ASSISTER TRAINING TABLE OF CONTENTS

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WVAHC & WV Primary Care Association PRESENT

OPEN ENROLLMENT 3 TRAINING

Meeting 1 – September 29, 2015
Holiday Inn
South Charleston, WV
Hosted by WV Offices of the Insurance Commissioner's Health Policy Division

west virginia OFFICES OF THE INSURANCE COMMISSIONER

Meeting 2 – October 6, 2015
Ramada Inn
Morgantown, WV
Hosted by WV Healthy Start Navigator Project

WVAHC & WV Primary Care Association PRESENT

OPEN ENROLLMENT 3 TRAINING

Agenda

8:30 – 9:00 am	Registration
9:00 – 9:05 am	Welcome and Introduction of Joanne Grossi (Terri Giles)
9:05 – 9:15 am	Joanne Grossi, Regional Director of the U.S. Department of Health and Human Services
9:15– 9:45 am	Cheryl O'Donnell, Enroll America
9:45 – 10:00 am	Enrollment Numbers and OEIII
10:00 – 10:15 am	Break
10:15 – 11:10 am	Breakouts A- Marketplace Plans or C- Medicaid
11:15 – 12:10 pm	Breakouts B- Dental or D- Healthcare.gov
12:10 – 12:40 pm	Lunch
12:40 – 1:35 pm	Breakouts C or A
1:35 – 2:30 pm	Breakouts D or B
2:30 – 3:15 pm	Regional Breakouts
3:15 – 3:45 pm	Regional Reports
3:45 – 4:00 pm	Let's Get Enrolling Closing Remarks

Bio

Joanne Corte Grossi, MIPP

In April, 2010, Joanne Grossi was appointed by the Obama Administration as the Regional Director of the U.S. Department of Health and Human Services for Region III, which includes the states of Pennsylvania, Delaware, Maryland, Virginia, West Virginia, and the District of Columbia. As Regional Director, Ms. Grossi serves as the key representative in this region in working with federal, state, local and tribal officials on a wide range of health and social services issues.

Prior to this appointment, Ms. Grossi served for seven years in the administration of Governor Edward G. Rendell, first as Deputy Secretary of Health and later as the first- ever Director of the Office of Women's Services.

Before joining the Governor's Administration, Ms. Grossi served for 13 years as a Senior Technical Advisor in the Bureau of Global Health at the United States Agency for International Development, where she oversaw international health programs in developing countries.

Earlier in her career, Ms. Grossi served on the staffs of Congressman Peter Kostmayer and Ambassador Millicent H. Fenwick at the American Embassy in Rome, Italy.

Ms. Grossi earned her master's degree in International Public Policy at the Johns Hopkins University's School of Advanced International Studies and completed additional graduate education at the Johns Hopkins University's School of Public Health and Hygiene.

Bio

Cheryl O'Donnell

Cheryl O'Donnell is the State Assistance Regional Manager for Enroll America, a national nonprofit organization focused on raising public awareness and engaging consumers about their new, affordable health insurance options. As regional manager, Cheryl establishes and maintains an ongoing relationship with community partners to support local enrollment efforts and identify best practices that inform efforts nationwide.

Prior to serving as regional manager, Cheryl served as Enroll America's Arizona State Director, working with community-based organizations across the state to help nearly 500,000 uninsured Arizonans get access to affordable health coverage, surpassing enrollment expectations and significantly reducing the uninsured rate throughout the state. Specific accomplishments during her tenure include launching a coordinated effort throughout the state's criminal justice system to identify uninsured ex-offenders and connect them to application assisters, and engaging more than 160 application assisters in 35 cities to use the Get Covered Connector to schedule more than 9,000 appointments and counting.

Cheryl's career has embraced a commitment to family and individual well-being. Prior to joining Enroll America, she served as senior director of community development at United Way of Tucson and Southern Arizona, where she developed programs to increase family financial stability, of which medical costs are a major concern. Cheryl provided direct assistance to families applying for Medicaid and the Children's Health Insurance Program (CHIP) and led the implementation of a statewide call center and phone-a-thon program to support families who were losing CHIP coverage. In addition, she directed the state's largest free tax preparation program and served as a Volunteer Tax Preparer, helping Arizona's working poor claim more than $8 million in Earned Income Tax Credit annually.

Cheryl spent seven years in Washington, DC creating award-winning public awareness campaigns to end domestic and sexual violence and provide better care for breast cancer survivors. During her time in DC, Cheryl also served as the director of communications and development for the National Network to End Domestic Violence, raising the national profile of domestic violence prevention and victim services.

Cheryl holds a bachelor of science degree in journalism from Ohio University and a master's of public administration degree from the University of Arizona.

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

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State of Enrollment

Getting America Covered

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Who We Are

Enroll America is the nation's leading health care enrollment coalition. An independent nonprofit, nonpartisan organization, Enroll America works with more than 4,600 partners in all 50 states to create cutting-edge tools, analyze data, inform policy, and share best practices in service of its mission: maximizing the number of Americans who enroll in and retain health coverage under the Affordable Care Act

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Agenda

1. Delivering on the Promise of the Affordable Care Act
2. The Remaining Uninsured
3. Lessons from Past Open Enrollments
4. Getting and Staying Covered in OE3

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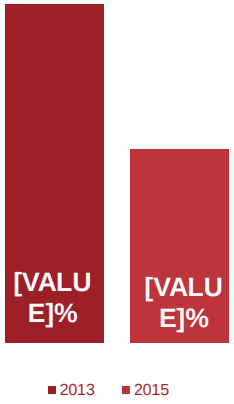
THERE'S MUCH TO CELEBRATE

- 15 million adults have gained coverage since October 2013
- National uninsured rate dropped 7.5 percentage points

Source: Urban Institute, Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015, http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html

National Uninsured Rate in 2013 and 2015



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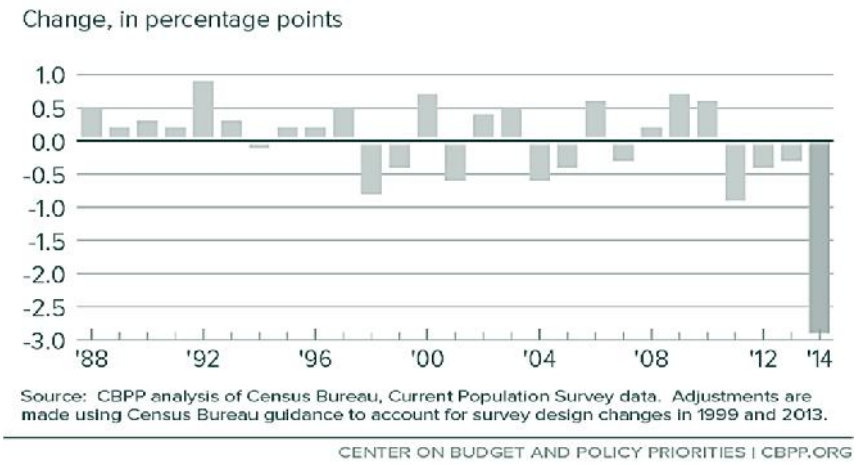
HISTORIC DROP IN UNINSURED



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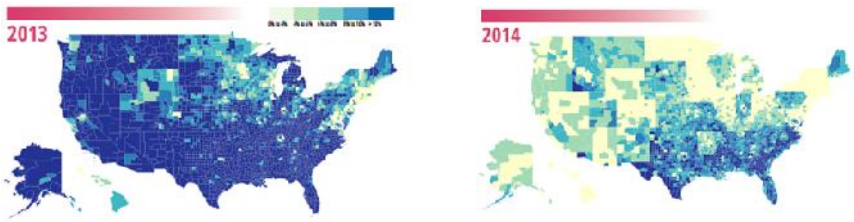
DROP IN UNINSURED RATE '13-'14

Estimated uninsured rates among non-elderly adults before and after OE1



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WHO ARE MARKETPLACE ENROLLEES?

FINANCIAL HELP

84% Receiving Tax Credits

$270 Average Monthly Tax Credit

$101 Average Premium After Tax Credits

4/5 enrollee incomes are less than 250% FPL

Source: HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*

Source: Center for Medicare and Medicaid Services, *June 30, 2015 Effectuated Enrollment Snapshot*

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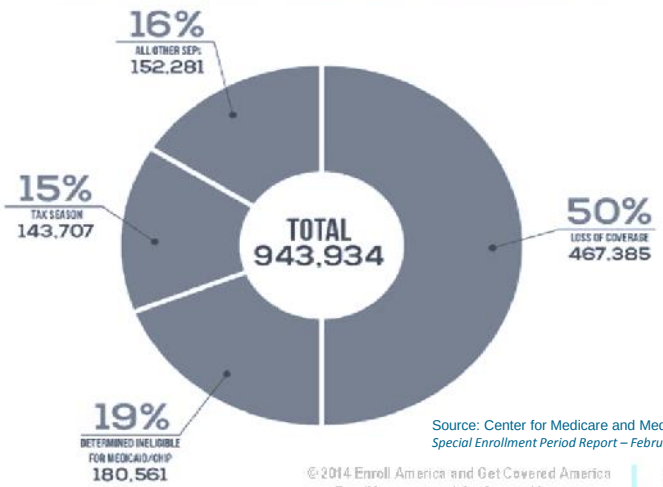
SPECIAL ENROLLMENT PERIOD ENROLLEES

943,934 consumers selected a plan in the Federally Facilitated Marketplace using an SEP that resulted in **new health coverage**.



Source: Center for Medicare and Medicaid Services, *2015 Special Enrollment Period Report – February 23 – June 30, 2015*

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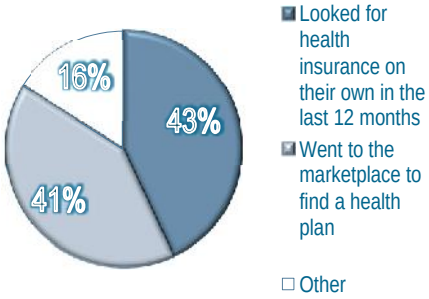
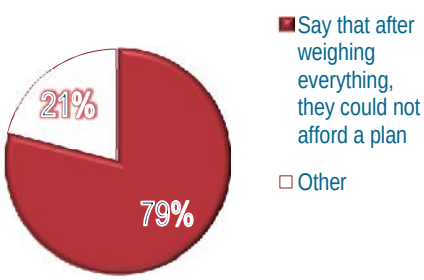
THE UNINSURED

Of Uninsured Individuals…



Of The Uninsured Who Looked for Insurance…



Source: "Understanding the uninsured now," Robert Wood Johnson Foundation Survey, April 2015

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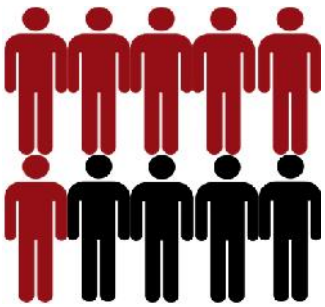
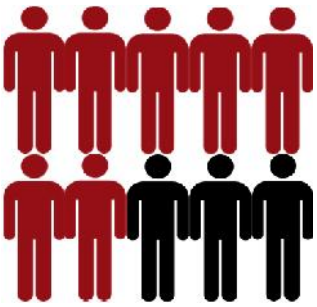
THE UNINSURED



Six in 10 are confused about or have not heard of the tax credit.



More than 7 in 10 want one-on-one help understanding their insurance options.

Source: "Understanding the uninsured now," Robert Wood Johnson Foundation Survey

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Major Lessons from OE1 & OE2

OE1

- Financial assistance messages were key
- Consumers wanted individualized information
- Multiple follow-ups had the best results
- Partnerships drove success
- In person help was crucial

OE2

- Financial assistance messages were still the most important motivator!
- Consumers needed to hear about the fine
- Successful outreach occurs year round
- Deadlines motivate – more enrolled towards end
- In person help is still crucial – 60% more likely to enroll

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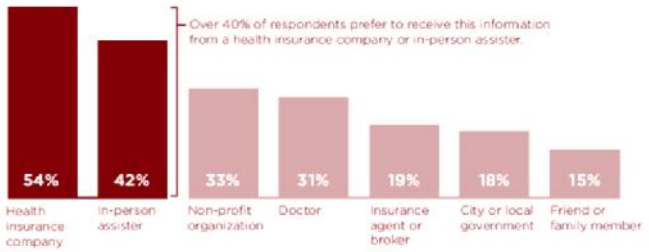
GETTING COVERED IN OE3

48%
Almost half of the uninsured lack confidence in choosing a plan for themselves.

9 out of 10
marketplace enrollees want more information about how to *use* their coverage.



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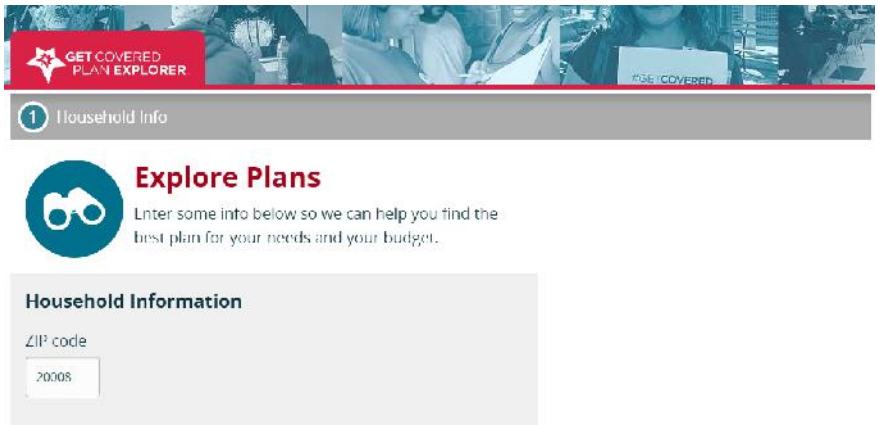
GET COVERED PLAN EXPLORER



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QUESTIONS

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ENROLL AMERICA

A Framework on Health Insurance Literacy for the Outreach and Enrollment Community

By Sophie Stern

This issue brief describes the connection between health insurance literacy (HIL) and coverage retention, early findings on how to address gaps in HIL from the consumer perspective, and key considerations for stakeholders working to improve retention and consumer comprehension.

Introduction

Until recently, there was limited evidence on when or how to engage consumers about health insurance to help them keep coverage.[1] While more research is needed, this issue brief presents new information about HIL from the consumer perspective — when, how, and from whom consumers want to receive information on health insurance and how it works.

As evidenced during the first two open enrollment periods for the health insurance marketplaces (OE1 and OE2), it is critical to give consumers the information they need and want at the appropriate times to motivate them to take action. For example, rigorous testing during OE1 and OE2 revealed that it was necessary to give individuals information about financial help in the initial outreach "touch" in order to motivate them to stay engaged and eventually take action. Information about the fine and deadlines was also important to ensure they enrolled, but that information could be provided in subsequent conversations.[2] Delivering HIL information at the right time and in the optimal way is just as important: It will contribute to increased consumer satisfaction with their coverage and increase the likelihood that a consumer maintains coverage over time.

> ***Substantial gaps in knowledge about health insurance remain, which may result in buyer's remorse, improper utlization of health care services, and/or loss of coverage completely.***

But certain questions remain about the most effective methods to engage consumers on HIL. For instance:

- What are the critical pieces of information that need to be shared — details about cost-sharing, the effect of networks on access to care, the importance of paying premiums?
- Who are the most appropriate consumers to reach with this information — individuals who are uninsured, those shopping for insurance, or new enrollees?
- What are the most effective methods for sharing this information — social media, in person, over the phone?

The answers to these questions will help the enrollment community build more effective programs that better empower consumers to find health insurance that meets their needs and budget, to use their coverage, and to keep their coverage over time.

Why Health Insurance Literacy Matters

Enroll America's mission is to help the uninsured get covered and stay covered. In 2014, following OE1, Enroll America administered several consumer surveys that yielded important early findings: We found that newly enrolled individuals were more knowledgeable about the Affordable Care Act (ACA) than the remaining uninsured, and knowledge about the law was associated with planned behavior necessary to maintain coverage, such as paying premiums and renewing coverage.[3] Among marketplace enrollees, we compared those who reported that they had enough information about the ACA — including information about new coverage provisions — to those who said they did not. The former were more likely to report that they would be able to retain their coverage:

1. They were confident that they could pay their premiums (86 percent vs. 56 percent).[4]
2. They expected to keep their insurance (86 percent vs. 74 percent).[5]
3. They planned to renew coverage (73 percent vs. 56 percent).[6]

The ACA significantly improved the individual health coverage shopping and enrollment experience. However, health insurance policies, terms, and concepts remain incredibly complex, and substantial gaps remain in the general public's knowledge about health insurance.[7] For some, these gaps in knowledge may result in buyer's remorse, improper utilization of health care services, and/or loss of coverage completely.

Consider the following illustrative examples:

Manuel dropped his marketplace coverage mid-year.

In 2014, with help from a tax credit, Manuel enrolled in a marketplace plan for $84 per month with a $6,300 deductible.[8] Manuel picked the plan with the lowest premium in his area. However, he did not know that he should also look at the amount of the deductible, and he later learned that his prescriptions were not covered until after his $6,300 deductible was met. With his income (sporadic and seasonal), it was very difficult to afford his premium and the costs of his prescriptions entirely out of pocket before the deductible. He stopped paying premiums mid-year because he did not see the value in paying for something he could not use right away. Manuel did not enroll in coverage for 2015.

Tanisha got covered and stayed covered.

On the other hand, Manuel's friend Tanisha purchased a marketplace plan with a premium of $73 per month and a $0 deductible, also with the help of a tax credit.[9] Tanisha sees a dermatologist every six months and is interested in seeing a therapist. Tanisha is a full-time graduate student, and with only a part-time job, she could not afford to pay a lot out of pocket for specialist doctor visits. With help from an **in-person assister**, she selected a plan with no deductible that covered the services she needed and created a monthly budget to figure out what she could afford. During the year, Tanisha received guidance on how to use her coverage through a **text message program** that she subscribed to through her school, which helped her understand the importance of finding an in-network provider. The majority of her mental and physical health care was covered in 2014, saving her money over the course of the year. In December 2014, Tanisha knew that she needed to go back to the marketplace to explore her options during open enrollment because of several **email and phone call reminders** from the assister that originally helped her. Tanisha used an **online plan comparison tool** and found coverage with a lower premium and comparable deductible that would meet her health care needs and budget for 2015.

Generally speaking, people do not need to be health insurance experts to purchase and retain coverage, but like Tanisha in the example above, they do need effective tools and resources at the appropriate times to make informed decisions so that they can maintain their coverage over time.

Findings on Health Insurance Literacy From the Second Open Enrollment Period

Enroll America's 2015 Post-Open Enrollment Survey

To better understand the more than 1.2 million consumers on the Get Covered America email list and their experiences looking for and obtaining health insurance, all subscribers were invited to take an online survey after the end of open enrollment in 2015.[10] Although the survey is not nationally representative, the results nevertheless provide insight into the needs of the uninsured and recent enrollees surrounding health insurance concepts and using coverage.[11] [12]

48%

Almost half of the uninsured lack confidence in choosing a plan for themselves.

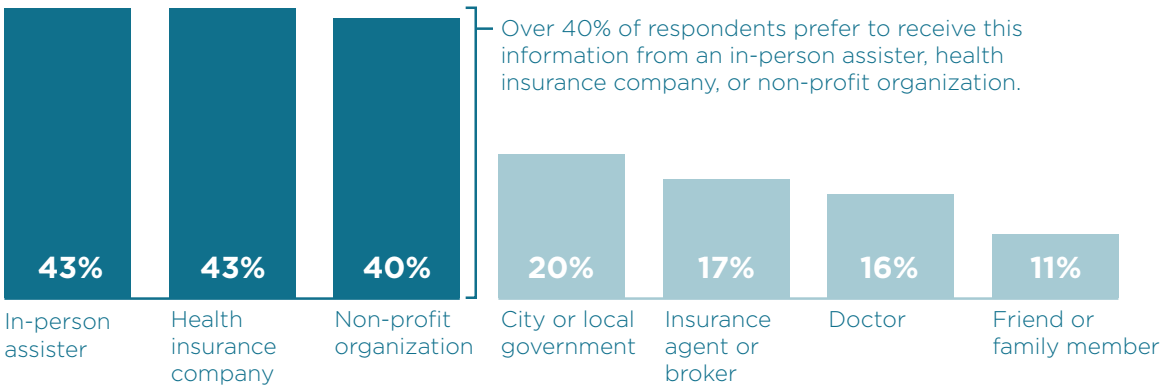
68%

Two-thirds of the uninsured want more information about health insurance terms.

The Uninsured Were Less Confident About Plan Selection and Wanted More Information

Almost half (48 percent) of the uninsured expressed a lack of confidence in choosing a plan for themselves in the future. Two-thirds (68 percent) reported that they wanted more information about health insurance terms from at least one of the following sources: in-person assisters (43 percent), health insurance companies (42 percent), and nonprofit organizations (40 percent). (See Figure 1.)

Figure 1. Who Do the Uninsured Want to Receive Information From on Health Insurance?



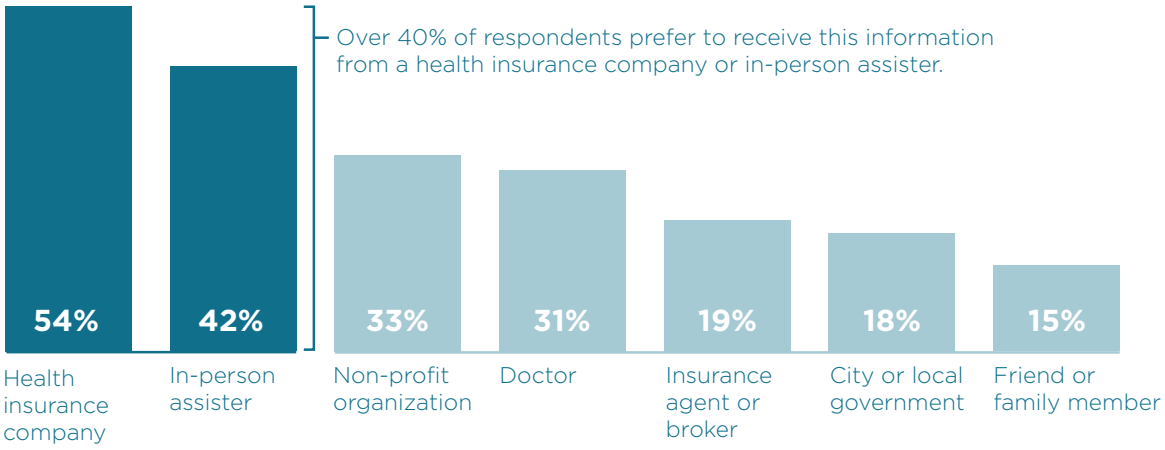
Marketplace Enrollees Were More Confident Than the Uninsured About Plan Selection But Still Want More Information About Health Insurance

Marketplace enrollees — those new to the marketplace and those renewing coverage in 2015 —reported being very or somewhat confident about their ability to choose a plan that would meet their needs and budget at a rate 21 percentage points higher than the remaining uninsured. The experience of enrolling may instill a degree of confidence in the plan comparison process. However, similarly to the uninsured, a significant proportion of marketplace enrollees reported still wanting more information about health insurance.[13] This is consistent with survey research released by the National Health Council in April 2015, which found that only 42 percent of marketplace enrollees who purchased Gold plans, 37 percent of marketplace enrollees who purchased Silver plans, and 24 percent of marketplace enrollees who purchased Bronze plans reported having the information they needed when selecting coverage.[14]

9 out of 10
marketplace enrollees want more information about how to *use* their coverage.

Furthermore, almost 90 percent of marketplace enrollees wanted more information about how to use their coverage. The majority wanted this information from their health insurance company (54 percent), an in-person assister (42 percent), or a nonprofit organization (33 percent). (See Figure 2.)

Figure 2. Who Do Marketplace Enrollees Want to Receive Information From on How to Use Their Coverage?



Some Marketplace Enrollees and Uninsured Individuals Reported Not Wanting to Receive Any Information About How Health Insurance Works

Not surprisingly, some respondents reported not wanting to receive information about how health insurance works. For some, this may be because they were more confident about their knowledge of health insurance concepts to begin with: Among the uninsured and marketplace enrollees, those that reported not wanting more information were more likely to report that they knew the definitions of complex health insurance terms, such as cost-sharing and co-insurance (42 percent and 28 percent, respectively). However, this does not mean that respondents actually knew these definitions. Research conducted by the American Institutes for Research found that individuals are often overconfident about their understanding of health insurance terms and concepts.[15]

It is also just as likely that some individuals reported not wanting this information because they do not want to know the ins and outs of health insurance until they actually use their coverage — when looking for a doctor in their provider network or when trying to understand their explanation of benefits after a health care visit, for example.

Additional Findings: Definitions of Health Insurance Terms and Concepts Sent by Email Did Not Significantly Affect Consumer Behavior or Self-Reported Knowledge

During OE1, the biggest enrollment gains were among consumers who could be reached by both phone and email: Consumers who received phone and email follow-up enrolled at a 10 percent higher rate than a control group that was not contacted by email.[16] And email remains an effective way to engage and educate consumers on the availability of affordable coverage.

During OE2, Enroll America conducted a randomized controlled test to determine whether providing information about health insurance terms and concepts through email would motivate consumers to take action or improve their confidence about related terms and concepts.[17] For the HIL test, individuals that subscribed to emails through Get Covered America were divided into two groups. Individuals in the test group received six emails over six weeks with information on health insurance concepts in addition to Get Covered America's standard email content about affordability, enrollment deadlines, and in-person help. (See Appendix for HIL email content.) Individuals in the control group continued to receive standard email communication from Get Covered America that did not include more detailed health insurance information. The test group received emails with information that consumers were less likely to know, such as cost-sharing and provider networks, based on findings from the Kaiser Family Foundation survey conducted in November 2014.[18] Then, all subscribers were invited to take an online survey after the end of open enrollment.

Compared to members of the control group in the HIL test, individuals that received

> ***Simply providing written information in plain language is not enough to move the needle on HIL.***

emails with HIL content did not report any measurable difference in knowledge or enrollment status. Furthermore, between the two groups, there was no measurable difference in consumer behavior. These findings, while not nationally representative, suggest that even though consumers desire more information about health insurance and how it works, simply providing written information in plain language is not enough to move the needle on HIL.[19] (See discussion on page 7.)

Discussion and Recommendations

Sending emails or distributing fliers with HIL-specific content to newly enrolled consumers is not sufficient. While further testing in this space is needed over a longer period of time, the results from the HIL survey and the HIL email test indicate that in order to make measurable progress on HIL, organizations will need to explore various methods of information sharing through a broader lens, and follow up with consumers to determine what the most effective methods of engagement were that helped them select a plan and keep coverage.

Consumers need information and tools that will help them make informed choices at the appropriate decision-making points (e.g. when selecting a plan and when using their coverage). Sharing personalized information with consumers will likely have the greatest impact on consumer knowledge, confidence, and retention. During OE1 and OE2, personalized information (e.g. using the Get Covered Calculator to give individuals an estimate of their premium cost with financial help) had the most powerful effect on consumer behavior.[20] However, in order to share personalized information with consumers about health insurance and how it works, information about provider networks and formularies needs to be more readily accessible to consumers and stakeholders working to improve retention and consumer comprehension. The U.S. Department of Health and Human Services (HHS) is taking steps in this direction by requiring health insurance issuers operating in federally facilitated marketplace states to submit formulary information to HHS in a machine-readable format for the 2016 plan year, and has increased provider network transparency requirements that will require health insurance issuers to submit data to HHS in a standardized format.[21]

Not all consumers will want to receive information on health insurance and how it works, but they might still benefit from well-placed tools that provide the right information at the right time. Therefore, it is just as important that tools, such as a plan comparison tool that helps consumers compare costs and benefits across plans, are made available at the appropriate times — without the consumer having to ask — during enrollment and renewal. This way, individuals who are interested in finding

> ***First, provide information to the uninsured that motivates them to explore their coverage options. Then, consider when and how to provide more granular information on health insurance.***

and keeping coverage, but who do not necessarily want to learn about complex health insurance terms and concepts, still have the information they need to make informed decisions.

The enrollment community must empower the remaining uninsured with tools and well-timed information to help them shop for and enroll in coverage that meets their needs and budget. This being said, because health insurance terms and concepts do not necessarily motivate individuals to take action to enroll, stakeholders should focus on first providing information to the uninsured that motivates them to explore their coverage options — information surrounding financial help, for instance — and then consider when and how (e.g. during an appointment with an in-person assister) to provide more granular information on health insurance.

Health insurance issuers, in-person assisters, relevant nonprofit and community-based organizations, providers, and county and local government are key players in improving health insurance literacy. These stakeholders will need to collaborate more in the future in order to ensure that consumers receive the information and support they need at the right time, depending on where they are in health coverage continuum (uninsured, shopping for coverage, or enrolled).

Five-Point Framework for Future Work on Health Insurance Literacy

1. Understand the most persistent HIL knowledge gaps among the remaining uninsured and newly enrolled.
2. Define what information consumers value about health insurance and how to use coverage.
3. Uncover the best times to expose consumers to information about health insurance in order to positively affect their behavior (e.g. when shopping for coverage or during the coverage year).
4. Discover how and under what circumstances consumers are interested in receiving new information about health insurance and how to use coverage.
5. Determine what messengers consumers want to hear from about health insurance and how to use coverage (family, doctor or other health care provider, in-person assister, health insurance company, etc.)

Conclusion

To keep America covered, the outreach and enrollment community has a large role to play in identifying the best methods for engagement on HIL. This effort will require continued attention so that consumers receive the information they need — at the appropriate times and with tested messages and mechanisms for information-sharing — to empower them to make informed decisions about plan selection and to help them keep their coverage.

Appendix

The screenshots below show two of the six health-insurance-specific emails that were sent to consumers in the HIL test group. To see all health-insurance-specific emails emails sent to the HIL test group, visit www.enrollamerica.org/hil-emails.

To: *First Last <user@example.com>*
From: Get Covered America Team <admin@getcoveredamerica.org>
Reply-To: admin@getcoveredamerica.org
Subject: Words to know before you enroll

GET COVERED. STAY COVERED.

Hey there,

It's time to get serious about shopping for health insurance. **The February 15th deadline will be here before you know it!**

Before you shop, here are a few terms to know:

- **Premium**: The amount you pay each month to your insurance plan
- **Deductible**: The amount of your medical costs you pay each year before your plan begins to pay
- **Coinsurance**: The percentage of your medical costs you pay once you've met your deductible
- **Co-pay**: The set amount you pay per visit

Depending on how much money you make, you might qualify for financial help with your monthly cost. You may also be able to get lower deductibles, coinsurance, and co-pays if you qualify for a "cost-sharing reduction."

Want to learn more about out-of-pocket costs before you shop?

Learn More

More soon,

The Get Covered America team

To: *First Last <user@example.com>*
From: Get Covered America Team <admin@getcoveredamerica.org>
Reply-To: admin@getcoveredamerica.org
Subject: How to pick a plan

GET COVERED. STAY COVERED.

Hey there,

Time is running out to enroll in Obamacare! February 15th is the last day to sign up, or you might have to pay a fine.

But how do you choose the right plan? There are four types of plans: Bronze, Silver, Gold, and Platinum.

- Most Bronze plans have lower monthly premiums. But you will likely have a higher deductible, so you'll pay more when you visit the doctor or fill a prescription.
- Most Platinum plans a have higher monthly premium but will likely have lower deductibles. If you choose a Platinum plan, you will likely pay less when you go to the doctor or fill a prescription.
- Silver and Gold plans fall in the middle.

Want to learn more about the plan types available?

Learn More

More soon,

The Get Covered America team

Acknowledgements

This piece was written by Sophie Stern, Deputy Director, Best Practices Institute.

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Heather Bates, Ricky Gonzales, Sara Little, Justin Nisly, Adam Stalker from Enroll America; Karen Pollitz from the Kaiser Family Foundation; and Lynn Quincy from Consumers Union for their input and guidance.

William Tomasko and Cynthia Youngblood from Enroll America for their editorial and design support.

Endnotes

[1] A working definition of HIL was developed in 2011 by a roundtable of experts convened by Consumers Union: "HIL measures the degree to which individuals have the knowledge, ability, and confidence to find and evaluate the information about health plans, select the best plan for their financial and health circumstances, and use the plan once enrolled." Consumers Union, Measuring Health Insurance Literacy: A Call to Action, February 2012. Available online at: http://consumersunion.org/pub/Health_Insurance_Literacy_Roundtable_rpt.pdf.

[2] Enroll America, State of Enrollment: Helping America Get Covered and Stay Covered, 2014-2015, February 2015. Available online at: http://www.enrollamerica.org/soe_report_2015/.

[3] Enroll America & PerryUndem, Voices from the Newly Enrolled and Still Uninsured: A Survey about the ACA's First Open Enrollment Period, July 2014. Available online at: http://www.enrollamerica.org/resources/public-education/voices-from-the-newly-enrolled-and-still-uninsured/.

[4] Ibid.

[5] Data is from an Enroll America follow-up survey of consumers who interacted with the Get Covered America campaign during open enrollment. June 2014.

[6] Ibid.

[7] Kaiser Family Foundation, Assessing Americans' Familiarity With Health Insurance Terms and Concepts, November 2014. Available online at: http://kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/; Enroll America and PerryUndem Research, Voices from the Newly Enrolled and Still Uninsured: A Survey about the Affordable Care Act's First Open Enrollment Period, op. cit.; Consumers Union, Measuring Health Insurance Literacy: A Call to Action, op. cit.

