 60 days.</p>	<p>The timeline for the standard external review process would seriously jeopardize your life, health, or ability to regain maximum function.</p> <p>A final decision about your external review request comes as quickly as your medical condition requires, but within no more than 72 hours after your request is received</p>

For more information, go to: www.healthcare.gov/appeal-insurance-company-decision



**The West Virginia Offices of the Insurance Commissioner
Consumer Services Division - Complaint Form**

1. YOUR NAME: _____
2. YOUR ADDRESS/CITY/STATE/ZIP: _____
3. YOUR TELEPHONE # AND/OR FAX #: _____
4. YOUR E-MAIL ADDRESS: _____
5. CLAIMANT'S NAME (if different from you): _____
6. INSURED'S NAME: _____
7. INSURANCE COMPANY AND/OR AGENT: _____
8. OTHER INDIVIDUALS OR ENTITIES INVOLVED: _____
9. TYPE OF COVERAGE: _____ DATE OF LOSS: _____
10. POLICY # (if known): _____ CLAIM # (if known): _____
11. SPECIFIC POLICY LANGUAGE IN QUESTION (if known): _____
12. STATUTORY/RULE PROVISION(S) IN QUESTION (if known): _____
13. REASON FOR COMPLAINT / RELIEF REQUESTED (Please describe the facts and circumstances which form the basis of your complaint. You may attach additional pages if necessary. Please attach copies of any relevant correspondence, policy provisions, etc.): _____

Please note that a complaint filed on behalf of a corporation must be signed by an officer of the corporation. In order for this division to take any action on your complaint, you must sign and date this form, indicating your agreement to the following:

I hereby authorize any insurance company, or their representative, to provide to the Offices of the Insurance Commissioner any documents, claim-related data, or other information necessary for consideration of this complaint, including but not limited to any medical records and/or private or personal information requested.

Signature: _____ Date: _____

Please complete, sign, date and return the original form and any attachments to:

Consumer Service Division
The WV Offices of the Insurance Commissioner
Post Office Box 50540
Charleston, West Virginia 25305-0540
Phone: (304) 558-3386
Toll-free in WV 1-888-TRY-WVIC
Fax: (304) 558-4965
www.wvinsurance.gov

How to File an Insurance Complaint



TRY US, WE CAN HELP!
1-888-TRY-WVIC

consumer.service@wvinsurance.gov
www.wvinsurance.gov



Consumer Service Division
P.O. Box 50540
Charleston, WV 25305-0540

A Message from Our Office

The West Virginia Offices of the Insurance Commissioner received nearly 2,500 insurance related complaints last year. We expect that number to be even higher in years to come as more people realize how serious we are about helping them solve their insurance problems.

We have prepared this publication to make filing an insurance complaint easier for you. It gives a step-by-step explanation of what you can expect from us once you have filed your complaint.

Helping you with your insurance disputes is one of the most important services we provide. We hope the tips we have included here will give you the help you need if you are thinking of filing an insurance complaint.



What The WV Offices of the Insurance Commissioner Can Do For You

- Protect you by enforcing West Virginia laws
- Provide you with consumer information
- Help you with insurance complaints involving:
 - * Sales and policyholder services
 - * Premium rates/refunds
 - * Cancellations/non-renewals
 - * Claim delays/denials
 - * Settlement issues and other insurance related matters

A copy of the complaint form is incorporated in this brochure. You may also obtain a copy of the form by calling the Consumer Service Division at:

1-888-TRY-WVIC

or by downloading a copy from our website at:

www.wvinsurance.gov

How To Complete the Complaint Form

Please complete the Complaint Form with as much information as you have available. You may attach additional sheets as necessary.

It is important that you provide a complete description of the circumstances leading up to the filing of the complaint. If a claim for insurance benefits is involved, whether from your own company or that of another party, please include a detailed statement of the facts. Tell us what happened (who, what, when, and where). If there is a dispute regarding who was at fault, tell us what you think and why.

If you have been in contact with an agent, adjuster or another representative of an insurance company, we will need those phone numbers so we can contact them on your behalf.

The Complaint Form must be signed and dated, providing authorization for us to proceed. A complaint filed on behalf of a corporation must be signed by an officer of the corporation. A complaint filed by legal counsel must be signed by the client. If you have questions about this form, contact The WV Offices of the Insurance Commissioner's Consumer Service Division.

What Should You Send With Your Complaint Form (Send COPIES Only)

- Letters you have written and received from the company or agent
- Letters from other parties relative to the situation
- Your policy or excerpt of benefits
- Relevant sales literature
- Your insurance ID card if possible

The Complaint Process

- Within two weeks of filing, you will receive an acknowledgement letter stating your file number and the name of the complaints specialist in charge of reviewing your complaint.
- The WV Offices of the Insurance Commissioner will send a copy of your complaint to the company or other appropriate parties and ask for an explanation of their position.

- All responses will be reviewed to assure the problem has been properly addressed. This may result in additional communications between specialists, the company or other parties.

Resolution

- The West Virginia Offices of the Insurance Commissioner (WVOIC) will respond in writing with the inquiry results. If no evidence of violation is found, the specialist will advise and explain why the complaint file is being closed.
- If the WVOIC is not satisfied with the company's response, the inquiry will continue.
- If a violation has been found, the WVOIC will pursue administrative action to correct the wrong doing.

Inquiry Status

- An inquiry usually takes about 60 days, depending on the complexity of the case.
- You will be provided periodic status reports to keep you informed.
- If you have any new information regarding the complaint, put it in writing. Include your file number and send it to your specialist.

Please Be Aware

The WVOIC CANNOT give legal advice, act as your lawyer or interfere in a pending lawsuit. The WVOIC CANNOT recommend an insurance company or agent over another, decide disputes based on who is negligent or at fault or decide disputes of medical fact or opinion.

Important Contact Information

General Information and Consumer Complaints
1-888-TRY-WVIC
304-558-3386

Telephone
1-800-435-7381
304-558-1296

FAX
304-558-4965

Email
consumer.service@wvinsurance.gov

www.wvinsurance.gov

MARKETPLACE ASSISTER TOOLKIT

The Assister's Roadmap to Resources





The Assister's Roadmap to Resources

Welcome to the Assister's¹ Roadmap to Resources!

The Assister's Roadmap to Resources (the Roadmap) serves as your quick guide to the resources the Centers for Medicare & Medicaid Services (CMS), and our federal partners have developed to help assisters and consumers navigate the Health Insurance Marketplace (Marketplace).

The Roadmap introduces important Marketplace² and other health coverage topics, provides links to helpful resources on those topics, and contains information that assisters “Need to Know” when helping consumers apply for and enroll in Marketplace and other health coverage.

Disclaimer: The information provided in this document is only intended to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance upon which it is based. This document summarizes current policy and operations as of the date it was published. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them and consumers.

What's inside?

- I. How to get the latest information on Marketplace policies and operations from CMS
- II. What coverage options are available to consumers
- III. What you need to know about the Marketplace eligibility and enrollment process to help consumers get coverage
- IV. How to access Marketplace information and resources in other languages



¹ The term “assister” is used in this document to refer to Navigators, certified application counselors (CACs), and Non-Navigator assistance personnel in the Federally-facilitated Marketplace, including State Partnership Marketplaces.

² The term “Marketplace” is used in this document to refer to the Federally-facilitated Marketplace, including State Partnership Marketplaces.



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Chapter I: Assister Resources and Communications

In this chapter you can learn about:

- How to get the latest information from CMS on Marketplace policies and operations
- Which agencies and organizations have resources on the Affordable Care Act
- How to get direct help with supporting consumers

A. How do I get the latest information from CMS on Marketplace policies and operations?

You can stay up-to-date on Marketplace policies and operations, eligibility and enrollment activities, and special announcements from CMS using the resources described below.

The Weekly Assister Newsletter

CMS e-mails the newsletter to assisters once every week. The newsletter provides information about the Affordable Care Act and the Marketplace. Subscribe to the newsletter by e-mailing the listserv ([see](#) listserv instructions below). Once subscribed, you will receive the latest information about Marketplace policies and operations, information from past Assister Webinars, answers to frequently asked questions (FAQs), invitations to upcoming webinars, and outreach resources and assister spotlights that highlight best practices from fellow assisters. Visit the link below to view an archive of past newsletters.

► See an archive of [past newsletters](#).

The Assister Webinar Series

Whether you are a new or returning assister, we encourage you to participate in the Assister Webinar series for additional training opportunities. Webinars cover various Marketplace and health coverage topics so you can help consumers get coverage. You can find the Assister Webinar schedule in the Weekly Assister Newsletter. Newsletter subscribers receive webinar invitations with log-in instructions.

Listserv (Assisterlistserv@cms.hhs.gov)

You can subscribe to the Weekly Assister Newsletter and the Assister Webinar series by e-mailing assisterlistserv@cms.hhs.gov. Include the phrase “add to listserv” in the subject line of your e-mail. Also, provide the e-mail address at which you would like to receive the newsletter and webinar invitations in the body of your e-mail request.

B. Which agencies and organizations have resources on the Affordable Care Act?

Many different federal and state entities play a role in implementing the Marketplace and other provisions of the Affordable Care Act. Non-governmental organizations also provide information and resources on the Affordable Care Act. This section provides information on some of these entities and organizations and links to resources they have made available.



1. CMS Resources

You can use the resources CMS has created while helping consumer's complete eligibility and enrollment activities.

HealthCare.gov

HealthCare.gov is the official website of the Federally-facilitated Marketplace (FFM) where consumers can apply for health coverage, browse plans, and enroll in coverage. HealthCare.gov is also the official website of the Small Business Health Options Program (SHOP) where small businesses can offer health coverage to their employees. The website also offers many resources for you and the consumers you help – it provides information about eligibility for health coverage, the Marketplace application, and how to complete enrollment.

- ▶ Go to [HealthCare.gov](https://www.healthcare.gov) for the Marketplace online application and helpful information about Marketplace eligibility and enrollment (also available in [Spanish](#)).
- ▶ See the [Quick Guide to the Marketplace](#) for an overview of Marketplace eligibility requirements and deadlines (also available in [Spanish](#)).

Marketplace.cms.gov

Marketplace.cms.gov is the official Marketplace information source for assisters and outreach partners. This site provides technical resources, tools, and tips to explain Marketplace concepts and better prepare you to help consumers. On this site, you will find a number of fact sheets, FAQs, PowerPoint presentations, and more on Marketplace policy and operations, and education and outreach. You can also download forms and other documents consumers may need, such as appeal and exemption forms.

- ▶ Go to [Marketplace.cms.gov](https://www.marketplace.cms.gov).

Center for Consumer Information & Insurance Oversight

The Center for Consumer Information & Insurance Oversight (CCIIO) is the center within CMS responsible for implementing many of the health coverage reform provisions under the Affordable Care Act, including the Marketplace and Marketplace consumer assistance programs. Visit CCIIO's website for the latest guidance and fact sheets on providing in-person assistance to consumers, as well as a number of other policies related to the Affordable Care Act.

- ▶ Go to the [CCIIO](https://www.cciio.gov) website.
-

**Registration for
Technical Assistance
Portal (REGTAP)**

REGTAP is an online hub and storage site for CMS sub-regulatory guidance related to the Marketplace and general health reform under the Affordable Care Act. On REGTAP, you can access the latest sub-regulatory guidance on topics like qualified health plans (QHPs), enrollment and eligibility, issuer payments, and the SHOP Marketplace.

- ▶ Register on the [REGTAP](#) website.

CMS zONE

CMS zONE is a social platform to connect and share information among communities. CMS hosts an Online Resource Library for Assisters on CMS zONE. Use this online community group to share materials and resources you have created, access materials other assisters have created, and publicize and learn about webinars and national conferences. You can request access to the Online Resource Library for Assisters through CMS zONE.

- ▶ See instructions on how to join the [Online Resource Library for Assisters](#).

Disclaimer: CMS does not endorse the information and resources provided by the members of the Online Resource Library for Assisters. By administering this online community, CMS does not intend to suggest that it is endorsing the information or resources provided by these organizations over information or resources that might be provided by other organizations.



2. Key Federal Partners

Many different agencies within the Department of Health & Human Services (HHS) and across the federal government are involved in implementing the Affordable Care Act. Inter-departmental and cross-agency collaboration is necessary to ensure consumers get access to affordable, quality health care coverage. Use the links provided below to access resources produced by other agencies. You can use these resources when helping consumers with eligibility and enrollment activities related to Marketplace coverage, Medicaid, Medicare, and other health care coverage programs and initiatives.

Department of Health & Human Services



HHS seeks to improve the health, safety, and well-being of Americans. HHS provides information on the Affordable Care Act and how it increases access to affordable, quality health care coverage for Americans. You can use the resources developed by HHS to support consumers and other stakeholders seeking to enroll in coverage and to help them transition from coverage to care.

- ▶ See [HHS resources related to the Affordable Care Act](#).

CMS-Medicaid



Medicaid is a federal program administered by CMS, a federal agency within HHS. Medicaid.gov is a one-stop shop for federal policy and program information about Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program. On Medicaid.gov, you can find information about Medicaid and CHIP coverage, benefits, and application processes to share with consumers. For information about state Medicaid offices, please see the [State Resources section](#).

- ▶ Go to the [Medicaid](#) website.
- ▶ Medicaid and CHIP eligibility requirements vary by state. Find information about the [Medicaid and CHIP programs in each state](#).
- ▶ Find [information about how the Affordable Care Act affects Medicaid beneficiaries](#).

CMS-Medicare



Medicare is a federal program administered by CMS, a federal agency within HHS. Medicare.gov provides Medicare beneficiaries, family members, and care-givers with the latest information on Medicare enrollment, policies, and benefits. You can refer beneficiaries to Medicare.gov for help with things like choosing a Medicare plan and finding providers.

- ▶ Go to the [Medicare](#) website.
 - ▶ Find information about [how the Affordable Care Act affects Medicare beneficiaries](#).
-



Health Resources and Services Administration



The Health Resources and Services Administration (HRSA), a federal agency within HHS, is committed to improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. HRSA's programs, such as federally-qualified health centers, rural health clinics, and Ryan White HIV/AIDS programs, aim to increase access to health care coverage and services for consumers who are geographically isolated, or economically or medically vulnerable. You can use these resources to learn about HRSA's programs.

- ▶ Go to the [HRSA](#) website.
- ▶ Find information about [how the Affordable Care Act impacts rural and vulnerable populations](#).
- ▶ Find information on some of the [HRSA-funded programs](#).

HHS Office of Minority Health



The Office of Minority Health (OMH), a federal agency within HHS, works to improve the health of racial and ethnic minority populations through the development of health policies and programs that aim to eliminate health disparities. OMH connects minority consumers and communities of color with information about affordable health coverage options.

- ▶ Go to the [OMH](#) website.

The Indian Health Service



The Indian Health Service (IHS), a federal agency within HHS, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to [566 federally recognized tribes](#) in 35 states.

- ▶ Go the [IHS](#) website for more information about the health care services they provide.
- ▶ See the IHS's [Fact Sheets](#) containing general information on the IHS and on specific health care topics concerning American Indian and Alaska Native people.



Internal Revenue Service



The Internal Revenue Service (IRS) is the federal agency responsible for tax collection and tax law enforcement. It provides information about provisions of the Affordable Care Act that impact consumers' federal taxes. The IRS publishes tax bulletins with detailed information on tax law and forms related to Affordable Care Act provisions, such as the Form 8962, Premium Tax Credit, and Form 8965, Health Coverage Exemptions.

- ▶ Go to the [IRS](#) website.
- ▶ Find information about [tax provisions of the Affordable Care Act](#), such as the premium tax credit, exemptions, and fee (also known as the penalty, fine, individual shared responsibility payment, or individual mandate) for not having health coverage.

Department of Labor



The Department of Labor (DOL) provides information about the Affordable Care Act provisions and other consumer protections (e.g., Consolidated Omnibus Budget Reconciliation Act [COBRA] coverage) related to employment-based group health plans for consumers and their families. You can use these resources to help employers, employees, and their families learn more about employment-based health coverage.

- ▶ Go to the [DOL](#) website.
- ▶ Find information about [provisions of the Affordable Care Act related to employers and employees](#).