[8] This scenario is for a 27-year-old non-smoker with an annual income of $23,000 living in Hillsborough County, Florida, and represents the actual premium and deductible of a Bronze plan in the service area for the 2015 plan year.

[9] This scenario is for a 27-year-old non-smoker with an annual income of $19,000 living in Hillsborough County, Florida, and represents the actual premium and deductible of a Silver plan in the service area for the 2015 plan year.

[10] Get Covered America is Enroll America's consumer-facing campaign.

[11] Enroll America's post-open enrollment survey (n=1,617). February 28 - March 4, 2015. Respondents are more likely to be over 55, female, and White (non-Hispanic). Full analysis is available upon request.

[12] Those most likely to be uninsured are young adults, Latinos, and African Americans. New York Times, Obama's Health Law: Who Was Helped Most, October 2014. Available online at: http://www. nytimes.com/interactive/2014/10/29/upshot/obamacarewho-was-helped-most.html.

[13] Enroll America's post-open enrollment survey, op. cit.

[14] National Health Council, What Patients Think About & Want From the Insurance Marketplace, April 2015. Available online at: http://www.nationalhealthcouncil.org/sites/default/files/Measuring-Patient-Experience-in-Exchanges.pdf.

[15] American Institutes for Research, A Little Knowledge Is a Risky Thing: Wide Gap in What People Think They Know About Health Insurance and What They Actually Know, October 2014. Available online at: http://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf.

[16] Enroll America, State of Enrollment: Helping America Get Covered and Stay Covered, 2014-2015, op. cit.

[17] The results from this test are from a survey taken by participants in the HIL experiment (n= 972). February 28 - March 4. Full analysis is available upon request.

[18] Kaiser Family Foundation, Assessing Americans' Familiarity With Health Insurance Terms and Concepts, op. cit.

[19] Knowledge and enrollment were assessed in an online follow-up survey after the end of open enrollment in 2015. Knowledge was based on self-reported confidence surrounding health insurance terms and concepts, and enrollment was based on self-reported coverage status. Consumer behavior was measured by the number of emails that were opened, the number of individuals that unsubscribed from the Get Covered America email list, and the percentage of individuals that moved on to start the enrollment process.

[20] Enroll America, State of Enrollment: Helping America Get Covered and Stay Covered, 2014-2015, op. cit.

[21] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, February 2015. Available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/11/HHS-Notice-of-Benefit-and-Payment-Parameters-for-2016.pdf.

GET COVERED PLAN EXPLORER™

WHAT IS THE GET COVERED PLAN EXPLORER?

Empowering marketplace consumers to better understand key features of their health plan choices — what they will pay out of pocket for health care services in a given year, and what doctors and drugs are covered — is crucial to maximizing the number of Americans who get covered and stay covered. That's why Enroll America is excited to announce the development of the Get Covered Plan Explorer.

This digital plan compare tool will be available to consumers in federally-facilitated marketplace states at no cost, and will provide personalized information about the plans available through the marketplace, including information about expected out-of-pocket costs and covered providers and drugs. The Get Covered Plan Explorer will be developed and maintained in partnership with an independent data and analytics firm, Clear Health Analytics, and will undergo extensive quality assurance testing.

How Does It Work?

The Get Covered Plan Explorer will not rank plans or make plan recommendations. Rather, it will give consumers a way to compare apples to apples. The Get Covered Plan Explorer will help consumers:

- Understand the lowest and highest possible annual out-of-pocket costs for every marketplace plan available in a given area.
- Obtain a more personalized cost estimate based on optional inputs such as health status and expected annual use of health care services.
- Sort and filter plans based on different criteria: premiums, maximum annual cost, annual deductible, personalized cost estimate, and more.
- See whether plans cover their providers and prescription drugs.

The Get Covered Plan Explorer Will Allow Assisters and Community Outreach Partners to:

- Expedite in-person assistance appointments by eliminating the need to manually calculate differences between available plans.
- Embed the tool on their organization's website for free, similar to the Get Covered Calculator (fee for customization applies).

When?

The Get Covered Plan Explorer is scheduled to launch on GetCoveredAmerica.org in November 2015.

Have Questions?

Email **PlanExplorer@EnrollAmerica.org** for more information and to become a Get Covered Plan Explorer partner.

Get Covered Plan Explorer Embeddable Tool Example

GET COVERED PLAN EXPLORER

ENTER INFO TO FIND YOUR PLAN

Next, we need a little more info about your household so we can help you find the best plans for your needs and your budget.

Anyone in your household pregnant? No

Anyone have a child 18 or younger? No

Anyone have a child under 18 not claimed on their taxes? No

Can you or anyone get insurance through work? No

Enter Household Info

Brought to you by GET COVERED AMERICA

Questions? | Privacy Policy | Methodology

© 2014, Enroll America

Get Covered Plan Explorer is still in development. Actual interface is subject to change.

The Plan Explorer will be embeddable on your website. Email **PlanExplorer@EnrollAmerica.org** for more information or to become a Get Covered Plan Explorer partner.

GET COVERED PLAN EXPLORER

< Go Back

EXPLORE HEALTH CARE PLANS

Plans are sorted based on estimates of your yearly cost. You can sort these plans using the categories below and mouse over the words for more info.

Based on the info you entered, there are
88 Health Insurance Plans
available to you in your area.

Sort By: Estimated Yearly Costs

Health Plan X of the United Health Care Plans of America
Silver | HMO | Plan ID #12345FL678910

Estimated Yearly Cost: $1,080

Lowest Possible Cost — Highest Possible Cost

Monthly premium: $84
Yearly deductible: $250
Highest Possible Yearly Cost: $3,258

Cost Details:

Preventive care: $0 before deductible
Primary doctor copay: $10 before deductible
Specialist doctor copay: $30 before deductible
Emergency room copay: $150 before deductible
Hospital visit coinsurance: 20% after deductible
Generic prescription copay: $10 before deductible
Name brand prescription copay: $20 after deductible

Benefit, Doctors and Drug Details:

Open Enrollment 3

Medical Plans

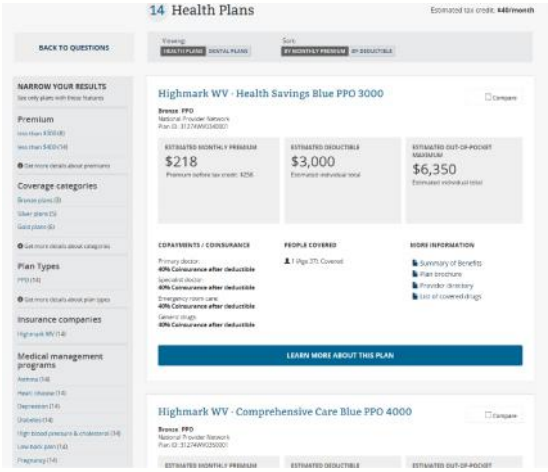
Information provided is current as of today. Please join the OIC listserv to keep up to date on federal and state updates.

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.



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

21 Individual Medical Insurance Plans through 2 Insurance Carriers

Health Plans on the FFE

- Same set of essential benefits

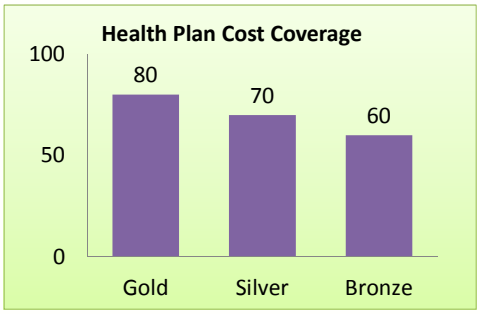
Ambulatory patient services	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance use disorder services, including 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

- Plans come in 4 categories: Catastrophic, Bronze, Silver, Gold
  - In general, the lower the premium, the higher the out-of-pocket costs. The higher the premium, the lower the out-of-pocket costs



Health Plans on the FFE: Metal Tiers

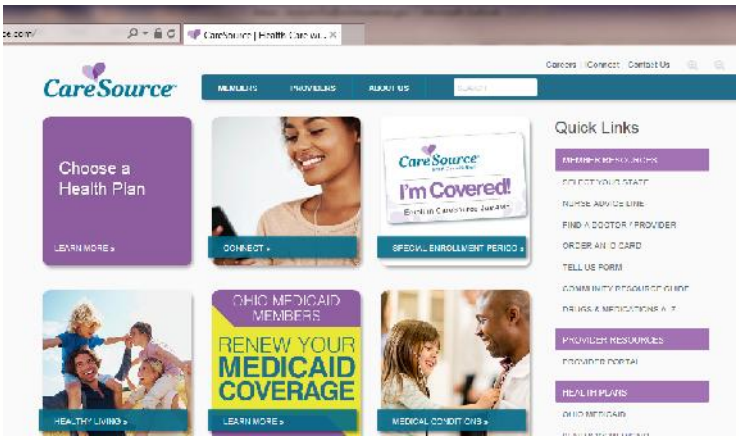
	Gold	Silver	Bronze
Monthly Cost	$$$	$$	$
Cost When You Get Care	$$	$$$	$$$$
Good Option If You...	want to save on monthly premiums while keeping your out-of-pocket costs low	need to balance your monthly premium with your out-of-pocket costs	don't plan to need a lot of health care services

Health Plans on the FFE

http://youtu.be/k1rxTQIbbWQ

Network

Network



Highmark

- 4 Products, Multiple Plans
  - Shared Cost
  - Balance Blue
  - Comprehensive Care
  - Health Savings
- Catastrophic
  - Major Events

Highmark West Virginia

Gold Balance Blue $500

- $500/$1000 Deductible
- $3000/$6000 OOP Max
- 80/60 Co-Insurance
- $40 Primary/$50 Specialist
- $150 Copay**, then 80% ER
- Rx $3/$50/$100/40%/50%
  - Tier 4 and 5 capped at $300 per script

Gold Balance Blue Plans Offered

- $500 Individual Deductible
- $750 Individual Deductible

- Balance Blue Plans offer Diagnostic Copays

**ER Copay waived if admitted.

GOLD

Highmark West Virginia

Gold Shared Cost $500

- $500/$1000 Deductible
- $3000/$6000 OOP Max
- 80/60 Co-Insurance
- $35 Primary/$45 Specialist
- $150 Copay**, then 80% ER
- Rx $3/$50/$100/40%/50%
  - Tier 4 and 5 capped at $300 per script

Gold Shared Cost Plans Offered

- $500 Individual Deductible
- $750 Individual Deductible
- $1000 Individual Deductible
- $1500 Individual Deductible

**ER Copay waived if admitted.

GOLD

Highmark West Virginia

Silver Balance Blue $1200

- $1200/$2400 Deductible
- $6850/$13,700 OOP Max
- 90/60 Co-Insurance
- $50 Primary/$90 Specialist
- $250 Copay**, then 100% ER
- Rx $3/$50/$100/40%/50%
  - Tier 4 and 5 capped at $300 per script

Silver Balance Blue Plans Offered

- $1200 Individual Deductible
- Balance Blue Plans offer Diagnostic Copays

**ER Copay waived if admitted.

SILVER

Highmark West Virginia

Silver Shared Cost $2500

- $2500/$5000 Deductible
- $6850/$13,700 OOP Max
- 80/60 Co-Insurance
- $40 Primary/$50 Specialist
- $150 Copay**, then 80% ER
- Rx $3/$50/$100/40%/50%
  - Tier 4 and 5 capped at $300 per script

Silver Shared Cost Plans Offered

- $2500 Individual Deductible
- $4750 Individual Deductible

**ER Copay waived if admitted.

SILVER

Highmark West Virginia

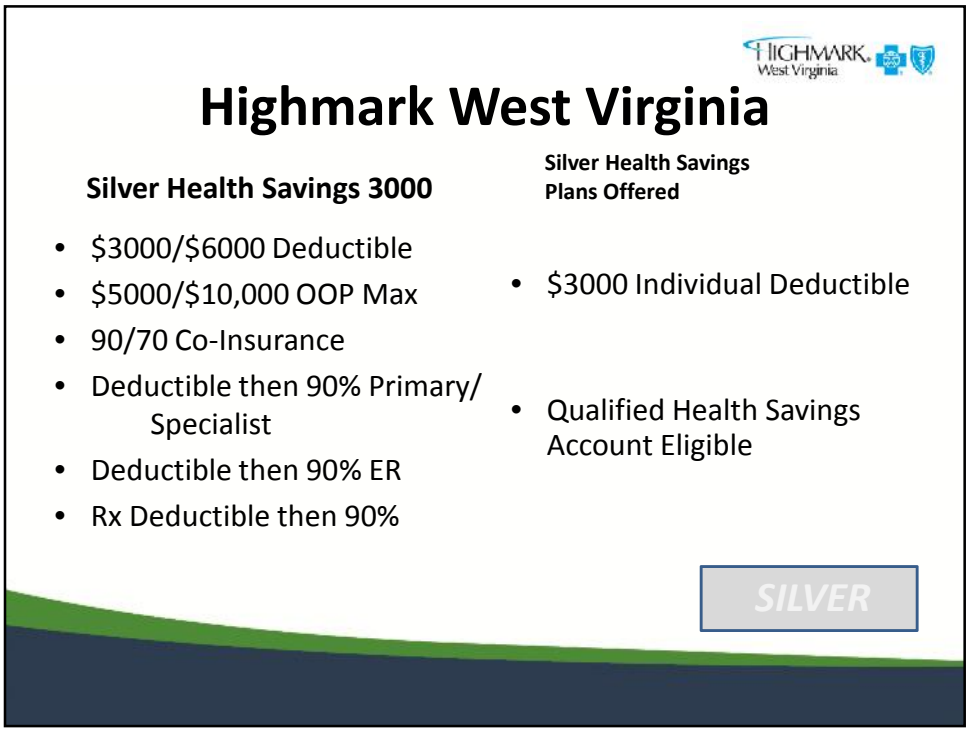
Silver Comprehensive Care $1500

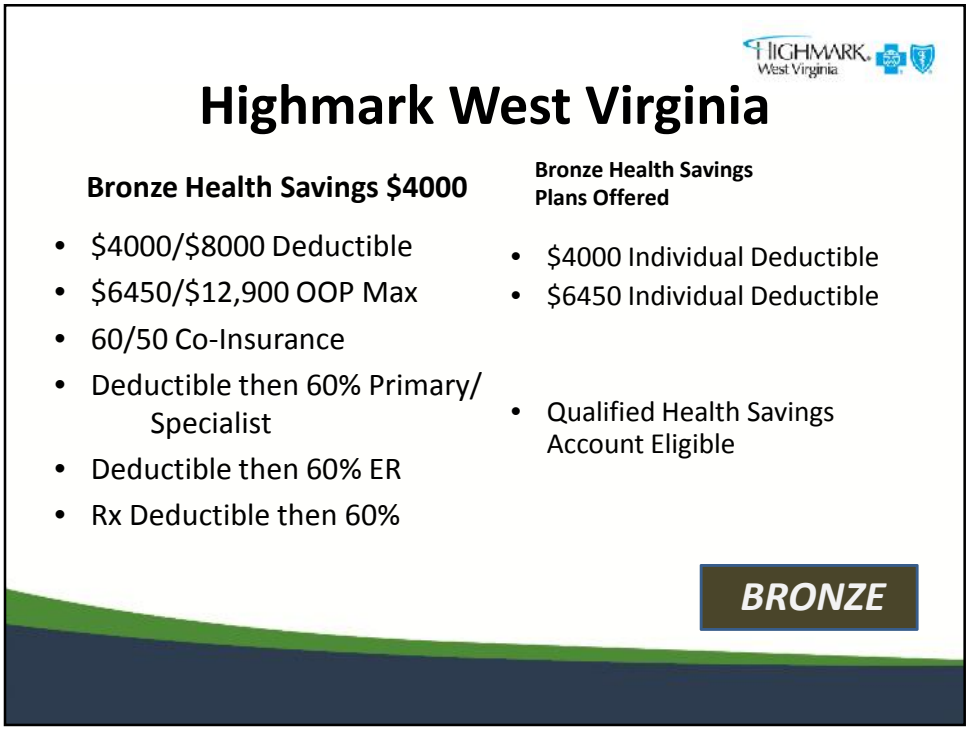
- $1500/$3000 Deductible
- $6850/$13,700 OOP Max
- 80/60 Co-Insurance
- Deductible then $35 Primary/ $70 Specialist
- Deductible then 80% ER
- Rx $3/$50/$100/40%/50%
  - Tier 4 and 5 capped at $300 per script

Silver Comprehensive Care Plans Offered

- $1500 Individual Deductible
- Office visit copays AFTER deductible

SILVER


HIGHMARK West Virginia
Highmark West Virginia
Silver Health Savings 3000
• $3000/$6000 Deductible
• $5000/$10,000 OOP Max
• 90/70 Co-Insurance
• Deductible then 90% Primary/ Specialist
• Deductible then 90% ER
• Rx Deductible then 90%
Silver Health Savings Plans Offered
• $3000 Individual Deductible
• Qualified Health Savings Account Eligible
SILVER


HIGHMARK West Virginia
Highmark West Virginia
Bronze Health Savings $4000
• $4000/$8000 Deductible
• $6450/$12,900 OOP Max
• 60/50 Co-Insurance
• Deductible then 60% Primary/ Specialist
• Deductible then 60% ER
• Rx Deductible then 60%
Bronze Health Savings Plans Offered
• $4000 Individual Deductible
• $6450 Individual Deductible
• Qualified Health Savings Account Eligible
BRONZE

Highmark West Virginia

Bronze Comprehensive Care $4000

- $4000/$8000 Deductible
- $6850/$13,700 OOP Max
- 50/50 Co-Insurance
- Deductible then $70 Primary/ $100 Specialist
- Deductible then 50% ER
- Rx Deductible then 50%

Bronze Comprehensive Care Plans Offered

- $4000 Individual Deductible
- Office visit copays AFTER deductible

BRONZE

Highmark West Virginia

Major Events Catastrophic Plan

- $6850/$13,700 Deductible
- $6850/$13,700 OOP Max
- 100% Co-Insurance
- 3 PCP Visits no cost sharing

TO OPM or NOT OPM… that is the question!

- MultiState Plans are those plans filed and regulated by the Office of Plan Management in Washington, D.C.
- Same benefits, Same network, Same rates
- Complaints go to OPM not the WV OIC

CareSource

Limited Availability in 2016

- Cabell
- Wayne
- Lincoln
- Putnam
- Kanawha
- Mason
- Marshall
- Ohio
- Brooke
- Hancock

Watch for more counties in 2017!!

CareSource

Gold

- $1000/$2000 Deductible
- $3500/$7000 OOP Max
  - $2000 Medical/$1500 Pharmacy
  - $4000 Medical/$3000 Pharmacy
- 80/60 Co-Insurance
- $0 Primary/$50 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

Silver

- $3500/$7000 Deductible
- $6500/$13,000 OOP Max
- 80/60 Co-Insurance
- $0 Primary/$50 Specialist
- $500 Copay**, then Deductible ER
- Rx $0/$50/$125/40%/50%
  - Tier 4 and 5 capped at $300 per script

**ER Copay waived if admitted.

SILVER

CareSource

Bronze

- $6650/$13,300 Deductible
- $6850/$13,700 OOP Max
- 80/60 Co-Insurance
- $40 Primary/$80 Specialist
- Deductible, then 40% ER
- Rx $20/$75/$200/40%/50%
  - Tier 4 and 5 capped at $200 per script

BRONZE

CareSource

Enhanced

- Each metal level plan has an enhanced match
- Enhanced Plans contain Dental and Vision Coverage
  - Dental has a $750 Annual Limit
    - Two Preventive visits per year
    - Basic Restorative and Major Restorative
  - Vision has a $150 Annual Limit
    - Prescription glasses or contacts
    - Frames
    - One exam a year covered under Medical

Gold Comparison

CareSource

- $1000/$2000 Deductible
- $3500/$7000 OOP Max
- 80/60 Co-Insurance
- $0 Primary/$50 Specialist
- $250 Copay, then Deductible ER
- Rx $0/$120/$160/40%/50%
  - Tier 4 and 5 capped at $300 per script

HighmarkWV

- $1000/$2000 Deductible
- $3500/$7000 OOP Max
- 80/60 Co-Insurance
- $35 Primary/$45 Specialist
- $150 Copay**, then 80% ER
- Rx $3/$50/$100/40%/50%
  - Tier 4 and 5 capped at $300 per script

GOLD

Silver Comparison

CareSource

- $3500/$7000 Deductible
- $6500/$13,000 OOP Max
- 80/60 Co-Insurance
- $0 Primary/$50 Specialist
- $500 Copay**, then Deductible ER
- Rx $0/$50/$125/40%/50%
  - Tier 4 and 5 capped at $300 per script

HighmarkWV

- $2500/$5000 Deductible
- $6850/$13,700 OOP Max
- 80/60 Co-Insurance
- $40 Primary/$50 Specialist
- $150 Copay**, then 80% ER
- Rx $3/$50/$100/40%/50%
  - Tier 4 and 5 capped at $300 per script

SILVER

Bronze Comparison

CareSource

- $6650/$13,300 Deductible
- $6850/$13,700 OOP Max
- 80/60 Co-Insurance
- $40 Primary/$80 Specialist
- Deductible, then 40% ER
- Rx $20/$75/$200/40%/50%
  - Tier 4 and 5 capped at $200 per script

HighmarkWV

- $4000/$8000 Deductible
- $6850/$13,700 OOP Max
- 50/50 Co-Insurance
- Deductible then $70 Primary/ $100 Specialist
- Deductible then 50% ER
- Rx Deductible then 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
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/16 – 12/31/16
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 1st.) 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. $4,850 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.

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 Numbers 1545-2229, 1210-0147, and 0938-1146 (corrected)
Released on April 23, 2015
1 of 12
WV-EXCM-73

CareSource: Just4Me Silver 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/16 – 12/31/16
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.
- **Coinsurance** 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.

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.

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ADVSBC, WV001(2016) B Silver 1

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 (corrected)
Released on Apr 23, 2015
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CareSource: Just4Me Silver 1

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

Coverage Period: 01/01/16 – 12/31/16
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	$50/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.	Manipulation therapy limited to 12 visits per Benefit Year.
	Preventive care/screening/immunization	$0/visit	Not covered.	Services must meet requirements as determined by federal and state law.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance after Deductible	Not covered.	
	Imaging (CT/PET scans, MRIs)	$150/procedure after Deductible	Not covered.	Prior Authorization Required.
If you need drugs to treat your illness or condition More information about prescription drug coverage 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.
	Preferred brand drugs	Retail: $40 Copay Mail Order: $100 Copay	Not covered.	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply.
	Non-preferred brand drugs	Retail: $125 Copay Mail-Order: $312.50 Copay	Not covered.	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.

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ADVSBC-WV001(2016)-B-Silver 1

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 (corrected)
Released on April 23, 2015
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CareSource: Just4Me Silver 1

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

Coverage Period: 01/01/16 – 12/31/16
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.
	Emergency medical transportation	30% Coinsurance after Deductible	30% Coinsurance after Deductible	
	Urgent care	$50/visit	Not covered.	If you receive services in addition to urgent care, additional Copays, Deductibles, or Coinsurance may apply.
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.	

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CareSource: Just4Me Silver 1

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

Coverage Period: 01/01/16 – 12/31/16
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	$300/stay 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	$300/stay after Deductible	Not covered.	
If you are pregnant	Prenatal and postnatal care	$50 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.

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ADVSBC-WV001(2016)-B-Silver 1

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 (corrected)
Released on April 23, 2013
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CareSource: Just4Me Silver 1

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

Coverage Period: 01/01/16 – 12/31/16
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.
	Rehabilitation services	30% Coinsurance after Deductible	Not covered.	Physical therapy, occupational therapy, speech therapy, and pulmonary rehab limited to 20 visits. Cardiac rehab is limited to 36 visits. Spinal manipulations are limited to 12 visits. Home health care limits apply when services are rendered in the home.
	Habilitation services	30% Coinsurance after Deductible	Not covered.	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	$100/stay 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 service	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.

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ADVSBC-WV001(2016)-B-Silver 1

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 (corrected)
Released on April 23, 2013
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CareSource: Just4Me Silver 1

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

Coverage Period: 01/01/16 – 12/31/16
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.	Limited 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
- Hearing Aids for Adults
- Routine foot care
- Dental Care (Adult)
- Long-term 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
- Bariatric Surgery
- Routine Eye Care
- Cosmetic Surgery
- Private Duty Nursing
- 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

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OMB Control Numbers 1545-2229, 1210-0147 and 0938-1146 (corrected)
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Coverage Examples

Coverage Period: 01/01/16 – 12/31/16
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
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,340
- **Patient pays** $1,200

Sample care costs:

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	**$7,540**

Patient pays:

Deductibles	$700
Copays	$350
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,790
- **Patient pays** $1,610

Sample care costs:

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**

Patient pays:

Deductibles	$1,150
Copays	$0
Coinsurance	$380
Limits or exclusions	$80
Total	**$1,610**

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

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ADVSBC-WV001(2016)-B-Silver 1

OMB Control Numbers 1545-2229, 1210-0147 and 0938-1146 (corrected)
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Highmark SBC

Highmark West Virginia: Balance Blue PPO 500
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 -12/31/2016
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, pediatric 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.
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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 -12/31/2016
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.
- **Coinsurance** 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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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

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

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

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——————

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Highmark West Virginia: Balance Blue PPO 500

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

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

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 **prescription drug coverage** 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/ $50 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.

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Highmark West Virginia: Balance Blue PPO 500

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

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

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 maintenance 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——
	Urgent care	$50 copay/visit	40% coinsurance	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——none——

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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

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

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

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

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

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

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. Combined network and cut-of-network: Habilitation and rehabilitation services.
	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——————
	Hospice service	20% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	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.
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WVHMK Balance Blue PPO500

Highmark West Virginia: Balance Blue PPO 500

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

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

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine foot care
- Termination of pregnancy, except in limited circumstances
- 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
- Chiropractic care
- Coverage provided outside the United States. See www.bcbsa.com
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine eye care (Adult)

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 Examples

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

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)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,730
- **Patient pays** $1,810

Sample care costs:

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	**$7,540**

Patient pays:

Deductibles	$500
Copays	$10
Coinsurance	$1,300
Limits or exclusions	$0
Total	**$1,810**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,300
- **Patient pays** $1,100

Sample care costs:

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**

Patient pays:

Deductibles	$500
Copays	$400
Coinsurance	$200
Limits or exclusions	$0
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.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.

10 of 11

WVHMK Balance Blue PPO500

Section 2

How to Enroll in a Health Plan in the FFE

Key Marketplace Dates for 2016

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

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

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 3

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.

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

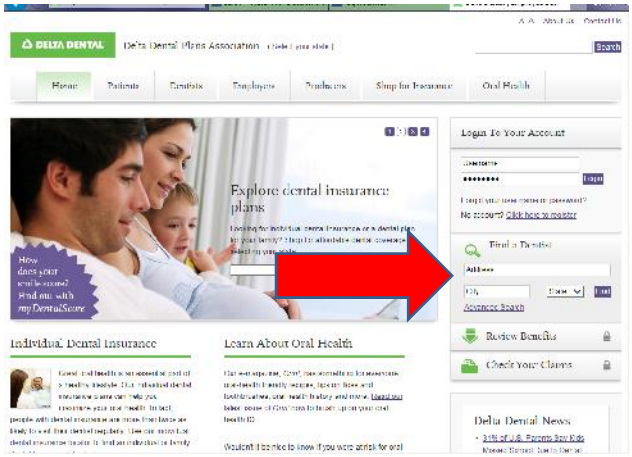
- $50 Deductible
- $1000 Annual Max
- 100/50
- No Major Coverage

Pediatric Benefits

- $45 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 Network



Dentegra Dental
Family Preferred

Adult Benefits
- $50 Deductible
- $1000 Annual Max
- 100/80/50

Pediatric Benefits
- $55 Deductible
- No Annual Max
- 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

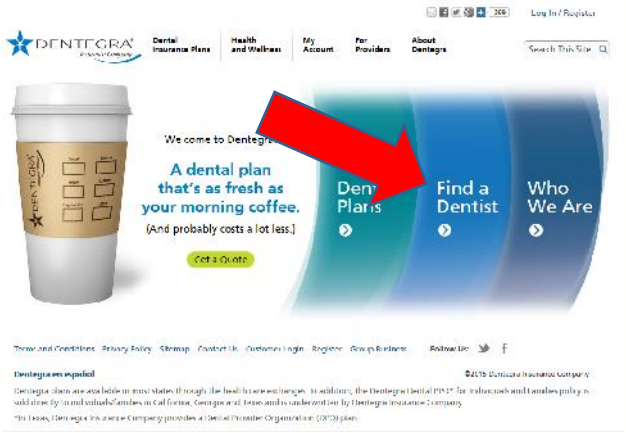
Dentegra Dental
Family Basic

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

Dentegra Network



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

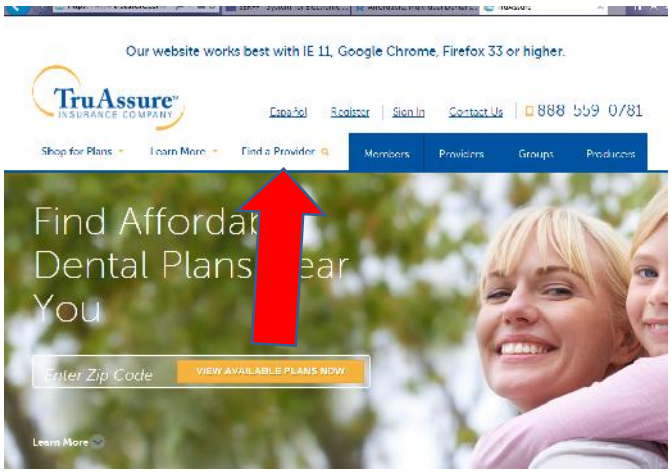
- $50 Deductible
- $2000 Annual Max
- 100/50 (6 month wait for Basic)
- No Major Coverage

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



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?

Better Solutions for Better Lives

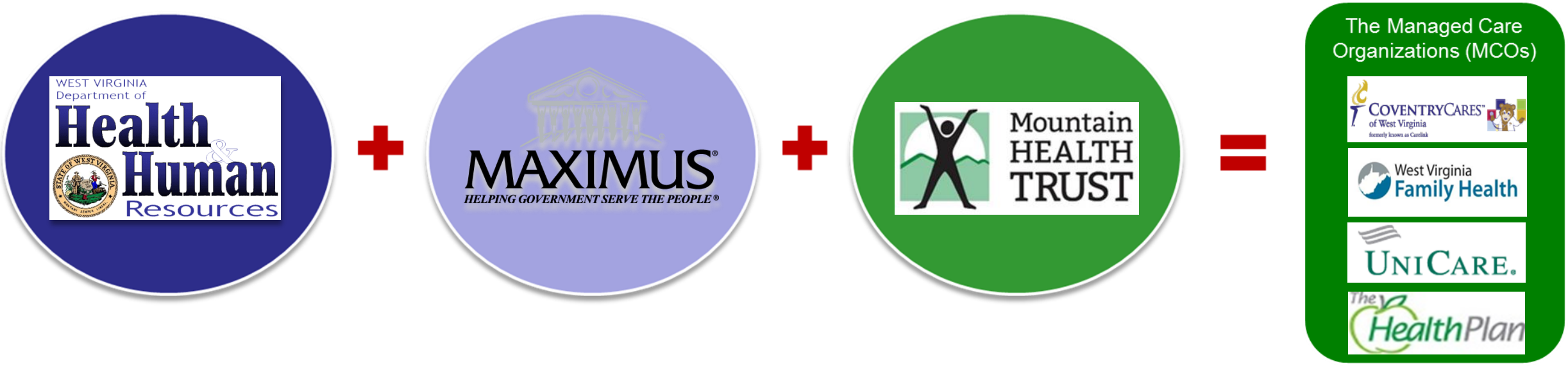
Mountain Health Trust: WV Enrollment Broker

MAXIMUS®
HELPING GOVERNMENT SERVE THE PEOPLE®

Mountain Health Trust
Member Enrollment
Health Plan Coverage
Medicaid Benefit
Collaboration

What is Mountain Health Trust?

- Mountain Health Trust is the Medicaid managed care program for West Virginia.
- With Mountain Health Trust, you choose a managed care organization (MCO) and a primary care provider (PCP).



Member enrollment: Medicaid Expansion

- As of August, 2015, approximately 148,810 expanded Medicaid members were transitioned from Fee-for-Service to a Managed Care Organization.

- Approximately 28% (513,680) of West Virginia's population is now covered by Medicaid utilizing either:
  - Fee-for-Service (126,236)
  - Managed Care (387,444)

- About 75% of the Medicaid population receives services through Mountain Health Trust.

Member enrollment: Materials

- All eligible members will receive an enrollment packet by mail. The packet will include:
  - Welcome Letter
  - Brochure that provides plan information on available MCO plans in West Virginia
  - Information on how to enroll into a MCO plan
  - Information regarding auto assignment

Member enrollment: Who must enroll?

- Mandatory enrollment!

- Most people who live in West Virginia and have a Medicaid card must enroll.
  - Traditional Medicaid Recipients (TR) (0% -133% of FPL)
  - Expanded Medicaid Recipients (MAGI) (133%-138% of FPL)

- Eligible members have (30-45) days to choose an MCO and PCP from their Medicaid eligibility effective date.

- If member does not choose before deadline, member will be auto assigned.

Member enrollment: Who does not have to enroll?

- You do not have to enroll in an MCO if you:
  - Are under the Aged/Disabled Waiver (SSI)
  - Are under the MR/DD Waiver
  - Have Medicare, but not Medicaid
  - Have both Medicare and Medicaid
  - Live in a long term care facility
  - Are in foster care
  - Are on the "spend down" program

What does a Health Plan cover?