Veterans Affairs



The Department of Veterans Affairs (VA) provides information about health coverage options available to veterans and their families, and the provisions of the Affordable Care Act that are relevant to this population. Refer consumers to these resources for more information about how the Affordable Care Act impacts veterans.

- ▶ Go to the [VA](#) website.
- ▶ Find information about [provisions of the Affordable Care Act related to veterans and their dependents](#).

Small Business Administration



The Small Business Administration (SBA) is an independent agency of the federal government formed to aid, counsel, assist, and protect the interests of small business concerns. The SBA provides information about the Affordable Care Act, the Marketplace, and regulations that impact self-employed individuals and small businesses. Refer to these resources to help self-employed consumers and/or small business owners explore their health coverage options.

- ▶ Go to the [SBA](#) website.
- ▶ Find information about [provisions of the Affordable Care Act related to small businesses or self-employed individuals](#).



3. State Resources

You can also consult state resources to learn about state-specific assister policies and regulations. Becoming familiar with these resources will help you provide consumers with relevant, state-specific information related to their health care coverage.

State Medicaid Agencies

Each state has a unique Medicaid program. You can visit the state's Medicaid website for accurate and up-to-date information on eligibility for Medicaid and CHIP in a particular state.

- ▶ Locate your [state's Medicaid profile](#).

State-specific Assister Information and Resources

States may have their own assister certification and training requirements. State Departments of Insurance (DOIs) and/or other state agencies may establish these requirements for assisters, and regulate many other aspects of health coverage within a state. Check with your state's DOI (and/or other applicable agency) to see what requirements you must meet to help consumers get health coverage.

- ▶ Find information about your [state's DOI](#).

State Health Insurance Assistance Programs



State Health Insurance Assistance Programs (SHIPs) provide free, in-depth, one-on-one coverage counseling to Medicare beneficiaries, their families, friends, and caregivers. SHIPs operate in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. SHIPs are grant-funded projects of HHS' Administration for Community Living (ACL). You can work with consumers to contact their state's SHIP office if they have questions or concerns about Medicare and other Medicare-related health coverage plans and programs.

- ▶ Click here to find information about [SHIP](#).
-



4. Non-governmental Resources

FamiliesUSA	▶ The FamiliesUSA Enrollment Assister Resource Center website contains webinars, presentations, and other resources.
In the Loop	▶ The In the Loop website provides access to an online community of assisters.
Enroll America	▶ The Enroll America website contains resources on consumer outreach and enrollment.
The Henry J. Kaiser Family Foundation	▶ The Kaiser Family Foundation website contains surveys, state health facts, and studies on national and international health care, as well as explanatory tools and resources on health reform.
Center on Budget and Policy Priorities	▶ The Center on Budget and Policy Priorities health reform website contains research in health policy and resources on Marketplace eligibility and enrollment activities.
The Center for Children and Families of the Georgetown University Health Policy Institute	▶ The Center for Children and Families of the Georgetown University Health Policy Institute website contains information about the Affordable Care Act and other health policy topics.
The Refugee Health Technical Assistance Center	▶ The Refugee Health Technical Assistance Center contains information about health coverage options for refugees and other immigrants.

Disclaimer: While CMS does not endorse the information and resources provided by the outside entities listed above, these entities have created websites with information intended for people helping consumers access coverage through the Marketplace. Other organizations not listed here may also provide information intended for the same audience. By providing these links, CMS does not intend to suggest that it endorses the information provided by these organizations over information provided by other organizations.



C. How can I get direct help?

This section describes support to help you answer specific questions or address issues that may arise when helping consumers with Marketplace eligibility and enrollment activities.

1. Marketplace Call Center

The Marketplace Call Center helps consumers enroll in health coverage and provides frontline support for consumers experiencing Marketplace eligibility or plan selection issues. For example, call center representatives can help consumers reset their HealthCare.gov passwords, walk them through how to select plans, and help triage and properly assign consumer cases dealing with more complex enrollment issues, if appropriate. You should refer consumers to the Marketplace Call Center if they are experiencing problems using HealthCare.gov or need additional help with eligibility and enrollment.

- ▶ [Contact the Marketplace Call Center](#) (contact information in [Spanish](#)).



Things You Should Know

- **Use** this [checklist](#) to help consumers gather the information they need to enroll before contacting the Marketplace Call Center for enrollment assistance.
- **Instruct** consumers who need to call the Marketplace Call Center with enrollment issues to gather as much information about their application as possible before contacting the Marketplace Call Center. Consumers should have their application ID available when they call.

2. The Assister Help Resource Center (AHRC)

The AHRC is a dedicated call center for assisters using the HealthCare.gov platform that provides timely information and solutions for resolving complex application and enrollment issues that assisters may encounter while helping consumers enroll in health insurance coverage through the Marketplace. The AHRC can provide guidance to assisters who are helping consumers with complex issues related to completing the Marketplace application, receiving eligibility determinations and redeterminations, enrollment, re-enrollment, and appeals policy.



- ▶ Then AHRC is intended for complex application and enrollment issues. The Marketplace Call Center will remain the central point of contact for applications and technical system issues. See the [Assister Help Desk Resource Guide](#) for information on when to contact the Marketplace Call Center versus the AHRC.
- ▶ See the [Assister Help Resource Center \(AHRC\) Questions and Answers](#) for more information on the AHRC and how it can help you assist consumers.

3. CMS Navigator Program Project Officers (Navigators only)

If you receive federal Navigator grant funds, you will be assigned a CMS Project Officer (PO). Your PO is the primary point of contact for Navigator program activities and issues, and is responsible for defining programmatic objectives and providing oversight of the Navigator grantee's programmatic performance. In general, your PO can help you by:

1. Providing programmatic assistance.
2. Directing you to helpful resources.
3. Updating you on Marketplace policy and operations.
4. Helping you stay in compliance with grant requirements.

Things You Should Know

Contact your PO for assistance with:

- Consumer issues and troubleshooting
- Questions about how to conduct outreach and education
- Questions about how to work with other organizations in your community
- Questions about the Navigator grant requirements

4. Regional Office Liaisons

CMS has 10 Regional Offices (ROs) located throughout the United States. The CMS ROs are CMS' local presence in your community. ROs are available to serve as a resource for consumers seeking assistance with Medicare, Medicaid, and the Marketplace. They are also available to serve as a resource for you as an assister.

RO's provide Marketplace technical assistance to you via trainings, seminars, and answering your questions. They can also help you set up your own outreach and education events. The RO is particularly interested in learning where and when your outreach and enrollment events are being held, and how they can help support your marketing. RO's can also help you connect with other organizations in your local community, such as state policymakers, advocacy organizations, state Medicaid offices, SHIP offices, and tribal communities. In some cases, ROs may speak at or attend your community events, or ask you to participate in a CMS-sponsored event to provide outreach or enrollment assistance.

You can access ROs directly through the contact list provided in this section or be connected through your assigned PO. The PO and RO for your state often work together and routinely meet with you to provide you with support on outreach and education-related events and planning. Your PO and RO will contact you directly about these meetings and the details of your participation.

- ▶ See a [drop-down menu of the ROs](#).
- ▶ See a [map of each RO by state](#).
- ▶ Find more information about the [ways ROs service your community](#).



5. Certified Application Counselor (CAC) Mailbox (CACs only)

If you are a CAC in a state with an FFM (including states with a State Partnership Marketplace [SPM]), you should direct inquiries regarding the CAC program, consumer issues and troubleshooting, and other assister-related issues to the CAC mailbox. E-mail the CAC mailbox at CACQuestions@cms.hhs.gov.

- ▶ Click here for a number of [resources for CACs in an FFM or SPM](#), including model authorization and CAC certification forms, and the CAC Standard Operating Procedures Manual.



Chapter II: Coverage Options Available to Consumers

There are a number of health care coverage options available to consumers, including:

- Marketplace coverage for individuals
- Medicaid and CHIP coverage
- SHOP Marketplace coverage for small employers and their employees
- Medicare
- Other coverage options such as employer-sponsored coverage, VA benefits, and private health coverage purchased outside the Marketplace

Learn about each coverage option in the sections below.

A. Marketplace Coverage

Most consumers are eligible to buy health coverage through the Marketplace. To be eligible for health coverage through the Marketplace, a consumer:

- Must be a resident of the state served by the Marketplace,
- Must be a U.S. citizen, U.S. national, or be lawfully present, and reasonably expect to be for the entire time they will be enrolled, and
- Cannot be incarcerated (other than incarceration pending disposition of charges).

Note: Generally, if consumers have Medicare coverage, issuers cannot sell individual market Marketplace coverage to them. Go to the [Chapter II, Section C on Medicare](#) for more information about the relationship between Medicare and the Marketplace.

1. When can consumers enroll in coverage through the Marketplace?

Consumers can generally enroll in a QHP through the Marketplace only during the annual **Open Enrollment period**. After the Open Enrollment period ends, you can help consumers who experience certain life changes find out if they qualify for a **special enrollment period** to get coverage through the Marketplace. In most cases, consumers qualify for a special enrollment period in the Marketplace for a 60-day period from the date following certain life events that involve a change in family status (e.g., marriage or birth of a child). In the case of the SHOP Marketplace, most special enrollment periods last for a 30-day period from the date of the life event. If consumers are already enrolled in coverage through the Marketplace when they experience a

Things You Should Know

- **Help** consumers report changes to the Marketplace during and after open enrollment online at HealthCare.gov and through the Marketplace Call Center.
- **Remember** that for some special enrollment periods, consumers can enroll online at HealthCare.gov or over the phone with the Marketplace Call Center, but other special enrollment periods are offered only through the Marketplace Call Center.



certain life event, you can help them find out if they are eligible to change Marketplace plans or add household members to their existing plan. See Chapter III, Section D, [How can I help consumers report life changes to the Marketplace?](#) for more information on reporting life changes to the Marketplace.

Learn the Basics and Find More Information:

- ▶ See a [list of life events](#) that may qualify consumers for a special enrollment period (also available in [Spanish](#)).
- ▶ Go to the [Special Enrollment Period Screener Tool](#), (also available in [Spanish](#)), an easy-to-use tool you can use to help consumers determine whether they may be eligible for a special enrollment period to enroll in coverage through the Marketplace outside the Open Enrollment period. You can also use this tool to help consumers determine if they may be eligible to enroll in Medicaid or CHIP. Remember, this tool is not an application for a special enrollment period; it is just a tool to help consumers understand what they may be eligible for.
- ▶ Find more detailed information on [different special enrollment periods](#).
- ▶ Consumers who qualify for a special enrollment period who sign up for coverage will have different coverage effective dates based on the type of special enrollment period for which they qualify.

QHP Effective Dates for Special Enrollment Period Events

Special Enrollment Period Event	QHP Effective Date
Loss of Minimum Essential Coverage	<ul style="list-style-type: none"> • Plan selection after the loss of coverage: first of the month following QHP selection. • Plan selection in advance of the loss of coverage: first of the month following the loss of coverage.
Marriage	<ul style="list-style-type: none"> • First of the next month following plan selection.
Denial of Medicaid or CHIP	<ul style="list-style-type: none"> • First of the next month following plan selection.
Birth, Adoption, Foster Care	<ul style="list-style-type: none"> • Date of birth, adoption, placement for adoption, or placement in foster care.
Gaining Lawfully Present Status <i>* Note: This special enrollment period does not apply in the SHOP Marketplace.</i>	<ul style="list-style-type: none"> • Plan selection on or before 15th of the month: first of the next month. • Plan selection on or after 16th of the month: first of the month after next.
Current Enrollee Newly Eligible or Ineligible for Premium Tax Credits; Change in Cost-sharing Reductions (CSR) <i>* Note: This special enrollment period does not apply in the SHOP Marketplace.</i>	<ul style="list-style-type: none"> • Plan selection on or before 15th of the month: first of the next month. • Plan selection on or after 16th of the month: first of the month after next.
Moving and Incarceration Release	<ul style="list-style-type: none"> • Plan selection on or before 15th of the month: first of the next month. • Plan selection on or after 16th of the month: first of the month after next.
American Indian or Alaska Native Status	<ul style="list-style-type: none"> • Plan selection on or before 15th of the month: first of the next month. • Plan selection on or after 16th of the month: first of the month after next.



2. What plans are available through the Marketplace?

You should let consumers know that all Marketplace plans have been certified by the Marketplace as QHPs. Other than Marketplace plans providing only dental benefits, all QHPs provide essential health benefits (EHB) (where a dental-only plan is available, some QHPs may omit pediatric dental benefits), follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. A QHP is certified by each Marketplace in which it is sold.

Learn the Basics and Find More Information:

- ▶ Use the [See Plans and Prices Tool](#) , (also available in [Spanish](#)), to help consumers estimate the costs of their health plan premiums and explore potential health plans before completing an eligibility application.
- ▶ See a list of the [10 EHB](#), (also available in [Spanish](#)), that must be covered by all QHPs offered through the Marketplace.

10 Essential Health Benefits



Pediatric Services



Hospitalization



Maternity and Newborn Care



Laboratory Services



Ambulatory Patient Services



Prescription Drugs



Emergency Services



Rehabilitative & Habilitative Services & Devices



Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment



Preventive & Wellness Services & Chronic Disease Management



- ▶ All Marketplace plans (other than dental-only plans) and many other plans must cover certain preventive services without charging consumers cost sharing, including a copayment or coinsurance. This is true even if consumers haven't met their yearly deductible. See lists of preventative services for [adults](#) (also available in [Spanish](#)), [women](#) (also available in [Spanish](#)) and [children](#) (also available in [Spanish](#)) that are available at no additional cost to consumers enrolled in QHPs.
- ▶ There are five categories of Marketplace health coverage: bronze, silver, gold, platinum, and catastrophic. Categories differ based on how consumers and insurers can expect to share in the costs of care; they do not indicate differences in quality of care. Find more information about the different [categories of Marketplace coverage](#) (also available in [Spanish](#)).
- ▶ One of the categories of Marketplace plans—catastrophic plans—may be available through the Marketplace for consumers who are younger than 30 when they enroll or consumers who received a hardship or affordability exemption. Find more information about [catastrophic coverage](#) (also available in [Spanish](#)).
- ▶ There are different types of plans sold through the Marketplace that often vary in network size and other plan features that may be important to consumers. See a [description of the different plan types consumers might find through the Marketplace](#) (also available in [Spanish](#)).
- ▶ Consumers may need help understanding commonly used health coverage terms. See a [glossary of terms](#) to help explain coverage concepts to consumers. This glossary is also included in plan materials and consumers can refer to it when choosing a plan and later when using their coverage.
- ▶ Find information about [how to choose Marketplace coverage](#) (also available in [Spanish](#)).
- ▶ Find information about [using Marketplace coverage](#) (also available in [Spanish](#)).

Things You Should Know

- **Direct** consumers to a plan's Summary of Benefits of Coverage (SBC), available on HealthCare.gov. A plan's SBC is an easy-to-read summary that lets consumers make apples-to-apples comparisons of costs and coverage between health plans. SBCs help consumers compare options based on price, benefits, and other features that may be important to them.
- **Ask** consumers whether they see a provider they would like to continue seeing or take certain prescription drugs they want to continue taking. If yes, help consumers compare plan provider networks and drug formularies.



B. Medicaid and CHIP Coverage

Medicaid and CHIP provide free or low-cost health coverage to millions of Americans, including some low-income individuals, families and children, pregnant women, the elderly, and people with disabilities. Both programs are run jointly by federal and state governments, and details vary between states.

The Affordable Care Act provides states with additional federal funding to expand their Medicaid programs to cover certain adults younger than 65 with income up to 133% of the federal poverty level (FPL). (Because of the way this threshold is calculated, it's effectively 138% FPL.) This means that in states that have opted to expand Medicaid, free or low-cost health coverage is available to individuals with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. However, not all states have expanded their Medicaid program yet. It is important to note that children (18 and younger) are eligible for this public program up to 133% FPL income level or higher in all states.

Consumers can use the Marketplace application to find out if they may qualify for Medicaid and CHIP. In certain states, known as “assessment states,” the Marketplace makes a preliminary assessment of a consumer’s Medicaid or CHIP eligibility, transfers the consumer’s account to the state Medicaid or CHIP agency, and the Medicaid or CHIP agency makes a final determination of the consumer’s Medicaid or CHIP eligibility. In other states, known as “determination states,” the Marketplace may make a final determination of a consumer’s Medicaid or CHIP eligibility.

Learn the Basics and Find More Information:

- ▶ Find information about [Medicaid expansion under the Affordable Care Act](#) (also available in [Spanish](#)) and if the state you work in has expanded its Medicaid program.
- ▶ Find more information about [state Medicaid and CHIP programs](#), including eligibility categories and income limits for consumers in each state.
- ▶ See for a [breakdown of which states are assessment versus determination states](#).
- ▶ Immigrants who are qualified non-citizens and have met the five-year bar are generally eligible for Medicaid or CHIP, if they meet their state’s income eligibility rules. Find more information about [coverage for lawfully present immigrants](#) (also available in [Spanish](#)) and view a presentation about [eligibility for non-citizens in Medicaid and CHIP](#).
- ▶ To qualify for financial assistance through the Marketplace, consumers who have recently been denied Medicaid or CHIP due to immigration status will need to answer the Medicaid block question and indicate they were recently found ineligible for Medicaid or CHIP when they return to the Marketplace and submit an application. Find more information about [answering the Medicaid block question](#) and [applying for coverage after receiving a Medicaid or CHIP denial](#).
- ▶ Find more information about [Medicaid and CHIP coverage](#) (also available in [Spanish](#)).



Things You Should Know

- **Inform** consumers they can apply for and enroll in Medicaid or CHIP any time of year. If they qualify, their coverage can begin immediately. Medicaid coverage may start retroactively for up to three months prior to the month of application, if consumers would have been eligible during the retroactive period had they applied then.
- **Help** consumers cancel their enrollment through the Marketplace with financial assistance if they are determined eligible for Medicaid or CHIP. Marketplace coverage does not end automatically if a consumer is found eligible for Medicaid or CHIP. Explain to consumers that if they don't cancel their enrollment with financial assistance through the Marketplace, they may have to pay back the advance payments of the premium tax credit that they received through the Marketplace for the months they were eligible for Medicaid or CHIP coverage.
- **Be aware** that some limited types of Medicaid coverage pay only for family planning, emergency treatment (Emergency Medicaid), tuberculosis services, or outpatient hospital services. Consumers who are only eligible for this type of Medicaid coverage can apply for more comprehensive coverage through the Marketplace and may also qualify for financial assistance paying for their Marketplace coverage. If you are helping consumers with limited Medicaid coverage fill out a Marketplace application, and they are asked whether they have coverage now, they should not check the box saying they have Medicaid.
- **Know** that some consumers who applied for coverage through the Marketplace during open enrollment (or during a special enrollment period) and were assessed as Medicaid eligible by the Marketplace, may have later been denied Medicaid coverage by the state after open enrollment ended (or after the 60-day window to enroll during a special enrollment period expired). When consumers in this situation return to the Marketplace to purchase a QHP they have the option of selecting coverage effective retroactively to the date they first applied for coverage. If they choose retroactive coverage, they will be responsible for premium payments for the preceding months.



C. Small Business Health Options Program (SHOP) Marketplace

The Federally-facilitated SHOP Marketplace helps eligible small employers (employers with from 1 to 50 full-time and full-time equivalent employees [FTEs] for plan years beginning before 2016, and 1 to 100 thereafter, who meet all SHOP eligibility requirements) provide health coverage to their employees. You can help small employers and persons offered coverage by eligible small employers apply for and enroll in health coverage through the SHOP Marketplace online at HealthCare.gov. You can help employers who participate choose which coverage to offer and how much they will pay toward premiums. Small employers who purchase coverage through a SHOP Marketplace may qualify for the Small Business Health Care Tax Credit, which can be worth up to 50percent of the employer's contribution toward enrollee premium costs.

Learn the Basics and Find More Information:

- ▶ See an [overview of the SHOP Marketplace](#) (also available in [Spanish](#)) from HealthCare.gov.
- ▶ Listen to a recording of the CMS webinar, [Getting Small Business Health Coverage through the SHOP Marketplace](#).

Resources for you and the employers you help:

- ▶ Find an introduction to [health and dental coverage in the SHOP Marketplace](#) for employers who are interested in enrolling.
- ▶ See the [Assisters Guide to Helping Employers Enroll in SHOP Marketplace Coverage](#), an infographic that outlines the five steps employers have to take to enroll in SHOP Marketplace coverage and explains how you can help them with these steps.
- ▶ See the [SHOP Marketplace Employer Enrollment User Guide](#), which will help you explain the enrollment process to employers interested in offering their employees coverage through the SHOP Marketplace.
- ▶ Find the [FTE Employee Calculator](#) (also available in [Spanish](#)), which you can share with small business owners to help them count the number of full time employees and FTEs they have to see if they may qualify for coverage through the SHOP Marketplace.
- ▶ Find information about the [Small Business Health Care Tax Credit](#) (also available in [Spanish](#)) and use the [Small Business Health Care Tax Credit Estimator](#) (also available in [Spanish](#)) to see whether the employers you work with may qualify for this tax credit. Find more detailed information on the [Small Business Health Care Tax Credit from the IRS](#).



Assisters' Guide to Helping Employers Enroll in SHOP Marketplace Coverage

<p>1 Create Account</p>	<ul style="list-style-type: none">• Create username and password• Create security questions• Complete profile• Verify ID
<p>2 Verify Eligibility</p>	<ul style="list-style-type: none">• Refer employer to list of authorized agents and brokers (optional)• Enter employer and contact information• Enter list of persons who will be offered coverage by the employer• Review and sign eligibility application• Get an eligibility confirmation
<p>3 Create Enrollment Criteria</p>	<ul style="list-style-type: none">• Set enrollment period• Confirm effective date of coverage• Select newly eligible employee waiting period• Decide whether to offer employees a single plan or employee choice• Set employer's premium contribution• Select coverage
<p>4 Enroll Employees</p>	<ul style="list-style-type: none">• Tell employees and others offered coverage about coverage offer• Track employee participation
<p>5 Submit Application</p>	<ul style="list-style-type: none">• Review group enrollment• Sign the SHOP user agreement to confirm information on application is accurate and true to the best of the employer's knowledge• Submit group enrollment• Pay first month's premium



Resources for you and the employees you help:

- ▶ See an [overview of the SHOP Marketplace for employees](#) (also available in [Spanish](#)) and others who receive an offer of coverage through the SHOP Marketplace from an employer.
- ▶ Find a general overview of [how employees and other persons offered coverage enroll through the SHOP Marketplace](#) (also available in [Spanish](#)).
- ▶ See the [SHOP Marketplace Employee Enrollment User Guide](#) for a more comprehensive manual on how to help employees and others who receive an offer of coverage from an employer through the SHOP Marketplace.

Assisters' Guide to Helping Employees and Other Persons Offered Coverage Enroll in SHOP Marketplace coverage



- Create a Marketplace account, or if consumers already have an individual or family Marketplace account, log into the same account for SHOP
- Enter applicant information including name, e-mail address, preferred password, and answers to a few security questions
- Verify e-mail address



- Log into HealthCare.gov
- Select the employee application
- Enter participation codes and Social Security numbers (SSNs) or tax ID numbers, or direct consumers to contact their employer—not the SHOP Marketplace—to get participation codes
- Select VERIFY and add employers to employees' accounts



- Review employer's coverage offer to determine whether to accept or waive offer
- If accepting coverage, enter employee details, such as mailing address and other contact information, add dependents (if dependent coverage is offered)
- If waiving coverage offer, select the reason from the drop down menu, and verify the decision
- Tell employees that they can change their response to accept or waive the coverage offer any time before submitting the application



- If accepting coverage, select one health plan and, if desired, one dental plan (if offered a choice of plans)



- If accepting coverage, review plan selection(s) and cost
- Read the summary of health and dental plan (if offered)
- Confirm plan choice(s)
- Submit the plan selection, get a confirmation, and view enrollment



Things You Should Know

- **Remember** that you, as an FFM assister, are required to help persons offered coverage by an employer through a SHOP (unless you are in a state that has a state-based SHOP-only Marketplace and an individual market FFM). Navigators and non-Navigator assistance personnel are also expected to help all small employers that come to them for assistance, but are not expected to seek out small employers to help, unless that is the community they intend to target. For additional assistance, consumers can contact the FF-SHOP Call Center at 1-800-706-7893 (TTY: 1-800-706-7915), Monday through Friday, 9:00 a.m. to 7:00 p.m. ET.
- **Explain** to small employers that they can complete a new group enrollment through the SHOP any time of year; there is no restricted enrollment period for new group enrollments. However, employees who have an offer of coverage through the SHOP Marketplace will have an Open Enrollment period set by their employer.
- **Inform** small employers that, even though they can complete a new group enrollment in SHOP any time throughout the year, after their group begins participating they can only change what plans they offer to their employees and change their employer contribution amounts when renewing their participation at the end of the group's plan year or by terminating their coverage and starting a new enrollment.
- **Refer** employers to a listing of agents or brokers if they are interested in that type of assistance. Learn more about when and how you can collaborate with and refer consumers to [agents and brokers](#).
- **Remind** persons offered coverage through the SHOP they cannot qualify for financial assistance through the individual Marketplace if they receive an offer of coverage through the SHOP Marketplace (or an offer of employer-sponsored coverage outside of the SHOP Marketplace) that is affordable and meets the minimum value standard.



D. Medicare

Medicare is a federal health coverage program for consumers who are 65 or older and certain people younger than 65 with disabilities. It also covers consumers of any age who have end-stage renal disease. There are different parts of Medicare that cover different services; these parts are commonly referred to as Medicare Parts A, B, C, and D. Medicare Part C, also called Medicare Advantage, includes managed care plans offered by private insurance companies that have contracted with Medicare to provide all the Part A and Part B benefits under a single plan. Most Medicare Advantage plans also provide Part D (prescription drug) coverage, but some do not.

Learn the Basics and Find More Information:

- ▶ Get an [overview of the different parts of the Medicare program](#) and the specific services they cover.
- ▶ Consumers who have Medicare Part A (either on its own or as part of a Medicare Advantage plan) are considered to have minimum essential coverage (MEC) which is required by the Affordable Care Act. However, having Medicare Part B alone does not meet this requirement. Learn more about how Medicare can [satisfy the requirement to have health coverage](#).
- ▶ Some consumers get Medicare Parts A and Part B automatically and some consumers need to sign up. See [when and how to sign up for Medicare Parts A and B](#) to help consumers determine whether they will need to actively sign up for this Medicare coverage.
- ▶ If a consumer is approaching age 65, they are likely approaching their initial enrollment period to sign up for Medicare. For most consumers, this initial enrollment period is seven months long – it starts three months before the month of their 65th birthday, includes the month of their 65th birthday, and ends three months after the month of their 65th birthday. Help consumers who are enrolled in a Marketplace plan and who are approaching Medicare eligibility or are newly eligible for Medicare learn about [changing from the Marketplace to Medicare](#) (also available in [Spanish](#)).

Medicare Initial Enrollment Period



- ▶ If consumers do not sign up for Medicare during their initial enrollment period, they may have to pay a late enrollment penalty for as long as they have Medicare. Learn more about how late enrollment penalties could impact consumers' monthly premium costs for [Part A](#), [Part B](#), and [Part D](#).
- ▶ Every state has a Medicare Savings Program that offers financial assistance to help pay Medicare premiums for those who are eligible, and in some cases, pay Medicare Part A and Medicare Part B deductibles, coinsurance, and copayments. Find information about the [Medicare Savings Program](#).



- ▶ Consumers who meet certain income and resource limits may qualify for help paying prescription drug costs (Part D) under Medicare. Find information about [getting help paying for Medicare prescription drug coverage](#).
- ▶ Some consumers who are eligible for Medicare are also eligible for Medicaid; this is called being a dual eligible. Consumers who have Medicare and full Medicaid coverage will likely have most of their health care costs covered. See the [standards for dual eligibility](#).
- ▶ Some consumers may be interested in purchasing a Medicare Supplement Insurance (Medigap) policy to help pay for additional health care costs and possibly other services original Medicare does not cover. Medigap insurance cannot be purchased through the Marketplace. The best time to buy a Medigap policy is during consumers' six-month Medigap open enrollment period, which begins the first month consumers are both age 65 and enrolled in Medicare Part B. After this enrollment period, they may not be able to buy a Medigap policy, or if they are able to buy one, it may cost more. However, there are several situations, beyond the open enrollment period, during which consumers may have a guaranteed right to buy a Medigap policy. Find more information about on [Medigap plans and the best time to sign up for a Medigap plan](#).
- ▶ Consumers who need help understanding their Medicare enrollment options can get help from their local SHIP. SHIP is a state program that gets funding from the federal government to provide free local health coverage counseling to people with Medicare or who are becoming eligible for Medicare. The name of the program varies in each state. Find contact information for [SHIP in your state](#).
- ▶ See a list of [frequently asked questions about Medicare and the Marketplace](#).
- ▶ See a short YouTube video about [Medicare and the Marketplace](#).

Things You Should Know

- **Explain** to consumers that they may keep their Marketplace plans and their financial assistance until their Medicare coverage begins. Once their Medicare Part A coverage starts, they are no longer eligible to receive financial assistance for their Marketplace plans.
- **Tell** consumers that if they wish to keep their Marketplace coverage after their Medicare Part A coverage starts, they should return to the Marketplace to report they now have access to other MEC. If consumers no longer want to keep their Marketplace coverage once their Medicare Part A coverage starts, they need to return to the Marketplace to terminate their coverage.
- **Inform** consumers who are enrolled in Medicare Part A they cannot purchase health coverage or dental-only plans through the Marketplace after their Medicare coverage starts; in fact, it is against the law for someone who knows a consumer has Medicare to sell them a Marketplace plan that duplicates Medicare benefits.
- **Caution** consumers that if they do not enroll in Medicare during their initial enrollment period, they will only be able to enroll during the Medicare general enrollment period from January 1 to March 31, and their coverage would not start until July of the year they enroll. This may create a gap in coverage and may subject them to a late enrollment penalty premium for as long as they have Medicare. Refer consumers to their state's SHIP office to be sure they get all the information they need to prepare for Medicare enrollment as they approach their 65th birthday.



E. Other Health Coverage Options

As an assister, you should know that consumers may have options for health coverage other than QHPs purchased through the Marketplace. Some options include employer-sponsored coverage, VA benefits, and commercial health plans purchased outside the Marketplace.

Learn the Basics and Find More Information:

- ▶ To avoid owing the fee for not having coverage, tell consumers they must have insurance that qualifies as MEC for each month during the year. Many of the options outside the Marketplace, such as employer-sponsored coverage, Medicare Parts A and C, most Medicaid coverage, and CHIP, among others, qualify as MEC.

Types of Health Coverage that Qualify as MEC

Coverage Type	Does it Qualify as MEC?
Any Marketplace plan, or any individual insurance plan you already have	Yes
Any job-based plan, including retiree plans and COBRA coverage	Yes
Medicare Part A	Yes
Medicare Part C	Yes
Most Medicaid coverage	Yes
Most CHIP coverage	Yes
Most individual health plans bought outside the Marketplace, including grandfathered plans (not all plans sold outside the Marketplace qualify as MEC)	Yes
Coverage under a parent's plan (that qualifies as MEC) for consumers younger than 26	Yes
Self-funded health coverage offered to students by universities for plan or policy years that started on or before December 31, 2014 (check with the university to see if the plan qualifies as MEC)	Yes
Health coverage for Peace Corps volunteers	Yes
Certain types of veterans' health coverage through the VA	Yes
Most TRICARE plans	Yes
Department of Defense Non-appropriated Fund Health Benefits Program	Yes
Refugee Medical Assistance	Yes
State high-risk pools for plan or policy years that started on or before December 31, 2014 (check with the high-risk pool plan to see if it qualifies as MEC)	Yes
Coverage only for vision care or dental care	No
Workers' compensation	No
Coverage only for a specific disease or condition	No
Plans that offer only discounts on medical services	No

*See a more detailed list of [coverage that qualifies as MEC](#).