- A plan will:
  - Coordinate the way you receive health care services.
  - Help you manage the high costs of services, such as doctor visits, hospital stays, prescription drugs, and preventive care.

Essential Services Included

- Inpatient/Outpatient
- Home Health
- Family Planning
- Hospice
- Prescriptions
- Tobacco Cessation
- Ambulance
- Up to Age 21:
  - Vision, Hearing, Dental

Medicaid benefit: Managed Care and Fee-for-Service

Medicaid Managed Care

- MCO members will utilize their health plan benefits when receiving healthcare services.
- MCO members should have their annual Medicaid medical card and their MCO membership ID card.
- Providers will bill the members MCO health plan for services provided.

Medicaid Fee-for-Service

- Individuals who are exempt from an MCO will utilize Fee-for-Service benefit when receiving healthcare services.
- Medicaid Fee-for-Service members should have their annual Medicaid medical card.
- Providers will bill Fee-for-Service for services provided.

Medicaid benefit: Verification

Molina Portal for Members

- Print temporary proof of coverage
- View your Medicaid programs and benefits
- Search the provider directory

Website: www.wvmmis.com
Member Services: 888-483-0797

Molina Portal for Providers

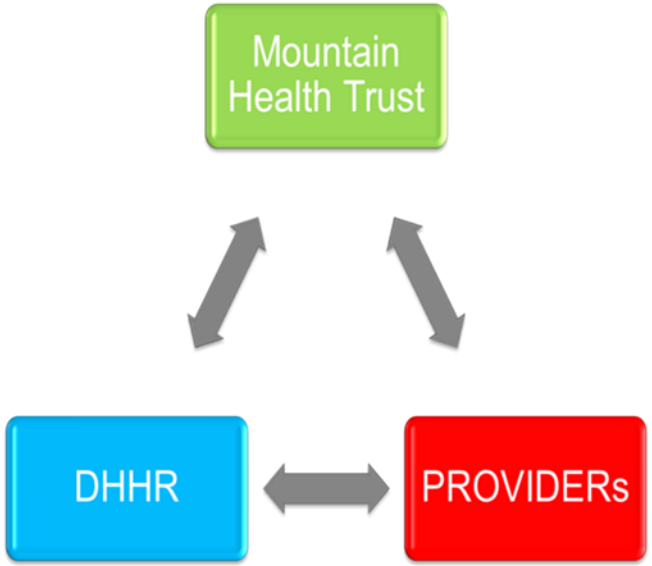
- Verify member eligibility
- Submit and adjust claims
- Verify claim status
- View authorizations
- Check Provider Enrollment
- Application Status

Website: www.wvmmis.com
Provider Services: 888-483-0793

Collaboration: Core Partners

Core Partner Relationships

- Provide services to the same Medicaid Members:
- Mountain Health Trust will focus on connecting with the WV DHHR and its many internal programs.
- Mountain Health Trust will also focus on connecting with healthcare providers.



Have Questions or Need Help?

Mountain HEALTH TRUST

MAXIMUS

	O&E Supervisor - Ronnie Smith Jr. RonnieSmith@Maximus.com (304) 741-8776
	Region I - OES Steven Richardson StevenPRichardson@Maximus.com (304) 844-6148
	Region II - Ronnie Smith Jr. RonnieSmith@Maximus.com (304) 741-8776
	Region III - OES Heather Ray HeatherRay@Maximus.com (304) 707-8501
	Region IV - OES Teresa Long TeresaLLong@Maximus.com (304) 550-1744

WEST VIRGINIA Department of Health Human Resources

Mountain HEALTH TRUST

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
- You can enroll in PAAS in Wayne or Cabell county

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

CoventryCares of West Virginia	**Member Services: 1-888-348-2922** **Provider Services: 1-800-348-2922** **Website:** www.chcwv.com
The HealthPlan	**Member Services: 1-888-613-8385** **Provider Services:1-877-847-7901** **Website:** www.healthplan.org
UniCare	**Member Services: 1-800-782-0095** **Provider Services: 1-800-782-0095** **Website:** www.unicare.com/Medicaid
West Virginia Family Health	**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

Plan Code	Benefit Package Code	Rate Code	Coverage Group	Description
MHT	TR	CMAAR	TANF Parent Caretaker/Relative	Adult Medicaid based on deprivation of natural or adoptive child - Deprivation factor is the death, absence, or incapacity of the other parent of child
MHT	TR	CMEC	Traditional TANF	Eligibility considered when the parent becomes ineligible for AFDC due to receipt of Child Support income (limited to 4 months of continuous coverage)
MHT	TR	CMED	Traditional TANF	When the parent is no longer eligible for the $30 disregard
MHT	TR	CMEI	Traditional TANF	Eligibility considered when parent's income exceeds AFDC limits and has received AFDC for 3 of the past 6 months - may be 6-12 months of coverage
MHT	TR	CMEP	TANF Pregnant Women	Formerly post-partum coverage, merged into MFPP in 2008
MHT	TR	CMES	Traditional TANF	Eligibility considered when the parent becomes ineligible for AFDC due to receipt of Spousal Support income (limited to 4 months of continuous coverage)
MHT	TR	CMET	Traditional TANF	When the parent is no longer eligible for the $30 & 1/3 disregard
MHT	TR	FCMAOR	Medically Needy	Caretaker-Relative Medicaid based on deprivation factor of a child which the adult is the caretaker for, may be a minor parent as caretaker relative - The deprivation factor in this category is the death, absence, or incapacity of one or both parents of the child
MHT	TR	FCMFPC	Traditional TANF	Medicaid coverage for child age 1-5 (under 133% FPL)
MHT	TR	FCMFPI	Traditional TANF	Medicaid coverage for children under age 1 - Used when the child's mother was not a Medicaid recipient at the time of birth & child is income eligible (under 150% Federal Poverty Level [FPL])
MHT	TR	FCMFPP	TANF Pregnant Women	Pregnancy & 60-day post-partum coverage If the mother is under 19 when post-partum coverage is closed, the worker should evaluate for MQCA at the time of closure
MHT	TR	FCMGAD	Medically Needy/MAGI	MAGI Adult - Medically Frail
MHB	AB	FCMGAD	MAGI Adult Expansion	MAGI Adult
MHT	TR	FCMGKF	Traditional TANF/MAGI	Children's Medicaid (1-5)
MHT	TR	FCMGKS	Traditional TANF/MAGI	Children''s Medicaid (under 19)
MHT	TR	FCMGME	Traditional TANF/MAGI	Extended Medicaid
MHT	TR	FCMGMS	Traditional TANF/MAGI	MAGI Spousal Support
MHT	TR	FCMGPE	TANF Pregnant Women/MAGI	MAGI Pregnancy Expansion
MHT	TR	FCMGPC	TANF Parent Caretaker/Relative/MAGI	MAGI Parent / Caretaker
MHT	TR	FCMGPR	TANF Pregnant Women/MAGI	MAGI Pregnancy
MHT	TR	FCMN	Traditional TANF	Continuously eligible newborn Medicaid - Mother must have been receiving Medicaid at the time of birth - This should be backdated to the date of birth; if not the client needs referred to the Change Center or Client Services for corrective action.
MHT	TR	FCMNMG	Traditional TANF/MAGI	Children's Medicaid for kids 0-1
MHT	TR	FCMQCA	Traditional TANF	Qualified Children under 19 born after 9/30/83 (under 100% FPL)
MHT	TR	FUMAOU	Medically Needy	Caretaker Relative Medicaid based on deprivation factor of underemployment or unemployment of the caretaker relative
MHT	TR	UMAAU	TANF Parent Caretaker/Relative	Adult Medicaid based on deprivation of natural or adoptive child - Deprivation factor in this category is unemployment

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

MEDICAID BENEFITS COMPARISON CHART

Benefit Provided	Traditional Medicaid Benefits Non-MAGI / TANF (TR) MCO Plan Choice Mandatory		WV Health Bridge Medicaid Benefits Alternative Benefit (AB) MAGI / EXPANSION MCO Plan Choice Mandatory	
	Covered	Service Limits	Covered	Service Limits
Primary Care Office Visits	X		X	
Specialty Care	X		X	
Podiatry	X		X	
Chiropractic	X		X	*Limit of 24 treatments/year. Additional 6 treatments per calendar year can be prior authorized if OT and PT services have not been utilized in combination with chiropractic services.*
Diagnostic X-ray	X		X	
Outpatient Hospital Services	X		X	
Hospice	X		X	
Nursing Home			*Not Covered*	
Emergency Room Outpatient Hospital Services	X		X	
Emergency Transportation/Ambulance	X		X	
Inpatient Hospital Care	X		X	
Hospital Inpatient/Maternity	X		X	
Outpatient/Maternity	X		X	
Outpatient Psychiatric Treatment	X		X	
Rehabilitative Psychiatric Treatment	X		X	
Inpatient Psychiatric Hospital	X		X	
Prescription Drugs	X		X	
Physical Therapy	X	*20 visits per year (combined PT and OT, additional authorization required over limit)*	X	*30 visits per year for Habilitative and Rehabilitative services (combined PT and OT)*

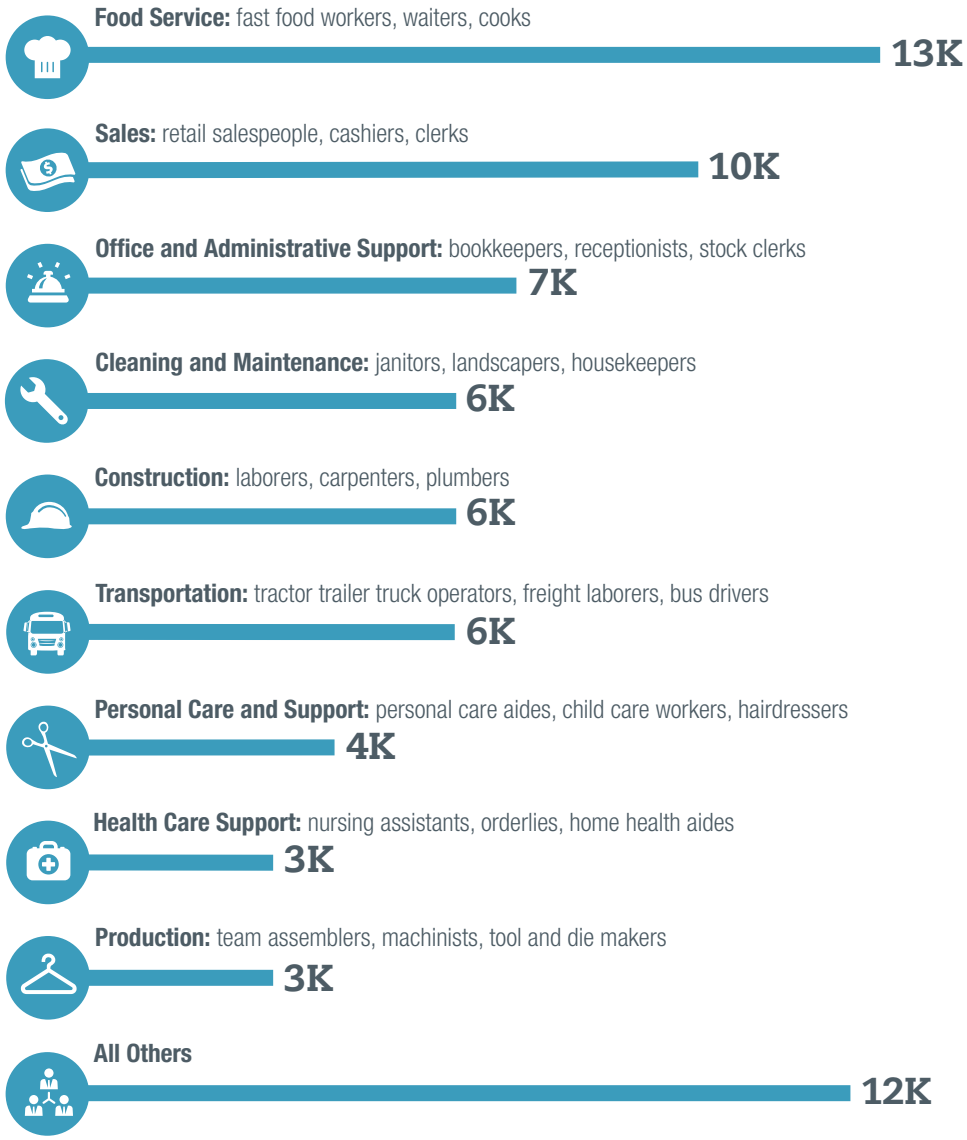
WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

MEDICAID BENEFITS COMPARISON CHART

Benefit Provided	Traditional Medicaid Benefits Non-MAGI / TANF ó¢WÚ MCO Plan Choice Mandatory		Alternative Benefit (AB) MAGI / EXPANSION MCO Plan Choice Mandatory	
	Covered	Service Limits	Covered	Service Limits
Occupational Therapy	X	*20 visits per year (combined PT and OT, additional authorization required over limit)*	X	*30 visits per year for Habilitative and Rehabilitative services (combined PT and OT)*
Speech Therapy	X		X	*Habilitative and Rehabilitative services*
Cardiac Rehabilitation	X		X	
Pulmonary Rehabilitation	X		X	
Durable Medical Equipment	X		X	
Orthotics and Prosthetics	X		X	
Home Health	X	*60 visits per year (additional authorization required over limit)*	X	*100 visits per year*
Inpatient Rehabilitation Hospital Services	X		X	
Laboratory Services and Testing	X		X	
Diabetes Education	X		X	
Early Periodic Screening, Diagnosis, and Treatment	X		X	
Family Planning Services and Supplies	X		X	
Nutritional Counseling	X		X	
Tobacco Cessation	X		X	
Non-Emergency Medical Transport (NEMT)	X		X	
Personal Care	X		*Not Covered*	

Top 9 occupations of the working West Virginia residents who can benefit from Medicaid expansion

In 2014, West Virginia accepted federal funds to provide health insurance to more low-income residents through Medicaid. That's meant health insurance for more hard-working West Virginians. Fully 55 percent of those who can benefit from Medicaid expansion are working adults. They work in industries that are the foundation of the state's economy.



Top 9 occupations of workers who can benefit from West Virginia's Medicaid expansion

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Medicaid expansion is a sound investment for West Virginia, creating a healthier workforce and strengthening the state's economy.

Our calculations define West Virginia adults with incomes under 138% of poverty who are employed but lack health insurance and who are currently working or who have worked in the last 12 months. This population is equal to 55 percent of 127,000 uninsured adults who could benefit from expanded coverage (based on 2010-2012 U.S. Census data). It excludes the following: people who have never worked or who have been out of the workforce for 5 years or more (28% of the 127,000 uninsured adults), and those we define as "unemployed," who had not worked in 1-5 years (17% of the 127,000 uninsured adults).

Note: People are classified according to the job they now have or the last job they held in the prior 12 months.

Source: These data are based on information from the American Community Survey, which is conducted by the U.S. Census Bureau. Data are for 2010-2012 and are based on an analysis of uninsured West Virginia residents ages 18-64 with family incomes up to 138% of the federal poverty level ($27,720 for a family of three in 2015).

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

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Medicaid: An Essential Program for States and Their Residents

Medicaid

Medicaid is a health insurance program that serves low-income Americans, including children, seniors, and people with disabilities. It is jointly funded by states and the federal government. Federal Medicaid funding is a reliable, vital source of financial support for states, and making even minor changes to Medicaid's financing structure would leave states with large budget holes.

Medicaid Is a State-Federal Partnership That Helps States Better Serve Residents' Health Care Needs

States don't have to have a Medicaid program, but all states do because they recognize that Medicaid helps them serve their residents' health care needs.

Without Medicaid, states would need to find ways to fund health care and long-term care for their low-income residents using state funding alone, as very few Medicaid enrollees can afford private coverage. More state dollars would be spent on hospital care that patients can't pay for (also called "uncompensated care"); institutional care, like care in nursing homes; and health care services for people who go bankrupt paying for medical care.

Medicaid Is a Reliable Source of Funding for States

For 50 years, Medicaid has been a consistent source of financial support for states.[1] The federal government pays for at least half of each state's Medicaid program costs, matching state spending at least dollar for dollar. In many states, the federal share, or "matching rate," is even higher. This matching rate is based on a formula that considers each state's economic condition. In 2015, the federal government is paying an average of 59 percent of total Medicaid costs, and in some states, it is paying more than 70 percent.[2]

For states that expand Medicaid coverage under the Affordable Care Act (ACA), the federal match is even more generous: The federal government pays all the costs of newly eligible enrollees through 2016, with the federal share gradually decreasing to 90 percent in 2020, where it will stay.[3]

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Medicaid's Funding Structure Protects States and Allows Innovation

The formula that is used to determine states' matching rates for their traditional Medicaid programs has remained essentially unchanged for 50 years (this excludes Medicaid expansions, referred to above, which are a new option under the ACA that have their own matching rate). In the few instances where the federal government has changed these matching rates, the changes were explicitly temporary and typically increased federal support to help states during times of economic crisis.[4] For example, all states received a temporary increase in federal Medicaid matching funds during the last recession.

Because federal support is linked to state costs, states can be sure they'll receive increased support if their residents' health needs change—like during a flu epidemic or a natural disaster.

This dependable funding structure gives states more latitude to experiment with different program designs. For example, states can test projects that pay for care coordination services for people with multiple chronic illnesses. If costs for these "pilot programs" are higher than anticipated, the federal government shares the cost.

States Have the Flexibility to Design Medicaid Programs That Work for Their Residents

There are broad federal guidelines designed to ensure that state Medicaid programs further the program goals that Congress laid out. But within these guidelines, states have wide latitude to design and adopt optional programs to suit their needs. For example, states can add services or cover additional populations, and a number of states use this flexibility to develop and run pilot programs aimed at improving quality of care and reducing costs.

Every state has taken advantage of this opportunity: All states provide some optional Medicaid services or cover some optional Medicaid populations.[5,6]

Medicaid Is Critical to State Budgets

Medicaid funding makes up more than half of all the federal funds that go to states.[7] Because Medicaid is a vital source of state revenue, enacting even minor changes to Medicaid's financing structure would have profound effects on state budgets.

For instance, many states that have expanded Medicaid under the ACA have realized budget savings as a result of their expansion:[8] Expanding Medicaid reduces the number of low-income uninsured

residents, which means the demand for state-funded health services declines. And because the federal government covers virtually all the costs of expansion, added costs to states will be minimal.[9]

On the other hand, federal proposals to cap or cut federal Medicaid spending would create large budget holes for states.[10]

Medicaid Dollars Are Spent Efficiently

Medicaid provides comprehensive coverage to enrollees at much lower costs per person than private insurance. For example, compared to private insurance, Medicaid spends, on average, 40 percent less on administrative costs like marketing, advertising, and collecting premiums.[11] Medicaid costs have also grown more slowly than costs in the private market.

As a lean program, Medicaid has very little fat to cut. Therefore, changing how Medicaid is financed will likely shift costs to states and enrollees.

Medicaid Helps Make the Health Care System Stronger for Everyone

Medicaid is a critical source of revenue for doctors, hospitals, nursing homes, and other health care providers that are the foundation of a state's health care system. This is especially true in underserved areas, like rural counties. For example, physicians in rural areas receive almost 20 percent of their patient revenue from Medicaid. Nationally, the average is about 17 percent.[12] Similarly, Medicaid is a critical payer for care that is provided at rural hospitals.[13]

The financial support that Medicaid provides to rural, suburban, and urban hospitals benefits not just Medicaid enrollees, but everyone in the health care system.

The Medicaid program is a reliable source of funding for states that bolsters their economies and allows them to do more to meet their residents' health care needs than they could on their own.

Endnotes

1 Melissa Burroughs, "Medicaid: 50 Years of Helping States Achieve Health and Economic Gains," Families USA blog (July 21, 2015), available online at http://familiesusa.org/blog/2015/07/medicaid-50-years-helping-states-achieve-health-and-economic-gains.

2 Kaiser Family Foundation, State Health Facts, *Federal and State Share of Medicaid Spending*, available online at http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/, accessed on August 14, 2015.

3 Robin Rudowitz, *Understanding How States Access the ACA Enhanced Medicaid Match Rates* (Washington: Kaiser Family Foundation, September 29, 2014), available online at http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/.

4 Edwin Park, *History Rebuts Claim That Federal Medicaid Matching Rates Are Unstable* (Washington: Center on Budget and Policy Priorities, February 3, 2014), available online at http://www.cbpp.org/blog/history-rebuts-claim-that-federal-medicaid-matching-rates-are-unstablehttps://kaiserfamilyfoundation.files.wordpress.com/2013/01/7872.pdf.

5 For example, every state provides some Medicaid coverage of home- and community-based services for seniors or people with disabilities. These are optional (not required) Medicaid services. See Kaiser Family Foundation, State Health Facts, *Medicaid Benefits: Home and Community-Based Services Waiver*, available online at http://kff.org/medicaid/state-indicator/home-and-community-based-services-waiver/, accessed on August 17, 2015.

6 Congressional Budget Office, *An Overview of the Medicaid Program* (Washington: Congressional Budget Office, September 18, 2013), available online at https://www.cbo.gov/publication/44588.

7 Brian Sigritz, "Medicaid Represents a Majority of All Federal Funds to States for the First Time," *NASBO Budget Blog*, June 25, 2015, available online at https://www.nasbo.org/budget-blog/medicaid-represents-majority-all-federal-funds-states-first-time.

8 Deborah Bacharach, Patricia Boozang, and Dori Glanz, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains* (New Jersey: The Robert Wood Johnson Foundation and Manatt Health Solutions, April 2015), available online at https://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/Manatt_StateExpandMedicaid_4_9_15.pdf; Stan Dorn, Norton Francis, Robin Rudowitz, and Laura Snyder, *The Effect of Medicaid Expansion on State Budgets: An Early Look in Select States* (Menlo Park, CA: The Kaiser Family Foundation, March 11, 2015), available online at http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/.

9 Under the ACA, the federal share of expansion costs never falls below 90 percent.

10 Dee Mahan, *How Per Capita Caps Would Hurt States* (Washington: Families USA, January 2015), available online at http://familiesusa.org/product/how-capita-caps-medicaid-would-hurt-states.

11 Federal spending on Medicaid administrative costs averaged just 8.5 percent of total Medicaid spending, compared to private health plans, where administrative spending averages 12 percent of total spending. Centers for Medicare and Medicaid Services, *National Health Expenditures by Type of Service and Source of Funds, CY 1960-2013* (Washington: Department of Health and Human Services, CMS, 2013), available online at http://www.cms.gov/Research- Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ NationalHealthExpendData/Downloads/NHE2013.zip.

12 Jon Bailey, *Medicaid and Rural America* (Lyons, NE: Center for Rural Affairs, February 2012), available online at http://files.cfra.org/pdf/Medicaid.pdf.

13 Ibid.

A selected list of relevant publications to date:

Medicaid: Connecting Low-Income Seniors and People with Disabilities to Health and Long-Term Care (July 2015)

Medicaid: Providing Enrollees with Access to Health Care (July 2015)

This publication was written by:
Andrea Callow, Medicaid Policy Analyst, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

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Dee Mahan, Director of Medicaid Advocacy

Evan Potler, Art Director

Ingrid VanTuinen, Director of Editorial

A complete list of Families USA publications is available at:
www.familiesusa.org/publications

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THE VOICE FOR HEALTH CARE CONSUMERS

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www.FamiliesUSA.org
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twitter / @FamiliesUSA

*Please keep and store this form to use in future years

Marketplace Enrollment Form

Email Address_____

Email Password_____

Website Used: ___**healthcare.gov**

Website Username_____

Website Password_____

Security Questions

Question 1_____

Question 2_____

Question 3_____

Question 4_____

Advanced Premium Tax Credit

Estimated Income Used_____

Advanced Premium Tax Credit Used Per Month_____

- If your income is **less** than the Estimated Income Used, you may receive the difference as refundable credit when you file your taxes.
- If your income is **more** than the Estimated Income Used, you may have to pay back some of the tax credit you received when you file your taxes.
- If any of the information on your application **changes** (including: income, family size, marriage/divorce, availability of insurance through your job, etc.) you should report it to the Marketplace by logging onto healthcare.gov or calling the call center at 1-800-318-2596.
- If you had a Marketplace health insurance plan and used advance payments of the premium tax credit to lower your monthly premiums, you **must** file a federal income tax return.

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***. Consumers should seek the advice of a tax professional to verify available tax subsidies.

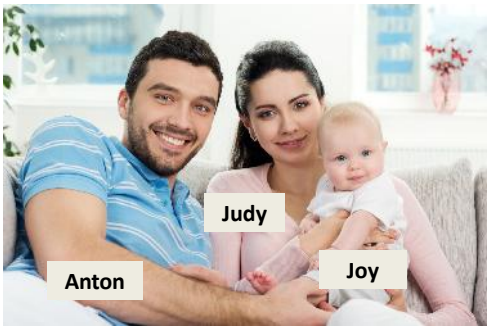
Apply for Coverage in the Marketplace

Updated Streamlined Application Process for Consumers New to the Marketplace

May 2015

Meet the Weiss Family (Simple Household Scenario)

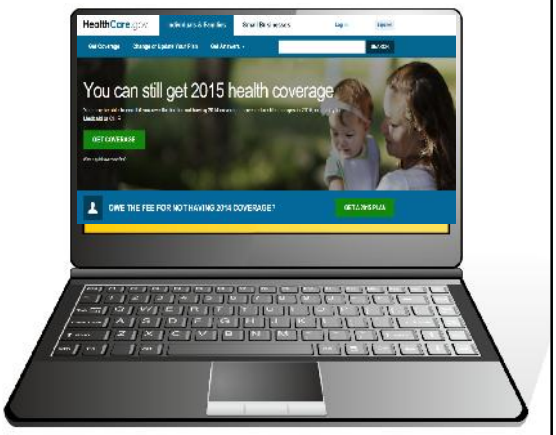
The Weiss family needs health coverage. They visit HealthCare.gov to view their Marketplace coverage options.



Anton Visits HealthCare.gov to Shop for Affordable Health Care

The family lives in Montgomery, Alabama.

HealthCare.gov allows everyone to enter their sta and automatically be directed to the proper Marketplace.



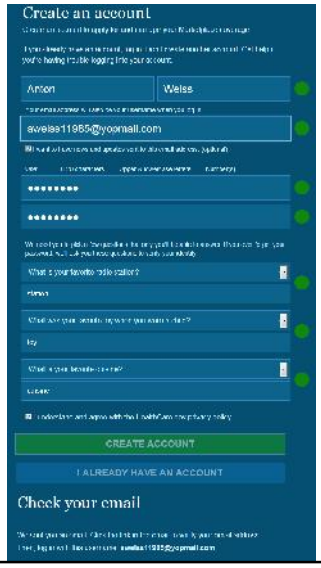
Get Coverage/ Select Your State

Anton picks his state to create a Marketplace account and start an application for coverage.

Create an Account

1. Your email address is also username
2. Real-time verification of email typos
3. Green checkmarks that dynamically pop up as you successfully complete each section and meet password criteria

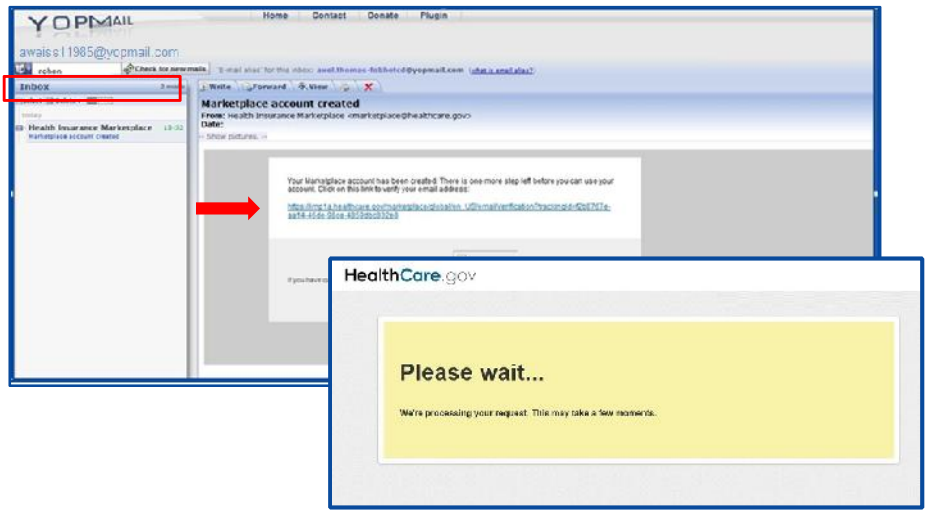
Verify Your Email



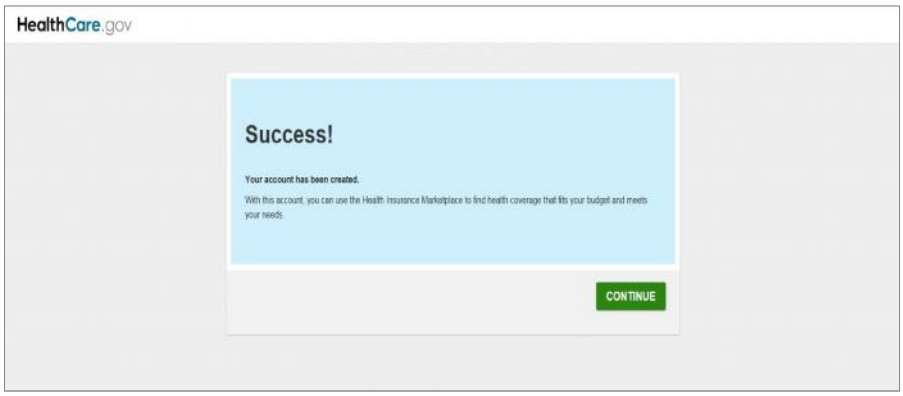
- Notification includes a direct link to major email providers

- Some email addresses will not include a direct link

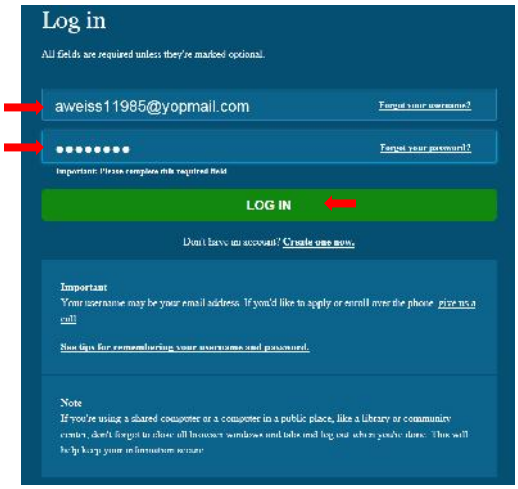
Verify Your Email



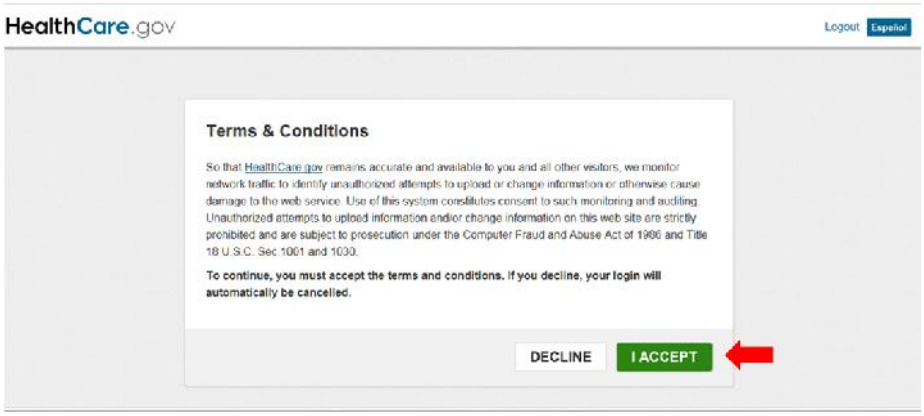
Account Created



Log In to Marketplace Account

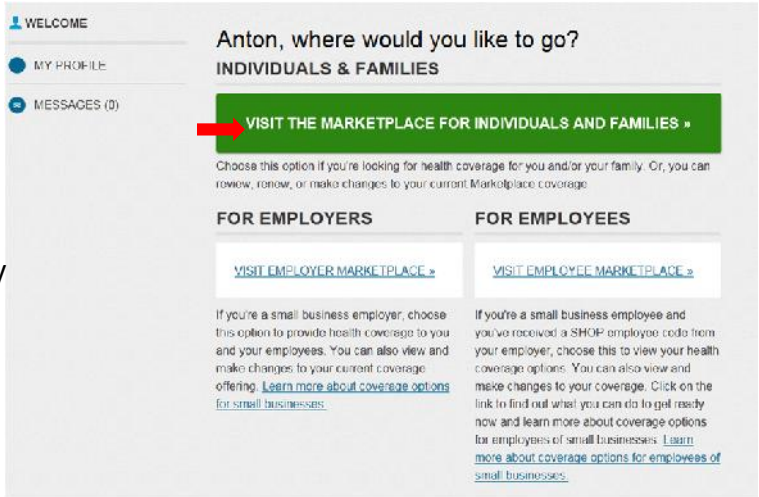


Accept Terms & Conditions

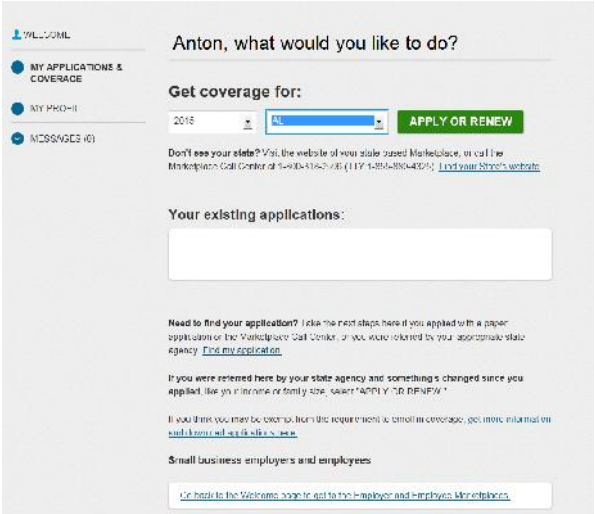


Consumer Paths

Anton will be applying for family coverage



Guiding Question

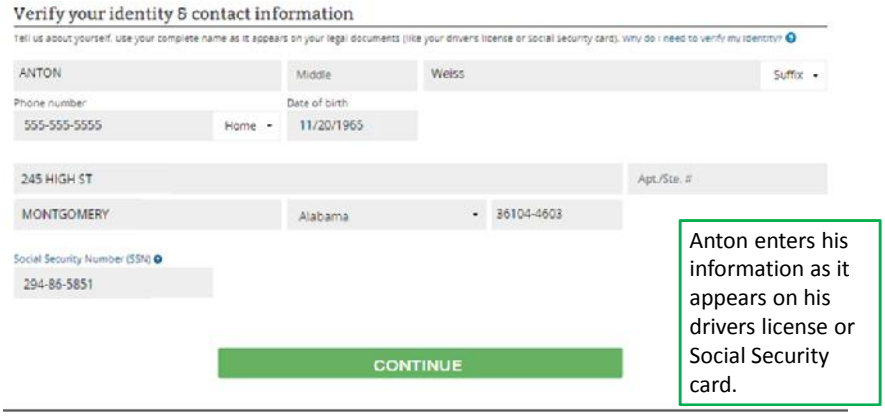


State Application

Anton gathers the information he will need.

May 2015 Marketplace Streamlined Application 13

Enter Your Information



Anton enters his information as it appears on his drivers license or Social Security card.

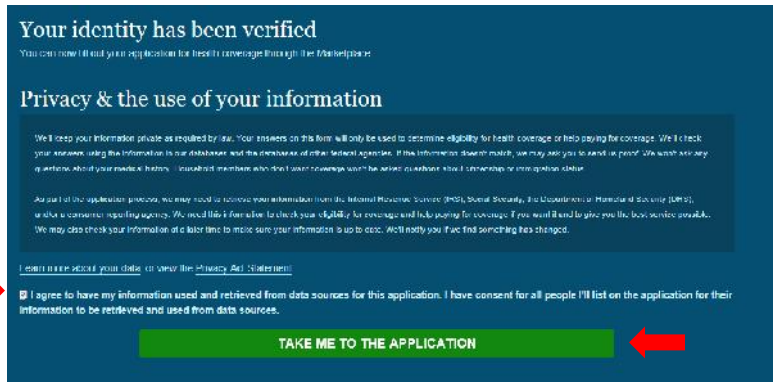
May 2015 Marketplace Streamlined Application 14

Verify Your Identity

And answers questions based on information he provided to verify his identity

Privacy Policy

Anton understands and checks he agrees with how his information will be used



Household Information

Anton's response to these questions will divert him between two possible paths:

- Financial Assistance
- Non- Financial Assistance

HealthCare.gov | Individuals & Families | Small Businesses

Apply

Before you get started

Are you single or married?

SINGLE MARRIED

How many tax dependents, like your children, will you claim on your 2015 tax return?

Who's applying for coverage? Select all that apply.

ME

MY SPOUSE

MY DEPENDENT

NEW Screener

How much income will you make this year? (optional)

$83,000 OR LESS MORE THAN $83,000

Based on your estimated household income in 2015 of less than $83,000, you may get help paying for coverage. Do you want to answer additional questions to see if you qualify for help paying for coverage?

YES NO

CONTINUE

Anton's household income is less than $83,000, and wants to know whether he qualifies for help paying for coverage.

May 2015

17

Response to These Questions Direct Consumer to Proper Application

NEW Questions have been re-grouped and organized

Questions about everyone:
You, your spouse, and 1 dependent

Questions about people applying for coverage:
You, your spouse, and 1 dependent

Questions about your 1 dependent

CONTINUE

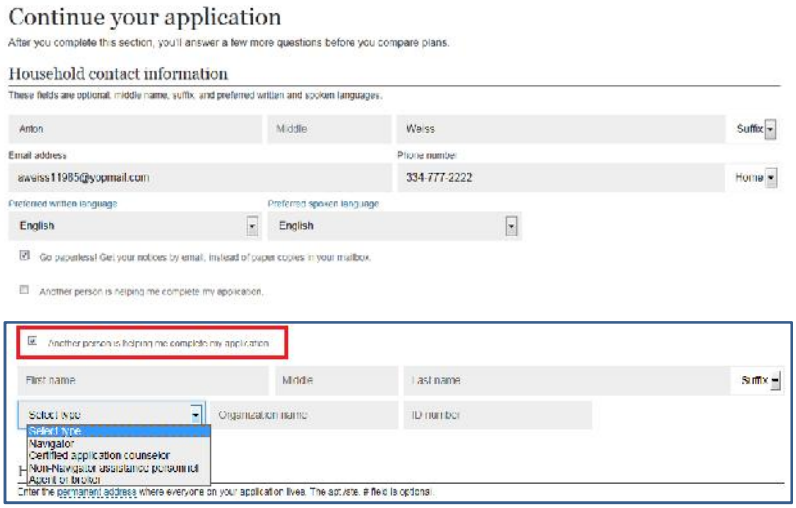
Anton's response to questions directs him to the shorter streamlined application.

May 2015

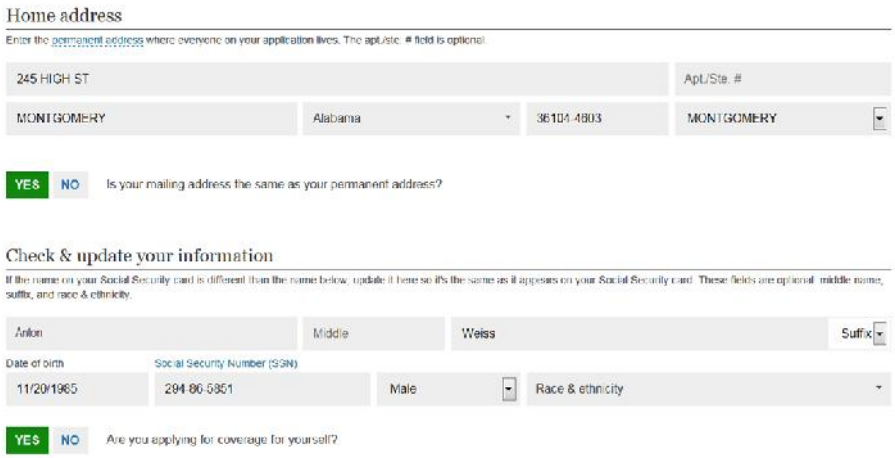
18

Contact Information

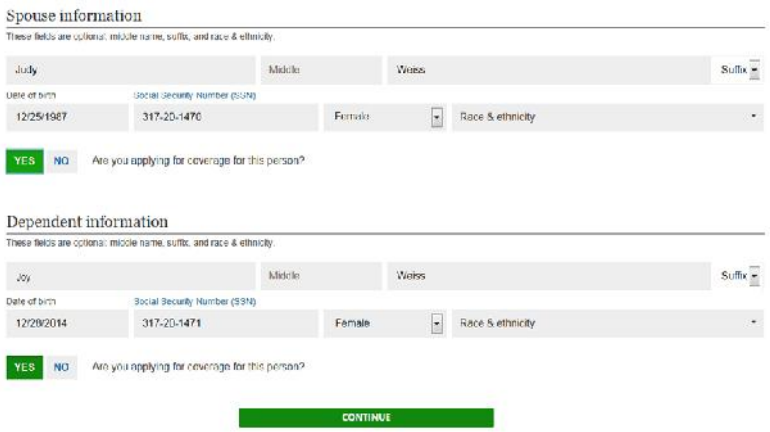
Anton enters his information as the point of contact for his household.



Contact Information Continued

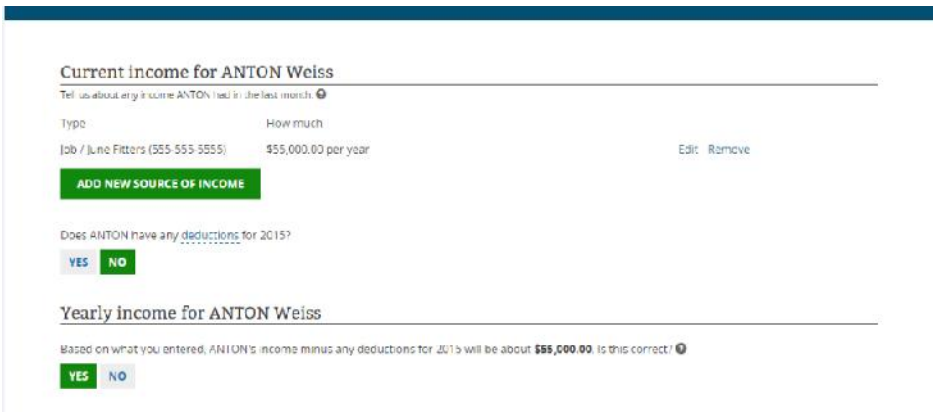


Adding Household Members



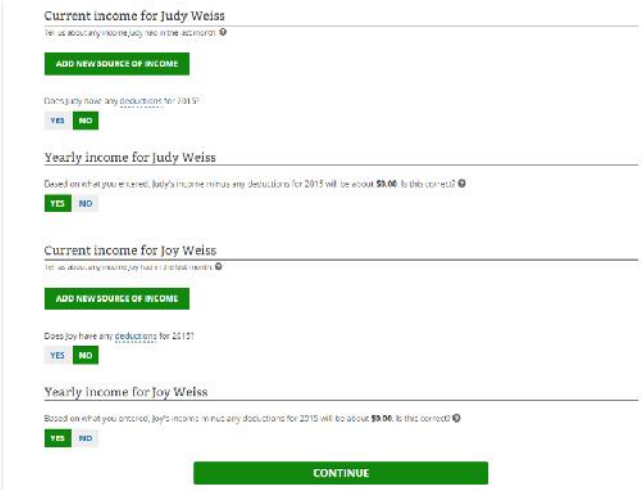
Income Information

Anton's Income



Spouse Income

Anton adds his spouse's income for a total household income



Special Circumstances

HealthCare.gov | Individuals & Families | Small Businesses

Apply

Additional questions

Application ID: 96910154

You're almost done. Answering these questions will give you a better chance of getting coverage.

Do any of these people have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs? (optional)

- ANTON Weiss
- Judy Weiss
- Joy Weiss

Do any of these people need help with daily activities (like dressing or using the bathroom), or live in a medical facility or nursing home? (optional)

- ANTON Weiss
- Judy Weiss
- Joy Weiss

Do any of these people need help paying their medical bills from the last 3 months? (optional)

- ANTON Weiss
- Judy Weiss
- Joy Weiss

CONTINUE

These few questions help determine whether Anton qualifies for Medicaid programs.

Current Coverage

ANTON Weiss's coverage information

Is ANTON Weiss currently enrolled in health coverage?

YES NO

Judy Weiss's coverage information

Is Judy Weiss currently enrolled in health coverage?

YES NO

Joy Weiss's coverage information

Is Joy Weiss currently enrolled in health coverage?

YES NO

Additional coverage questions

Do you need 2015 coverage because you didn't know (and after February 15th, 2015) that the health care law required you and your household to have health coverage, or because you didn't understand how the requirement to have coverage would impact you and your household?

YES NO

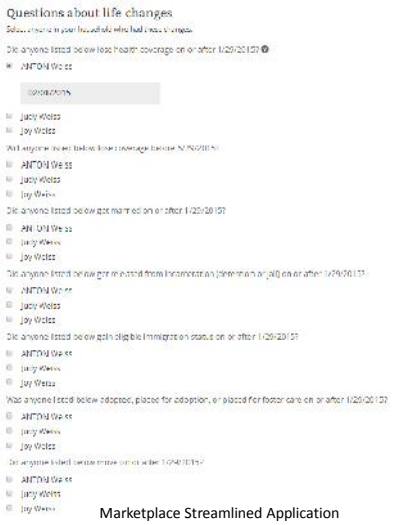
Does a child on this application have a parent living outside the home?

YES NO

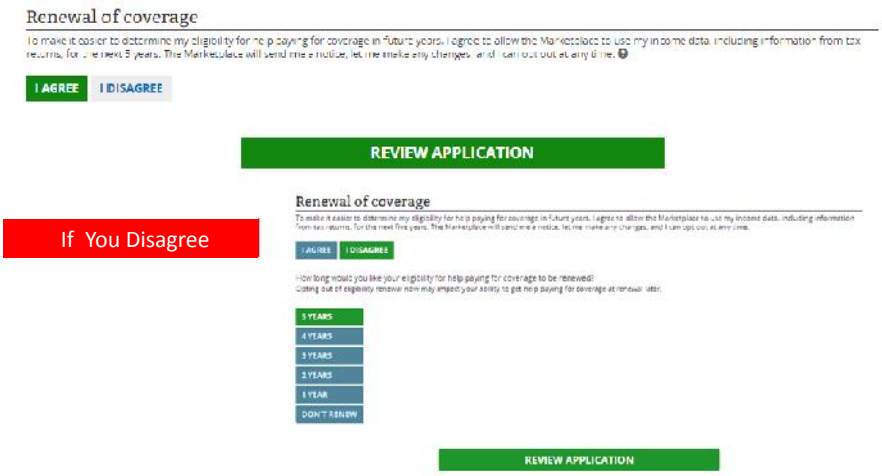
Were any of these people found not eligible for either Medicaid or the Children's Health Insurance Program (CHIP) after November 15, 2014?

- ANTON Weiss
- Judy Weiss
- Joy Weiss

Life Changing Events



Renewal of Coverage



Application Summary

Application summary

Application ID: 96850154

Take a few minutes to review the information you gave us and make changes. If necessary. Once everything is correct, you can sign and submit your application.

Household contact

EDIT

Full name	Anton Weiss
Address	243 HIGHST MONTGOMERY, AL 36104-4003
Phone number	334-777-2222
Email address	3w86311ldb@yahoo.com
Get updates by email	No
Preferred written language	English
Preferred spoken language	English

Household members

EDIT

Full name	Date of Birth	SSN	Relationship	Sex
ANTON Weiss	11/23/1985	XXX-XX-5851	Self	Male
Judy Weiss	12/25/1987	XXX-XX-1475	Spouse	Female
Joy Weiss	12/23/2014	XXX-XX-1471	Child	Female

Anton reviews the information entered for accuracy and can make any corrections using the edit function.

Review Household Income

Household income

EDIT

Name	Type	Amount
ANTON Weiss	Job / June Fitters (555-555-5555)	$55,000.00 per year
Judy Weiss	-	-
Joy Weiss	-	-

Income summary

EDIT

Name	Last month's income	Expected income in 2015
ANTON Weiss	$4,583.33	$55,000.00
Judy Weiss	$0.00	$0.00
Joy Weiss	$0.00	$0.00

Review Basic Household Questions

Basic household questions EDIT

Everyone:

- Has the same permanent home address and currently lives there.
- Is included on the tax return I'll file jointly with my spouse for 2015, and my spouse and I aren't claimed as dependents by anyone else.

No one:

- Is currently pregnant or has had a child in the last 60 days.
- Is 18-22 and a full-time student.

We're not living with and responsible for a child 18 or younger not on our tax return.

Everyone applying for coverage is a U.S. citizen or U.S. national.

No one applying for coverage:

- Is currently incarcerated/detained or in jail.
- Is American Indian or Alaska Native.
- Is a naturalized or derived citizen.
- Is not a name on the application that doesn't agree with the one on the Social Security card.
- Is eligible for health coverage from their job (including COBRA) or someone else's job, or will be in 2015.
- Was in foster care or 18/AND is currently 25 or younger.

Everyone listed as a dependent:

- Is 26 or younger.
- Is not married.
- Will be claimed as a dependent on our federal tax return for 2015.
- Is our child.
- Is not our stepchild.
- Does not live with a different parent who's not on our tax return.

May 2015 31

Review Additional Questions and Current Coverage

Additional questions EDIT

No one applying for coverage has a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs.

No one applying for coverage needs help with daily activities (like dressing or using the bathroom) or lives in a medical facility or nursing home.

No one applying for coverage needs help paying their medical bills from the last 3 months.

ANTON Weiss lost coverage on or after 1/29/2015.

No one applying for coverage got married on or after 1/29/2015.

No one applying for coverage was released from incarceration (detention or jail) on or after 1/29/2015.

No one applying for coverage gained eligible immigration status on or after 1/29/2015.

No one applying for coverage was adopted, placed for adoption, or placed for foster care on or after 1/29/2015.

No one applying for coverage will lose coverage before 5/29/2015.

No one applying for coverage moved on or after 1/29/2015.

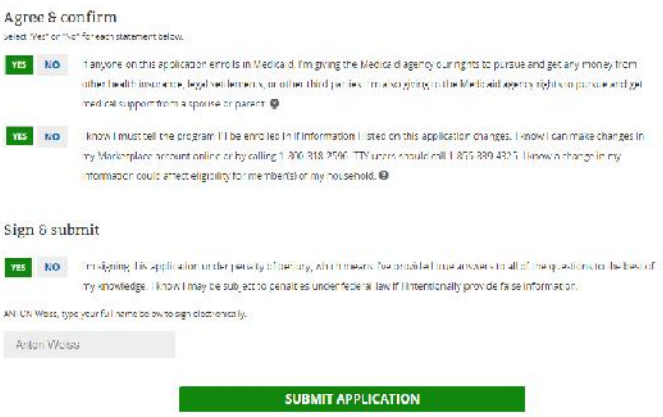
Name	Current health coverage	Recently lost health coverage
ANTON Weiss		Yes
Judy Weiss		No
Joy Weiss	-	No

You don't need 2015 coverage for this reason: you didn't know or understand the requirement to have health coverage until after February 15, 2015.

May 2015 Marketplace Streamlined Application 32

Agree & Confirm, Sign & Submit Application

Anton provides electronic signature and submits his application



Eligibility Results

View Eligibility Results

Application Date: March 15, 2015
Application ID: 99794546

Dear Anton:

Thank you for reporting a change in circumstance to the Marketplace.

What are the results of my application?

Review the table below with your eligibility results.

Family Member(s)	Results	Next Steps
Anton Weiss	• Can choose a health plan with lower copayments, coinsurance, and deductibles (05)	• Choose a health plan and make first month's payment
Anton Weiss	• Eligible to purchase health coverage through the Marketplace, but more information is needed • Eligible for a tax credit ($353.00 each month, which is $4,236.00 for the year), but more information is needed	• Send the Marketplace more information
Judy Weiss	• Can choose a health plan with lower copayments, coinsurance, and deductibles (05)	• Choose a health plan and make first month's payment
Joy Weiss	• Can choose a health plan with lower copayments, coinsurance, and deductibles (05)	• Choose a health plan and make first month's payment

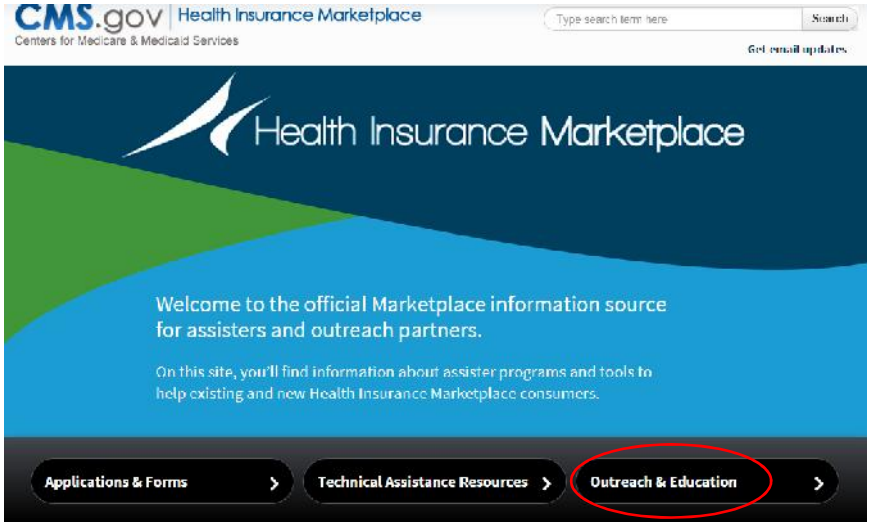
If you have questions: Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

1358192543807134L 1 of 14

Key Points to Remember

- ✓ Updated, shorter Marketplace application will be used with consumers who have simple household situations who are applying for the first time
- ✓ Consumers will be automatically routed through the correct application process for their situation
- ✓ You won't see the updated application for every consumer you help
- ✓ Consumers coming to report a change will see the traditional application

Marketplace.cms.gov



Want More Information about the Marketplace?

- Stay connected
  - Sign up to get email and text alerts at HealthCare.gov/subscribe
    - CuidadoDeSalud.gov for Spanish
  - Updates and resources for organizations are available at Marketplace.cms.gov
  - Twitter@HealthCareGov
  - Facebook.com/Healthcare.gov

Failing to file 2014 tax returns will prevent advance payments in 2016

Information from IRS.gov

The IRS reminds taxpayers who received advance payments of the premium tax credit in 2014 that they should file their 2014 tax return as soon as possible this summer to ensure they can timely receive advance payments next year from their Marketplace.

If advance payments of the premium tax credit were paid on behalf of you or an individual in your family in 2014, and you do not file a 2014 tax return, you will not be eligible for advance payments of the premium tax credit or cost-sharing reductions to help pay for your Marketplace health insurance coverage in 2016. This means you will be responsible for the full cost of your monthly premiums and all covered services. In addition, we may contact you to pay back some or all of the 2014 advance payments of the premium tax credit.

Because Marketplaces will determine eligibility for advance tax credit payments and cost-sharing reductions for the 2016 coverage year this fall, it will substantially increase your chances of avoiding a gap in receiving this help if you file your 2014 tax return with Form 8962 electronically as soon as possible.

If you missed the April 15 deadline or received an extension to file until Oct. 15, you should file your return as soon as possible. You should not wait to file. File now to reconcile any advance credit payments you received in 2014 and to maintain your eligibility for future premium assistance. You can file a federal return for free by using Free File.

Remember that filing electronically is the best and simplest way to file a complete and accurate tax return as it guides you through the process and does all the math.

People are asking…

The IRS hears many questions about the health care law. Here are commonly-asked questions that we are hearing from taxpayers and seeing on social media.

***Q:* I do not normally have to file a tax return. Why is the IRS telling me that I should file as soon as possible?**

A. The IRS believes that you enrolled in health coverage through the Health Insurance Marketplace. If the government sent advance payments of the premium tax credit to your insurer, you are required to file a 2014 income tax return. If you do not file a 2014 income tax return, you will not be eligible for financial help next year. This means you will be responsible for the full cost of your monthly premiums. *Do not wait to file*. File now to stay eligible for future premium assistance.

Q. **My income is below the threshold to be required to file a tax return, but advance payments of the premium tax credit were sent to my insurance company in 2014 to help pay my monthly premium; do I need to file a tax return?**

A. Yes, you are required to file a tax return. If advance payments of the premium tax credit were paid for you or an individual in your tax family, you must file a tax return to reconcile the difference between the advance credit payments made on your behalf and the actual amount of the credit that you may claim. This requirement applies whether or not you would otherwise be required to file a return. File as soon as you can even if you missed the April 15 deadline. If you missed the April 15 deadline or you received an extension to file until Oct. 15, you should file your return as soon as possible. You should not wait to file. File now to reconcile any advance credit payments that were made for you or a member of your tax family in 2014 and to maintain your eligibility to get advance credit payments for your 2016 coverage.

If you don't file a 2014 tax return, you will not be eligible for advance payments of the premium tax credit to help pay for your Marketplace health insurance coverage in 2016. This means you will be responsible for the full cost of your monthly premiums and all covered services.

You should file your 2014 tax return with Form 8962 as soon as possible even if you don't usually have to file. You should have received Form 1095-A from your Marketplace. This form provides the information you will need to complete Form 8962. If you need a copy of your Form 1095-A, go to HealthCare.gov or your state Marketplace website and log into your Marketplace account or call your Marketplace call center.

Q. **I filed my return claiming the premium tax credit. Why did I get a letter from the IRS asking for more information and a copy of my 1095-A?**

A. You do not have to send your Form 1095-A to the IRS with your tax return when you file and claim the premium tax credit. However, using the information on your Form 1095-A you must complete and file Form 8962, Premium Tax Credit. The IRS verifies the information on your Form 8962 by comparing it to information received from the Marketplace and to other information you entered on your tax return.

In some situations, before we can send your refund, the IRS may send you a letter asking you to clarify or verify information that you entered on your income tax return. The letter may ask for a copy of your Form 1095-A.

Some common examples of issues or questions that may arise are:

- It appears that you are required to reconcile but did not include Form 8962.
- You submitted Form 8962 but it is incomplete.

- Based on the income that you reported, it appears that you are not eligible for the credit.
- The income or other entries on your Form 8962 are inconsistent with information on your tax return.
- The premium that you entered on your Form 8962 appears to be an annual amount, rather than monthly.
- There are questions about entries on your Form 8962 that may be clarified by a review of your 1095-A.
- We need to review your Form 1095-A to verify your Marketplace coverage.

You should follow the instructions on the correspondence that you receive in order to help the IRS verify information that has been entered on the tax return and issue the appropriate refund. For more information about Forms 1095-A, visit our Health Insurance Marketplace Statements page.

***Q.* What documentation or proof of insurance coverage do I have to submit with my return?**

A. You do not need to attach documentation or proof of insurance coverage to your tax return. If you had coverage for yourself and everyone in your household for the entire year, you or your preparer will check a box on your tax return. Although nothing in the IRS rules or regulations require you to provide proof of coverage at the time you file, if you have documents that verify your coverage, you should show them to your tax preparer. The IRS will follow its normal compliance approach to filed tax returns, and may ask you to substantiate the information on your tax return, therefore you should keep these documents with your tax records. Learn more about the types of documents you should keep at our Gathering Your Health Coverage Documentation page.

***Q.* Does everyone need to have health insurance coverage?**

A. The Affordable Care Act requires you and each member of your family to have basic health coverage (called minimum essential coverage), qualify for an exemption from the requirement to have coverage, or make an individual shared responsibility payment when you file your federal income tax return. If you are not required to file a tax return and don't want to file a return, you do not need to file a return solely to report your coverage or to claim an exemption.
Visit our Individual Shared Responsibility Provision page for information about what coverage qualifies, and our Exemptions page for details about who is eligible for an exemption from the requirement to have coverage.

For more questions and answers about the health care law, see the Affordable Care Act Tax Provisions Questions and Answers page.

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October 15, 2014

Key Facts You Need to Know About: Income Definitions for Marketplace and Medicaid Coverage

Health reform provides new opportunities for millions of Americans to get affordable health coverage. Eligibility and benefit amounts are determined in part by household income. For premium tax credits, most categories of Medicaid eligibility, and the Children's Health Insurance Program (CHIP), states and the federal government use a new tax-based measure of income called Modified Adjusted Gross Income (MAGI) to assess financial eligibility. The following key facts explain MAGI and what counts as income in determining eligibility for premium tax credits, Medicaid, and CHIP.

How do Marketplaces, Medicaid, and CHIP measure a person's income?

For premium tax credits, most categories of Medicaid eligibility, and CHIP, all Marketplaces and state Medicaid and CHIP agencies determine a household's income using MAGI. States' previous rules for counting income continue to apply to people who qualify for Medicaid on the basis of age or disability or because they are children in foster care.

MAGI is Adjusted Gross Income (AGI) plus tax-exempt interest, Social Security benefits not included in gross income, and excluded foreign income. Each of these items has a specific tax definition; in most cases they can be located on an individual's tax return (see Figure 1). (Medicaid does not count certain Native American and Alaska Native income in MAGI.)

What Is Adjusted Gross Income?

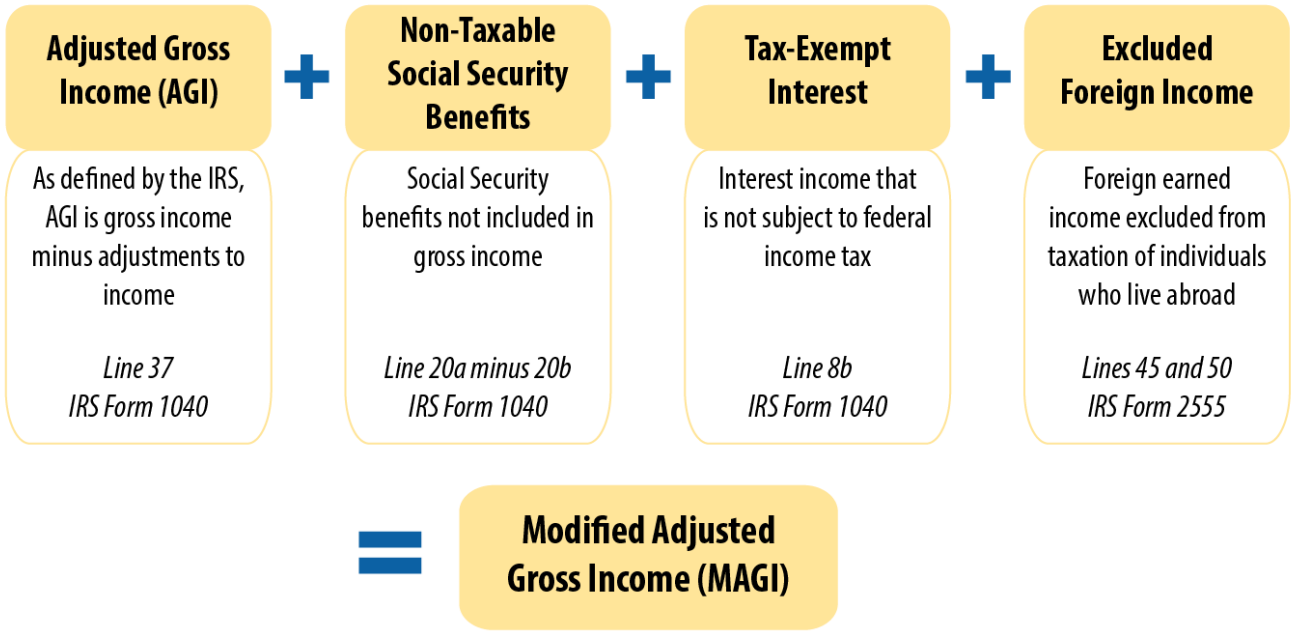
Adjusted Gross Income is the sum of an individual's gross income (that is, total earnings subject to income tax) minus deductions for certain expenses.

The deductions taken to calculate AGI are referred to as "adjustments to income" or "above the line" deductions. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Among the most common are alimony payments, IRA contributions, job-related moving expenses, student loan interest, and tuition and fees. For many of these adjustments, the amount of the deduction is capped or limited based on the person's income. IRS Publication 17 explains how to qualify for these adjustments.

What types of income are taxable and count towards MAGI?

All income is subject to taxation unless it's specifically exempted by law. Income does not only refer to cash wages. It can come in the form of money, property, or services that a person receives.

Figure 1
Formula for Calculating Modified Adjusted Gross Income



An applicant's most recent tax return can be useful in estimating income if their income has not changed. If a tax return is not available, or if income is different for any reason, the tax return can still be a useful list of what income and adjustments to include.

Table 1 provides examples of taxable and non-taxable income. IRS Publication 525 provides a detailed discussion of many kinds of income and explains whether they are subject to taxation.

Is income deducted from workers' paychecks for pre-tax deductions counted in MAGI?

No. Pre-tax deductions are deductions that can be used to discount the amount of taxable wages. Among the most common are health care expenses such as insurance premiums or health savings account contributions, retirement account contributions, and flexible spending accounts for medical or child care expenses. Since income set aside for these purposes is not taxed, it does not count towards a household's MAGI.

Does MAGI count any income sources that are not taxed?

Yes. Some forms of income that are non-taxable or only partially taxable are included in MAGI and thus affect financial eligibility for premium tax credits and Medicaid, specifically:

- **Tax-exempt interest.** Interest on certain types of investments is not subject to federal income tax but is included in MAGI. These investments include many state and municipal bonds as well as exempt-interest dividends from mutual fund distributions. However, some other forms of tax-exempt interest, such as interest earned on an IRA, HSA, Archer or Medicare Advantage MSA, or Coverdell education savings account, is *not* included in MAGI.