- ▶ If consumers are eligible for employer-sponsored coverage, they may not be eligible for financial assistance through the Marketplace, unless their employer's offer of coverage does not meet the minimum value standard or is unaffordable. Find information about [employer-sponsored coverage](#) (also available in [Spanish](#)) and learn how to determine whether an employer's offer of coverage meets the [minimum value standard and is affordable](#) (also available in [Spanish](#)).
- ▶ COBRA gives some employees and their families the option to continue receiving health coverage through their employer's plan for a limited time after their employment ends, but COBRA can be costly. Consumers may want to consider buying a plan on the Marketplace instead. Learn more about [COBRA coverage and the Marketplace](#) (also available in [Spanish](#)).
- ▶ Find information about [health coverage options for veterans](#) (also available in [Spanish](#)), including Marketplace plans and veterans' health programs that satisfy the MEC requirement.
- ▶ If you work with consumers younger than 26, inform them they may have multiple options for health coverage, including coverage under a parent's plan, a student health plan for college students, private health coverage through the Marketplace, catastrophic health coverage, or Medicaid coverage. See HealthCare.gov's page on [health coverage for young adults](#) (also available in [Spanish](#)) for more information options for young adults.
- ▶ If you work with consumers with physical, developmental, or intellectual disabilities, tell them that they may be eligible for coverage through Medicare or Medicaid. Find information about [health coverage options for consumers with physical, developmental, or intellectual disabilities](#) (also available in [Spanish](#)).
- ▶ Assisters working with consumers with physical, developmental, or intellectual disabilities should be aware of the accommodations that may be required to effectively communicate with these consumers to ensure they understand their health coverage options and are able to enroll in a plan that best fits their needs and budgets. See a fact sheet on [helping consumers with physical, developmental, or intellectual disabilities](#).

Things You Should Know

- **Inform** consumers who are enrolled in retiree coverage they can buy coverage through the Marketplace but that they will not qualify for financial assistance through the Marketplace. If consumers are eligible for, but not enrolled in, retiree coverage, they may qualify for financial assistance through the Marketplace if otherwise eligible.
- **Tell** consumers who are considering enrolling in COBRA coverage that if they are eligible for COBRA, but not yet enrolled in COBRA, they may still qualify for financial assistance through the Marketplace, if they are otherwise eligible. If consumers are eligible for COBRA and are enrolled in COBRA, they are not eligible for financial assistance through the Marketplace until they exhaust their COBRA coverage.
- **Note** that even if consumers have access to a student health plan, they may be able to buy coverage through the Marketplace instead and may even qualify for financial assistance through the Marketplace. If these consumers would like to apply for Marketplace coverage, they should choose "No" on their Marketplace application when answering whether they currently have health coverage, even if they have a student plan now and plan to drop it to enroll in a Marketplace plan.



Chapter III: The Marketplace Application and Enrollment Process

If consumers decide that Marketplace coverage is right for them, you can help them:

- *Apply for and enroll in Marketplace coverage*
- *Renew their Marketplace coverage each year*
- *Learn about how to file a Marketplace eligibility appeal*
- *Report life changes to the Marketplace*
- *Learn about the federal income tax implications of enrollment decisions*
- *Use their Marketplace coverage*

A. How can I help consumers apply for and enroll in Marketplace coverage?

You can help consumers use the Marketplace to find and enroll in coverage that fits their needs and budget.

1. Application Process

Consumers can use the Marketplace to apply for coverage, compare plans, and enroll in coverage. Consumers can also use the Marketplace to find out if they can get help paying premiums and cost-sharing amounts to reduce their Marketplace coverage costs. They can also apply for free or low-cost coverage through Medicaid and CHIP through the Marketplace application.

When consumers apply for or renew their coverage and want help paying for their coverage, they will need to provide some information about their household, including income, any health coverage they currently have, and some additional information. Help them gather the information they need before they begin their applications. Consumers can apply for health coverage through HealthCare.gov or the Marketplace Call Center on their own, with your in-person help, or with a certified agent or broker. As a trained assister, you can help consumers apply for health coverage online, by phone, or with a paper application.

Things You Should Know

- **Inform** consumers that once they enroll in an individual market Marketplace plan, they must pay their first premium directly to the insurance company—not to the Marketplace. Insurance companies handle payments differently. Consumers should follow the instructions from their insurer about how and when to make their premium payments.
- **Tell** consumers they can terminate a Marketplace plan without replacing it at any time. There are important things to consider before they do this: if they terminate their health coverage without replacing it, they may have a gap in coverage and may have to [pay a fee](#) (also available in [Spanish](#)) for the months they're not covered.



Learn the Basics and Find More Information:

- ▶ Find out what information you should share with consumers about [how to apply and enroll in coverage](#) (also available in [Spanish](#)).
- ▶ See information about the [four ways to apply for Marketplace coverage](#) (also available in [Spanish](#)).

Four Ways to Apply for Marketplace Coverage

	HealthCare.gov (Online)	<ul style="list-style-type: none"> • Visit the Get Coverage page (also available in Spanish) on HealthCare.gov. • Select state of residence • Create a HealthCare.gov account if consumers live in an FFM state • After creating an account, consumers can start a Marketplace application and see their eligibility results online
	Call Center (Phone)	<ul style="list-style-type: none"> • Call 1-800-318-2596 (TTY: 1-855-889-4325), 24 hours a day, seven days a week. The Call Center is closed on certain holidays • Customer representatives are available to help consumers complete an application, review eligibility results, or answer questions about eligibility or enrollment
	In-Person Help	<ul style="list-style-type: none"> • Use the Find Local Help (also available in Spanish) tool to find assisters who can help consumers in-person • Consumers can meet with a Navigator, non-Navigator assistance personnel, or certified application counselors. These assisters can sit with consumers and help them apply online or using a paper application
	Paper Application (Mail)	<ul style="list-style-type: none"> • Fill out a paper application • Send the application to the Marketplace at: Health Insurance Marketplace, Dept. of Health and Human Services 465 Industrial Blvd., London, KY 40750-0001 • Consumers will receive their eligibility results in the mail. They should contact the Call Center or create an online account to enroll in a QHP



- ▶ See information from Marketplace.cms.gov about the [application process](#), including training and consumer-facing outreach materials.
- ▶ See a step-by-step [guide to applying for coverage](#).
- ▶ Find more information about [how to help consumers fill out paper applications](#).

Marketplace Application Checklist



To make the application process quicker and easier, it's helpful for consumers to gather certain information about themselves and their household before they start their Marketplace application or renew their Marketplace coverage. This includes:

- Information about the consumer's household
- Home and/or mailing addresses for everyone applying for coverage
- Information about everyone applying for coverage
- SSNs for everyone on the consumer's application (required for all applicants and the tax filer, if they have one)
- Immigration document information for legal immigrants
- Information on how consumers file their taxes
- Employer and income information for everyone in the consumer's household
- A best estimate of the consumer's household income for the year they will be covered
- Policy numbers for everyone in the consumer's household who currently has a health insurance plan
- Employer information for each member of the consumer's household
- A completed employer coverage tool, if applicable
- Notices from the consumer's current Marketplace plan that contain the plan ID, if applicable

Help consumers understand exactly what information they need to gather using the information in this [checklist](#).



2. Application Troubleshooting

a. IT issues (e.g., browser settings, cookies)

When helping consumers apply online for Marketplace coverage, some web browsers offer a smoother experience than others. You and the consumers you are helping should have browsers set to accept cookies.

Learn the Basics and Find More Information:

- ▶ Learn more about [browser compatibility](#) (also available in [Spanish](#)), including the types of browsers that work best with HealthCare.gov.
- ▶ Find [tips on troubleshooting technical issues](#) (also available in [Spanish](#)) consumers may encounter when applying for and enrolling in Marketplace coverage through HealthCare.gov.

b. Retrieving Username and Resetting Password

If consumers are having trouble logging into their Marketplace accounts, ask them to reset their passwords. If they don't get a password reset e-mail from the Marketplace, they may be using the wrong username. Ask them if they may have used any other usernames to create their account. Consumers should not try to create a new Marketplace account.

Learn the Basics and Find More Information:

- ▶ Find [tips for resetting passwords and unlocking accounts](#) (also available in [Spanish](#)).
- ▶ Find [troubleshooting tips and requirements for Marketplace accounts](#) (also available in [Spanish](#)).

3. Verification of Consumer Information

When consumers apply for coverage, the Marketplace needs to verify their identities and certain information about them. Verification of consumer information is important to protect consumers' privacy and prevent fraud. You should explain to them this verification will also allow the Marketplace to accurately determine their eligibility for enrollment in a QHP and see whether they qualify for financial assistance.

If consumers create a HealthCare.gov account, they will go through identity (ID) proofing. Once consumers complete Marketplace applications, the Marketplace will check their application information against data sources. If their application information cannot be verified, it creates data matching issues (also known as "inconsistencies") in consumers' applications.



Things You Should Know

- **Prepare** consumers to complete ID proofing. They might need to answer questions on topics such as: addresses of current and past places they lived; names of current and past employers; and information about mortgages, credit cards, and/or loans they have.
- **Tell** consumers CMS uses credit reporting agencies like Experian and Equifax to verify their identity and application information, so they may see an inquiry from CMS when checking their credit reports. This CMS inquiry does not affect consumers' credit scores.
- **Tell** consumers whose identities couldn't be verified through HealthCare.gov to resolve their ID proofing issues:
 - Call the Experian Help Desk at 1-866-587-5409 and provide the reference code as shown on the Marketplace application screen.
 - If the Experian Help Desk cannot verify a consumer's identity, the consumer can upload documents showing his/her identity to his/her Marketplace account on HealthCare.gov or mail in documents to the Marketplace.
 - If consumers are *still* having trouble with ID proofing, consumers should contact the Marketplace Call Center and complete the online application with a Marketplace Call Center representative.

a. ID Proofing

ID proofing verifies a consumer's identity and must be completed for consumers to create and submit an online application for coverage. It is one of the first steps in creating a HealthCare.gov account. Make sure consumers know what ID proofing is for, and prepare them to complete ID proofing. Let them know they will need to enter information about their personal and financial history such as their current and past employers and addresses of where they lived and details on any loans they may have. The Marketplace attempts to match this information with information from a credit reporting agency.

Learn the Basics and Find More Information:

- ▶ Find more information about [identity proofing and information inconsistencies](#), including why it is important and what to do if consumers have issues (also available in [Spanish](#)).
- ▶ See [FAQs about ID proofing](#).
- ▶ Consumers who want to learn more about why they need to submit personally identifiable information (PII) and how the Marketplace uses this information should review [How We Use Your Data](#) (also available in [Spanish](#)) and the [Privacy Act Statement](#) (also available in [Spanish](#)) on HealthCare.gov.



b. Data Matching

A data matching issue occurs when particular information consumers enter in their application does not match the data the Marketplace checks in trusted resources, such as Social Security records or IRS databases. Consumers who have data matching issues can still apply for and enroll in coverage, if they are otherwise eligible. However, the Marketplace will ask these consumers to submit documentation to resolve their data matching issues. If they fail to resolve their data-matching issues, they could lose eligibility for Marketplace coverage or experience changes to the amount of financial assistance they receive through the Marketplace. Consumers have 90 days from the date of their eligibility notice to submit documentation to resolve their data matching issues, other than citizenship and immigration status, for which consumers have 95 days to resolve their data matching issues. As the deadline approaches, consumers will get warning notices by mail and a reminder phone call approximately 14 days before their deadline.

Consumers with outstanding citizenship/immigration data matching issues risk having their enrollment through the Marketplace terminated if they do not resolve their data matching issues. If these consumers ultimately submit documentation to the Marketplace and resolve their data matching issues, they can regain their enrollment in coverage through the Marketplace through a special enrollment period. Consumers have 60 days from the date they receive the special enrollment period to select a plan and enroll in coverage.

Consumers enrolling in coverage through this special enrollment period can either request a retroactive effective date of enrollment through the Marketplace that dates back to the day following termination to prevent a gap in the coverage they get through their Marketplace plan, or they can request a prospective effective date.

Learn the Basics and Find More Information:

- ▶ Consumers can have data matching issues for: citizenship, immigration status, SSN, annual household income, incarceration status, an offer of or enrollment in employer-sponsored MEC that is affordable and meets minimum value standards, access to non-employer-sponsored MEC, and unverified American Indian/Alaska Native status. Find instructions on [how to resolve a data-matching issue](#) (also available in [Spanish](#)).
- ▶ Consumers with data matching issues need to submit more information to the Marketplace. You can help them by providing instructions for how to submit their documents. Find information about [how to upload documents](#) (also available in [Spanish](#)) as well as [tips for submitting supporting documents](#) to the Marketplace.
- ▶ See the [Five Things Assisters Should Know about Data Matching Terminations](#), a quick guide to helping consumers with data matching issues.
- ▶ See a presentation that provides [tips to resolve outstanding data matching issues](#).



Data Matching Checklists

Use the checklists below to help consumers **prevent** data matching issues, **confirm** whether they have a data matching issue, and, if they do, **resolve** their data matching issue.

Data Matching Checklists



Help consumers prevent data-matching issues.

- Double check there are no errors or typos in the application.
- Confirm all members of the household applying for coverage have provided accurate SSNs, *if they have one*. Remember: non-applicants (other than the tax filer) are not required to provide their SSNs, but are strongly encouraged to do so if possible.
- Review projected income to make sure it is as accurate as possible and remind consumers to report any changes in income or other application information within 30 days of the change.
- Make sure document types/document numbers/ID numbers are included with immigration documents, as applicable.

Think a consumer may have a data-matching issue? Help them confirm they do.

- Read the full eligibility notice from the Marketplace. If a consumer has a data matching issue, the notice will say, "Send the Marketplace more information." It is important to identify which members of the household have data matching issues that need to be resolved.
- Consumers can also determine whether they have an unresolved data matching issue by checking the *Application Details* sections of their Marketplace accounts for a list of all unresolved inconsistencies.

Confirmed a consumer has a data-matching issue? Help them resolve the issue.

- It may be necessary to submit multiple documents to resolve one data matching issue. For example, consumers who submit birth certificates to prove citizenship will also need to submit an additional document (that has a photograph **or** other information, like their name, age, race, height, weight, eye color, or address): Find out [which documents consumers should submit](#) (also available in [Spanish](#)).
- Remember not every document consumers may want to upload is included in the drop-down menu of *Document Types* viewable after clicking *Verify* in the *Application Details* section of consumers' *My Account*. If consumers need to upload a document that is not listed, they should choose "Other" from the drop-down menu.
- Encourage consumers to upload their documents instead of mailing them. If the document is uploaded successfully, it should show up as *submitted* under *Application Details* right away.
- Ensure that the documents consumers submit electronically are in one of the following formats: .pdf, .jpeg, .jpg, .gif, .xml, .png, .tiff, or .bmp, and are no larger than 10 megabytes.
- Double-check that the file name(s) on consumers' electronic document(s) DOES NOT INCLUDE any of the following: a colon, semicolon, asterisk, or any other special character. Here are a few examples of special characters that cannot be in the file name: / \ : * ? " < > |.
- If consumers do mail in documents, tell them to send copies, not their originals, and to include the barcode from their notice and also include their name, state, and application ID on any documentation they are submitting.
- After submitting documentation, consumers can call the Marketplace Call Center to see if their data matching issue is resolved or whether additional documentation may be required.



c. Providing a Social Security Number (SSN)

Consumers applying for health coverage through the Marketplace must provide an SSN if they have one. Non-applicants are not required to provide their SSNs unless all of the following are true: (1) they have a spouse or tax dependent seeking financial assistance through the Marketplace; (2) the non-applicant is a tax filer; (3) the non-applicant has an SSN; and (4) the non-applicant filed a federal tax return in the previous tax year. You should encourage all applicants to include all of the information they have, including their SSN. Working with consumers to provide as much information as possible increases the chance the Marketplace will verify their citizenship or immigration status, and other information more quickly, and reduces the likelihood that consumers will have to provide additional information later.

- ▶ Refer concerned consumers to [The Facts about the Affordable Care Act and Immigration Enforcement](#) (also available in [Spanish](#)).

Things You Should Know

- **Direct** consumers who want help applying for an SSN to visit SocialSecurity.gov or call 1-800-772-1213 (TTY: 1-800-325-0778). The Marketplace cannot use Individual Taxpayer Identification Numbers (ITINs) to electronically verify income information and should not be entered in place of an SSN on the Marketplace application. Note, however, that an SSN is not required to complete a Marketplace application if you do not have one. SSNs are not required to be provided for household members who are not applying for coverage and who are not the tax filer for the household, or who do not have an SSN. However, providing SSNs even when not required can help match annual household income information with our data sources and avoid data matching issues
- **Reassure** consumers the immigration information they provide the Marketplace will not be used to pursue immigration enforcement action.

4. Immigration Status and the Marketplace

Many immigrants are eligible for health coverage through the Marketplace, or through Medicaid or CHIP. A consumer does not have to be a U.S. citizen or U.S. national to qualify for Medicaid or CHIP, or to enroll in a QHP through the Marketplace. If you are helping consumers who are immigrants enroll in health coverage, you must be aware of federal and state rules that affect these consumers' eligibility for different health care and coverage options.



Immigration Statuses Eligible for Marketplace Coverage

Lawfully Present Immigration Statuses

Statuses eligible for enrollment in a QHP through the Marketplace⁺

- Individual with valid nonimmigrant status (includes worker visas [such as H1, H-2A, H-2B], student visas, U-visa, T-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Aliens whose visa petitions have been approved and who have a pending application for adjustment of status
- Individuals granted employment authorization (*Exception*: Deferred Action for Childhood Arrivals (DACA) (as described in June 2012 Department of Homeland Security [DHS] policy) are not considered lawfully present)
- Temporary Protected Status (TPS)
- Paroled into the U.S.
- Deferred Action Status (*Exception*: DACA [as described in June 2012 DHS policy] are not considered lawfully present)
- Deferred Enforced Departure (DED)
- A child who has a pending application for Special Immigrant Juvenile status
- Granted relief under the Convention Against Torture (CAT)
- Lawful Temporary Resident
- Family Unity beneficiaries
- **All of the Medicaid-eligible statuses listed below**

Medicaid/CHIP-eligible statuses (if 5-year bar is met)*

- Lawful Permanent Resident (LPR/Green Card holder) paroled into the U.S. for 1 year or more
- Battered Spouse, Child, or Parent who has a pending or approved petition with DHS
- Applicants for Victim of Trafficking Visa
- Conditional Entrant (granted before 1980)

Medicaid/CHIP-eligible statuses (5-year bar does not apply)**

- Lawful Permanent Residents who adjusted from a status exempt from the 5-year bar
- Veterans or active duty military, and their spouses or unmarried dependents who also have a “qualified non-citizen” status
- Refugee
- Asylee
- Cuban/Haitian Entrants
- Granted Withholding of Deportation or Withholding of Removal
- Trafficking Survivors and their spouses, children, siblings, or parents
- Member of a federally recognized Indian tribe or American Indian Born in Canada
- Amerasian Immigrants
- Iraqi and Afghani Special Immigrants

For more lawfully present immigration statuses, visit: www.healthcare.gov/immigrants/immigration-status/

⁺Children and/or pregnant women with listed statuses may be eligible for Medicaid or CHIP in certain states. For more information, visit: www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/lawfully-residing.html.

* Indicates lawfully present immigration statuses that are considered qualified non-citizen statuses for purposes of Medicaid and CHIP eligibility.

** Indicates lawfully present immigration statuses that are considered qualified non-citizen statuses for purposes of Medicaid and CHIP eligibility and that are NOT subject to the Medicaid 5-year bar

This chart represents a summary of complex federal statutes relating to immigration status. As a summary, it does not include all relevant detail. This publication is not a legal document and does not grant rights or impose obligations. It is not intended to take the place of either the written law or regulations.

**Learn the Basics and Find More Information:**

- ▶ Find [more lawfully present immigration statuses](#) (also available in [Spanish](#)) on HealthCare.gov.
- ▶ See an overview of [coverage options for lawfully present immigrants](#) (also available in [Spanish](#)).
- ▶ Find a complete [list of immigration document types](#) (also available in [Spanish](#)), including pictures of what they look like, that consumers can use to verify their immigration status.
- ▶ See a fact sheet on [helping consumers with different immigration statuses](#) navigate their health coverage options.
- ▶ Find [tips for helping non-citizens apply for Marketplace coverage](#) (also available in [Spanish](#)).
- ▶ See the [Dos and Don'ts for providing non-discriminatory, culturally, and linguistically appropriate services](#).

Things You Should Know

- **Explain** to immigrant applicants that information provided by applicants or beneficiaries will not be used for immigration enforcement purposes.
- **Recognize** that many immigrant families are of mixed status, with members having different immigration and citizenship statuses. Different family members could be eligible for different health coverage options, and you may need to help family members apply for different health coverage.
- **Encourage** applicants to fill out as many of the fields in the application as possible, such as their SSN and all information related to their immigration documentation, if they have it, to expedite the application process.
- **Remind** immigrant applicants that enrolling in Medicaid or CHIP, or getting financial assistance through the Marketplace, does not make them a public charge. This means it will not affect their chances of becoming a lawful permanent resident or U.S. citizen.
- **Remember** that consumers with income less than 100% FPL who are lawfully present but ineligible for Medicaid due to immigration status may be eligible for financial assistance through the Marketplace, if otherwise eligible.



5. Health Coverage for American Indians and Alaska Natives

There are a number of provisions in the Affordable Care Act aimed at helping make health coverage more affordable and accessible for American Indians and Alaska Natives that you should be familiar with in your consumer assistance role.

American Indians and Alaska Natives receive special Marketplace protections and benefits. Here are few:

- **Special cost-sharing rules:** American Indians and Alaska Natives who purchase health coverage through the Marketplace and who have incomes between 100% - 300% FPL can enroll in a zero-cost sharing plan. If they have household incomes that are below 100% FPL or higher than 300%FPL, they can enroll in a limited cost-sharing plan.
- **Special enrollment rules:** American Indians and Alaska Natives can enroll in a Marketplace plan at any time, not just during open enrollment. They can also change Marketplace plans up to once a month.
- **An exemption from the requirement to have MEC:** American Indians and Alaska Natives (as defined by section 45A(c)(6) of the Internal Revenue Code) and those eligible for Indian health care services do not have to pay the fee for not having health coverage if they apply for an exemption. While services through the Indian Health Service tribal programs or urban Indian programs are not considered MEC for purposes of fulfilling the Affordable Care Act's requirement to have health insurance, American Indians and Alaska Natives, and other consumers eligible for services through these programs don't have to pay the fee for not having health coverage if they apply for the Indian health coverage exemption from the individual shared responsibility payment.

Learn the Basics and Find More Information:

- ▶ Learn more about these [Marketplace special protections and benefits for American Indians and Alaska Natives](#) (also available in [Spanish](#)).
- ▶ American Indians, Alaska Natives and consumers eligible for Indian health care services can apply for the Indian health coverage exemption in two ways:

1

Filling out a [Marketplace Exemption Application](#) and mailing it to the Marketplace

or

2

Claiming it on [IRS Form 8965](#) when they file their federal income tax return

- ▶ Learn more about the [two ways these consumers can file the Indian health coverage exemption](#) (also available in [Spanish](#)).
- ▶ Learn tips to keep in mind when [working with American Indians and Alaska Natives](#).



Things You Should Know

- **Review** tribal provisions and available health coverage options for consumers who are American Indians or Alaska Natives. Remember that receiving medical care from an Indian health care provider does not satisfy the requirement to have MEC. Therefore, American Indians and Alaska Natives must either:



6. Financial Assistance through the Marketplace

Consumers applying for coverage through the Marketplace may be eligible for financial assistance in the form of advanced payments of the premium tax credit (APTC) to help save on their monthly premiums, and cost-sharing reductions (CSR) to help save on out-of-pocket health care costs. Eligibility for these savings depends on a consumer's household income, family size, and whether they already have access to or are enrolled in certain other forms of MEC. Some consumers seeking financial assistance may also be assessed or determined as Medicaid- or CHIP-eligible by the Marketplace.

Learn the Basics and Find More Information:

- ▶ Consumers who are eligible for MEC outside of the Marketplace (other than individual market coverage available outside of the Marketplace) are generally not eligible for financial assistance through the Marketplace. See [information on MEC](#) (also available in [Spanish](#)) for a list of coverage that counts as MEC. See a more [detailed list](#) of coverage that qualifies as MEC.
- ▶ Consumers who are eligible for, but not enrolled in, COBRA or retiree coverage may still qualify for financial assistance through the Marketplace, if otherwise eligible. Find more information about [COBRA and the Marketplace](#) (also available in [Spanish](#)), and learn about [retiree coverage and the Marketplace](#) (also available in [Spanish](#)).
- ▶ Find information that you can share with consumers about how they may be able to [save on monthly premiums by receiving APTC](#) (also available in [Spanish](#)).
- ▶ Find information you can share with consumers about how they may be able to [save on out-of-pocket costs through CSR](#) (also available in [Spanish](#)). If consumers are eligible for CSR, most can only receive them if they enroll in a silver-level plan.
- ▶ Learn about what is included when [calculating household income](#) (also available in [Spanish](#)), including gross versus net income and how to provide information about modified adjusted gross income (MAGI) when helping consumers who are applying for premium tax credits.



- ▶ Click here for information about how to help consumers with income levels that [qualify for lower costs](#) (also available in [Spanish](#)).
- ▶ Marketplace enrollees must report changes in eligibility information, including income, family size, address, and eligibility for other coverage as soon as possible, within 30 days of the change. These changes may affect their eligibility for financial assistance through the Marketplace. Find information about how to help consumers who are [reporting life changes to the Marketplace](#) (also available in [Spanish](#)). See Chapter III, Section D, [How can I help consumers report life changes to the Marketplace?](#) for more information on reporting life changes to the Marketplace.

Things You Should Know

- **Explain** to consumers who are found eligible for CSR that those CSR are only available if they enroll in silver-level coverage. **(This does not apply to American Indians or Alaska Natives.)**
- **Remind** consumers who are married they must file a joint tax return to be eligible for financial assistance through the Marketplace, unless they are a victim of domestic abuse or spousal abandonment.
- **Tell** married consumers who are victims of domestic abuse or spousal abandonment who want to file a separate tax return they should indicate they are not married on their Marketplace application. This will allow consumers to obtain an eligibility determination that may find them eligible for financial assistance through the Marketplace, if they are otherwise eligible. Note these consumers will not be penalized for representing they are not married on the application.
- **Explain** to consumers who receive financial assistance through the Marketplace they must file a federal income tax return even if their income level would not otherwise require them to file a return. Advise consumers if they don't file a tax return in this instance, their financial assistance will be discontinued in future years.
- **Explain** to consumers that checking the box at the end of the application allows the Marketplace to request updated income information from the IRS. This information helps the Marketplace accurately redetermine eligibility for financial assistance.



B. How can I help consumers with the annual Marketplace coverage renewal and redetermination process?

The Marketplace annually redetermines consumers' eligibility for enrollment in QHPs and for financial assistance through the Marketplace. Coverage through the Marketplace is generally available starting on January 1st of a calendar year (unless, for example, consumers enrolled later in the year through a special enrollment period) and ending on December 31st of that same year. Marketplace issuers must renew coverage for most consumers as long as they continue to pay their premiums. In general, the Marketplace will re-enroll eligible enrollees who don't select a QHP by the last day on which a plan selection may be made for coverage effective January 1st.

Learn the Basics and Find More Information:

- ▶ Find more information about the [2016 FFM redetermination and re-enrollment process](#).
- ▶ See the [2016 Redetermination and Re-enrollment Basics for Assisters](#) guide.

Things You Should Know

- **Encourage** consumers to return to the Marketplace during the Open Enrollment period to update and confirm the information on their application is still accurate. Work with consumers to help them provide updated eligibility information, get an updated eligibility determination, and browse available plans to find the best options for their families.



C. How can I help consumers learn how to appeal a Marketplace eligibility decision?

Consumers who have applied for coverage through the Marketplace will get an eligibility notice explaining what they qualify for. For example, the notice may say they are not eligible to enroll in Marketplace coverage, or they do not qualify for coverage through Medicaid or CHIP. If they disagree with the determination in the notice, you should let them know they may be able to appeal that determination. Consumers have 90 days from the date they receive their eligibility notice to start an appeal. As an assister, you can help them understand this process.

Walk consumers through the following steps for filing a Marketplace Appeal:

Steps for Filing a Marketplace Appeal



Review
eligibility notice

Don't agree? Consumers have 90 days to start an appeal.



Mail or fax
appeal request
form or letter

Get the [Form](#).



Resolve
appeals
informally

The Marketplace Appeals Center will contact consumers.



Request
a hearing

Request a hearing if consumers can't resolve their appeals informally.

Learn the Basics and Find More Information:

- ▶ See [what Marketplace decisions can be appealed](#) (also available in [Spanish](#)).
- ▶ Consumers can submit an appeal request by mailing in an appeal request form, mailing in an appeal request letter, or faxing in one or the other. See the [different ways in which consumers can send in an appeal request](#) (also available in [Spanish](#)).
- ▶ Find [Appeal Request Forms](#) that apply for the consumer's state (also available in [Spanish](#)).
- ▶ Consumers can file a request for an expedited appeal if the time needed for the standard appeal process would jeopardize the consumer's life, health, or their ability to attain, maintain, or regain maximum function. Find out [how to file an expedited appeal for urgent appeals](#) (also available in [Spanish](#)).

Things You Should Know

- **Help** consumers review their eligibility notices to see if they should file an appeal through the Marketplace or with their state Medicaid or CHIP agency, which depends on their state and eligibility result.
- **Encourage** consumers to include a copy of their eligibility notice when they file an appeal.
- **Help** consumers learn how to request an urgent appeal if the time needed for the standard appeal process would jeopardize the consumer's life, health, or ability to attain, maintain, or regain maximum function.



- ▶ If a consumer wants an [authorized representative](#) (also available in [Spanish](#)) to be able to ask for the appeal on behalf of the consumer and/or to speak for them in the appeal, they should be sure to complete, sign, and send the [Designation of Authorized Representative form](#) to the Marketplace with their appeal request. See a fact sheet about [Marketplace appeals and health plan appeals](#).
- ▶ Find information about [appealing SHOP Marketplace decisions](#).

Getting Help with Appeals:

- ▶ Visit the [HealthCare.gov page on appeals](#) (also available in [Spanish](#)).
- ▶ Call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 711.
- ▶ Get [help filing a Marketplace eligibility appeal](#) (also available in [Spanish](#)).



D. How can I help consumers report life changes to the Marketplace?

Once consumers have Marketplace coverage, they must report changes to their eligibility information, including income, family size, address, and health coverage eligibility within 30 days. You can help consumers report these changes and advise them that any updates they make may change the coverage or savings for which they are eligible. The updates they make may qualify them for a special enrollment period to change plans or add new members to their current plan.

Three Ways to Report a Life Change to the Marketplace

**To report changes on the phone, consumers should:**

1. Call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325)
2. Talk to a customer representative and detail the particular life change

**To report change online, consumers should:**

1. Log in to their Marketplace account and select their current application
2. Go to the menu on the left and select the “Report Life Change” button
3. Update their application with changes to income, household members, and other information and complete all the steps to complete the updating process

**To report a change in-person, consumers should:**

1. Use the Find Local Help tool to find assisters in their area
2. Contact the assister or assister organization to set up an appointment or simply walk-in for an appointment
3. Update their application with changes to income, household members, and other information and complete all the steps to complete the updating process, or call the Marketplace Call Center to report the life change

Note: Consumers should not report changes via mail.

Learn the Basics and Find More Information:

- ▶ See a [list of changes that should be reported](#) to the Marketplace (also available in [Spanish](#)).
- ▶ Find instructions about [how to report changes to the Marketplace](#) (also available in [Spanish](#)).
- ▶ Certain life changes may qualify consumers for a special enrollment period that allows them to enroll in a plan, change plans, or add new members to their plan outside the Open Enrollment period. See Chapter II, Section A, [When Can Consumers Enroll in Coverage through the Marketplace](#) for more information on special enrollment periods.
- ▶ See a detailed presentation about [helping consumers report a life event or change in circumstance after the Open Enrollment period](#), which explains the types of changes that may qualify consumers for a special enrollment period.