Table 1	
Examples of Taxable Income	
Wages, salaries, bonuses, commissions	IRA distributions
Alimony	Jury duty fees
Annuities	Military pay
Awards	Military pensions
Back pay	Notary fees
Breach of contract	Partnership, estate, and S-corporation income
Business income/Self-employment income	Pensions
Compensation for personal services	Prizes
Debts forgiven	Punitive damages
Director's fees	Unemployment compensation
Disability benefits (employer-funded)	Railroad retirement—Tier I (portion may be taxable)
Discounts	Railroad retirement—Tier II
Dividends	Refund of state taxes
Employee awards	Rents (gross rent)
Employee bonuses	Rewards
Estate and trust income	Royalties
Farm income	Severance pay
Fees	Self-employment
Gains from sale of property or securities	Non-employee compensation
Gambling winnings	Social Security benefits (portion may be taxable)
Hobby income	Supplemental unemployment benefits
Interest	Taxable scholarships and grants
Interest on life insurance dividends	Tips and gratuities
Examples of Non-Taxable Income	
Aid to Families with Dependent Children (AFDC)	Meals and lodging for the employer's convenience
Child support received	Payments to the beneficiary of a deceased employee
Damages for physical injury (other than punitive)	Payments in lieu of worker's compensation
Death payments	Relocation payments
Dividends on life insurance	Rental allowance of clergyman
Federal Employees' Compensation Act payments	Sickness and injury payments
Federal income tax refunds	Social Security benefits (portion may be taxable)
Gifts	Supplemental Security Income (SSI)
Inheritance or bequest	Temporary Assistance for Needy Families (TANF)
Insurance proceeds (accident, casualty, health, life)	Veterans' benefits
Interest on tax-free securities	Welfare payments (including TANF) and food stamps
Interest on EE/I bonds redeemed for qualified higher education expenses	Worker's compensation and similar payments

Source: Internal Revenue Service, Income Quick Reference Guide

- **Non-taxable Social Security benefits.** For many people, particularly those with no other source of income, Social Security benefits are not taxable. However, the full amount of a person's Social Security benefits as indicated on Form SSA-1099 (the Social Security Benefit Statement) — whether or not those benefits are taxable — is included in MAGI.
- **Foreign income.** Under section 911 of the Internal Revenue Code, U.S. citizens and resident aliens living outside the U.S. can exclude up to $97,600 (in 2013) of earned income for tax purposes if they meet certain residency or physical presence tests. Any foreign income excluded under this section must be added back when calculating MAGI.

Whose income is included in a household's MAGI?

A household's MAGI is the sum of the MAGI of each household member who has a tax filing requirement. The *requirement* to file taxes, not whether someone actually files taxes, determines whether an individual's income must be included in a household's MAGI.

Is a tax dependent's income ever counted in determining the household's MAGI?

Sometimes a dependent files a tax return even though he is not required to do so — for example, to get a refund of taxes withheld from his paycheck. In this situation, the dependent's income would not count toward the household's MAGI. However, if a dependent has a tax filing requirement, his MAGI is calculated and added to the taxpayer's MAGI to determine the household's MAGI.

In general, individuals claimed as dependents on someone else's tax return must file taxes if they receive at least $6,100 in earned income or $1,000 in unearned income (for the 2013 tax year). Supplemental Security Income (SSI) and Social Security benefits are not counted for the purposes of determining whether a dependent will be required to file a tax return. However, if the dependent does have a tax filing requirement, then the dependent's Social Security benefits will be counted toward the household's MAGI.

What time frame is used to determine a household's MAGI?

Financial eligibility for premium tax credits and Medicaid is based on income for a specified "budget period." For premium tax credits, the budget period is the tax year (which coincides with the calendar year) during which the advance premium tax credit is received. When determining eligibility for advance premium tax credits, the Marketplace estimates the applicant's household MAGI over the entire calendar year for which the applicant seeks coverage.

Medicaid eligibility, however, is based on current monthly income. Some states allow current Medicaid beneficiaries to project their income for the rest of the calendar year; the state assesses eligibility based on the average monthly total. So, for example, if a family member has seasonal work that temporarily raises household income, that increase is effectively spread across all months of the year. States may also allow both applicants and beneficiaries to account for any reasonably predictable increases or decreases in income they anticipate over the year. These options help minimize coverage gaps that could result if beneficiaries had to recertify their income every month.

How does MAGI differ from Medicaid's former rules for counting household income?

The MAGI methodology for calculating income differs significantly from previous Medicaid rules.

Table 2		
Differences in Counting Income Sources Between Former Medicaid Rules and MAGI Medicaid Rules		
Income Source	**Former Medicaid Rules**	**MAGI Medicaid Rules**
Self-employment income	Counted with deductions for some, but not all, business expenses	Counted with deductions for most expenses, depreciation, and business losses
Salary deferrals (flexible spending, cafeteria, and 401(k) plans)	Counted	Not counted
Child support received	Counted	Not counted
Alimony paid	Not deducted from income	Deducted from income
Veterans' benefits	Counted	Not counted
Workers' compensation	Counted	Not counted
Gifts and inheritances	Counted as lump sum income in month received	Not counted
TANF & SSI	Counted	Not counted

Some income that Medicaid used to consider part of household income is no longer counted, such as child support received, veterans' benefits, workers' compensation, gifts and inheritances, and Temporary Assistance for Needy Families (TANF) and SSI payments. Table 2 summarizes the differences between the former Medicaid rules and the new MAGI rules.

In addition, states can no longer impose asset or resource limits, and various income disregards have been replaced by a standard disregard equal to 5 percent of the poverty line. There are also changes to who is included in a household and, therefore, whose income is counted.

2015 Federal Poverty Guidelines to use for 2016 Marketplace Enrollment

Household	2015	Medicaid Eligibility (138% of FPL)	Cost Sharing (250%)	Premium Subsidy Threshold (400% of FPL)
1	$11,770	$16,243	$29,425	$47,080
2	$15,930	$21,983	$39,825	$63,720
3	$20,090	$27,724	$50,225	$80,360
4	$24,250	$33,465	$60,625	$97,000
5	$28,410	$39,206	$71,025	$113,640
6	$32,570	$44,947	$81,425	$130,280
7	$36,730	$50,687	$91,825	$146,920
8	$40,890	$56,428	$102,225	$163,560

Health Care Law: What's New for Individuals & Families

PUBLICATION 5187

TAX YEAR 2014

Affordable Care Act (ACA)

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Introduction

This publication covers some of the tax provisions of the Affordable Care Act (ACA). It provides information that explains how taxpayers satisfy the individual shared responsibility provision by enrolling in minimum essential coverage, qualifying for an exemption, or making a shared responsibility payment. It also provides information about the new premium tax credit. A glossary is included to help taxpayers understand new terms related to ACA.

What new forms may be used to prepare the return?

- Form 1095-A, *Health Insurance Marketplace Statement*
- Form 8962, *Premium Tax Credit, & Instructions*
- Form 8965, *Health Coverage Exemptions & Instructions*

Taxpayers, tax professionals, and volunteer preparers should consider preparing and filing tax returns electronically. Using tax preparation software is an easy way to file a complete and accurate tax return as it does the math and completes the appropriate forms based on information provided by the taxpayer. Visit IRS.gov for information about electronic filing options, including Free File.

What publications may be useful?

- Publication 17, *Your Federal Income Tax (For Individuals)*
- Publication 974, *Premium Tax Credit*
- Publication 5172 – Flyer, *Facts about Health Care Coverage Exemptions* (English; Spanish)
- Publication 5185 – Flyer, *Facts about making a shared responsibility payment*
- Publication 5152 – Flyer, *Premium Tax Credit – Report changes in circumstances* (English; Spanish)
- Publication 5156 – Flyer, *Facts about Individual Shared Responsibility provision* (English; Spanish)
- Publication 5120 – Flyer, *Facts about the Premium Tax Credit* (English; Spanish)
- Publication 5121 – Brochure, *Facts about the Premium Tax Credit* (English; Spanish)
- Publication 5093 – *Healthcare Law Online Resource*

The IRS resource page on IRS.gov/aca is routinely updated as new publications are issued.

Affordable Care Act Overview

What is the Affordable Care Act?

Under the Affordable Care Act, the federal government, state governments, insurers, employers, and individuals share responsibility for improving the quality and availability of health insurance coverage in the United States. The ACA reforms the existing health insurance market by prohibiting insurers from denying coverage or charging higher premiums because of an individual's preexisting conditions.

The ACA also creates the Health Insurance Marketplace, also known as the Marketplace or the Exchange. The Marketplace is where taxpayers find information about health insurance options, purchase qualified health plans and, if eligible, obtain help paying premiums and out-of-pocket costs. A new tax credit, the premium tax credit, is available only if the taxpayer purchased a qualified health plan through the Marketplace. This credit helps eligible taxpayers pay for coverage.

The ACA also includes the individual shared responsibility provision, which requires individuals to have qualifying health care coverage for each month of the year, qualify for a coverage exemption, or make a shared responsibility payment when filing their federal income tax returns. For purposes of ACA, qualifying health care coverage is also called minimum essential coverage. Most taxpayers already had minimum essential coverage prior to the start of the year and only had to maintain that coverage during the entire year. If taxpayers and their dependents had minimum essential coverage for each month of the year, the taxpayer will simply check a box indicating that coverage when filing the federal income tax return. No further action is required.

Some taxpayers are exempt from the coverage requirement of the individual shared responsibility provision and do not have to make a shared responsibility payment when filing a federal income tax return. Coverage exemptions are available for individuals specifically described as having a religious, economic, or other justification for not having minimum essential coverage. Taxpayers who qualify for an exemption will attach a Form 8965*, Health Coverage Exemptions*, to their federal income tax return to claim that exemption.

Taxpayers or any dependents who did not maintain minimum essential coverage for each month of their tax year and did not qualify for a coverage exemption must make an individual shared responsibility payment with their federal tax return.

Individual Shared Responsibility Provision

What is the individual shared responsibility provision?

For each month of the year, the individual shared responsibility provision calls for individuals to:

- Have qualifying health care coverage (also called minimum essential coverage), or
- Qualify for an exemption from coverage, or
- Make an individual shared responsibility payment when filing their federal income tax return

Individuals are treated as having minimum essential coverage for the month as long as the individuals are enrolled in and entitled to receive benefits under a plan or program identified as minimum essential coverage for at least one day during that month.

Who must have health care coverage?

In general, all U.S. taxpayers are subject to the individual shared responsibility provision. Under the provision, a taxpayer is potentially liable for him or herself, and for any individual the taxpayer could claim as a dependent for federal income tax purposes. Thus, all children generally must have minimum essential coverage or qualify for a coverage exemption for each month in the year. Otherwise, the primary taxpayer(s) (e.g., parents) who can claim the child as a dependent for federal income tax purposes will generally owe an individual shared responsibility payment for the child.

Senior citizens must also have minimum essential coverage or qualify for a coverage exemption for each month in the year. Both Medicare Part A and Medicare Part C (also known as Medicare Advantage) are minimum essential coverage.

All U.S. citizens are subject to the individual shared responsibility provision, as are all non-U.S. citizens who are in the U.S. long enough during a calendar year to qualify as resident aliens for federal income tax purposes. Foreign nationals who live in the U.S. for a short enough period that they do not become resident aliens for tax purposes are exempt from the individual shared responsibility provision even though they may have to file a U.S. income tax return.

All bona fide residents of U.S. territories are treated as having minimum essential coverage and are not required to take any action to comply with the individual shared responsibility provision other than to indicate their status on their federal income tax returns.

What is minimum essential coverage?

Under the ACA, minimum essential coverage, is a health care plan or arrangement specifically identified in the law as minimum essential coverage, including:

- Specified government-sponsored programs (e.g., Medicare Part A, Medicare Advantage, most Medicaid programs, CHIP, most TRICARE programs, and comprehensive health care coverage of veterans)
- Employer-sponsored coverage under a group health plan (including self-insured plans)
- Individual market coverage (e.g., a qualified health plan purchased through the Marketplace or individual health coverage purchased directly from an insurance company)
- Grandfathered health plans (in general, certain plans that existed before the ACA and have not changed since the ACA was passed)
- Other plans or programs that the Department of Health and Human Services recognizes as minimum essential coverage for the purposes of the ACA

IRS.gov/aca has a chart that shows these and other types of coverage that qualify as minimum essential coverage and some that do not.

How will taxpayers report minimum essential coverage?

Taxpayers whose entire tax household had minimum essential coverage for each month of their tax year will indicate this on their federal income tax return by simply checking a box on their Form 1040, 1040A or 1040EZ. No further action is required.

Form 1040 Other Taxes section showing line 61 "full-year coverage" checked

Other Taxes				
57	Self-employment tax. Attach Schedule SE	57		
58	Unreported social security and Medicare tax from Form: a ☐ 4137 b ☐ 8919	58		
59	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required	59		
60a	Household employment taxes from Schedule H	60a		
b	First-time homebuyer credit repayment. Attach Form 5405 if required	60b		
61	Health care: individual responsibility (see instructions) Full-year coverage ☑	61		
62	Taxes from: a ☐ Form 8959 b ☐ Form 8960 c ☐ Instructions; enter code(s)	62		
63	Add lines 56 through 62. This is your **total tax** ▶	63		

If anyone in the taxpayer's household did not have minimum essential coverage for each month of the year, the taxpayer will claim a coverage exemption or calculate an individual shared responsibility payment.

What are the health coverage exemptions?

The following is a partial list of exemptions:

- **Unaffordable coverage –** The amount the taxpayer would have paid for the lowest cost employer-sponsored coverage available or for coverage through the Marketplace is more than eight percent of the taxpayer's household income for the year.
- **Short coverage gap –** The taxpayer went without coverage for less than three consecutive months during the year.
- **Household income below the return filing threshold –** The taxpayer's household income is below the taxpayer's minimum threshold for filing a tax return.
- **Certain noncitizens –** The taxpayer was neither a U.S. citizen, U.S. national, nor an alien lawfully present in the U.S.
- **Members of a health care sharing ministry –** The taxpayer was a member of a health care sharing ministry, which is a tax-exempt organization whose members share a common set of ethical or religious beliefs and have shared medical expenses in accordance with those beliefs continuously since at least December 31, 1999.
- **Members of Indian tribes –** The taxpayer was a member of a federally-recognized Indian tribe, including an Alaska Native Claims Settlement Act (ANCSA) Corporation Shareholder (regional or village), or is otherwise eligible for services through an Indian health care provider or the Indian Health Service.
- **Incarceration –** The taxpayer was in a jail, prison, or similar penal institution or correctional facility after the disposition of charges.
- **Members of certain religious sects –** The taxpayer was a member of a religious sect that has been in existence since December 31, 1950, and is recognized by the Social Security Administration as conscientiously opposed to accepting any insurance benefits, including Medicare and social security.

There are also exemptions for certain hardships. In general, an event or condition that prevents an individual from obtaining minimum essential coverage, such as:

- The taxpayer is ineligible for Medicaid solely because the state in which the individual resides does not participate in the Medicaid expansion under the Affordable Care Act.

- The taxpayer purchased a qualified health plan through the Marketplace during the initial open enrollment period, but the coverage is not effective until April 1 or later.

See the **chart** on IRS.gov/aca for a complete list of exemptions, including a description of additional hardship circumstances and certain transition relief effective for 2014.

If taxpayers think they qualify for a coverage exemption, how do they obtain it?

How taxpayers receive a coverage exemption depends upon the type of exemption for which they are eligible. Some exemptions are granted only by the Marketplace, others are claimed only on a tax return, and some exemptions may be obtained from the Marketplace or claimed on a return.

Taxpayers whose gross income is below their applicable minimum threshold for filing a federal income tax return are exempt from the individual shared responsibility provision and are not required to file a federal income tax return to claim the coverage exemption. However, if the taxpayer files a return anyway (for example, to claim a refund), they can claim a coverage exemption with their return.

Taxpayers claim coverage exemptions on **Form 8965, *Health Coverage Exemptions,*** and attach it to Form 1040, Form 1040A and Form 1040EZ. These forms can be filed electronically. Taxpayers should visit IRS.gov for additional **filing options,** including **Free File.**

How will taxpayers report health care coverage exemptions obtained from the Marketplace?

Requests for exemptions that can be granted only by the Marketplace should be submitted as soon as possible, so that taxpayers can properly report the exemption on their federal income tax return.

Taxpayers who are granted a coverage exemption from the Marketplace will receive an exemption certificate number (ECN) from the Marketplace and will enter their ECN in Part I (Marketplace-Granted Coverage Exemptions for Individuals) of Form 8965, Health Coverage Exemptions, column c.

How will taxpayers claim health care coverage exemptions with the IRS?

Taxpayers will use Part II (Coverage Exemptions for Your Household Claimed on Your Return) of Form 8965 to claim a coverage exemption with the IRS because of income below the filing threshold.

Other coverage exemptions may be claimed with the IRS using Part III (Coverage Exemptions for Individuals Claimed on Your Return) of Form 8965, Health Coverage Exemptions. Use a separate line for each individual and exemption type claimed on the return.

What is the individual shared responsibility payment?

If anyone in the taxpayer's tax household does not have minimum essential coverage, and does not qualify for a coverage exemption, the taxpayer will need to make an individual shared responsibility payment (SRP) when filing their federal income tax return.

Although the process to determine the individual shared responsibility payment is described in detail below, using tax preparation software is an easy way to determine the payment.

The annual SRP amount is the greater of a percentage of household income or a flat dollar amount, but is capped at the national average premium for a bronze level qualified health plan available through the Marketplace that would cover everyone in the tax household who does not have coverage and does not qualify for a coverage exemption.

Taxpayers owe 1/12th of the annual SRP for each month they or their dependent(s) do not have coverage and do not qualify for a coverage exemption.

For 2014, the annual SRP amount is the greater of

- 1 percent of the household income that is above the tax return filing threshold for the taxpayer's filing status, or
- The family's flat dollar amount, which is $95 per adult and $47.50 per child (under age 18), limited to a family maximum of $285.

The shared responsibility payment is capped at the national average premium for a bronze level qualified health plan available through the Marketplace in 2014 that would cover everyone in the tax household who does not have coverage and does not qualify for a coverage exemption.

Taxpayers must know their household income and applicable income tax return filing threshold to calculate the SRP amount owed. See the Filing Requirement Threshold **information** on IRS.gov/aca. Taxpayers should use the worksheets located in the Instructions to Form 8965, Health Coverage Exemptions, to figure the shared responsibility payment amount due.

In the examples below, assume that the applicable national average bronze plan premium exceeds the flat dollar and income percentage amounts. These examples are used only to represent the mechanics of calculating the individual shared responsibility payment and are not estimates of current or future health insurance premium costs. For information on the cost of bronze level plans, visit **HealthCare.gov.**

Example

Single individual with $40,000 income:

Jim, an unmarried adult with no dependents, did not have minimum essential coverage for any month during 2014 and does not qualify for a coverage exemption. For 2014, Jim's household income was $40,000 and his filing threshold is $10,150.

- To determine his payment using the income formula, subtract $10,150 (filing threshold) from $40,000 (2014 household income). The result is $29,850. One percent of $29,850 equals $298.50.
- Jim's flat dollar amount is $95.

Because $298.50 is greater than $95 (and is less than the national average premium for bronze level coverage for 2014), Jim's shared responsibility payment for 2014 is $298.50, or $24.87 for each month he is uninsured (1/12 of $298.50 equals $24.87).

Jim will make his shared responsibility payment for the months he was uninsured when he files his 2014 income tax return.

Example

Married couple with 2 children, $70,000 income:

Eduardo and Julia are married and have two children under 18. They did not have minimum essential coverage for any family member for any month during 2014 and no one in the family qualifies for a coverage exemption. For 2014, their household income was $70,000 and their filing threshold is $20,300.

To determine their payment using the income formula, subtract $20,300 (filing threshold) from $70,000 (2014 household income). The result is $49,700. One percent of $49,700 equals $497.

Eduardo and Julia's flat dollar amount is $285, or $95 per adult and $47.50 per child.

Because $497 is greater than $285 (and is less than the national average premium for bronze level coverage for 2014), Eduardo and Julia's shared responsibility payment is $497 for 2014, or $41.41 per month for each month the family was uninsured (1/12 of $497 equals $41.41).

The percentages and flat dollar amounts increase over the first three years. In 2015, the income percentage increases to 2 percent of household income, and the flat dollar amount increases to $325 per adult and $162.50 per child under 18. In 2016, these figures increase to 2.5 percent of household income and $695 per adult ($347.50 per child under 18). After 2016, the flat dollar amounts may increase with inflation.

The IRS routinely works with taxpayers who owe amounts they cannot afford to pay. This sometimes includes enforced collection action such as liens and levies. However, the law prohibits the IRS from using liens or levies to collect any individual shared responsibility payment. If taxpayers owe an individual shared responsibility payment, the IRS may offset that liability with any tax refund that may be due to them.

Who can claim a premium tax credit?

Only taxpayers who purchased qualified health plan from a State-based or Federally-facilitated Health Insurance Marketplace (Marketplace) may be eligible for the premium tax credit. This is a new federal tax credit to help eligible taxpayers pay for health insurance premiums. When enrolling in a qualified health plan through the Marketplace, eligible taxpayers choose to have some or all of the benefit of the credit paid in advance to their insurance company as advance credit payments or wait to claim all of the benefit of the premium tax credit on their tax return. Taxpayers must file a tax return to claim the premium tax credit. Those who choose advance credit payments must file a tax return to reconcile their advance credit payments with their actual premium tax credit even if they have gross income that is below the income tax filing threshold.

In general, taxpayers are allowed a premium tax credit if they meet all of the following:

- The taxpayer, spouse (if filing a joint return), or dependents were enrolled at some time during the year in one or more qualified health plans offered through the Marketplace.
- One or more of the individuals listed above were not eligible for other minimum essential coverage during the months they were enrolled in the qualified health plan through the Marketplace.
- The taxpayer is an applicable taxpayer. A taxpayer is an applicable taxpayer if he or she meets the following three requirements:
  - The taxpayer's income is at least 100 percent but not more than 400 percent of the federal poverty line for the taxpayer's family size. (See the exception below for taxpayers with household income below 100 percent of the federal poverty line who are not citizens, but are lawfully present in the U.S. See the definition of "applicable taxpayer" in the glossary for another exception for taxpayers with household income below 100 percent of the federal poverty line for whom advance credit payments were made.)
  - If married, the taxpayer files a joint return with his or her spouse (unless the taxpayer is considered unmarried for Head of Household filing status, or meets the criteria in Notice 2014-23 or T.D. 9683, which allows certain victims of domestic abuse or spousal abandonment to claim the premium tax credit using the MFS filing status). See the glossary for more information about domestic abuse or spousal abandonment and the instructions for Form 8962, Premium Tax Credit, for more details about these exceptions.
  - The taxpayer cannot be claimed as a dependent by another person.

A taxpayer with household income below 100 percent of the federal poverty line can be an applicable taxpayer as long as the taxpayer, the taxpayer's spouse, or a dependent who enrolled in a qualified health plan is not a U.S. citizen, but is lawfully present in the U.S. and not eligible for Medicaid because of immigration status.

Federal Poverty Line (FPL)

The federal poverty line (FPL) is an income amount (adjusted for family size considered poverty level for the year. The U.S. Department of Health and Human Services (HHS) determines the federal poverty line amounts annually and publishes a table reflecting these amounts at the beginning of each calendar year. You can also find this information on the HHS website at **hhs.gov.** HHS provides three federal poverty lines:

- one for residents of the 48 contiguous states and D.C.,
- one for Alaska residents, and
- one for Hawaii residents.

For purposes of the premium tax credit, eligibility for a certain year is based on the most recently published set of poverty guidelines as of the first day of the annual open enrollment period. As a result, the premium tax credit for 2014 is based on the 2013 federal poverty lines that were available when the open enrollment period began on October 1, 2013.

What is household income and what are its limits?

A taxpayer's household income is the total of the taxpayer's modified adjusted gross income (MAGI), the taxpayer's spouse's MAGI if married filing a joint return, and the MAGI of all dependents required to file a federal income tax return.

Example:

David and Melinda are Married Filing Jointly taxpayers. They have one child, Philip, age 17, whom they claim as a dependent. Philip works part time and has a filing requirement. David and Melinda's household income calculation would include their MAGI, as well as Philip's MAGI.

MAGI, for the purpose of the premium tax credit, is the adjusted gross income on the federal income tax return plus any excluded foreign income, nontaxable social security benefits (including tier 1 railroad retirement benefits), and tax-exempt interest. It does not include Supplemental Security Income (SSI).

In general, only taxpayers and families whose household income for the year is between 100 percent and 400 percent of the federal poverty line for their family size may be eligible for the premium tax credit. A taxpayer who meets these income requirements must also meet the other eligibility criteria.

For 2013, residents of one of the 48 contiguous states or Washington, D.C., the following illustrates when household income would be between 100 percent and 400 percent of the federal poverty line:

- $11,490 (100%) up to $45,960 (400%) for an individual
- $15,510 (100%) up to $62,040 (400%) for a family of two
- $23,550 (100%) up to $94,200 (400%) for a family of four

Are taxpayers allowed a premium tax credit for all enrolled family members?

A taxpayer is allowed a premium tax credit only for months that a member of the taxpayer's tax family is (1) enrolled in a qualified health plan offered through the Marketplace and (2) not eligible for minimum essential health coverage (other than individual market coverage). The taxpayer's tax family consists of the taxpayer, the taxpayer's spouse if filing jointly, and all other individuals for whom the taxpayer claims a personal exemption deduction. The family members who meet the above two requirements are the taxpayer's "coverage family."

Is a taxpayer allowed a premium tax credit for the coverage of a family member if the family member enrolls in employer coverage?

If an individual enrolls in an employer-sponsored plan, including retiree coverage, the individual is not a member of the coverage family for the months in which the individual is enrolled in the employer plan, even if the plan is unaffordable or fails to provide minimum value. That means that a premium tax credit is not allowed for this individual's coverage for the months the individual is enrolled in employer coverage. If only one spouse is enrolled in employer coverage that is not affordable and does not provide minimum value, the non-enrolled spouse may be eligible for a premium tax credit.

If the individual changed enrollment from Marketplace coverage to employer-sponsored coverage during the year, the individual is a member of the coverage family only for the months the individual is enrolled through the Marketplace and was not eligible for coverage under the employer-sponsored plan or other coverage (not counting individual market coverage), such as coverage through a government-sponsored plan. See the **minimum essential coverage chart** on irs.gov for more information on the types of coverage that qualify as minimum essential coverage. An individual is eligible for employer-sponsored coverage for any month the individual is enrolled in the employer coverage or could have enrolled in employer coverage that is affordable and provides minimum value.

Example:

Cedric is single and has no dependents. When enrolling through the Marketplace in November 2013, Cedric projected his 2014 household income to be $27,925. Cedric enrolled in a qualified health plan. The Marketplace determined the advance credit payments for which he was eligible, but Cedric decided to wait and take all of the benefit of the credit on his 2014 return.

In August 2014, Cedric began a new job and became eligible for employer-sponsored coverage on September 1st. Since Cedric became eligible for employer-sponsored coverage on September 1st, he may be able to claim a premium tax credit only for the months January through August of 2014.

Is a taxpayer allowed the premium tax credit for a family member's coverage if the family member is eligible for coverage through a government-sponsored program?

An individual eligible for coverage through a government-sponsored program such as Medicaid, Medicare, CHIP or TRICARE, is not a member of the coverage family for the months in which the individual is eligible for government-sponsored coverage. This includes taxpayers who lived in states that chose not to participate in the Medicaid expansion. A premium tax credit is not allowed for this individual's coverage for the months the individual is eligible for the government-sponsored coverage.

How does the taxpayer get the premium tax credit?

Only taxpayers who purchased qualified health plans from the Marketplace may be eligible for the premium tax credit. During enrollment, the Marketplace uses the taxpayer's projected income and family composition to estimate the amount of the premium tax credit a taxpayer would be able to claim.

If eligible for advance credit payments of the premium tax credit, taxpayers may choose to:

- Have some or all of the estimated credit paid in advance directly to the insurance company to lower what is paid out-of-pocket for monthly premiums; or
- Wait to get all the benefit of the credit when they file their tax return

The amount of advance credit payments will appear on Form 1095-A, *Health Insurance Marketplace Statement* issued by the Marketplace.

How is the amount of the premium tax credit determined?

The law bases the size of the premium tax credit on a sliding scale. A taxpayer with household income at 200 percent of the FPL for the taxpayer's family size gets a larger credit to help cover the cost of insurance than a taxpayer with the same family size who has household income at 300 percent of the FPL. In other words, the higher the household income, the lower the amount of the credit.

Although the process to determine the premium tax credit is described in detail below, using tax preparation software is an easy way to determine the credit.

The premium tax credit is the sum of the credit amount for each month. The credit amount for a month is the lesser of two amounts: (1) the monthly premium for the plan or plans in which the taxpayer's family enrolled (enrollment premium) and (2) the monthly premium for the taxpayer's applicable second lowest cost silver plan (SLCSP) minus the taxpayer's monthly contribution amount. This calculation is done on Form 8962, *Premium Tax Credit.* The applicable SLCSP premium will generally be determined by the Marketplace and included on Form 1095-A. *Health Insurance Marketplace Statement.* A taxpayer's contribution amount is the taxpayer's household income multiplied by the applicable figure (from the table in the instructions for Form 8962).

The monthly contribution amount is the contribution amount divided by 12. Taxpayers enrolled in the same qualified health plan for all 12 months of the year and who have the same applicable SLCSP for all 12 months can do a single, annual calculation to compute their premium tax credit, as in the below example.

Example

Ervin is single and has no dependents. He enrolled in a qualified health plan with an annual premium of $5,000. The applicable SLCSP premium as shown on his Form 1095-A is $5,200. Ervin's 2014 household income is $28,725, which is 250 percent of the FPL for a family size of one. His applicable figure is .0805, per the chart in the instructions for Form 8962. Consequently, Ervin's premium tax credit for 2014 is the lesser of $5,000, his enrollment premium, and $2,888, which is the SLCSP of $5,200 less contribution amount of $2,312 (household income of $28,725 x .0805).

Form **8962** — **Premium Tax Credit (PTC)** — OMB No. 1545-0074 — 2014

Department of the Treasury, Internal Revenue Service

▶ Attach to Form 1040, 1040A, or 1040NR.

▶ Information about Form 8962 and its separate instructions is at *www.irs.gov/form8962.*

Attachment Sequence No. 73

Name shown on your return | Your social security number | Relief (see instructions) ☐

Part 1: Annual and Monthly Contribution Amount

1	Family Size: Enter the number of exemptions from Form 1040 or Form 1040A, line 6d, or Form 1040NR, line 7d	1	1
2a	Modified AGI: Enter your modified AGI (see instructions) — 2a: 28725 — b Enter total of your dependents' modified AGI (see instructions)	2b	
3	Household Income: Add the amounts on lines 2a and 2b	3	28725
4	Federal Poverty Line: Enter the federal poverty amount as determined by the family size on line 1 and the federal poverty table for your state of residence during the tax year (see instructions). Check the appropriate box for the federal poverty table used. a ☐ Alaska b ☐ Hawaii c ☑ Other 48 states and DC	4	11490
5	Household Income as a Percentage of Federal Poverty Line: Divide line 3 by line 4. Enter the result rounded to a whole percentage. (For example, for 1.542 enter the result as 154, for 1.549 enter as 155.) (See instructions for special rules.)	5	250 %
6	Is the result entered on line 5 less than or equal to 400%? (See instructions if the result is less than 100%.) ☑ **Yes. Continue to line 7.** ☐ **No.** You are not eligible to receive PTC. If you received advance payment of PTC, see the instructions for how to report your Excess Advance PTC Repayment amount.		
7	Applicable Figure: Using your line 5 percentage, locate your "applicable figure" on the table in the instructions	7	.0805
8a	Annual Contribution for Health Care: Multiply line 3 by line 7 — 8a: 2312 — b Monthly Contribution for Health Care: Divide line 8a by 12. Round to whole dollar amount	8b	

Part 2: Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit

9 Did you share a policy with another taxpayer or get married during the year and want to use the alternative calculation? (see instructions)
☐ **Yes.** Skip to Part 4, Shared Policy Allocation, or Part 5, Alternative Calculation for Year of Marriage. ☑ **No. Continue to line 10.**

10 Do all Forms 1095-A for your tax household include coverage for January through December with no changes in monthly amounts shown on lines 21–32, columns A and B?
☑ **Yes. Continue to line 11.** Compute your annual PTC. Skip lines 12–23 and continue to line 24. ☐ **No. Continue to lines 12–23.** Compute your monthly PTC and continue to line 24.

Annual Calculation	A. Premium Amount (Form(s) 1095-A, line 33A)	B. Annual Premium Amount of SLCSP (Form(s) 1095-A, line 33B)	C. Annual Contribution Amount (Line 8a)	D. Annual Maximum Premium Assistance (Subtract C from B)	E. Annual Premium Tax Credit Allowed (Smaller of A or D)	F. Annual Advance Payment of PTC (Form(s) 1095-A, line 33C)
11 Annual Totals	5000	5200	2312	2888		
Monthly Calculation	**A.** Monthly Premium Amount (Form(s) 1095-A, lines 21–32, column A)	**B.** Monthly Premium Amount of SLCSP (Form(s) 1095-A, lines 21–32, column B)	**C.** Monthly Contribution Amount (Amount from line 8b or alternative marriage monthly contribution)	**D.** Monthly Maximum Premium Assistance (Subtract C from B)	**E.** Monthly Premium Tax Credit Allowed (Smaller of A or D)	**F.** Monthly Advance Payment of PTC (Form(s) 1095-A, lines 21–32, column C)

Taxpayers who receive a Form 1095-A, *Health Insurance Marketplace Statement,* from the Marketplace showing changes in monthly amounts must do a monthly calculation to determine their premium tax credit in Section 2 of Form 8962, *Premium Tax Credit.* Taxpayers who have changes in monthly amounts not shown on Form 1095-A (for example, a taxpayer enrolled in a qualified health plan became eligible for employer coverage during the year, but did not notify the Marketplace) must also do a monthly calculation to determine their premium tax credit.

The premium tax credit is a refundable tax credit. If the amount of the credit is more than the amount of the tax liability on the return, taxpayers will receive the difference as a refund. If no tax is owed, taxpayers can get the full amount of the credit as a refund.

If taxpayers received the benefit of advance credit payments, they will reconcile the advance credit payments with the amount of the actual premium tax credit that is calculated on the tax return. If excess advance credit payments were made on their behalf, taxpayers will enter the excess advance credit payment amount on their return and repay the excess when they file their federal income tax return.