- ▶ When consumers experience certain life changes and report the change to the Marketplace, they may have different coverage options. Find more information about consumers' [options to select different Marketplace coverage, cancel or terminate Marketplace coverage, and report changes to the Marketplace](#) (also available in [Spanish](#)).
- ▶ Learn the steps to help consumers [cancel their Marketplace coverage](#) (also available in [Spanish](#)).

Things You Should Know

- **Instruct** consumers not to mail written requests for reporting life changes to the Marketplace. Consumers should report life changes either online or through the Marketplace Call Center. If consumers have already mailed a written life change request, you should instruct them to contact the Marketplace Call Center or go online to their account to report the change.
- **Remind** consumers they usually have 60 days from the date of the qualifying event to enroll in a plan or change their plan during a special enrollment period, if they qualify for one.
- **Remember** that consumers can terminate their Marketplace plan at any time if they get health coverage outside the Marketplace—like from a job-based plan or a program such as Medicare, Medicaid, or CHIP.



E. How can I help consumers learn about the tax implications of enrollment decisions?

1. Tax Forms to Report Having Health Coverage or Report an Exemption from Health Coverage

Consumers or anyone in their household enrolled in Marketplace coverage will receive one or more Forms 1095-A from the Marketplace; these contain important health coverage information consumers will use when filing their federal tax returns. Consumers may also have to complete one or two new tax forms, including IRS Form 8962 (Premium Tax Credit) or Form 8965 (Health Coverage Exemptions) and use the second lowest silver plan and lowest cost bronze plan tax tools on HealthCare.gov to reconcile any APTC received, or report an exemption to complete their federal tax returns. To avoid paying a Shared Responsibility Payment for not having coverage, consumers must report on their federal income tax returns that they were enrolled in MEC during the entire tax year or were eligible for an exemption for any months they were not enrolled in MEC. Your role as an assister is to help consumers understand what they will receive and why, and to tell consumers where to go for more information and support from the Marketplace or IRS.

Learn the Basics and Find More Information:

- ▶ Understanding how health coverage affects taxes can be difficult. See a simple [IRS chart that illustrates how health coverage affects taxes](#) in various scenarios, and an [IRS publication detailing how health coverage affects taxes](#).
- ▶ Consumers must now report whether they were enrolled in minimum essential coverage or were eligible for an exemption when filing their federal income tax returns. Consumers may have to complete additional tax forms, such as IRS Form 8962 to reconcile APTC received from the Marketplace, or 8965 to report an exemption. Find information to share with consumers about [how health coverage affects tax returns](#) (also available in [Spanish](#)).
- ▶ Go to the [IRS page on the Affordable Care Act](#) for IRS tax forms, including Forms [8962](#) and [8965](#), and answers to tax-related questions, tax filing assistance, and information about the Shared Responsibility Payment for not having coverage. Note: the IRS tax forms and their instructions may be updated in advance of a tax filing season, be sure you are accessing the correct forms and instructions for the correct tax year.
- ▶ Consumers enrolled in coverage through the Marketplace will receive Form 1095-A from the Marketplace. This form includes important information consumers will use when filing their tax returns. Find [information about Form 1095-A](#). (also available in [Spanish](#)).
- ▶ See the [Cover Page of Form 1095-A](#) (also available in [Spanish](#)), which includes helpful information that you can explain to help consumers accurately complete IRS Form 8962.
- ▶ Find the [instructions for using Form 1095-A](#) (also available in [Spanish](#)).
- ▶ Be prepared to answer [frequently asked questions from consumers about Form 1095-A](#) (also available in [Spanish](#)).
- ▶ Go to the [HealthCare.gov page about taxes](#) or contact the Marketplace Call Center for additional information on Form 1095-A and how provisions of the Affordable Care Act affects consumers' taxes.



- ▶ Find a useful fact sheet, [No Coverage? What That Means for Your Taxes](#) (also available in [Spanish](#)).
- ▶ Consumers may need information about either the premium for the lowest cost bronze plan, or the second lowest cost silver plan in their area when filing their tax return. Direct consumers to the [two tax tools](#) on HealthCare.gov (also available in [Spanish](#)) that can help them calculate these amounts. This information is used to determine eligibility for the affordability exemption and eligibility for financial assistance from the Marketplace.
- ▶ There are numerous resources for you and other assisters to help consumers understand the impacts of health coverage on their taxes. See the [Online Catalog of Tax Resources for Assisters](#).

Things You Should Know

- Consumers should report changes in eligibility information, including income, family size, address, and eligibility for other coverage to the Marketplace within 30 days as these changes may affect their eligibility for financial assistance from the Marketplace, such as APTC, which may affect their tax returns.
- Consumers enrolled in Marketplace coverage should wait to receive Form(s) 1095-A from the Marketplace before filing their tax returns.
- Consumers who received financial assistance in the form of APTC through the Marketplace should file Form 8962 and attach it to their tax return even if their income would not otherwise require them to file a tax return.
- Consumers who don't enroll in coverage may owe the Shared Responsibility Payment for not having coverage unless they qualify for an exemption. If consumers obtained health coverage outside the Marketplace, they must still report whether they had coverage or were eligible for an exemption when filing their tax returns.
- If consumers have questions specifically about IRS tax forms or filing their federal income tax returns, you should direct them to either the IRS or a tax professional for assistance.



2. Applying for an Exemption from the Requirement to Have Coverage

Consumers must have qualifying health coverage (also known as MEC), obtain an exemption, or pay a Shared Responsibility Payment. If consumers qualify for an exemption, they don't have to pay the Shared Responsibility Payment for each month they qualify for an exemption. There are different kinds of exemptions. How consumers get an exemption depends on the type of exemption. Consumers can obtain some exemptions only from the Marketplace while others they may claim when they file their tax returns, both types of exemptions are reported on IRS Form 8965 when filing a tax return.

Categories of Health Coverage Exemptions

				
Income-related exemptions	Health coverage-related exemptions	Group membership exemptions	Hardship exemptions	Other exemptions
<i>Examples include having an income below the tax filing threshold or not having access to affordable coverage</i>	<i>Examples include being uninsured for less than three consecutive months or living in a state that didn't expand Medicaid and the consumer had household income below 138% of FPL</i>	<i>Examples include being a member of a federally recognized tribe, or member of a health care sharing ministry</i>	<i>Examples include facing an eviction or foreclosure, the death of a close family member, filing for bankruptcy, or experiencing domestic violence</i>	<i>Examples include being incarcerated or living abroad</i>

Learn the Basics and Find More Information:

- ▶ Start by using the [Exemptions Screener Tool](#) (also available in [Spanish](#)) to help determine what exemptions a consumer might be eligible for.
- ▶ Make clear to consumers who were not enrolled in health coverage during the year that they may owe the Shared Responsibility Payment for not having coverage for any month that they or their dependents do not qualify for an exemption. See a [full list of all types of available exemptions](#), and whether they must be: a) granted by the Marketplace, b) claimed on a consumer's tax return, or c) either granted by the Marketplace or claimed on a tax return.
- ▶ If the Marketplace is responsible for granting a coverage exemption, it will send consumers notices with their exemption eligibility results. If a consumer qualifies for an exemption, the notice will include the consumer's unique Exemption Certificate Number (ECN). Consumers use their ECN to complete [IRS Form 8965 - Health Coverage Exemptions](#).



Things You Should Know

- **Be aware** that hardship exemptions usually cover the month before the hardship, the month(s) of the hardship, and the month after the hardship. In some cases, the Marketplace may provide the exemption for additional months, including up to a full calendar year.
- **Let** consumers who qualify for a hardship exemption know that they can (but don't have to) buy a catastrophic plan no matter how old they are or what their household income is. To buy catastrophic coverage with a hardship, consumers need to provide their ECNs to the insurance company selling the plan.
- **Tell** consumers who don't agree with a decision about their exemption that they can appeal that decision.
- **Inform** consumers that if they do not apply for an exemption but are without coverage for part of the year, 1/12 of the yearly fee applies to each month the consumer is uninsured, unless the consumer is uninsured for less than three consecutive months of the year.



F. How can I help consumers use their coverage?

Once consumers have coverage, it is important they know how to use it. As an assister, you can help. HHS has an initiative called Coverage to Care (C2C), which helps consumers understand their coverage and connect to the care they need. By educating consumers about their coverage, empowering them with the tools they need to be able to use it, and making the health care system easier to navigate, the C2C initiative aims to reduce health care costs and improve health outcomes.

Learn the Basics and Find More Information:

- ▶ See the [C2C materials](#) available at Marketplace.cms.gov.
- ▶ See the [Roadmap to Better Care and a Healthier You](#) (available in multiple languages), which lays out a path for newly covered consumers to get care and explains the basics of health coverage and how to select a provider.

Using Coverage Checklist

Selecting a Provider and Scheduling an Appointment

Many consumers who are newly covered may be insured for the first time and might not know how to find a provider in their service area or make an appointment. To help consumers find a provider and schedule an appointment:

- Review the plan's Provider Directory.
- Identify available providers based on geography or patient preferences.
- Help consumers get ready to call providers to schedule an appointment. Consumers may have to provide information from their insurance card (company, product, ID or group number) when they call a provider. See pages 24-25 of the [C2C Roadmap](#) for more details about what information consumers may need when scheduling an appointment.
- Remind patients to ask their plan if they need prior authorization before they visit their provider. If patients need but don't get preauthorization, they may be charged for services their health plan would have paid for otherwise.
- Remind patients to ask about the costs of their appointment (i.e., copayments or coinsurance) and the types of payments that are accepted.
- Once an appointment has been scheduled, remind the patient to bring their health insurance card and appropriate identification to the appointment.

If any problems should arise, consumers should contact their health insurance company directly.

- ▶ See the [Enrollment Toolkit](#), which is available to help you educate consumers about why they need to sign up for coverage, what they should know before enrolling and choosing a plan, and what they should do after they receive coverage. The Enrollment Toolkit also has helpful tips about how you can help specific populations, such as immigrants, and American Indians and Alaska Natives.



- ▶ Find a [guide to discussions with consumers](#) that offers ways you can personalize your conversations with consumers, as well as suggested questions you can ask them, and other helpful tips for interacting with consumers in the Marketplace.
- ▶ Watch a [training video](#) that will walk you through the discussions that you should have with consumers during eligibility and enrollment activities.

Things You Should Know

- **Order** free C2C materials and have them shipped directly to you at no cost, so you can refer to them and share them with consumers. Find more information about [ordering C2C materials](#).
- **Remember** that C2C materials and resources are available in additional languages, including Spanish, Arabic, Chinese, Haitian Creole, Korean, Russian, Vietnamese, as well as tribal versions.



Chapter IV: Information in Other Languages

The Marketplace provides numerous resources in other languages to assist non-English speaking individuals. This chapter describes which resources are available and where they can be accessed.

A. How do I access information and materials in other languages?

There are a number of ways to access information and materials in other languages:

- Find resources in other languages developed by CMS.
- Go to CuidadoDeSalud.gov for the Spanish version of HealthCare.gov.
- Use Find Local Help to [find support in non-English languages](#).
- Find resources in other languages in the Online Resource Library for Assisters.

The sections below provide details about accessing information and materials in other languages from each of these sources.

Things You Should Know

- **Understand [your assister duties related to language access](#).** As Navigators and non-Navigator assistance personnel, you must provide services that are culturally and linguistically appropriate to the consumers you are helping, including consumers with limited English proficiency. CACs are not required, but are encouraged, to provide translation and other language access services. If a CAC cannot assist a consumer with limited English proficiency, the CAC should refer the consumer to a local Navigator, non-Navigator assistance personnel, or the Marketplace Call Center.

1. CMS-Developed Resources in Other Languages

CMS has produced resources in multiple languages to ensure all consumers, including non-English speaking consumers, have access to information about the Marketplace, Medicare, and Medicaid. CMS' Office of Minority Health has compiled an index of these resources.

Learn the Basics and Find More Information:

- ▶ Use this Index of [CMS Resources by Language](#) to find resources in English and non-English languages.

2. Marketplace Call Center (Hotline and Interpreter Information)

If consumers speak languages other than English and would like to get personal assistance in another language free of charge, they can contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). The Marketplace Call Center is available 24 hours a day, seven days a week.



Steps to Connect to a Marketplace Call Center Interpreter

Step 1

When consumers contact the Marketplace Call Center, they will initially be given the language options of English or Spanish via automated prompt. Consumers who speak a language other than English or Spanish can request to connect to a representative for assistance at any time.

Step 2

The representative will first try to determine what language is being spoken by asking the consumer what language he or she speaks, or by seeking assistance from another member of the consumer's household.

Step 3

Once the representative identifies the consumer's language, the consumer will be connected to the language line for assistance from an interpreter.

Step 4

On subsequent calls, the system will recognize the language preference set on the initial call, so if the consumer contacts the Marketplace Call Center again, the call will then be automatically connected to a representative who will initiate a language line conference by connecting the consumer to an interpreter/language line operator.

3. CuidadoDeSalud.gov

Consumers can be directed to the Spanish version of the Marketplace website, CuidadoDeSalud.gov, for the Spanish version of the application, as well as information about the Marketplace in Spanish.

▶ Go to [CuidadoDeSalud.gov](https://www.CuidadoDeSalud.gov).

4. Find Local Help

A search result of assisters on Find Local Help may include assisters who provide application and enrollment assistance in languages other than English. Select the Show Details section to see if an assister provides non-English speaking assistance and has indicated it on Find Local Help.

▶ Search [Find Local Help](#) (also available in [Spanish](#)).

5. The Online Resource Library for Assisters

CMS hosts an Online Resource Library for Assisters on CMS zONE. You can use this online community group to share materials and resources you have created or to access materials other assisters have created, both in English and [in other languages](#).

▶ Find out how to join the [Online Resource Library for Assisters](#).

Disclaimer: CMS does not endorse the information and resources provided by the members of the Online Resource Library for Assisters. By administering this online community, CMS does not intend to suggest that it is endorsing the information or resources provided by these organizations over information or resources that might be provided by other organizations.



Appendix: Links Referenced in the Assisters' Roadmap to Resources

CHAPTER I. ASSISTER RESOURCES AND COMMUNICATIONS

A. How do I get the latest information from CMS on Marketplace policies and operations?

1. Weekly Assister Newsletter

- Archive of past Weekly Assister Newsletters: <https://marketplace.cms.gov/technical-assistance-resources/assister-newsletters.html>

2. Weekly Assister Webinar

- N/A.

3. Listserv (ASSISTERLISTSERV@cms.hhs.gov)

- Assister listserv: ASSISTERLISTSERV@cms.hhs.gov

Note: Write “Add to listserv” in the subject line, and include the e-mail address that you would like to add in the body of your e-mail.

B. Which agencies and organizations have resources on the Affordable Care Act?

1. CMS

- HealthCare.gov: <https://www.healthcare.gov/>
- HealthCare.gov (Spanish version): <https://www.cuidadodesalud.gov/es/>
- Quick Guide to the Marketplace: <https://www.healthcare.gov/quick-guide/>
- Quick Guide to the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/quick-guide/>
- Marketplace.cms.gov: <https://marketplace.cms.gov/>
- CCIIO website: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html>
- REGTAP: <https://www.regtap.info/>
- CMS zONE Online Resource Library for Assisters: <https://marketplace.cms.gov/technical-assistance-resources/join-resource-library.PDF>

Disclaimer: CMS does not endorse the information and resources provided by the members of the Online Resource Library for Assisters. By administering this online community, CMS does not intend to suggest that it is endorsing the information or resources provided by these organizations over information or resources that might be provided by other organizations.

2. Key Federal Partners

- HHS resources related to the Affordable Care Act: <http://www.HHS.gov/healthcare/>
- Medicaid website: <http://www.medicaid.gov/>
- Medicaid and CHIP programs by state: <http://medicaid.gov/medicaid-chip-program-information/by-state/by-state.html>
- How the Affordable Care Act Affects Medicaid Beneficiaries: <http://www.medicaid.gov/affordablecareact/affordable-care-act.html/>
- Medicare website: <http://www.medicare.gov/>
- How the Affordable Care Act Affects Medicare Beneficiaries: <http://www.medicare.gov/about-us/affordable-care-act/affordable-care-act.html>
- HRSA website: <http://www.hrsa.gov/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- How the Affordable Care Act Impacts Rural and Vulnerable Populations: <http://www.hrsa.gov/affordablecareact>
- HRSA-funded programs: <http://www.hrsa.gov/gethealthcare/index.html>
- OMH website: <http://minorityhealth.hhs.gov/>
- IHS Tribal Directory: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm>
- IHS website: <http://www.ihs.gov/aboutihs/>
- IHS fact sheets: <http://www.ihs.gov/newsroom/factsheets/>
- IRS website: <http://www.irs.gov/>
- IRS Affordable Care Act: <http://www.irs.gov/Affordable-Care-Act>
- IRS Affordable Care Act (Spanish version): <http://www.irs.gov/Spanish/Disposiciones-Tributarias-de-la-Ley-de-Cuidado-de-Salud-a-Bajo-Precio>
- DOL website: <http://www.dol.gov/>
- DOL Affordable Care Act: <http://www.dol.gov/ebsa/healthreform/consumer.html>
- VA website: <http://www.va.gov/>
- VA Affordable Care Act: <http://www.va.gov/health/aca/>
- SBA website: <https://www.sba.gov/>
- SBA Affordable Care Act: <https://www.sba.gov/healthcare>

3. States

- State Medicaid profiles: <http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html>
- State DOIs: http://www.naic.org/state_web_map.htm
- SHIP centers: <https://www.shiptacenter.org/>

4. Non-governmental Organizations

- Families USA Assisters: <http://familiesusa.org/issues/navigators-assisters%3e>
- Families USA Enrollment Assister Resource Center: <http://familiesusa.org/initiatives/enrollment-assister-resource-center>
- In the Loop: <http://enrollmentloop.org/>
- Enroll America: <http://www.enrollamerica.org/>
- The Kaiser Family Foundation Affordable Care Act: <http://kff.org/health-reform/>
- The Center on Budget and Policy Priorities Affordable Care Act: <http://www.healthreformbeyondthebasics.org>
- The Center for Children and Families Affordable Care Act: <http://ccf.georgetown.edu/aca/>
- Refugee Health Technical Assistance Center: <http://refugeehealthta.org/access-to-care/affordable-care-act/>

Disclaimer: While CMS does not endorse the information and resources provided by the outside entities listed above, these entities have created websites with information intended for people helping consumers access coverage through the Marketplace. Other organizations not listed here may also provide information intended for the same audience. By providing these links, CMS does not intend to suggest that it endorses the information provided by these organizations over information provided by other organizations.

C. How can I get direct help?

1. Marketplace Call Center

- Contact the Marketplace Call Center: <https://www.healthcare.gov/contact-us/>
- Contact the Marketplace Call Center (Spanish version): <https://www.cuidadodesalud.gov/es/contact-us/>
- Checklist: Get Ready to Apply for or Renew Your Health Insurance Marketplace Coverage: <https://marketplace.cms.gov/outreach-and-education/apply-for-or-renew-coverage.pdf>

**2. The Assister Help Resource Center (AHRC)**

- Assister Help Desk Resource Guide: <https://marketplace.cms.gov/technical-assistance-resources/assister-help-desk-guide.pdf>
- Assister Help Resource Center (AHRC) Questions and Answers: <https://marketplace.cms.gov/technical-assistance-resources/ahrc-questions-and-answers.pdf>

3. CMS Navigator Program Project Officers (Navigator Only)

- N/A.

4. Regional Office Liaisons

- Drop-down menu of ROs: <http://www.cms.gov/medicare-coverage-database/staticpages/region-descriptions.aspx>
- Map of ROs by state: <http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/RegionalMap.html>
- Ways ROs Service Your Community: <http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/index.html>

5. Certified Application Counselor (CAC) Mailbox (CACs only)

- CAC mailbox: CACQuestions@cms.hhs.gov
- Resources for CACs: <https://marketplace.cms.gov/technical-assistance-resources/assister-programs/general-information-assister-programs.html>

CHAPTER II. COVERAGE OPTIONS AVAILABLE TO CONSUMERS**A. Marketplace Coverage for Individuals****1. When Can Consumers Enroll in Coverage through the Marketplace?**

- List of life events that may qualify for a special enrollment period: <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>
- List of life events that may qualify for a special enrollment period (Spanish version): <https://www.cuidadodesalud.gov/es/coverage-outside-open-enrollment/special-enrollment-period/>
- Special Enrollment Period Screener Tool: <https://www.healthcare.gov/screener/>
- Special Enrollment Period Screener Tool (Spanish version): <https://www.cuidadodesalud.gov/es/screener/>
- Detailed special enrollment period resources: <https://marketplace.cms.gov/technical-assistance-resources/special-enrollment-periods-.html>

2. What coverage is available through the Marketplace?

- See plans and prices tool: <https://www.healthcare.gov/see-plans/>
- See plans and prices tool (Spanish version): <https://www.cuidadodesalud.gov/see-plans/>
- List of the 10 EHB: <https://www.healthcare.gov/blog/10-health-care-benefits-covered-in-the-health-insurance-marketplace/>
- List of the 10 EHB (Spanish version): <https://www.cuidadodesalud.gov/es/blog/10-health-care-benefits-covered-in-the-health-insurance-marketplace/>
- List of preventive services for adults: <https://www.healthcare.gov/preventive-care-benefits/>
- List of preventive services for adults (Spanish version): <https://www.cuidadodesalud.gov/es/preventive-care-benefits/>
- List of preventive services for women: <https://www.healthcare.gov/preventive-care-benefits/women/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- List of preventive services for women (Spanish version): <https://www.cuidadodesalud.gov/es/preventive-care-benefits/women/>
- List of preventive services for children: <https://www.healthcare.gov/preventive-care-benefits/children/>
- List of preventive services for children (Spanish version): <https://www.cuidadodesalud.gov/es/preventive-care-benefits/children/>
- Categories of Marketplace coverage: <https://www.healthcare.gov/choose-a-plan/plans-categories/>
- Categories of Marketplace coverage (Spanish version): <https://www.cuidadodesalud.gov/es/choose-a-plan/plans-categories/>
- Catastrophic coverage: <https://www.healthcare.gov/choose-a-plan/catastrophic-plans>
- Catastrophic coverage (Spanish version): <https://www.cuidadodesalud.gov/es/choose-a-plan/catastrophic-plans/>
- Description of the different coverage types: <https://www.healthcare.gov/choose-a-plan/plan-types/>
- Description of the different coverage types (Spanish version): <https://www.cuidadodesalud.gov/es/choose-a-plan/plan-types/>
- Glossary of commonly used health coverage terms: <http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf>
- How to choose Marketplace coverage: <https://www.healthcare.gov/choose-a-plan/benefits/>
- How to choose Marketplace coverage (Spanish version): <https://www.cuidadodesalud.gov/es/choose-a-plan/benefits/>
- How to use Marketplace coverage: <https://www.healthcare.gov/using-marketplace-coverage/>
- How to use Marketplace coverage (Spanish version): <https://www.cuidadodesalud.gov/es/using-marketplace-coverage/>

B. Medicaid and CHIP Coverage

- Medicaid expansion under the Affordable Care Act: <https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/>
- Medicaid expansion under the Affordable Care Act (Spanish version): <https://www.cuidadodesalud.gov/es/medicaid-chip/medicaid-expansion-and-you/>
- State Medicaid and CHIP programs: <http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html>
- Assessment versus determination states: <http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/medicaid-chip-marketplace-interactions.html>
- Coverage for lawfully present immigrants: <https://www.healthcare.gov/immigrants/lawfully-present-immigrants/>
- Coverage for lawfully present immigrants (Spanish version): <https://www.cuidadodesalud.gov/es/immigrants/lawfully-present-immigrants/>
- Eligibility for non-citizens in Medicaid and CHIP: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/downloads/overview-of-eligibility-for-non-citizens-in-medicaid-and-chip.pdf>
- Answering the Medicaid block question: <https://marketplace.cms.gov/technical-assistance-resources/applicants-denied-chip-medicaid.pdf>
- Applying for coverage after receiving a Medicaid/CHIP denial: <https://marketplace.cms.gov/outreach-and-education/applying-for-coverage.pdf>
- More information about Medicaid and CHIP coverage: <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip>
- More information about Medicaid and CHIP coverage (Spanish version): <https://www.cuidadodesalud.gov/es/medicaid-chip/>



C. SHOP Marketplace Coverage

- Overview of the SHOP Marketplace: <https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/>
- Overview of the SHOP Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/small-businesses/provide-shop-coverage/shop-marketplace-overview/>
- Getting Small Business Health Coverage through the SHOP Marketplace: <https://www.youtube.com/watch?v=KRAMSZxatLA&feature=youtu.be>
- Health and Dental Coverage in the SHOP Marketplace: <https://marketplace.cms.gov/outreach-and-education/health-dental-plans-shop.pdf>
- Assisters Guide to Helping Employers Enroll in SHOP Marketplace Coverage: <https://marketplace.cms.gov/technical-assistance-resources/logo-and-infographics/assisters-guide-help-employers-enroll-shop.pdf>
- Employer Enrollment User Guide: <https://marketplace.cms.gov/outreach-and-education/shop-employer-enrollment-user-guide.pdf>
- FTE Employee Calculator: <https://www.healthcare.gov/shop-calculators-fte/>
- FTE Employee Calculator (Spanish version): <https://www.cuidadodesalud.gov/es/shop-calculators-fte/>
- Small Business Health Care Tax Credit: <https://www.healthcare.gov/small-businesses/provide-shop-coverage/small-business-tax-credits/>
- Small Business Health Care Tax Credit (Spanish version): <https://www.cuidadodesalud.gov/es/small-businesses/provide-shop-coverage/small-business-tax-credits/>
- Small Business Health Care Tax Credit from the IRS: <http://www.irs.gov/Affordable-Care-Act/Employers/Small-Business-Health-Care-Tax-Credit-and-the-SHOP-Marketplace>
- SHOP Tax Credit Estimator: <https://www.healthcare.gov/shop-calculators-taxcredit/>
- SHOP Tax Credit Estimator (Spanish version): <https://www.cuidadodesalud.gov/es/shop-calculators-taxcredit/>
- Overview of the SHOP Marketplace for Employees: <https://www.healthcare.gov/small-businesses/employees-shop/overview/>
- Overview of the SHOP Marketplace for Employees (Spanish version): <https://www.cuidadodesalud.gov/es/small-businesses/employees-shop/overview/>
- How Employees can Enroll in the SHOP Marketplace: <https://marketplace.cms.gov/outreach-and-education/enroll-in-shop-employees.pdf>
- How Employees can Enroll in the SHOP Marketplace (Spanish version): <https://marketplace.cms.gov/outreach-and-education/enroll-in-shop-employees-spanish.pdf>
- Employee Enrollment User Guide: <https://marketplace.cms.gov/outreach-and-education/shop-employee-enrollment-user-guide.pdf>
- Guidance for Assisters on Agents and Brokers: <https://marketplace.cms.gov/technical-assistance-resources/agents-and-brokers-guidance-for-assisters.PDF>

D. Medicare Coverage

- Overview of the Medicare program: <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html>
- How Medicare satisfies the requirement to have health coverage: <https://www.medicare.gov/about-us/affordable-care-act/medicare-and-the-marketplace.html>
- *When and How to Sign-up for Medicare Parts A and B:* <https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-how-to-sign-up-for-part-a-and-part-b.html>
- Changing from the Marketplace to Medicare: <https://www.healthcare.gov/medicare/changing-from-marketplace-to-medicare/>
- Changing from the Marketplace to Medicare (Spanish version): <https://www.cuidadodesalud.gov/es/medicare/changing-from-marketplace-to-medicare/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- Part A Late enrollment penalty: <https://www.medicare.gov/your-medicare-costs/part-a-costs/penalty/part-a-late-enrollment-penalty.html>
- Part B Late enrollment penalty: <https://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html>
- Part D enrollment penalty: <https://www.medicare.gov/part-d/costs/penalty/part-d-late-enrollment-penalty.html>
- Medicare savings program: <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html>
- SHIP: <https://www.shiptacenter.org/>
- Standards for dual eligibility: <http://www.medicare.gov/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html>
- Medigap plans: <https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/when-can-i-buy-medigap.html>
- SHIP in your state: <https://www.shiptacenter.org/>
- Frequently asked questions about Medicare and the Marketplace: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_6-11-15.pdf
- Medicare and the Marketplace video: <https://www.youtube.com/watch?v=4bYQrWK3wr0>

E. Other Coverage Options

- Employer-sponsored coverage: <https://www.healthcare.gov/have-job-based-coverage/>
- Employer-sponsored coverage (Spanish version): <https://www.cuidadodesalud.gov/es/have-job-based-coverage/>
- Minimum value standard and affordability: <https://www.healthcare.gov/have-job-based-coverage/change-to-marketplace-plan/>
- Minimum value standard and affordability (Spanish version): <https://www.cuidadodesalud.gov/es/have-job-based-coverage/change-to-marketplace-plan/>
- COBRA coverage and the Marketplace: <https://www.healthcare.gov/unemployed/cobra-coverage/>
- COBRA coverage and the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/unemployed/cobra-coverage/>
- Health coverage options for veterans: <https://www.healthcare.gov/veterans/>
- Health coverage options for veterans (Spanish version): <https://www.cuidadodesalud.gov/es/veterans/>
- Health coverage for young adults: <https://www.healthcare.gov/young-adults/>
- Health coverage for young adults (Spanish version): <https://www.cuidadodesalud.gov/es/young-adults/>
- Health coverage for people with disabilities: <https://www.healthcare.gov/people-with-disabilities/>
- Health coverage for people with disabilities (Spanish version): <https://www.cuidadodesalud.gov/es/people-with-disabilities/>
- Helping consumers with disabilities fact sheet: <https://marketplace.cms.gov/technical-assistance-resources/consumers-with-disabilities.pdf>

CHAPTER III. THE MARKETPLACE APPLICATION AND ENROLLMENT PROCESS**A. How can I help consumers apply for and enroll in Marketplace coverage?****1. Application Process**

- Fee for not being covered: <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/>
- Fee for not being covered (Spanish version): <https://www.cuidadodesalud.gov/es/fees-exemptions/fee-for-not-being-covered/>
- How to Apply and Enroll in Coverage: <https://www.healthcare.gov/apply-and-enroll/get-ready-to-apply/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- How to Apply and Enroll in Coverage (Spanish version): <https://www.cuidadodesalud.gov/es/apply-and-enroll/get-ready-to-apply/>
- Four Ways to Apply for Coverage: <https://www.healthcare.gov/apply-and-enroll/how-to-apply/>
- Four Ways to Apply for Coverage (Spanish version): <https://www.cuidadodesalud.gov/es/apply-and-enroll/how-to-apply/>
- Get coverage: <https://www.healthcare.gov/get-coverage/>
- Get coverage (Spanish version): <https://www.cuidadodesalud.gov/es/get-coverage/>
- Find Local Help: <https://localhelp.healthcare.gov/>
- Find Local Help (Spanish version): <https://ayudalocal.cuidadodesalud.gov/es/>
- Application process: <https://marketplace.cms.gov/technical-assistance-resources/application-process-assistance.html>
- Guide to applying for coverage: <https://marketplace.cms.gov/technical-assistance-resources/training-materials/apply-for-coverage.zip>
- How to help consumers fill out paper applications: <https://marketplace.cms.gov/technical-assistance-resources/assisting-consumers-with-paper-applications.pdf>
- Checklist to get Ready to apply for or renew your Marketplace coverage: <https://marketplace.cms.gov/outreach-and-education/apply-for-or-renew-coverage.pdf>