What happens if income or family size changed during the year?

A taxpayer's premium tax credit for the year typically will differ from the advance credit payment amount estimated by the Marketplace because the taxpayer's family size and household income are estimated at the time of enrollment. The more the actual family size or household income differs from the estimates the Marketplace used to compute the advance credit payments, the more significant the difference will be between the advance credit payments and the actual credit.

Taxpayers should notify the Marketplace about changes in circumstances when they happen, which allows the Marketplace to update the information used to determine the expected amount of the premium tax credit and adjust the advance credit payment amount. This adjustment decreases the likelihood of a significant difference between the advance credit payments and the actual premium tax credit. Changes in circumstances that can affect the amount of the actual premium tax credit include:

- Increases or decreases in household income
- Marriage
- Divorce
- Birth or adoption of a child
- Other changes in household composition
- Gaining or losing eligibility for government-sponsored or employer-sponsored health care coverage
- Change of address

What documentation will taxpayers receive?

By January 31 of the year following the year of coverage, the Marketplace will send taxpayers who purchased insurance through the Marketplace Form 1095-A, *Health Insurance Marketplace Statement.* The information statement includes the monthly premium for the applicable SLCSP used to compute the credit, the total monthly premium for the coverage of the taxpayer or family member, the amount of the advance credit payments, the SSN and names for all covered individuals, and all other required information. The Marketplace also reports this information to the IRS.

Taxpayers will use the information on Form 1095-A, *Health Insurance Marketplace Statement*, to compute the premium tax credit on their tax return and to reconcile the advance credit payments made on their behalf with the amount of the actual premium tax credit on Form 8962.

What do taxpayers do if they lost or never received their Form 1095A or if it is incorrect?

If Form 1095-A was lost, never received, or is incorrect, taxpayers should contact their Marketplace directly for a copy. Information regarding how to reach the Marketplace is available on HealthCare.gov as well as IRS.gov/aca. If taxpayers experience difficulty obtaining the Form 1095-A, *Health Insurance Marketplace Statement,* from their Marketplace, they should review the monthly billing statements provided by their health coverage provider or contact the provider directly to obtain the coverage information, monthly premium amount, and amount of monthly advance credit payments made on their behalf

How is the premium tax credit claimed on the tax return?

Only taxpayers who purchased qualified health plans from the Marketplace may be eligible for the premium tax credit. Eligible taxpayers claim the premium tax credit on their federal income tax return. Taxpayers who received the benefit of advance credit payments must file a federal income tax return even if they otherwise are not required to file.

On Form 8962, *Premium Tax Credit,* a taxpayer must subtract the advance credit payments for the year from the amount of the taxpayer's premium tax credit calculated on the tax return. If the premium tax credit computed on the return is more than the advance credit payments made on the taxpayer's behalf during the year, the difference will increase the refund or lower the amount of tax owed. This will be reported in the Payments section of Form 1040. If the advance credit payments are more than the premium tax credit (an excess advance credit payment), the difference will increase the amount owed and result in either a smaller refund or a balance due. This will be entered in the Tax and Credits section of the return. There may be a limitation on the amount of tax liability a taxpayer owes as a result of an excess advance credit payment. The limitation is based on the taxpayer's household income.

For taxpayers with household income below 400 percent of the FPL, the amount of tax liability due to excess advance credit payments is limited as provided in the repayment limitation table (see below).

Repayment Limitation Table

Household Income Percentage of Federal Poverty Line	Limitation Amount for Single	Limitation Amount for all other filing statuses
Less than 200%	$300	$600
At least 200%, but less than 300%	$750	$1,500
At least 300%, but less than 400%	$1,250	$2,500
400% or more	No limit	No limit

For taxpayers eligible to use the Married Filing Separately filing status, the repayment limitation above applies to the spouses separately based on the household income reported on each return.

Taxpayers who chose not to get advance credit payments during the tax year will get all of the benefit of their premium tax credit on their tax return. This will either increase their refund or lower the balance due.

Example:

Brandon Talbot is single, has no dependents and lives in Alabama. When he enrolled through the Marketplace, Brandon was approved for advance credit payments based on his projected 2014 household income of $39,095. The applicable figure for his household income is .095. Brandon enrolled in a qualified health plan. The applicable SLCSP is $5,200. Brandon's Form 1095-A shows advance credit payments of $1,486. Brandon's actual modified AGI for 2014 was $46,000, which is more than the FPL limit shown in Publication 4012, ACA tab (more than 400% of the FPL for a family of 1). Since Brandon's household income is above 400% of the FPL, he may not claim any premium tax credit, and must increase his tax liability by the amount of his advance credit payments. Brandon will complete Form 8962 and enter $1,486 on the excess advance premium tax credit repayment line on his tax return.

What about unusual situations?

For situations listed below, consult the instructions for Form 8962, *Premium Tax Credit.*

What if taxpayers have a shared policy purchased through the Marketplace?

If a taxpayer is enrolled in a policy with a person not in the taxpayer's tax family (a shared policy), the taxpayer may have to allocate the items on Form 1095-A, *Health Insurance Marketplace Statement.* (the enrollment premium, the premium for the applicable SLCSP, and the advance credit payments) with another taxpayer (a shared policy allocation). The following taxpayers may have to do a shared policy allocation:

- Taxpayers who got divorced or legally separated in during the tax year
- A taxpayer who claims a personal exemption deduction for an individual enrolled in a policy by another taxpayer
- A taxpayer who enrolls an individual in a policy, but another taxpayer claims a personal exemption deduction for the individual
- A taxpayer filing a separate return from his or her spouse

Taxpayers complete the shared policy allocation on Form 8962, *Premium Tax Credit*, Part 4.

What if taxpayers get married during the year?

If taxpayers got married during the tax year and one or both spouses received advance credit payments for the year, the spouses may be eligible to use an alternative calculation to determine their excess advance credit payments. See the instructions for Form 8962, *Premium Tax Credit,* for eligibility. If eligible, taxpayers will complete Form 8962, Part 5, Alternative Calculation of Year of Marriage.

U.S. Citizens Living Abroad

How does the Affordable Care Act affect U.S. citizens living abroad?

U.S. citizens living abroad are subject to the individual shared responsibility provision. However, U.S. citizens who are not physically present in the United States for at least 330 full days within a 12-month period are treated as having minimum essential coverage for that 12-month period regardless of whether they enroll in any health care coverage.

In addition, U.S. citizens who are bona fide residents of a foreign country (or countries) for an entire taxable year are treated as having minimum essential coverage for that year. In general, these individuals qualify for the foreign earned income exclusion under section 911.

Individuals may qualify for this rule even if they cannot use the section 911 exclusion for all of their foreign earned income because, for example, they are employees of the United States. Individuals that qualify for this rule need take no further action to comply with the individual shared responsibility provision during the months when they qualify. They will report their status with their federal income tax return on Form 8965.

Tip **See Publication 54, Tax Guide for U.S. Citizens and Resident Aliens Abroad, for further information on the foreign earned income exclusion.**

U.S. citizens who do not meet the physical presence or residency requirements must have minimum essential coverage, qualify for a coverage exemption, or make an individual shared responsibility payment when they file their federal income tax returns. Note that minimum essential coverage includes a group health plan provided by an overseas employer.

Summary

The Affordable Care Act addresses health insurance coverage and financial assistance options for individuals and families, including the premium tax credit. It also includes the individual shared responsibility provision and coverage exemptions from that provision.

The individual shared responsibility provision requires every U.S. taxpayer and their dependent(s) to:

- Have qualifying health care coverage, also called minimum essential coverage, or
- Qualify for an exemption from the responsibility to have minimum essential coverage, or
- Make an individual shared responsibility payment when filing their federal income tax return.

Taxpayers will report minimum essential coverage, report exemptions, or make any individual shared responsibility payment when filing their federal income tax return.

Taxpayers whose entire tax household had minimum essential coverage for each month of their tax year will indicate this on their federal income tax return by checking the box on their Form 1040, 1040A, or 1040EZ. No further action is required.

Taxpayers who did not maintain minimum essential coverage for each month of their tax year may claim a coverage exemption. Form 8965, Health Coverage Exemptions must be used to claim exemptions or report exemptions granted by the Marketplace.

Taxpayers who did not maintain minimum essential coverage for each month of their tax year, or qualify for an exemption from coverage will make a shared responsibility payment. Taxpayers should use the worksheets located in the instructions to Form 8965 to calculate the individual shared responsibility payment amount due. The shared responsibility payment amount due is reported on Form 1040, line 61 in the Other Taxes section, and on the corresponding lines on Form 1040A, and 1040EZ.

If a taxpayer or a member of the taxpayer's family enrolled in a qualified health plan through the Marketplace, the taxpayer must reconcile any advance credit payments with their actual premium tax credit on Form 8962, Premium Tax Credit. If excess advance credit payments were made on a taxpayer's behalf, the taxpayer will enter the excess advance credit payments on their tax return and repay the excess when they file their federal income tax return.

Taxpayers who purchased qualified health plans from the will receive Form 1095-A, *Statement of Insurance from the Marketplace*, which will contain the information necessary to complete Form 8962, *Premium Tax Credit.*

The net premium tax credit is claimed in the Payments section of the federal income tax return. Any excess advance credit payments are entered in the Tax and Credits section of the federal income tax return.

Glossary

Adopted children – If a child is adopted during the year, the child is included in the taxpayer's household only for the full months that follow the month in which the adoption occurs. Similarly, if the taxpayer places a child for adoption or foster care, the child is included in the tax household only for the full months before the month in which the placement occurs.

Applicable taxpayer (for purpose of premium tax credit) – A taxpayer must be an applicable taxpayer to claim the premium tax credit (PTC). Generally, an applicable taxpayer is one who has household income of at least 100 percent but not more than 400 percent of the Federal poverty line (FPL) for the family size, and cannot be claimed as a dependent. If the taxpayer is married at the end of the year, the taxpayer must file a joint return to be an applicable taxpayer unless an exception is met.

A taxpayer with household income below 100 percent of the FPL is an applicable taxpayer if all of the following requirements are met:

- The taxpayer, the taxpayer's spouse or a dependent enrolled in a qualified heath plan through a Marketplace.
- The Marketplace estimated at the time of enrollment that the taxpayer's household income would be between 100 percent and 400 percent of the FPL for the taxpayer's family size.
- Advance credit payments were made for the coverage for one or more months during the year.
- The taxpayer otherwise qualifies as an applicable taxpayer.

A taxpayer with household income below 100 percent of the FPL can be an applicable taxpayer as long as the taxpayer, the taxpayer's spouse, or a dependent who enrolled in a qualified health plan is not a U.S. citizen but is lawfully present in the U.S. and not eligible for Medicaid because of immigration status.

Coverage Family – All members of the taxpayer's family who are enrolled in a qualified health plan and are not eligible for minimum essential coverage (other than coverage in the individual market). (See below for the definition of the individual market.) The members of the coverage family may change from month to month. A taxpayer is allowed a premium tax credit only for health insurance purchased for members of the coverage family.

Dependents of more than one taxpayer – The tax household does not include someone that can, but is not, claimed as a dependent if the dependent:

- is properly claimed on another taxpayer's return, or
- can be claimed by a taxpayer with higher priority under the tie-breaker rules.

Domestic abuse – Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused. Abuse of the victim's child or any family member living in household may constitute abuse of the victim.

Exchange – See Marketplace.

Exemption Certificate Number (ECN) – The number the taxpayer received from the Marketplace for the individual listed in Part I (Marketplace-Granted Coverage Exemptions for Individuals) on Form 8965, *Health Coverage Exemptions,* column c.

Family – Taxpayer family includes all individuals and only those individuals for whom the taxpayer claims a personal exemption deduction on the tax return (taxpayer, spouse, or dependents).

Family coverage (for the purpose of determining if coverage is unaffordable in order to claim a coverage exemption) – If taxpayer (or spouse if filing jointly) is eligible for family coverage under an employer's plan, the

required contribution amount for any member of the family is the premium the taxpayer would pay for the lowest cost family coverage that would cover the taxpayer and everyone in the non-exempt family.

Family size – For the purposes of the premium tax credit, family size includes the individuals for whom the taxpayer can claim a personal exemption deduction on the tax return (taxpayer, spouse if filing a joint return, and dependents).

FPL - Federal Poverty Line – An income amount considered poverty level for the year, adjusted for family size. Department of Health and Human Services (HHS) determines the federal poverty guideline amounts annually. The government adjusts the income limits annually for inflation.

Form 1095-A, Health Insurance Marketplace Statement – Used to report certain information to the IRS about family members who enroll in a qualified health plan through the Marketplace. Form 1095-A, *Health Insurance Marketplace Statement*, also is furnished to individuals to allow them to claim the premium tax credit, to reconcile the credit on their returns with advance payments of the premium tax credit (advance credit payments), and to file an accurate tax return.

Form 1095-B, Health Coverage – Used to report certain information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment. Form 1095-B is not required for 2014. Most taxpayers will not receive Form 1095-B for 2014.

Form 1095-C, Employer Provided Health Insurance Offer and Coverage – Employers with 50 or more full-time employees use this form to report information about offers of health coverage and enrollment in health coverage for their employees. Form 1095-C is used to report information about each employee. Form 1095-C is not required to be provided by any employer for 2014. However, in preparation for the first required filing (filing in 2016 for 2015), employers may, if they wish, voluntarily file in 2015 for 2014. Most taxpayers will not receive Form 1095-C for 2014

Health Insurance Marketplace – See Marketplace.

Household income – The sum of the taxpayer's modified adjusted gross income (MAGI), the spouse's MAGI (if Married Filing Jointly), and the MAGI of all dependents required to file a tax return.

Incarceration – The taxpayer can claim a coverage exemption for a member of the tax household for any month in which the individual was incarcerated for at least 1 day in the month. An individual is incarcerated if he or she was confined, after the disposition of charges, in a jail, or similar penal institution or correctional facility.

Individual Market – The insurance market that provides private, individual (non-group) health insurance coverage to individuals who purchase health insurance on their own. This includes Qualified Health Plans offered through the Marketplace. Each individual generally must pay the entire cost of the health insurance premium, but certain individuals may be eligible for insurance premium subsidies for coverage offered through the Marketplace.

MAGI – See Modified Adjusted Gross Income.

Marketplace (also: Exchange, Health Insurance Marketplace) – A governmental agency or nonprofit entity that makes qualified health plans available to individuals. The term "Marketplace" refers to state Marketplaces, regional Marketplaces, subsidiary Marketplaces, and a federally-facilitated Marketplace.

Married taxpayers (for purposes of the premium tax credit) – If a taxpayer is married at the end of 2014, the taxpayer generally must file a joint return with spouse in order to claim the premium tax credit unless the taxpayer meets one of the two exceptions below:

- Exception 1 (Head of Household filing status). If taxpayer was not divorced or legally separated at the end of the year, he or she is considered unmarried if all of the following apply:
  - The taxpayer lived apart from spouse for the last 6 months of the year. (Temporary absences for special circumstances, such as for business, medical care, school, or military service, count as time lived in the home.)

- The taxpayer filed a separate return from spouse.
- The taxpayer paid over half the cost of keeping up his or her home for the year.
- The taxpayer home was the main home of the taxpayer's child, stepchild, or foster child for more than half of the year. (Temporary absences for special circumstances, such as for school, vacation, medical care, military service, and detention in a juvenile facility, count as time lived in home.)
- The taxpayer can claim the child as a dependent or could claim the child as a dependent except that the child's other parent can claim him or her under the rule for children of divorced or separated parents.

- Exception 2. If taxpayer is a victim of domestic abuse or abandonment and does not qualify to use Head of Household filing status, the taxpayer may claim a premium tax credit if he or she files a return as Married Filing Separately and meets the following:
  - The taxpayer is living apart from his or her spouse at the time the taxpayer filed the current year tax return.
  - The taxpayer is unable to file a joint return because he or she is a victim of domestic abuse or spousal abandonment.
  - The taxpayer certifies on the return that the taxpayer is a victim of domestic abuse or spousal abandonment.

Medicaid Expansion – The health care law provides states with additional federal funding to expand their Medicaid programs to cover adults under 65 who make up to 138 percent of the federal poverty level. Children (18 and under) are eligible up to that income level or higher in all states.

The U.S. Supreme Court ruled that the Medicaid expansion is voluntary with states. As a result, some states have not expanded their Medicaid programs. Many adults in those states with incomes below 100 percent of the federal poverty level fall into a gap. Their incomes are too high to get Medicaid under their state's current rules but their incomes are too low to qualify for the premium tax credit.

Minimum essential coverage (MEC) – Coverage under a government-sponsored program, an eligible employer-sponsored plan, a plan in the individual market, a grandfathered health plan, or other coverage recognized by the Department of Health and Human Services (HHS), in coordination with the Secretary of the Treasury, as minimum essential coverage.

Modified Adjusted Gross Income (MAGI) – For purposes of Form 8962, *Premium Tax Credit,* MAGI is a taxpayer's adjusted gross income plus certain income that is not subject to tax (foreign earned income, tax-exempt interest, and social security benefits not included in income).

Modified Adjusted Gross Income (MAGI) – For purposes of Form 8965, *Health Coverage Exemptions,* MAGI is a taxpayer's adjusted gross income plus certain income that is not subject to tax (foreign earned income and tax-exempt interest).

National Average Bronze Plan Premium (NABPP) – This figure is used in calculating the shared responsibility payment (SRP). A table of NABPP amounts can be found in the Instructions for Form 8965, *Health Coverage Exemptions*, and in Publication 4012, ACA tab.

Premium tax credit – A tax credit for certain people who enroll in a qualified health plan offered through the Marketplace (Exchange). The credit reduces the amount of tax the taxpayer owes. It may also give the taxpayer a refund or increase the refund.

If applicable, the taxpayer is allowed a credit amount for any month during the year that the taxpayer or one or more of the family members [spouse or dependent(s)] were:

- Enrolled in one or more qualified health plans through a Marketplace;
- Not eligible for other minimum essential coverage.

Qualified Health Plan – A health plan certified by the Department of Health and Human Services to be offered through the Marketplace. Qualified health plans offered through the Marketplace must be one of four tiers, or "metal levels" – bronze, silver, gold, or platinum. Individuals and families can choose from a variety of qualified health plans, as well as catastrophic plans for young adults and those without affordable options.

Recognized religious sect – For purposes of Form 8965, a religious sect that has been in existence since December 31, 1950, that is recognized by the Social Security Administration (SSA) as conscientiously opposed to accepting any insurance benefits, including Medicare and social security.

Relief – A taxpayer can certify an exemption from Married Filing Jointly by checking a box on Form 8962, Premium Tax Credit.

Required Contribution – the amount an individual would be required to pay toward minimum essential coverage.

If an individual is eligible to purchase minimum essential coverage through an employer (other than through the Marketplace), the required contribution is the portion of the annual premium that is paid by the individual for self-only coverage, or

For individuals not included above, the required contribution is the annual premium for the lowest cost bronze plan available in the individual market through the Marketplace in the state in which the individual resides, reduced by the amount of the premium tax credit for the taxable year.

Second Lowest Cost Silver Plan (SLCSP) – The second lowest cost silver plan offered through the Marketplace for the rating area in which the taxpayer resides. A taxpayer who enrolled in a qualified health plan through the Marketplace will receive Form 1095-A *, Health Insurance Marketplace Statement,* from the Marketplace which will include the SLCSP amount. This figure is used on Form 8962, *Premium Tax Credit,* to calculate the amount of the premium tax credit that the taxpayer is allowed.

Self-only coverage – (for the purpose of determining if coverage is unaffordable in order to claim a coverage exemption) – If a member of a tax household is eligible for self-only coverage under his or her employer's plan, the required contribution amount is the amount the individual would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.

Shared responsibility payment (SRP) – If the taxpayer or any other member of the tax household did not have either minimum essential coverage or an exemption for any month during the tax year, the taxpayer must compute the shared responsibility payment.

Spousal abandonment – A taxpayer is a victim of spousal abandonment for a taxable year if, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence.

Tax household– For purposes of Form 8965, *Health Coverage Exemptions,* includes the taxpayer, the taxpayer's spouse (if filing a joint return), and any individual claimed as a dependent on the tax return. It also generally includes each person the taxpayer can, but does not, claim as a dependent.

Timing – For purposes of Form 8965, *Health Coverage Exemptions,* an individual has minimum essential coverage for a month if the individual is enrolled in and entitled to receive benefits under a plan or program identified as minimum essential coverage for at least one day during the month.

Unaffordable coverage – For purposes of Form 8965, *Health Coverage Exemptions,* coverage is unaffordable if the individual's required contribution (see definition above) is more than 8 percent of household income.

West Virginia Enrollment		
	Open Enrollment 2014*	Open Enrollment 2015**
Marketplace Enrollment	19,856	31,106
Breakdown by Metal Level		
Bronze	2,780	4,383
Silver	13,502	21,624
Gold	3,376	5,038
Platnium	NA	NA
Catastrophic	198	61
Financial Assistance		
Yes	86%	86%
No	14%	14%

*Department of Health & Human Services ASPE Issue Brief May 1, 1994
**CMS June 30, 2015 Effectuated Enrollment Snapshot

2015 Enrollment I Insured under ACA

County	Population < 65	Medicaid Expansion	Marketplace	Total Insured	Uninsured*
Barbour County	13,811	1,654	-	1,654	991
Berkeley County	93,208	8,410	3,106	11,516	5,575
Boone County	20,573	2,616	-	2,616	1,354
Braxton County	11,609	1,462	234	1,696	903
Brooke County	18,840	1,579	717	2,296	1,239
Cabell County	81,430	9,580	2,373	11,953	5,357
Calhoun County	6,170	752	-	752	443
Clay County	7,613	1,280	-	1,280	546
Doddridge County	6,895	617	64	681	495
Fayette County	37,636	4,874	758	5,632	2,701
Gilmer County	7,430	573	55	628	578
Grant County	9,451	926	178	1,104	565
Greenbrier County	28,237	3,672	1,104	4,776	2,027
Hampshire County	19,208	1,961	331	2,292	1,264
Hancock County	24,296	2,282	1,138	3,420	1,598
Hardy County	11,060	1,258	198	1,456	794
Harrison County	57,408	5,146	1,894	7,040	3,777
Jackson County	23,706	2,454	436	2,890	1,418
Jefferson County	46,920	3,670	1,735	5,405	2,245
Kanawha County	157,490	17,429	4,990	22,419	9,419
Lewis County	13,301	1,686	378	2,064	875
Lincoln County	17,976	2,650	134	2,784	1,398
Logan County	30,187	5,050	244	5,294	1,986
Marion County	48,256	4,607	1,211	5,818	1,354
Marshall County	26,475	2,406	543	2,949	3,175
Mason County	22,064	2,385	229	2,614	1,742
McDowell County	17,411	2,994	-	2,994	1,584
Mercer County	50,540	7,352	1,371	8,723	3,930
Mineral County	22,635	1,958	474	2,432	1,625

Mingo County	22,176	3,437	186	3,623	1,459
Monongalia County	89,469	4,687	2,441	7,128	5,351
Monroe County	10,527	1,092	389	1,481	693
Morgan County	13,986	1,471	478	1,949	1,004
Nicholas County	21,254	3,048	346	3,394	1,525
Ohio County	35,677	3,275	1,362	4,637	2,134
Pendleton County	5,740	659	154	813	378
Pleasants County	7,032	464	100	564	463
Pocahontas County	6,772	890	211	1,101	446
Preston County	28,170	2,699	580	3,279	1,685
Putnam County	47,503	3,424	1,368	4,792	2,273
Raleigh County	64,925	7,999	1,521	9,520	4,271
Randolph County	23,502	2,604	519	3,123	1,687
Ritchie County	8,194	804	-	804	588
Roane County	11,901	1,454	294	1,748	854
Summers County	10,865	1,319	181	1,500	780
Taylor County	13,558	1,369	237	1,606	973
Tucker County	5,719	574	61	635	376
Tyler County	7,060	738	169	907	464
Upshur County	20,112	2,341	531	2,872	1,443
Wayne County	34,143	3,898	551	4,449	2,246
Webster County	7,211	1,301	-	1,301	561
Wetzel County	12,971	1,434	432	1,866	853
Wirt County	4,788	527	74	601	372
Wood County	71,059	7,746	2,155	9,901	4,675
Wyoming County	19,304	2,727	64	2,791	1,385
TOTAL	**1,535,454**	**165,264**	**38,299**	**203,563**	**99,896**
* estimates based on Enroll America data				-	

2015 Medicaid Data By County

County	Total Population	Magi Population	Other Medicaid	Total Medicaid	Percent w/Medicaid
Barbour County	16,589	3,638	1,450	5,088	31%
Berkeley County	104,169	21,615	4,604	26,219	25%
Boone County	24,629	6,443	2,383	8,826	36%
Braxton County	14,523	3,298	1,319	4,617	32%
Brooke County	24,069	3,580	1,218	4,798	20%
Cabell County	96,319	20,640	7,514	28,154	29%
Calhoun County	7,627	1,659	899	2,558	34%
Clay County	9,386	2,974	1,183	4,157	44%
Doddridge County	8,202	1,459	478	1,937	24%
Fayette County	46,039	11,045	4,221	15,266	33%
Gilmer County	8,693	1,193	531	1,724	20%
Grant County	11,937	2,111	816	2,927	25%
Greenbrier County	35,480	7,762	2,698	10,460	29%
Hampshire County	23,964	4,800	1,430	6,230	26%
Hancock County	30,676	5,344	1,581	6,925	23%
Hardy County	14,025	3,094	857	3,951	28%
Harrison County	69,099	12,419	4,654	17,073	25%
Jackson County	29,211	5,990	2,117	8,107	28%
Jefferson County	53,498	8,365	1,813	10,178	19%
Kanawha County	193,063	39,919	14,182	54,101	28%
Lewis County	16,372	3,843	1,412	5,255	32%
Lincoln County	21,720	6,401	2,642	9,043	42%
Logan County	36,743	10,606	3,868	14,474	39%
Marion County	56,418	10,750	3,694	14,444	26%
Marshall County	33,107	5,888	1,804	7,692	23%
Mason County	27,324	5,690	2,216	7,906	29%
McDowell County	22,113	6,950	3,689	10,639	48%
Mercer County	62,264	16,349	6,322	22,671	36%
Mineral County	28,212	4,714	1,516	6,230	22%
Mingo County	26,839	8,211	3,837	12,048	45%
Monongalia County	96,189	10,667	3,384	14,051	15%

Monroe County	13,502	2,482	824	3,306	24%
Morgan County	17,541	3,375	803	4,178	24%
Nicholas County	26,233	6,382	2,310	8,692	33%
Ohio County	44,443	7,121	2,582	9,703	22%
Pendleton County	7,695	1,404	527	1,931	25%
Pleasants County	7,605	1,184	491	1,675	22%
Pocahontas County	8,719	1,789	588	2,377	27%
Preston County	33,520	6,084	2,152	8,236	25%
Putnam County	55,486	8,444	2,491	10,935	20%
Raleigh County	78,859	18,270	6,447	24,717	31%
Randolph County	29,405	5,927	2,412	8,339	28%
Ritchie County	10,449	1,914	819	2,733	26%
Roane County	14,926	3,514	1,592	5,106	34%
Summers County	13,927	2,876	1,400	4,276	31%
Taylor County	16,895	3,051	1,222	4,273	25%
Tucker County	7,141	1,258	474	1,732	24%
Tyler County	9,208	1,634	541	2,175	24%
Upshur County	24,254	5,517	1,811	7,328	30%
Wayne County	42,481	9,581	3,724	13,305	31%
Webster County	9,154	2,739	1,202	3,941	43%
Wetzel County	16,583	3,483	1,280	4,763	29%
Wirt County	5,717	1,345	550	1,895	33%
Wood County	86,956	18,254	6,816	25,070	29%
Wyoming County	23,796	6,107	2,536	8,643	36%
TOTAL	**1,852,994**	**381,152**	**135,926**	**517,078**	**28%**
Data from WV Department of Health and Human Resources 7-19-2015				-	#DIV/0!

WVAHC
West Virginians for Affordable Health Care

Marketplace Information

- Definitions
- Comparing Health Insurance Plans
- Understanding the Marketplace
- Medicare
- Learning Library
- Steps for Assister Training
- Coverage To Care

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.

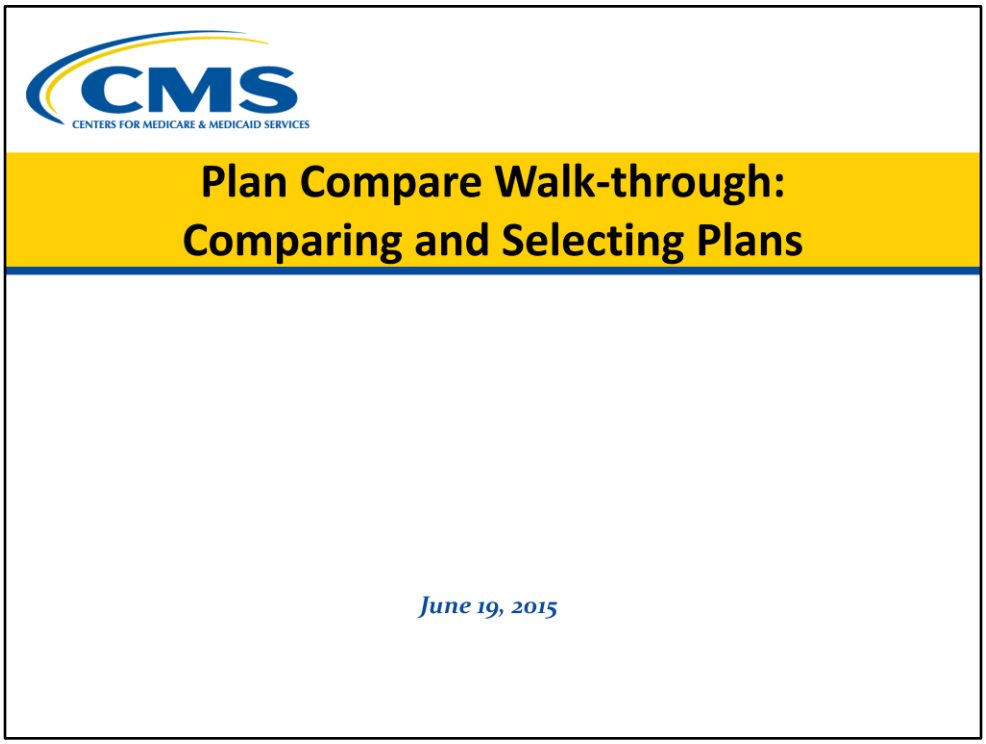
Solvency — The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous. In extreme circumstances, a state may seize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



This session will spotlight the section of applications on the Federally-facilitated Marketplace and State Partnership Marketplace application process that covers plan compare, choosing how much advance premium tax credits (APTCs) to apply, enrolling family members in different plans, and plan selection.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

The information in this module was correct as of June 2015.

Please note that the information presented is informal, technical assistance for assisters and is not intended as official CMS guidance or legal advice. All relevant law is contained in the applicable statutes and regulations.
The online application begins with account creation (including identity proofing) and ends with the applicant seeing their eligibility results. The applicant will then move on to compare plans and select a Qualified Health Plan (QHP), if he or she is eligible to enroll in a QHP through the Marketplace. The following includes an in-depth look into the plan comparison and selection process.

Agenda

- Introduction
- Plan Compare Walk-through
- Choosing APTC
- Enrolling Family Members in Different Plans
- Plan Selection
- Question and Answer Session

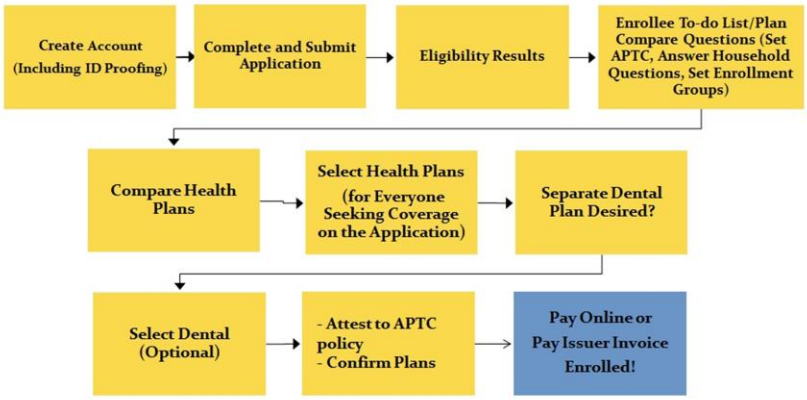
Plan Compare Overview

- Plans display based on information submitted on the eligibility application, including
  - Rating area (zip code & county)
  - Number of family members seeking coverage
  - Family members' ages and tobacco status
- Browse plans before applying at https://www.healthcare.gov/see-plans/
- Only qualified health plans are displayed

Plans displayed are based on information submitted on the eligibility application, including:
Rating area (zip code & County)
Number of family members seeking coverage
Family members' ages and tobacco status

Only qualified health plans are displayed. Consumers can browse plans before applying at https://www.healthcare.gov/see-plans/

Plan Compare Flow



These steps depict the online application flow. It begins with account creation (including identity proofing) and ends with the applicant paying for their selected plan. After being determined eligible to enroll in coverage through the Marketplace, the applicant will then move on to select a Qualified Health Plan. If the applicant qualifies for Medicaid or CHIP, the Marketplace transfers the information to the state Medicaid or CHIP agency, which will send enrollment information to the applicant.