2. Application Troubleshooting

- HealthCare.gov browser compatibility: <https://www.healthcare.gov/browser-compatibility/>
- HealthCare.gov browser compatibility (Spanish version): <https://www.cuidadodesalud.gov/es/browser-compatibility/>
- Tips on Troubleshooting Technical Issues: <https://www.healthcare.gov/apply-and-enroll/tips-and-troubleshooting/>
- Tips on Troubleshooting Technical Issues (Spanish version): <https://www.cuidadodesalud.gov/es/apply-and-enroll/tips-and-troubleshooting/>
- Tips for Resetting Marketplace Passwords and Unlocking Marketplace Accounts: <https://www.healthcare.gov/blog/tips-for-resetting-your-password-and-unlocking-your-account/>
- Tips for Resetting Marketplace Passwords and Unlocking Marketplace Accounts (Spanish version): <https://www.cuidadodesalud.gov/es/blog/tips-for-resetting-your-password-and-unlocking-your-account/>
- Troubleshooting Tips and Requirements for Marketplace Accounts: <https://www.healthcare.gov/help/i-am-having-trouble-logging-in-to-my-marketplace-account/>
- Troubleshooting Tips and Requirements for Marketplace Accounts (Spanish version): <https://www.cuidadodesalud.gov/es/help/i-am-having-trouble-logging-in-to-my-marketplace-account/>

3. Authentication Process

- Identity Proofing and Information Inconsistencies: <https://marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf>
- Identity Proofing and Information Inconsistencies (Spanish version): <https://marketplace.cms.gov/technical-assistance-resources/id-proofing-spanish.pdf>
- Frequently Asked Questions about ID Proofing: <https://marketplace.cms.gov/technical-assistance-resources/remote-identity-proofing-faqs.pdf>
- How We Use Your Data: <https://www.healthcare.gov/how-we-use-your-data/>
- How We Use Your Data (Spanish version): <https://www.cuidadodesalud.gov/es/how-we-use-your-data/>
- Privacy Act statement: <https://www.healthcare.gov/individual-privacy-act-statement/>
- Privacy Act statement (Spanish version): <https://www.cuidadodesalud.gov/es/individual-privacy-act-statement/>
- How to Resolve a Data-Matching Issue: <https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- How to Resolve a Data-Matching Issue (Spanish version): <https://www.cuidadodesalud.gov/es/help/how-do-i-resolve-an-inconsistency/>
- How to Upload Documents: <https://www.healthcare.gov/help/how-to-upload-documents/>
- How to Upload Documents (Spanish version): <https://www.cuidadodesalud.gov/es/help/how-to-upload-documents/>
- Tips for Submitting Supporting Documents: <https://marketplace.cms.gov/technical-assistance-resources/submitting-supporting-documents.pdf>
- Five Things Assisters Should Know about Data Matching Terminations: <https://marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf>
- Tips to Resolve Outstanding Data Matching Issues: <https://marketplace.cms.gov/technical-assistance-resources/resolve-data-match-issues.pdf>
- Documents that consumers can submit to resolve data matching issues: <https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/>
- Documents that consumers can submit to resolve data matching issues (Spanish version): <https://www.cuidadodesalud.gov/es/help/how-do-i-resolve-an-inconsistency/>
- The Facts about the Affordable Care Act and Immigration Enforcement: <https://www.whitehouse.gov/blog/2014/12/03/facts-about-affordable-care-act-and-immigration-enforcement>
- Facts about the Affordable Care Act and Immigration Enforcement (Spanish version): <https://www.whitehouse.gov/blog/2014/12/03/informaci-n-sobre-la-ley-de-cuidado-de-salud-bajo-precio-y-el-control-de-inmigraci-n>

4. Immigration Status and the Marketplace

- Lawfully present immigration statuses: <https://www.healthcare.gov/immigrants/immigration-status/>
- Lawfully present immigration statuses (Spanish version): <https://www.cuidadodesalud.gov/es/immigrants/immigration-status/>
- Coverage options for lawfully present immigrants: <https://www.healthcare.gov/immigrants/lawfully-present-immigrants/>
- Coverage options for lawfully present immigrants (Spanish version): <https://www.cuidadodesalud.gov/es/immigrants/lawfully-present-immigrants/>
- List of immigration document types: <https://www.healthcare.gov/help/immigration-document-types/>
- List of immigration document types (Spanish version): <https://www.cuidadodesalud.gov/es/help/immigration-document-types/>
- Helping Consumers With Different Immigration Statuses: <https://marketplace.cms.gov/technical-assistance-resources/immigration-fast-facts.pdf>
- Tips for Helping Non-citizens Apply for Marketplace Coverage: <https://marketplace.cms.gov/technical-assistance-resources/helping-naturalized-citizens-apply.pdf>
- Tips for Helping Non-citizens Apply for Marketplace Coverage (Spanish version): <https://marketplace.cms.gov/technical-assistance-resources/helping-naturalized-citizens-apply-spanish.pdf>
- Dos And Don'ts For Providing Non-Discriminatory, Culturally And Linguistically Appropriate Services: <https://marketplace.cms.gov/technical-assistance-resources/dos-and-donts-clas.pdf>

5. Health Coverage for American Indians and Alaska Natives

- Marketplace Special Protections and Benefits for American Indians and Alaska Natives: <https://www.healthcare.gov/american-indians-alaska-natives/>
- Marketplace Special Protections and Benefits for American Indians and Alaska Natives (Spanish version): <https://www.cuidadodesalud.gov/es/american-indians-alaska-natives/>
- Two Ways Consumers Can File the Indian Health Coverage Exemption: <https://www.healthcare.gov/american-indians-alaska-natives/exemptions/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- Two Ways Consumers Can File the Indian Health Coverage Exemption (Spanish version): <https://www.cuidadodesalud.gov/es/american-indians-alaska-natives/exemptions/>
- Tips for Working with American Indians and Alaska Natives: <https://marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf>

6. Financial Assistance through the Marketplace

- Information about MEC: <https://www.healthcare.gov/glossary/minimum-essential-coverage/>
- Information about MEC (Spanish version): <https://www.cuidadodesalud.gov/es/glossary/minimum-essential-coverage/>
- Detailed list of MEC: <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage>
- Information about COBRA and the Marketplace: <https://www.healthcare.gov/unemployed/cobra-coverage/>
- Information about COBRA and the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/unemployed/cobra-coverage/>
- Retiree coverage and the Marketplace: <https://www.healthcare.gov/retirees/>
- Retiree coverage and the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/retirees/>
- How to Save on Monthly Premiums by Receiving APTC: <https://www.healthcare.gov/lower-costs/save-on-monthly-premiums/>
- How to Save on Monthly Premiums by Receiving APTC (Spanish version): <https://www.cuidadodesalud.gov/es/lower-costs/save-on-monthly-premiums/>
- How to Save on Out-of-Pocket Costs Through CSRs: <https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/>
- How to Save on Out-of-Pocket Costs Through CSRs (Spanish version): <https://www.cuidadodesalud.gov/es/lower-costs/save-on-out-of-pocket-costs/>
- Calculating household income: <https://www.healthcare.gov/income-and-household-information/income/>
- Calculating household income (Spanish version): <https://www.cuidadodesalud.gov/es/income-and-household-information/income/>
- Qualifying for Lower Costs: <https://www.healthcare.gov/lower-costs/qualifying-for-lower-costs/>
- Qualifying for Lower Costs (Spanish version): <https://www.cuidadodesalud.gov/es/lower-costs/qualifying-for-lower-costs/>
- Reporting Life Changes to the Marketplace: <https://www.healthcare.gov/reporting-changes/>
- Reporting Life Changes to the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/reporting-changes/>

B. How can I Help Consumers with the Annual Marketplace Coverage Renewal and Redetermination Process?

- 2016 FFM Redetermination and Re-Enrollment Process: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf>
- 2016 Redetermination and Re-Enrollment Basics for Assisters Guide: <https://marketplace.cms.gov/technical-assistance-resources/2016-redetermination-and-reenrollment.pdf>

C. How can I Help Consumers Appeal a Marketplace Eligibility Decision?

- What Marketplace Decisions can be Appealed: <https://www.healthcare.gov/marketplace-appeals/what-you-can-appeal/>
- What Marketplace Decisions can be Appealed (Spanish version): <https://www.cuidadodesalud.gov/es/marketplace-appeals/what-you-can-appeal/>
- Three Ways in Which Consumers can File an Appeal Request: <https://www.healthcare.gov/marketplace-appeals/ways-to-appeal/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- Three Ways in Which Consumers can File an Appeal Request (Spanish version): <https://www.cuidadodesalud.gov/es/marketplace-appeals/ways-to-appeal/>
- Marketplace appeal request form: <https://www.healthcare.gov/marketplace-appeals/appeal-forms/>
- Marketplace appeal request form (Spanish version): <https://www.cuidadodesalud.gov/es/marketplace-appeals/appeal-forms/>
- How to file an expedited appeal: <https://www.healthcare.gov/marketplace-appeals/expedited-appeal/>
- How to file an expedited appeal (Spanish version): <https://www.cuidadodesalud.gov/es/marketplace-appeals/expedited-appeal/>
- Designation of Authorized Representative: <https://www.healthcare.gov/marketplace-appeals/getting-help/>
- Designation of Authorized Representative (Spanish version): <https://www.cuidadodesalud.gov/es/marketplace-appeals/getting-help/>
- Designation of Authorized Representative form: <https://www.healthcare.gov/downloads/marketplace-authorize-appeal-representative-form.pdf>
- Marketplace Appeals and Health Plan Appeals Fact Sheet: <https://marketplace.cms.gov/outreach-and-education/appeals-eligibility-and-health-plan-decisions.pdf>
- Appealing SHOP Marketplace Decisions: <https://marketplace.cms.gov/outreach-and-education/shop-appeals.pdf>
- Healthcare.gov page on appeals: <https://www.healthcare.gov/marketplace-appeals/>
- Healthcare.gov page on appeals (Spanish version): <https://www.cuidadodesalud.gov/es/marketplace-appeals/>
- Get help with Marketplace applications or eligibility appeals: <https://www.healthcare.gov/marketplace-appeals/getting-help/>
- Get help with Marketplace applications or eligibility appeals (Spanish version): <https://www.cuidadodesalud.gov/es/marketplace-appeals/getting-help/>

D. How can I Help Consumers Report Life Changes to the Marketplace?

- List of changes that should be reported to the Marketplace: <https://www.healthcare.gov/reporting-changes/which-changes-to-report/>
- List of changes that should be reported to the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/reporting-changes/which-changes-to-report/>
- How to Report Changes to the Marketplace: <https://www.healthcare.gov/reporting-changes/how-to-report-changes/>
- How to Report Changes to the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/reporting-changes/how-to-report-changes/>
- Helping Consumers Report a Life Event or Change in Circumstance After the Open Enrollment Period: <https://marketplace.cms.gov/technical-assistance-resources/report-life-event.pdf>
- Options to Select Different Marketplace Coverage, Cancel or Terminate Marketplace Coverage, and Report Changes to the Marketplace: <https://www.healthcare.gov/keep-or-change-plan/>
- Options to Select Different Marketplace Coverage, Cancel or Terminate Marketplace Coverage, and Report Changes to the Marketplace (Spanish version): <https://www.cuidadodesalud.gov/es/keep-or-change-plan/>
- How to Cancel Marketplace Coverage: <https://www.healthcare.gov/reporting-changes/cancel-plan/>
- How to Cancel Marketplace Coverage (Spanish version): <https://www.cuidadodesalud.gov/es/reporting-changes/cancel-plan/>

E. How can I Help Consumers Prepare for Tax-Filing Season?**1. Preparing Tax Forms to Report Having Health Coverage**

- How Health Coverage Affects Tax Returns: <https://www.healthcare.gov/taxes/>
- How Health Coverage Affects Tax Returns (Spanish version): <https://www.cuidadodesalud.gov/es/taxes/>



Appendix: Links Referenced in the Assisters' Roadmap to Resources

- IRS page on the Affordable Care Act: <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage>
 - Information about Form 8962: http://www.irs.gov/file_source/pub/irs-pdf/f8962.pdf
 - Information about Form 8965: http://www.irs.gov/file_source/pub/irs-pdf/f8965.pdf
 - Information about Form 1095-A: <https://www.healthcare.gov/taxes/marketplace-health-plan/>
 - Information about Form 1095-A (Spanish version): <https://www.cuidadodesalud.gov/es/taxes/marketplace-health-plan/>
 - Cover page of Form 1095-A: <https://marketplace.cms.gov/technical-assistance-resources/training-materials/1095a-cover-page.pdf>
 - Cover page of Form 1095-A (Spanish version): <https://marketplace.cms.gov/technical-assistance-resources/training-materials/1095a-cover-page-spanish.pdf>
 - Instructions for using Form 1095-A: <http://www.irs.gov/instructions/i1095a/ar01.html>
 - Instructions for using Form 1095-A (Spanish version): <https://marketplace.cms.gov/technical-assistance-resources/spanish-form-1095-a-and-instructions.pdf>
 - Frequently asked questions about Form 1095-A: <https://marketplace.cms.gov/technical-assistance-resources/1095a-faqs.pdf>
 - Frequently asked questions about Form 1095-A (Spanish version): <https://www.cuidadodesalud.gov/es/taxes/>
 - No Coverage? What That Means for Your Taxes: <https://marketplace.cms.gov/outreach-and-education/no-health-coverage-and-your-taxes.pdf>
 - No Coverage? What That Means for Your Taxes (Spanish version): <https://marketplace.cms.gov/outreach-and-education/no-health-coverage-and-your-taxes-spanish.pdf>
 - Tax Tools to Claim the Affordability Exemption and to Calculate Premium Tax Credit: <https://www.healthcare.gov/taxes/tools/>
 - Tax Tools to Claim the Affordability Exemption and to Calculate Premium Tax Credit (Spanish version): <https://www.cuidadodesalud.gov/es/taxes/tools/>
 - How Health Coverage Affects Taxes (chart): <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Health-Care-Law-and-Your-Tax-Return>
 - How Health Coverage Affects Taxes (publication): <http://www.irs.gov/pub/irs-pdf/p5187.pdf>
 - Online Catalog of Tax Resources for Assisters: <https://marketplace.cms.gov/technical-assistance-resources/tax-information.html>
- 2. Applying for an Exemption from the Requirement to Have Coverage**
- Exemptions screener tool: <https://www.healthcare.gov/exemptions-tool/#/>
 - Exemptions screener tool (Spanish version): <https://www.cuidadodesalud.gov/es/exemptions-tool/#/>
 - Full list of types of exemptions: <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions>
 - IRS Form 8965 – Health Coverage Exemptions: <http://www.irs.gov/pub/irs-pdf/f8965.pdf>

F. How can I Help Consumers Use Their Coverage?

- C2C materials: <https://marketplace.cms.gov/c2c>
- Roadmap to Better Care and a Healthier You: <https://marketplace.cms.gov/technical-assistance-resources/c2c-roadmap.pdf>
- Enrollment Toolkit: <https://marketplace.cms.gov/technical-assistance-resources/c2c-enrollment-toolkit.pdf>
- Guide to Discussions with Consumers: <https://marketplace.cms.gov/outreach-and-education/downloads/c2c-discussion-guide.pdf>
- Training Guide video: <http://www.youtube.com/watch?v=rsxLMrWvIAU&feature=youtu.be>
- Ordering C2C materials: <https://marketplace.cms.gov/outreach-and-education/order-coverage-to-care-materials.html>

**CHAPTER IV. INFORMATION IN OTHER LANGUAGES****A. How do I access information and materials in other languages?****1. CMS-Developed Resources in Other Languages**

- CMS resources by language: http://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Dwnld-IndexByLanguage_rev060115_v070715.pdf

2. Marketplace Call Center (hotline and interpreter information)

- Marketplace Call Center: 1- 800-318-2596 (TTY: 1-855-889-4325)

3. CuidadoDeSalud.gov

- CuidadoDeSalud.gov (Spanish version of HealthCare.gov): <https://cuidadodesalud.gov/es/>

4. Find Local Help

- Find Local Help: <https://localhelp.healthcare.gov/>
- Find Local Help (Spanish version): <https://ayudalocal.cuidadodesalud.gov/es/>

5. The Online Resource Library

- Online Resource Library for Assisters: <https://marketplace.cms.gov/technical-assistance-resources/join-resource-library.PDF>

Disclaimer: CMS does not endorse the information and resources provided by the members of the Online Resource Library for Assisters. By administering this online community, CMS does not intend to suggest that it is endorsing the information or resources provided by these organizations over information or resources that might be provided by other organizations.