Plan Compare Scenario

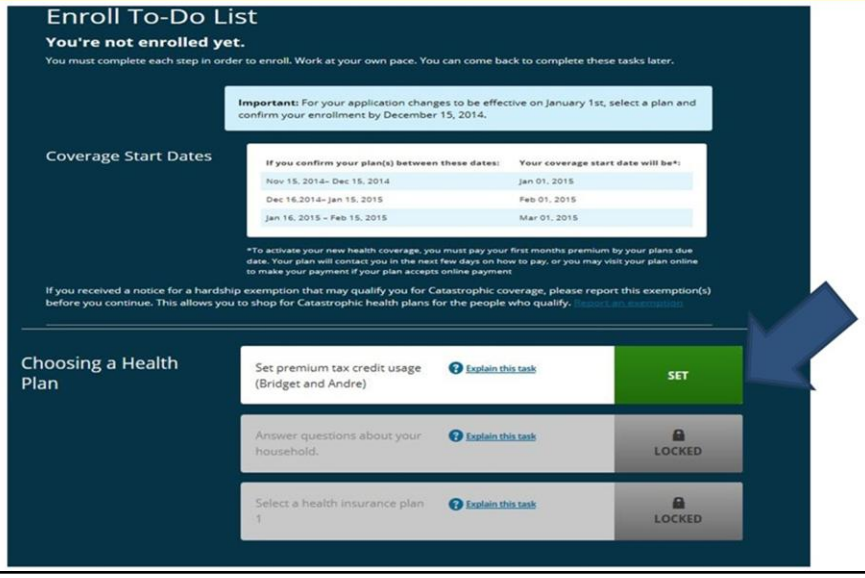
- Andre is applying for coverage and financial assistance for himself and his wife Bridget
- Eligible to enroll in a Qualified Health Plan through the Marketplace
- Eligible for up to $67/month in payments of the Advance Premium Tax Credit (APTC)

The following screenshots will demonstrate the application process for a married couple.

If anyone on the application is eligible for the APTC, the maximum amount is determined before plan selection and is not impacted by of how many plans the family selects. If a family has more than one plan, APTC is allocated to each plan not by the consumer, but by the Marketplace.

Note: Applicants are given the option to apply for enrollment in a QHP through the Marketplace without applying for financial assistance.

Plan Compare Navigation: To-Do List



After receiving eligibility results, the applicant will be shown their “Enroll to-do list” to help navigate through the plan comparison process. They will be asked plan compare questions including how much of their maximum APTC they want to apply to reduce their monthly premiums, as well as questions about their tobacco use status and enrollment grouping.

Set APTC Amount Used for Premium Discount

Set Premium Tax Credit

Decide how much of your premium tax credit to use each month

You qualify for a NEW tax credit you can use right away to lower your monthly premium costs.

You'll choose how much of your tax credit to apply to your monthly premium. But the amount you may get depends on when you enroll. For example, if you enroll in September, the amount of tax credit you may get will be based on 4 months (September-December), instead of 12 months.

After you file your federal tax return, you'll find out if you might get money back based on the actual amount of tax credit you qualified for, and how much of the credit you used. If you didn't use all of the tax credit you qualified for, you may get money back. If you used more tax credit than you qualified for, you may owe money.

We'll help you understand the different ways you may want to use your premium tax credit.

SKIP QUESTION | CONTINUE

Applicants who are eligible for APTC have the option to decide how much of their premium tax credit to use on a monthly basis. This choice is then reflected in the prices displayed for the plans they will see and compare. The system will prompt the applicant to select how much APTC amount they want to apply to their premium cost each month.

Instruct Applicants on APTC

Set Premium Tax Credit

Review the 3 ways that you can use your premium tax credit

You'll choose how much of your tax credit to apply to your monthly premium. But the amount you may get depends on when you enroll. For example, if you enroll in September, the amount of tax credit you may get will be based on 4 months (September-December), instead of 12 months.

After you file your federal tax return, you'll find out if you might get money back based on the actual amount of tax credit you qualified for, and how much of the credit you used. If you didn't use all of the tax credit you qualified for, you may get money back. If you used more tax credit than you qualified for, you may owe money.

Keep in mind:

- Getting a new job, having a baby, or other life changes can affect the amount of your premium tax credit.
- If the amount of your expected 2015 income you report isnt correct, you may not get the right amount of premium tax credit.
- As soon as you have a change to your income or family size, come back to HealthCare.gov and log-in to your Marketplace account to report it. This will reduce your chance of having to pay money back at the end of the year.

3 ways to use your premium tax credit:

1. Use ALL	2. Use SOME	3. Use NONE

Will my premium be lower?

Yes	Yes	No

Will I get more money back as a credit on my Federal tax return?

Not Likely	Maybe	Yes

Will I have to pay money back if my circumstances change?

Maybe	Maybe	No

Why you might choose this option:

Why you might not chose this option

See some examples of how you might use your tax premium

I HAVE REVIEWED

Applicants who are eligible for APTC will see a screen that gives them three different options on how to use their advance premium tax credit. Applicants can generally use all, some or none of their APTCs. The three scenarios show whether or not their monthly premium cost will be lower, if they likely will get money back as a credit on their Federal income tax return, and if they may have to pay money back on their taxes if their circumstances change.

After reviewing, the applicant will select “I have reviewed” in the bottom right corner.

Set APTC Amount:

Does Andre want to use all $67 for premium discount?

Set premium tax credit amount for Bridget and Andre

Bridget and Andre are currently eligible for **$67 each month** ($804 for the year).

Getting a new job, having a baby, or other life changes can affect the amount of your premium tax credit. Keep this in mind as you decide how much of your tax credit to use to lower your monthly premium.

Do you want to use all of your $67 premium tax credit each month?

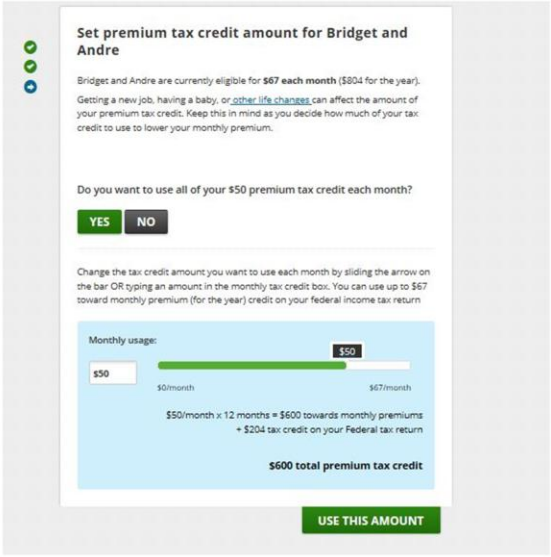
YES NO

USE THIS AMOUNT

The applicant still has the ability to decide how much of his or her maximum APTC will be applied each month to the premiums for the plans selected (and how much is potentially left as a tax credit when an applicant files taxes, depending on eligibility for the premium tax credit as determined through the tax filing process). The applicant has the option to use some or all of his or her APTC, if he or she wants to reduce the monthly amount he or she is responsible for paying, or not use any at all.

Slider for APTC Amount:

Bridget and Andre select $50 of $67 for monthly discount



There is a slider tool to help the applicant select the amount of APTC to apply monthly.

Confirm APTC Amount

You've chosen how much of your premium tax credit to use each month.

As you compare plans, the amount of your tax credit will be applied to the monthly premium of each plan.

You may get up to **$0** as a credit on your federal income tax return at the end of the year. This amount is based on a 12-month coverage year starting in January. But the amount you may get depends on when you enroll. For example, if you enroll in September, the amount of tax credit you may get will be based on 4 months (September-December), instead of 12 months.

After you file your federal tax return, you'll find out if you might get money back based on the actual amount of tax credit you qualified for, and how much of the credit you used. If you didn't use all of the tax credit you qualified for, you may get money back. If you used more tax credit than you qualified for, you may owe money.

If you have income or family size changes, report them to the Marketplace as soon as possible, because life changes can affect your tax credit eligibility status. **To report changes, come back to HealthCare.gov and log in to your Marketplace account.**

CONFIRM YOUR TAX CREDIT AMOUNT

After choosing how much of their advance premium tax credit the applicant wants to use each month, he or she will confirm their APTC amount by selecting the green button at the bottom of the screen.

In this scenario, Bridget and Andre likely may have a $204 credit on their federal income taxes, assuming their household income and family size for the year don't change from what they entered on the application.

Enrolling Family Members into Different Plans

Can a family can still apply all together on an application and enroll in separate plans?

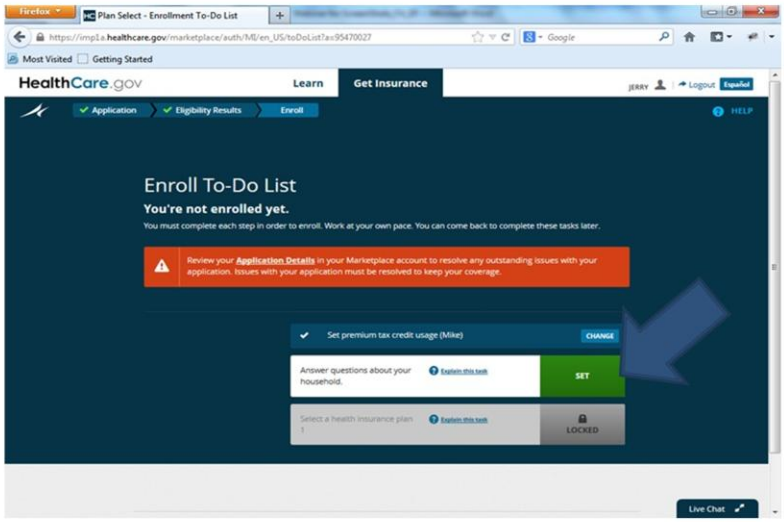
Yes, the family can apply together and be determined eligible for a Qualified Health Plan. Once determined eligible, the family can take the steps below to select a different plan for different family members (or groups of family members). APTC is allocated to each plan not by the applicants but by a business rule described in 155.340(f) (although the application filer can decide how much of the family's maximum APTC is applied each month, as discussed above).

Please note that enrolling family members into different plans cannot be done if one of the plans being selected is a catastrophic plan.

Assisters may find that some families want to include all members of the family on one application but want to enroll individuals in separate plans. For example, family members may have doctors in different provider networks, requiring separate plans.

Enrollment group refers to who will be on a plan together. Plans have different rules about who is an eligible dependent, such as spouses and children. Plan Compare will provide valid default enrollment groups that enable an applicant to see plans, but the applicant can also form a different enrollment group. If an applicant forms an enrollment group that isn't supported by any plans, he or she will be prompted to regroup until valid groups are formed. Families with more than three children under 21 may benefit from one enrollment group, since additional premium isn't charged for additional children under 21 on the same plan.

Household Questions

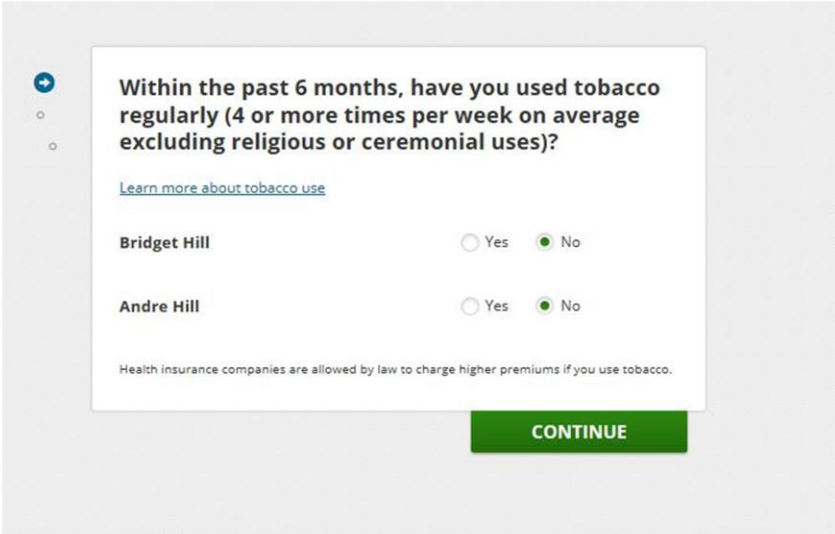


Step 1: The applicants in the family are determined eligible to enroll in coverage through the Marketplace. The primary applicant proceeds to enrollment.

Step 2: The applicant determines the enrollment groups for individual family members. This grouping will allow the family to select different plans for different family members.

The applicant clicks the “Answer questions about your household” Enrollment To Do task.

Tobacco Usage



Next the applicant will be asked additional questions about tobacco usage for each member of the household who is over the age of 18 and applying for coverage, prior to seeing available plans. Enrollees in coverage through the Marketplace for 2015 who are automatically reenrolled in coverage and who do not return to the Marketplace to update their eligibility information will have their tobacco usage rating for 2015 continued for 2016 coverage.

When you are assisting applicants, you should tell them to answer this question truthfully. So, if during the past 6 months, they have used tobacco 4 or more times per week, on average, they should answer yes to the question on whether they use tobacco regularly. The only exception to this is if they are using tobacco for religious or ceremonial purposes. Religious or ceremonial use of tobacco does not count as "tobacco use" when determining whether an individual uses tobacco regularly. If a person answers "yes" to the question about regular tobacco use, they will also be asked on the application to provide the date when they last used tobacco regularly. This question should be answered truthfully for each household member who answered yes to the question about regular tobacco use. A tobacco user can't change their tobacco usage status until the next enrollment period.

Enrollment Grouping

Recommended health plan groups

You have multiple people in your household who qualify for coverage. You can choose whether you want to find one plan for everyone to enroll in together, a separate plan for each person, or some other grouping.

Based on your application, we put your household(s) into 1 groups.

- If you want to keep it that way, you don't need to do anything.
- To make changes, choose "Change groups" below. If you decide to make changes, some plans may not be available.

Tax Household 1

Group 1 - These people will enroll in the same plan.

Bridget Hill

Andre Hill

CHANGE GROUPS

* Insurance companies have different rules about who can enroll in a plan together. If you don't have the option to group certain people together, it means the insurance company doesn't allow people related in that way to enroll in a plan together. Keep in mind, everyone will get health coverage, even if it takes more than one plan. In general, the way your family is grouped won't change your monthly premium.

USE THESE GROUPS

Spouses Default Together into One Group

Step 3: The applicant separates the initial enrollment grouping into self-only groups by selecting "change groups."

Enrollment Grouping

Choose your health plan groups

You have multiple people in your household who qualify for coverage. In order to meet the needs of everyone, you can:

- Enroll everyone in the group(s) below
- Rearrange your family members into different groups*

To keep the groups below, select "Use these groups". To change groups

- Select the groups or people you want to move.
- Use the drop-down box to make your changes, then choose "Submit".

The Marketplace will see if at least one health plan exists for the group(s) you created. If not, you'll get an error message and can make other changes, or keep the previous groups by choosing "Use these groups".

Note: If you want to combine more than one tax household, then you must move all members of each tax household into one group.

Tax Household 1

Group 1 - These people will enroll in the same plan.

Bridget Hill

Andre Hill

Create new group

SUBMIT

Dividing in Separate Groups

Step 4: To create a new group, the applicant selects one of the family members and selects “create a new group.”

Once all groups have been created, the applicant enters “submit.”

Enrollment Grouping

Recommended health plan groups

You have multiple people in your household who qualify for coverage. You can choose whether you want to find one plan for everyone to enroll in together, a separate plan for each person, or some other grouping.

Based on your application, we put your household(s) into 2 groups.

- If you want to keep it that way, you don't need to do anything.
- To make changes, choose "Change groups" below. If you decide to make changes, some plans may not be available.

Tax Household 1

Group 1 - This person will enroll in a separate plan.

Andre Hill

Group 2 - This person will enroll in a separate plan.

Bridget Hill

CHANGE GROUPS

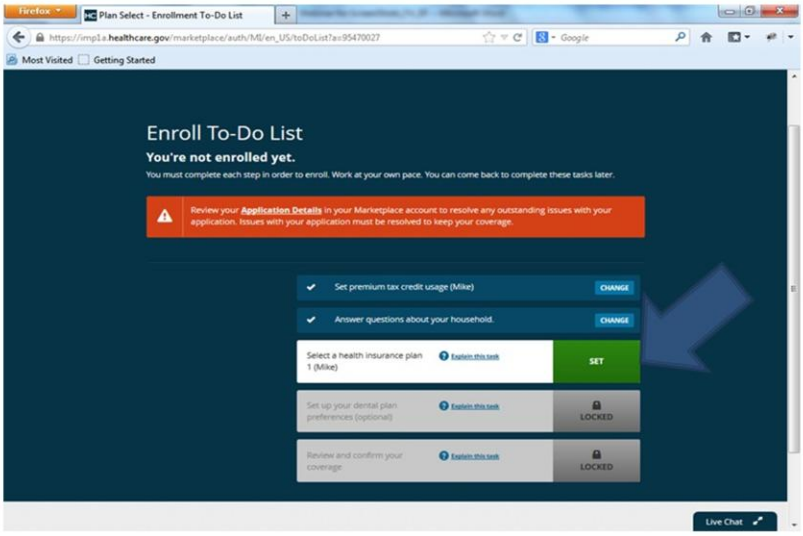
* Insurance companies have different rules about who can enroll in a plan together. If you don't have the option to group certain people together, it means the insurance company doesn't allow people related in that way to enroll in a plan together. Keep in mind, everyone will get health coverage, even if it takes more than one plan. In general, the way your family is grouped won't change your monthly premium.

USE THESE GROUPS

Separate Groups

The family is separated into various enrollment groups after reviewing options in Plan Compare.

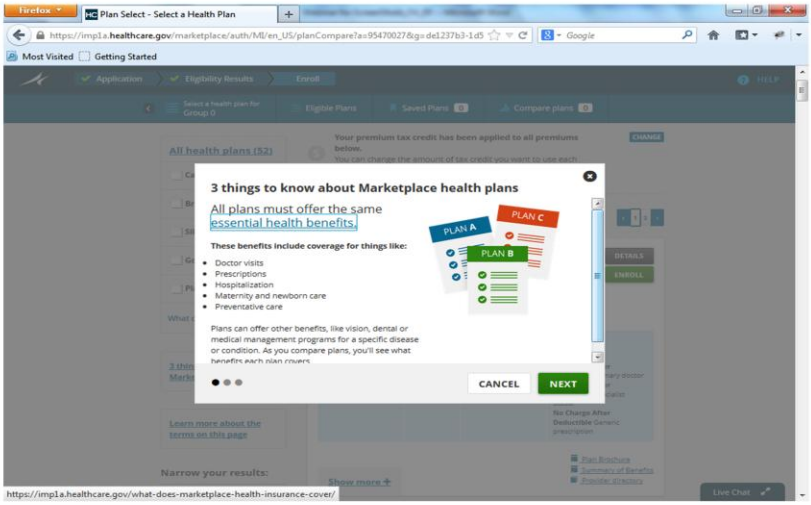
Selecting a Plan



Some consumers wait until they are enrolled in a plan before they check to see if their doctors are in network. However, it is very important that consumers do this before enrolling in a plan because it is not uncommon for doctors and other providers to go in and out of plans' provider networks for a variety of reasons. Assisters should remind applicants to make sure their doctor or provider is in network for the specific plan they are considering before they enroll. Some providers may participate in a network for a different plan offered by the same issuer, but may not be covered under all plans offered by the issuer. The best way for consumers to ensure a provider participates in the specific plan they are selection is for consumers to call their doctor or provider as well as the insurance company to make sure the doctor is in the relevant network.

After the enrollment grouping is complete, the applicant should select "Select a health insurance plan" option on the Enroll To-Do List.

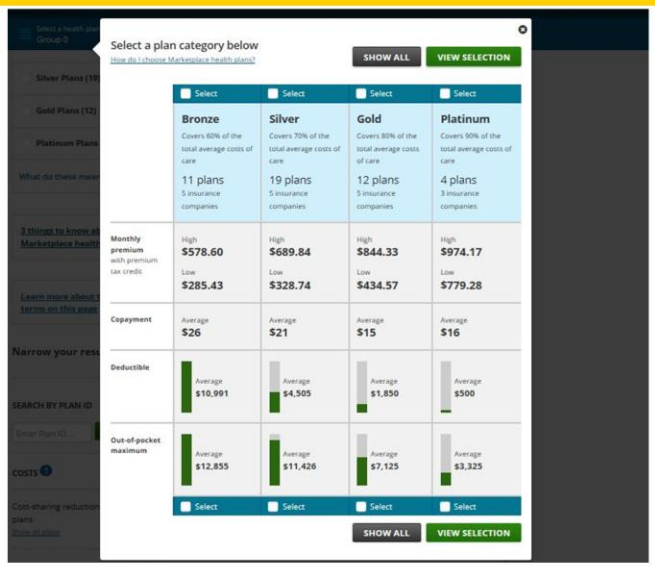
Before Seeing Plan Results, Consumer is Shown Information on Plans



Before seeing the different plans, the applicant is shown certain information about all health plans available through the Marketplace. The information provided lists the essential health benefits.

Overview of Plans:

the "Metal Table" summarizes plans by metal level, displaying premium ranges and cost sharing like deductibles and copayments



Next, the applicant will be able to compare health plans generally using the "Metal Table" which summarizes plans by metal level, displaying premium ranges (after APTC) and cost sharing, such as deductibles, for all the plans that are available to at least one enrollment group on the application .

Please note that consumers who are eligible to enroll for catastrophic coverage outside of the Open Enrollment Period must fill out a hardship exemption form and review a list of catastrophic plans through HealthCare.gov.

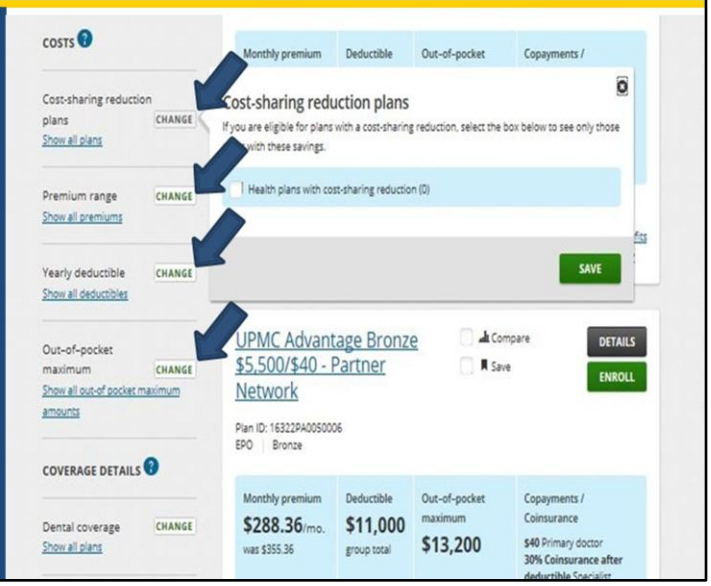
Overview of Plans

Once the applicant is on the plan results page, summary information about individual plans is presented, including the cost of premiums. The more prominent premium shows the monthly price net of APTC, but the applicant can also see the pre-APTC premium. Please note that although APTCs can be applied to all metal levels, cost-sharing reductions (CSRs) are only available for Silver qualified health plans. Consumers who are eligible for CSRs, should be reminded that they will have lower out-of-pocket costs for deductibles, coinsurance, and copayments only if they pick a plan from the Silver plan category. Note that if the consumer is a member of a federally recognized tribe, they may qualify for additional cost-sharing benefits.

Filters

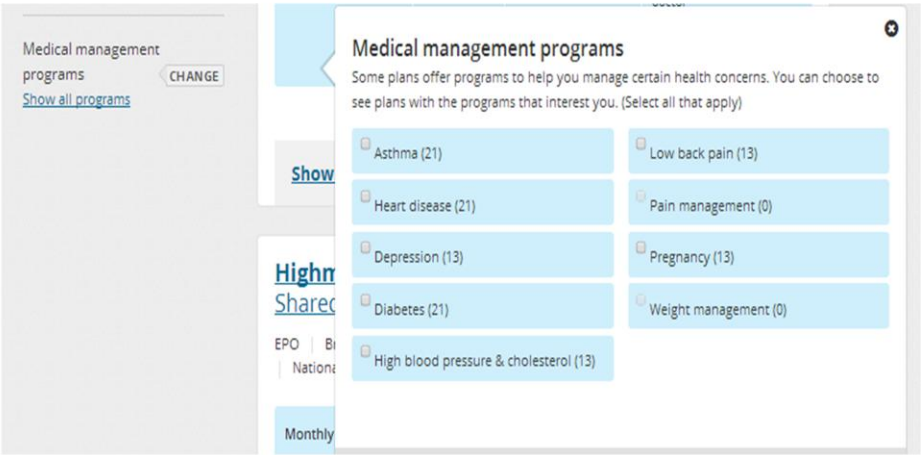
Filters on the left navigation

- Premium range
- Deductible range
- Max out-of-pocket (OOP) range
- Dental coverage
- Plan Type
  - Including National Network
- Health Savings Account (HSA)-eligible?
- Medical Management Program



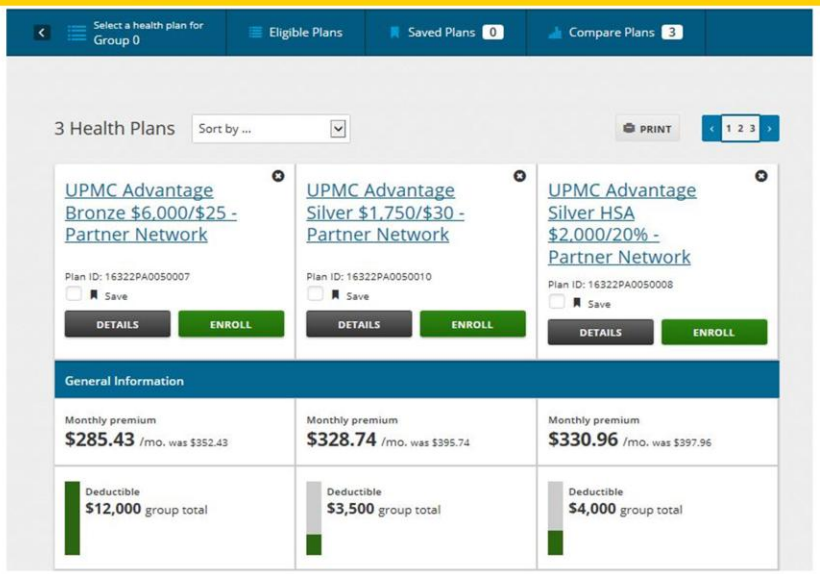
The consumer can filter by premium, deductible, maximum out of pocket, whether adult/child dental is included, plan type including national network, HSA eligibility, and Medical Management Program. If an enrollment group includes an out of state family member, they may want to give consideration to a plan with a national network. The applicant can also compare plans in detail or using a side-by-side view.

Example Filter: Medical Management Program



There is also a filter option for medical management programs to help a consumer manage certain health concerns.

See All Plans



After selecting plans to compare, the applicant can see multiple plans, demonstrating an apples-to-apples comparison.

Comparison Categories include:
General Information
Premium, Deductible, Maximum OOP
Dental Coverage for child or adult
Costs for Medical Care
Primary Care Provider
Specialist
Labs and Outpatient Professional Services
Emergency Room Visit
Inpatient Surgery
Prescription Drug Coverage
Costs for Generic, Preferred Brand, Non-preferred, Specialty Drugs
List of covered drugs
3-month mail order availability
Coverage Examples
Displays cost scenarios for pregnancy and diabetes
Adult Dental
Costs covered (if any) for Routine, Basic, Major, Orthodontia
Child Dental

Costs covered (if any) for Routine, Basic, Major, Orthodontia

Medical Management Programs

Other Services

Acupuncture

Chiropractic

Infertility Service

Bariatric Services

Selecting a Plan:

Press "enroll" from results; side-by-side, or details view

2 Eligible Saved Health Plans

Sort by ...

PRINT

The pricing has been updated based on your application. You can enroll in a plan or view the other plans that are available to you.

Plan saved for Group 0

UPMC Advantage Bronze $6,000/$25 - Partner Network

Compare View

Save Remove

DETAILS

ENROLL

Plan ID: 16322PA0050007
EPO | Bronze

Monthly premium	Deductible	Out-of-pocket maximum	Copay / Coinsurance
$285.43/mo. was $352.43	$12,000 group total	$13,200 worst case scenario	$25 Primary doctor No Charge After Deductible Specialist doctor $15 Generic drugs

Dental: Child only

Plan brochure

Summary of Benefits

Provider directory

Show more +

Plan saved for Group 0

UPMC Advantage Silver $1,750/$30 - Partner Network

Compare View

Save Remove

DETAILS

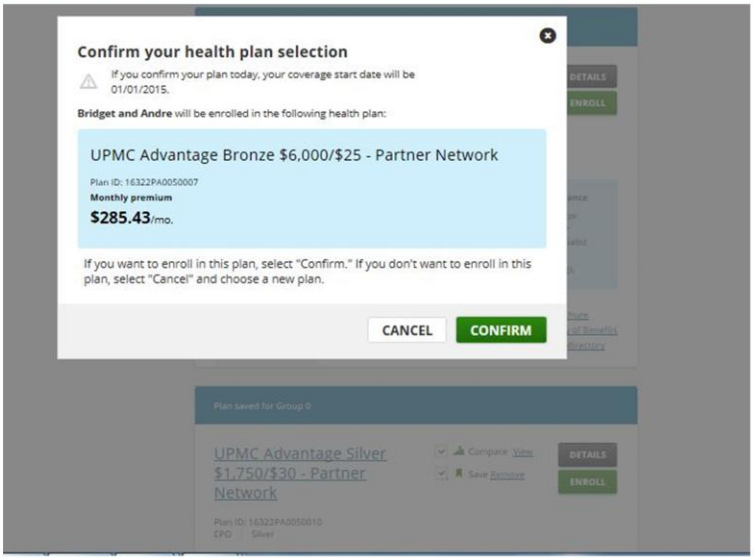
ENROLL

Plan ID: 16322PA0050010
EPO | Silver

If the applicant checked "save", the saved plans will be available for them to look at without sorting through all of the available plans.

Next, the applicant can select health plans for everyone seeking coverage in the enrollment group by clicking "enroll" from the results, side-by-side, or details views. Different warnings may appear that indicate the applicant may have missed the opportunity to participate in a plan with cost-sharing reductions (for example, if the applicant has selected a plan that is not a silver-level plan) or that they selected a plan covering a child that does not provide child dental coverage.

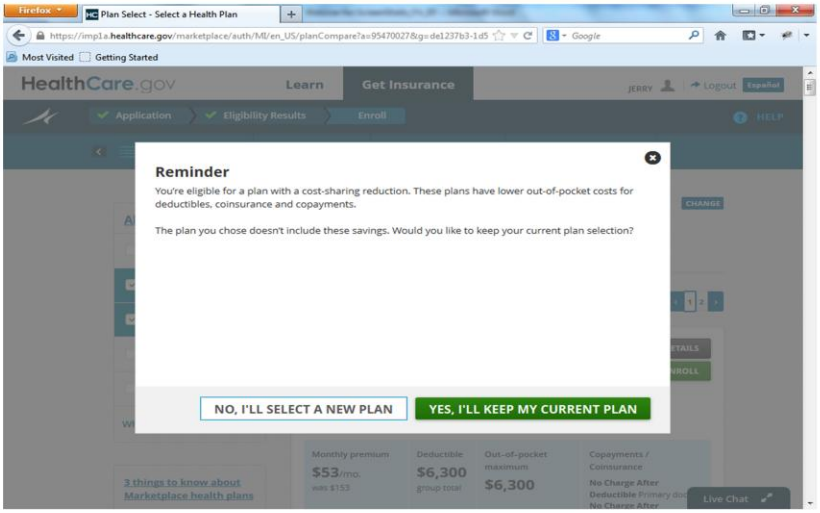
Confirmation of Plan Selection



Once the applicant selects “enroll,” a confirmation window will appear. It will provide a summary of the plan selection and if the consumer agrees, he or she will select “confirm.”

Different Warnings May Display

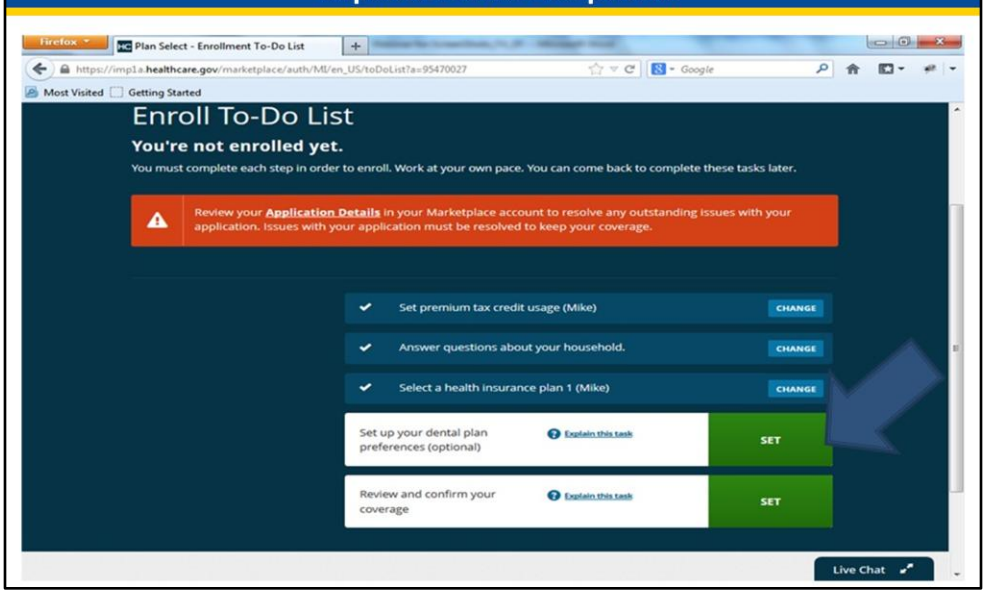
- Plan selected doesn't have reduced cost sharing (CSR, displayed)
- Plan doesn't have child dental



Cost-sharing reductions (CSRs) generally are only available for Silver level qualified health plans. If you're assisting a consumer who is eligible for CSRs (generally, a person whose household income is between 100-250% FPL), make sure that as you discuss the consumer's plan options, you remind the consumer that he or she will have lowered out-of-pocket costs for deductibles, coinsurance, and copayments only if they pick a plan from the Silver QHP category. Note that if the consumer is a member of a federally recognized Indian tribe or member of an Alaska Native Claims Settlement Act (ANCSA) corporation, he or she may able to receive CSRs for enrolling in a qualified health plan at any metal level plan category (including Bronze, Silver, Gold, and Platinum). If a member of a federally-recognized Indian tribe or ANCSA corporation has income below 300% FPL, they may qualify for a zero cost-sharing plan. If such an individual has income above 300% FPL, they may qualify for a limited cost-sharing plan. APTC can be applied to all metal levels, but CSRs are only for Silver plans (except in certain circumstances, as noted above). Neither CSRs nor the APTC can be applied to catastrophic plans.

Dental Selection

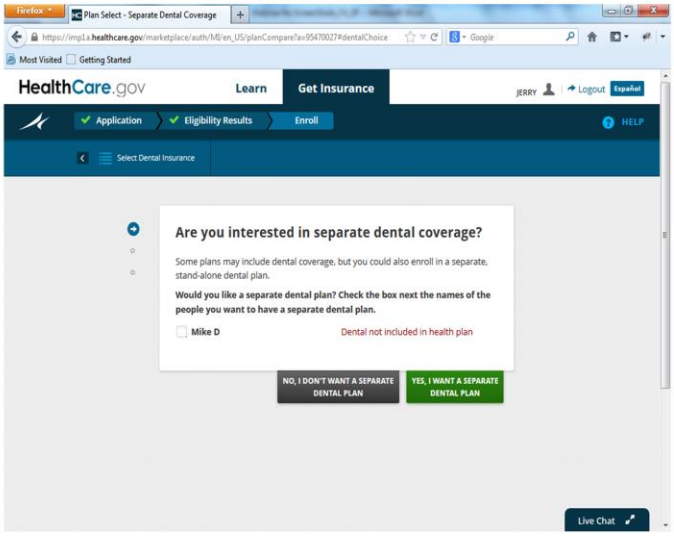
- Marketplace health plan required to purchase dental plan
- Separate dental is optional



Next, the applicant has the option to select a separate dental plan if they choose one (if no separate dental plan is desired, the consumer can skip directly to the "Review and Confirm" task). In order to purchase a dental plan, a Marketplace health plan is required to continue with enrollment, while dental plan selection is optional. In other words, a dental plan cannot be purchased alone.

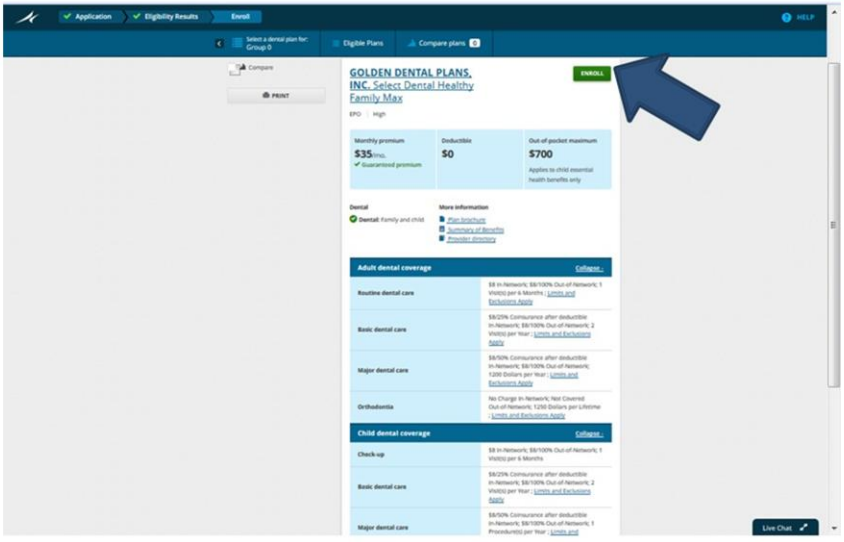
Dental Selection (Optional)

Note that this question highlights whether dental was included in the health plan



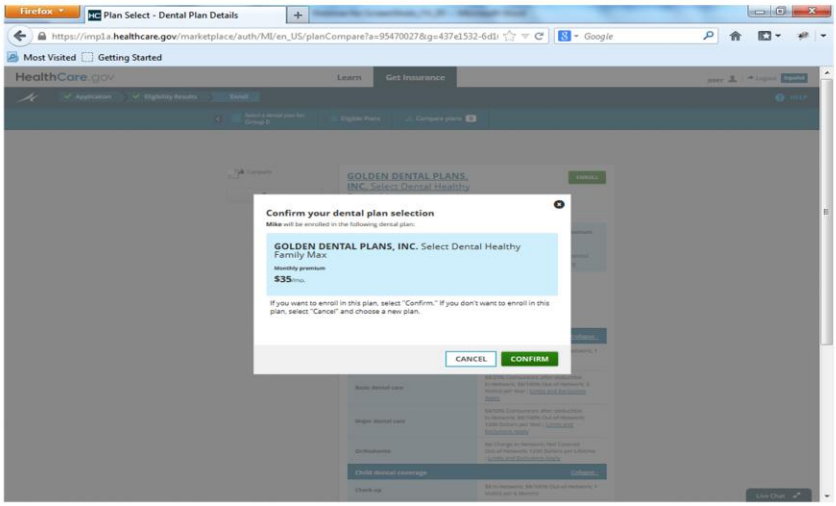
The consumer will be asked if they are interested in separate dental coverage and the process will proceed similarly to the major medical plan compare and selection process. If someone wants to apply for dental coverage only (e.g., their employer doesn't offer it), he or she cannot apply for dental only through the Marketplace at this time, as dental plans are not sold through the major medical health plan purchased through the Marketplace. Some medical plans do include child or even adult dental. If a consumer would like to purchase a supplemental dental plan, he or she must do so prior to the start of their health plan coverage.

Dental Plan Details



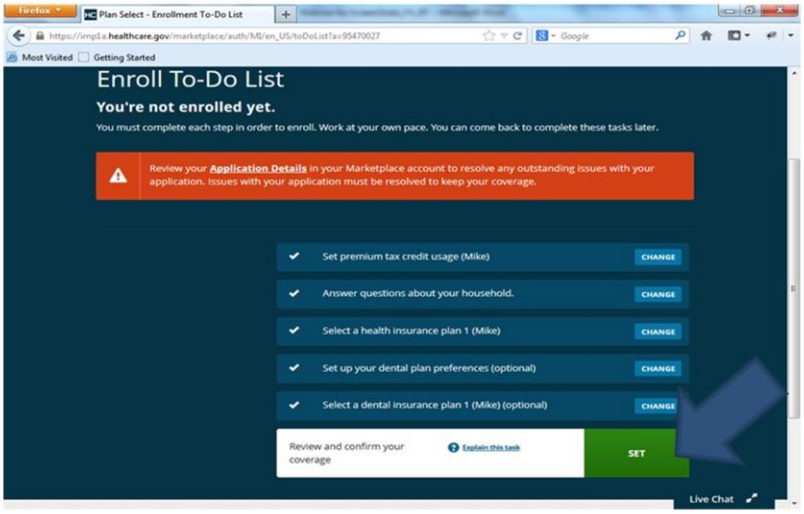
Once dental plans in which the applicant is eligible to enroll eligible dental plans appear, the applicant will select “enroll” to enroll in a dental plan.

Confirm Dental Plan Selection



Once the applicant selects “enroll”, a confirmation window will appear. It will provide a summary of the plan selection and if the applicant agrees, he or she will select “confirm.”

Review and Confirm

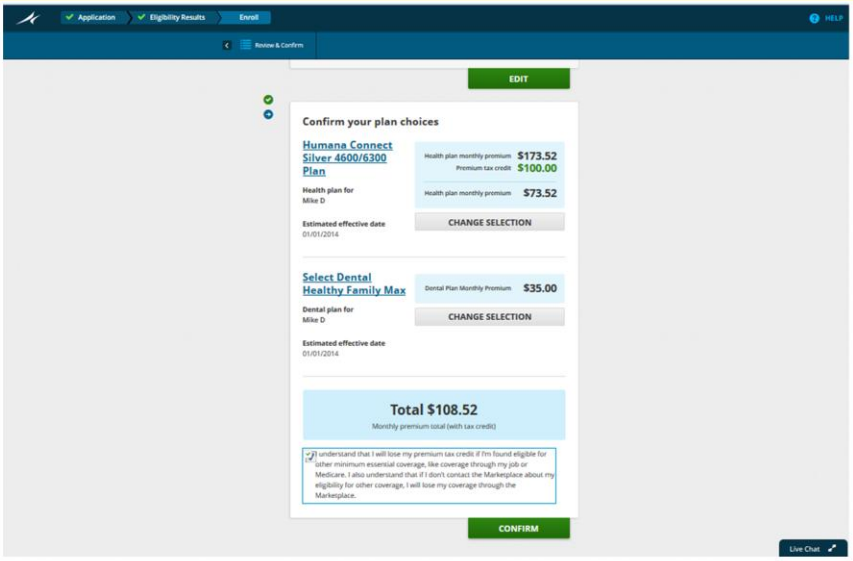


After confirming their dental plan, the applicant will be brought back to the “Enroll To-Do List” page and select “Review and confirm your coverage.”

APTC Attestation

Next, the applicant will attest to their APTC by agreeing or disagreeing to filing a federal income tax return in 2016 for the tax year 2015 and by accepting to file a joint income tax return with spouse, if married by the end of 2015. The applicant is also agreeing to no else being able to claim him or her as a dependent on their 2015 federal income tax return. After selecting “agree” or “disagree”, the applicant will click “save & continue.”

Confirm Choice of Major Medical Health and Dental Plans



The applicant will now review both of their selected major medical health and dental plans and confirm their choices. Applicants must also check the box acknowledging what happens to their Marketplace coverage if the FFM determines that the applicant has become eligible for other coverage during the year.

Plan Payment Page

Green "Pay for Plan" button means online payment is available

Enroll to-do list

Congratulations!
You've successfully completed all steps of your application. See below for next steps or return to **My Account.**

Your Plans
For **Andre**, and **Bridget**

UPMC Advantage Bronze $6,000/$25 - Partner Network Health Insurance plan for Andre,Bridget

To activate your new coverage, you must pay your first month's premium by your plan's due date. Your plan will contact you in the next few days with details on how to pay, or visit your health plan online to make your payment now if your plan accepts online payment. Your payment must be received and processed by the effective date to be fully enrolled. Contact the plan's customer service if you have any payment questions or issues. Don't send payment to the Health Insurance Marketplace.

Submit Payment to | **Customer Service:**

Amount Due: **$285.43**

Your plan will confirm your final premium amount with you.

Estimated Effective Date: **01/01/2015**

PAY FOR HEALTH PLAN

Making their first premium payment is the final step of enrollment. Applicants must pay their premiums monthly in order to maintain their health insurance coverage (if their payment responsibility, net of any APTCs, is greater than zero). After the applicant selects a plan he or she will either see a link to the insurance company's website or instructions on how to pay their premium payments to their insurance company. The green "Pay for Plan" button means online payment is available. Applicants should check with their insurance company to find out when their first premium is due in order for coverage to be effective January 1, 2016. Remember, a plan selection must be made by December 15, 2015 in order for coverage to be effective on January 1. Open enrollment runs through January 31, 2016, but a plan selection made on December 16 or later will not be effective on January 1.

Understanding the Health Insurance Marketplace

Find health care options that meet your needs and fit your budget.

Health Insurance Marketplace

September 2015

Objectives

This session will help you

- Explain the Health Insurance Marketplace
- Define who might be eligible
- Define options for those with limited income
- Explain the enrollment process
- Explain available options for people with Medicare
- Locate resources

Session Topics

- Health Insurance Marketplace (Marketplace)
- Eligibility and enrollment
- Ways to lower costs
  - Monthly premiums
  - Out-of-pocket costs
- Medicaid and the Children's Health Insurance Program (CHIP)
- Assistance with applying and enrolling
- Key points

What Is the Health Insurance Marketplace?

- Created by the Affordable Care Act
- Where qualified individuals and families can directly compare private health insurance options
  - Known as qualified health plans (QHPs)
  - Can directly compare on the basis of price, benefits, quality, and other factors
- Also known as Exchanges
- Small Business Health Options Program (SHOP)
  - Marketplace for small employers
  - Provides coverage for their employees

Marketplace Establishment

- Each state can decide to
  - Create and run its own Marketplace
  - Engage actively with the federal government in operating certain Marketplace functions
  - Have a Marketplace established and operated by the federal government

How the Health Insurance Marketplace Works

- It uses one process to determine eligibility for
  - Qualified health plans through the Marketplace
  - Premium tax credits to lower monthly premiums
  - Reduced cost sharing
  - Medicaid
  - Children's Health Insurance Program (CHIP)
- It offers choice of plans and levels of coverage
- Insurance companies compete for business

Qualified Health Plans (QHPs)

- A QHP
  - Is offered through the Marketplace by an issuer that is licensed by the state and in good standing
  - Covers essential health benefits
  - Is offered by an issuer that offers at least one plan at the "Silver" and one at the "Gold" plan category of cost sharing
  - Charges same premium whether offered through the Marketplace or outside the Marketplace

Qualified Health Plans Cover Essential Health Benefits

- Essential health benefits include at least these 10 categories
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)

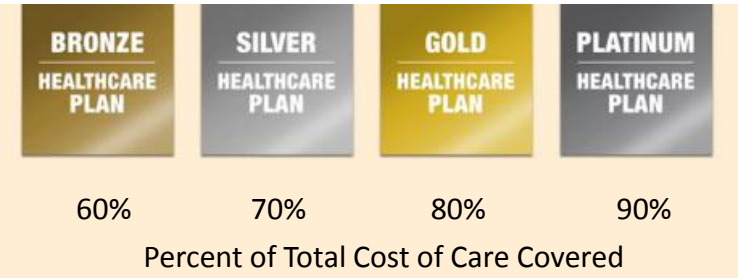
How Qualified Health Plans Can Vary

- Some plans may cover additional benefits
- You may have to see certain providers or use certain hospitals (networks)
- The premiums, copayments, and coinsurance are different
- Quality of care data will be available
- The coverage level can vary within each plan
- Some special types of plans are structured differently
  - Like high-deductible (catastrophic) plans
- Out-of-pocket costs include deductibles, copayments and coinsurance

Health Plan Categories

Lowest Premiums
Highest Out-of-Pocket Costs

Highest Premiums
Lowest Out-of-Pocket Costs



Catastrophic Health Plans

- What is catastrophic coverage?
  - Plans with high deductibles and lower premiums
  - You pay all medical costs up to a certain amount
  - Includes 3 primary care visits per year and preventive services with no out-of-pocket costs
  - Protects you from high out-of-pocket costs
- Who is eligible?
  - Young adults under 30
  - Those who qualify for a hardship exemption
  - Those whose plan was cancelled and believe Marketplace plans are unaffordable

Eligibility and Enrollment in the Individual Market

- To be eligible for Marketplace coverage, you must
  - Live in its state, or service area, and
  - Be a U.S. citizen or national, or
  - Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
  - Not be incarcerated except when pending disposition of charges
    - Anyone can apply for Medicaid/CHIP at any time, even if incarcerated

What is the Federally-facilitated SHOP Marketplace?

- The Small Business Health Options Program = SHOP
  - Part of the Health Insurance Marketplace created by the Affordable Care Act (ACA)
  - Offers small employers a choice of qualified health and dental plans and tools for making informed choices
  - Gives otherwise eligible qualified small employers access to the Small Business Health Care Tax Credit—worth up to 50% of employer's premium contributions
  - Works with new insurance reforms to spur competition based on price and quality

What is the Federally-facilitated SHOP Marketplace? Continued

- For coverage starting in 2015: Offers online purchase and enrollment in health and dental coverage through HealthCare.gov
  - Offers small employers in 14 states the option to give employees a choice of plans
  - In 2016 small employers in all states and DC will have the option to give employees a choice of SHOP Marketplace plans

Note: Employers with fewer than 50 full-time-equivalent employees, aren't required to offer health insurance, and there's no penalty if they choose not to

Who Can Purchase SHOP Marketplace Coverage and When?

- Small employers:
  - With 1-50 full-time equivalent employees (increases to 1-100 as of 2016)
  - With at least one employee who is not a co-owner or spouse
  - Including tax-exempt and religious employers
  - Who offer coverage to all full-time employees
  - FTE in the FF-SHOP
  - employees working on average 30 or more hours/week
  - Visit the SHOP FTE Calculator
    - HealthCare.gov/shop-calculators-fte/

Who Can Purchase SHOP Marketplace Coverage and When? Continued

- Enroll in FF-SHOP coverage:
- Initial group enrollment can occur anytime during the year—no limited Open Enrollment period
  - Before 15th of month for coverage starting next month
  - After 15th of month for coverage starting 2nd following month

How the SHOP Marketplace Works Moving Towards Employee Choice

- A key goal of the SHOP:
  - Options for small employers and their employees
- In 2015:
  - Employers in 14 states using the FF-SHOP Marketplace can offer employees a choice of plans
- In 2016:
  - The SHOP Marketplace will offer small employers an Employee Choice option in all states and DC

The Small Business Health Care Tax Credit

- Certain small employers that meet certain requirements, may qualify for the Health Care Tax Credit:
- Those with fewer than 25 "full-time equivalent" employees (FTEs)
- Whose employees' wages average less than $50,000 per year, adjusted for inflation beginning in 2014
  - Employers whose employees' wages average less than $51,000 in 2015
- Who contribute at least 50% of employees' premium costs

The Small Business Health Care Tax Credit

Continued

- Available only to employers with employees enrolled in a Qualified Health Plan through the SHOP
- Worth up to 50% of employer's premium contribution to SHOP health and dental plans (up to 35% for tax exempt employers)
- Can be claimed for 2 consecutive years
- Visit the SHOP Tax Credit Estimator
  - HealthCare.gov/shop-calculators-taxcredit/

SHOP Marketplace on HealthCare.gov Benefits for Small Employers

- convenience:
  - Find, and compare all available SHOP health and dental plans in the area
  - Complete the entire enrollment process online for coverage beginning in 2015
- Access to tax credits
  - Worth up to 50% of contributions to employee premiums, for eligible employers who buy SHOP coverage
- Useful online information, tools and links

SHOP Marketplace on HealthCare.gov Benefits for Small Employers Continued

- A choice of plans
  - For employers, and
  - For employees in the 14 Employee Choice states
- Many ways to get help
  - Toll-free call center
  - "Find Local Help" on Healthcare.gov where employers can search for FF-SHOP-registered agents and brokers

Lower Premium Costs

- The premium tax credit may be taken as advance payments to lower monthly premium costs, or as a refundable credit on the tax return you file
- Eligibility is based on
  - Household income and family size
    - Household income between 100% to 400% FPL
      - $23,850 – $95,400 for a family of 4 in 2015
  - Obtaining health insurance through the Marketplace
  - Ineligibility for government-sponsored coverage, affordable employer-sponsored insurance, or certain other minimum essential coverage

How Much Is the Premium Tax Credit?

- Amount of the premium tax credit depends on
  - **Actual** household income as a percentage of the federal poverty level (FPL) and family size
    - Sliding scale that increases your contribution toward the premium as income as percentage of FPL increases
  - The premium for the second lowest cost Silver-level qualified health plan (QHP) adjusted for age
    - May apply premium tax credit to QHP in any health plan category (i.e., Bronze, Silver, Gold, or Platinum)

Ways to Use a Premium Tax Credit

Choose to Get It Now: Advance Payments of the Premium Tax Credit
▪ All or some of the premium tax credit is paid directly to your plan on a monthly basis ▪ You pay the difference between the monthly premium and advance payment ▪ You reconcile when you file a tax return for the coverage year*
Choose to Get It Later
▪ Don't request any advance payments ▪ You pay the entire monthly plan premium ▪ Claim the full amount on the tax return filed for the coverage year

*You should report all changes in the information you provided on your application to avoid owing money after reconciliation on your tax return.

Who's Eligible for Cost-Sharing Reductions?

- Lower costs on deductibles, copayments, and coinsurance
- To be eligible, you must
  - Have income at or below 250% FPL
    - $59,625 annually for a family of 4 in 2015
  - Receive the premium tax credit
  - Enroll in a Marketplace Silver-level plan
- Members of federally recognized Indian tribes
  - Don't have to pay cost-sharing if household income is at or below 300% of the federal poverty level (FPL)
    - Up to around $71,550 for a family of 4 ($89,460 in Alaska) in 2015

Medicaid Eligibility

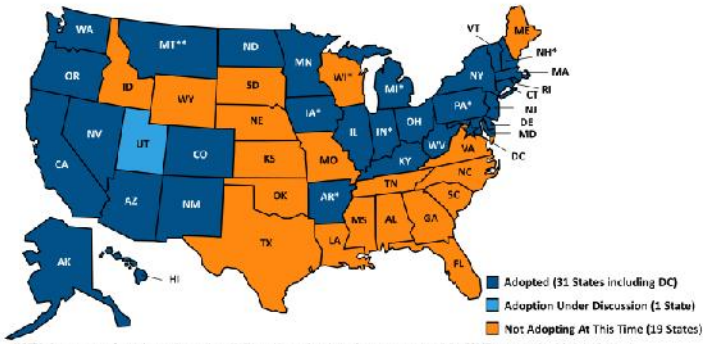
- Eligibility tied to groups specified under the federal Medicaid law
  - Pregnant women
  - Children
  - People with disabilities
  - Seniors
- States must cover certain groups, such as children and pregnant women, and have the option to cover other groups
- Financial and non-financial requirements

Eligibility—Medicaid Expansion

- Affordable Care Act's Eligibility Groups (state option) effective 1/1/2014
  - Adult group
    - 19–64 with income below 133% of Federal Poverty Level (FPL)
  - Former foster care group
    - Under 26 and enrolled in Medicaid while in foster care at 18 or "aged out" of foster care
  - Optional eligibility group for individuals with income above 133% of FPL
    - Under 65 with income above 133% of FPL

Medicaid Expansion in 2015: 31 States and the District of Columbia

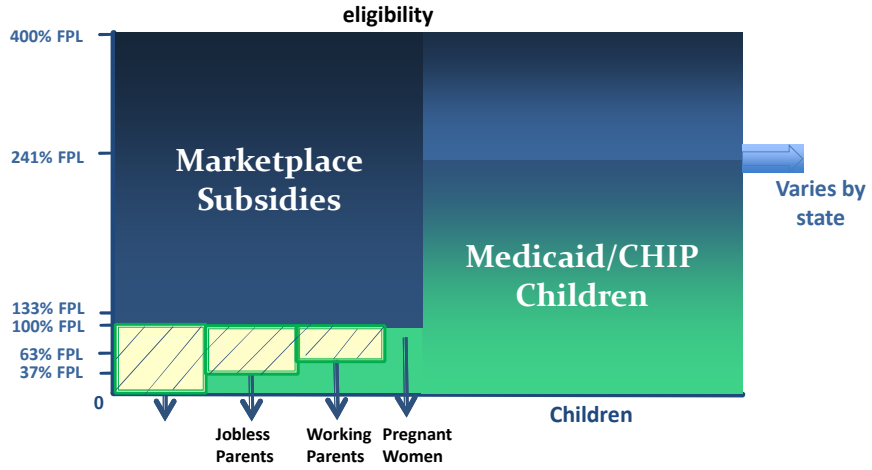
Current Status of State Medicaid Expansion Decisions



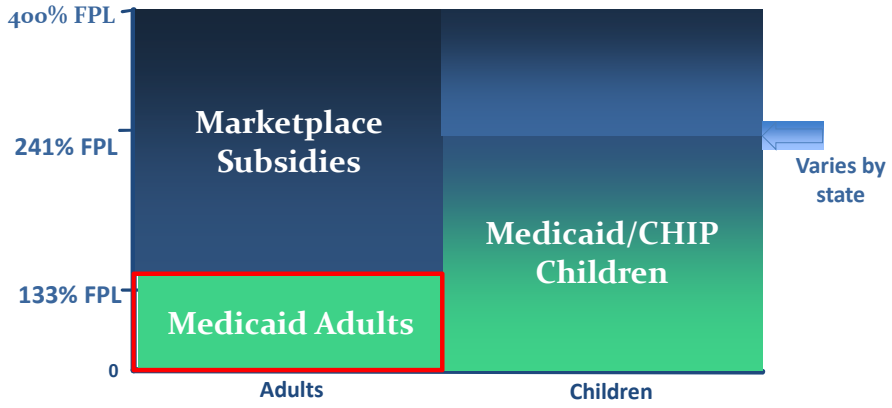
NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not accept the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated July 20, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Affordable Insurance Programs Without Expansion

For non-elderly, non-disabled individuals, based on current median state eligibility



A Seamless System of Coverage With Expansion



States Not Expanding Medicaid

- If you live in a state that's NOT expanding Medicaid you may
  - Have fewer coverage options
  - Not qualify for either Medicaid or reduced costs on a private insurance plan in the Marketplace
  - Be able to get a hardship exemption and won't have to pay a fee if you don't have minimum essential health coverage

Streamlined Application

- One application for all programs
- Application can lead seamlessly from comparing Qualified Health Plans in the Marketplace to enrollment
- May be able to enroll immediately once eligibility determination is complete
  - Depending on the program for which the applicant is eligible

Application and Enrollment Process

- Application process
  - Relies primarily on electronic data
  - Reduces need for paper documentation
- Apply online, by phone, by mail, or in person
- 12-month eligibility period for most
  - Adults
  - Parents
  - Children

Verification

- Primary reliance on electronic data sources
- Supported by Federal Data Services Hub
  - Social Security
  - Internal Revenue Service
  - U.S. Department of Homeland Security
- Decreased reliance on documentation
- Increased reliance on self-attestation

State Options for Coordinated Eligibility Determinations With the Marketplace

- Marketplace makes Medicaid/Children's Health Insurance Program (CHIP) Modified Adjusted Gross Income eligibility determinations using state Medicaid/CHIP eligibility rules and standards
  - Must be a governmental entity
- Marketplace makes initial assessment of Medicaid/CHIP eligibility; state Medicaid and CHIP agencies make the final eligibility determination

Everyone Must:

1. **Have minimum essential coverage**

They're already covered and don't need to do anything.

OR

2. **Have an exemption from the shared responsibility payment (fee)**

They don't have to get coverage and won't have to pay a fee for not having coverage.

OR

3. **Pay a fee** (shared responsibility payment)

They should consider getting coverage. If they don't, they'll pay a fee.

1. What is Minimum Essential Coverage?

- If you have coverage from any of the following, you are covered and **don't have to do anything**
  - Employer-sponsored coverage, including COBRA and retiree
  - Individual coverage (outside the Marketplace)
  - Marketplace coverage
  - Medicare (Part A) and Medicare Advantage Plans
  - Most Medicaid coverage
  - Children's Health Insurance Program (CHIP)
  - Certain Veterans health coverage (from the VA)

About 85% of Americans already have minimum essential coverage.

What is Minimum Essential Coverage? Continued

- If you have coverage from any of the following, you are covered and **don't have to do anything** related to the Marketplace
  - Most types of TRICARE coverage
  - Coverage provided to Peace Corp volunteers
  - Coverage under the Nonappropriated Fund Health Benefit Program
  - Refugee Medical Assistance (ACF)
  - Self-funded health coverage offered to students by universities
  - State high risk pools
  - Other coverage recognized by the Secretary of HHS

2. Who is Eligible for an Exemption?

- You may get a coverage exemption if you

EXEMPT

  - Are a member of a recognized religious sect with religious objections to insurance
  - Are a member of a recognized health care sharing ministry
  - Are a member of a federally recognized tribe or eligible for services through an Indian Health Services provider
  - Don't make the minimum income required to file taxes

Who is Eligible for an Exemption? Continued

- You may get a coverage exemption if you

EXEMPT

  - Had a short coverage gap (less than 3 consecutive months)
  - Suffered a hardship (that affects his or her ability to purchase health insurance coverage)
  - Didn't have access to affordable coverage (cost of available coverage greater than 8% of household income)
  - Were incarcerated (unless pending disposition of charges)
  - Weren't lawfully present in the U.S.
  - Had your health insurance cancelled and the Marketplace plans weren't affordable

3. You May Pay a Fee (Shared Responsibility Payment)

- You may pay a fee when you file your 2015 federal tax return in 2016 (and thereafter)
  - If you don't have minimum essential coverage, and
  - Don't qualify for an exemption
- Paying the fee doesn't provide health coverage

How much is the fee?

You pay the Greater Amount of	Percent of Annual Household Income		A Flat Dollar Amount
For 2015	2%	or	$325 per adult, and $162.50 per child under 18
For 2016*	2.5%	or	$695 per adult, and $347.50 per child under 18

*After 2016 - Plus an increase based on cost of living.
Penalty for noncompliance can't exceed the national average premium for a Bronze level Marketplace QHP (for the relevant family size).

When You Can Enroll in Coverage

- During the Annual Open Enrollment Period (OEP)
  - The OEP for coverage in 2015 ended February 15
  - For coverage in 2016, the OEP will be November 1, 2015 -January 31, 2016
- During a Special Enrollment Period (SEP), if eligible
- Once per month if member of federally recognized Indian tribe or Alaska native shareholder
- Anytime you're eligible for Medicaid or the Children's Health Insurance Program

Special Enrollment Periods (SEPs)

- You can enroll if you're eligible for an SEP because you have
  - A qualifying life event, or
  - Another qualifying circumstance
- Most SEPs last 60 days from the date of the qualifying event
  - 30 days in the Small Business Health Options Program (SHOP) Marketplace

Qualifying Life Events

- Lose minimum essential coverage not including
  - Voluntary termination
  - Failure to pay premiums on a timely basis
    - Including COBRA premiums prior to expiration of COBRA coverage
  - Situations allowing for a rescission
- Enrolled in any non-calendar year group health plan or individual health insurance coverage
- Lose pregnancy-related coverage
- Lose medically needy coverage
  - Only once per calendar year

Qualifying Life Events—Continued

- Gain a dependent or becomes a dependent
  - Marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order
- Enrollee loses a dependent or is no longer considered a dependent
  - Divorce or legal separation, or death
- The qualified individual, or dependent, who wasn't previously a citizen, national, or lawfully present individual gains such status

Qualifying Life Events—Continued

- The qualified individual's or dependent's enrollment or non-enrollment in a Qualified Health Plan (QHP) is unintentional, inadvertent, or erroneous
- QHP substantially violated a material provision of its contract in relation to the enrollee

Qualifying Life Events—Continued

- The enrollee (or the enrollee's dependent enrolled in the same Qualified Health Plan) is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions
- A qualified individual or dependent who’s enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC

Qualifying Life Events—Continued

- Consumers living in a non-Medicaid expansion state becoming newly eligible for advanced payment of your premium tax credit
- Gaining access to new Qualified Health Plans (QHPs) as a result of a permanent move
- Gaining or continuing status as a member of an Indian tribe or an Alaska Native shareholder
  - May enroll in a QHP or change from one QHP to another one time per month

Qualifying Life Events—Continued

- Exceptional circumstances
- Enrollment errors
- Survivors of domestic violence, domestic abuse or spousal abandonment
- Members of AmeriCorps, VISTA, and NCCC programs

Plan Selection for Other Circumstances Special Enrollment Periods (SEPs)

- Generally you have 60 days to select a plan
  - From date you're granted Other Circumstances SEP
- Plan selection timeframe starts when
  - You get a letter telling you you're eligible for an SEP
  - You contact the Call Center and are found eligible
  - A CMS caseworker finds you eligible

How to Use a Special Enrollment Period for a Life Change

- If you have a qualifying life change, you can contact the Marketplace
  - Online at HealthCare.gov
    - Log into your account and click on Report a life change
  - By phone
    - Call the Marketplace Call Center at 1-800-318-2596
    - TTY 1-855-889-4325

Online at HealthCare.gov/screener

Use the screening tool to see if you qualify for a Special Enrollment Period

Please enter a valid ZIP code and select a county.

Enter your ZIP code

85283 Maricopa County

What do you want to do first?

- **Find out if you qualify for a Special Enrollment Period.** If you qualify, you can enroll in a Marketplace health plan outside the annual Open Enrollment.
- **Find out if you're eligible for Medicaid or CHIP.** These programs cover millions of individuals and families with limited incomes and disabilities. If you qualify, you can enroll any time.
- **Start a Marketplace application.** If you know you qualify for a Special Enrollment Period or Medicaid/CHIP, apply or update now.

CONTINUE

Answer a Few Questions about Life Changes

Did you or anyone in your household lose health coverage in the past 60 days OR do you expect anyone in your household to lose coverage in the next 60 days?

YES NO

Did any of the following apply to you or anyone in your household in the past 60 days?

Changes in household size:

- YES NO Got married
- YES NO Had a baby
- YES NO Adopted a child or had a child placed with you for foster care
- YES NO Got divorced and lost health insurance
- YES NO Death

Changes in circumstance:

- YES NO Moved outside your health plan's coverage area
- YES NO Had a change in income

Changes in status:

- YES NO Gained citizenship or lawful presence in the U.S.
- YES NO Released from incarceration (jail or prison)

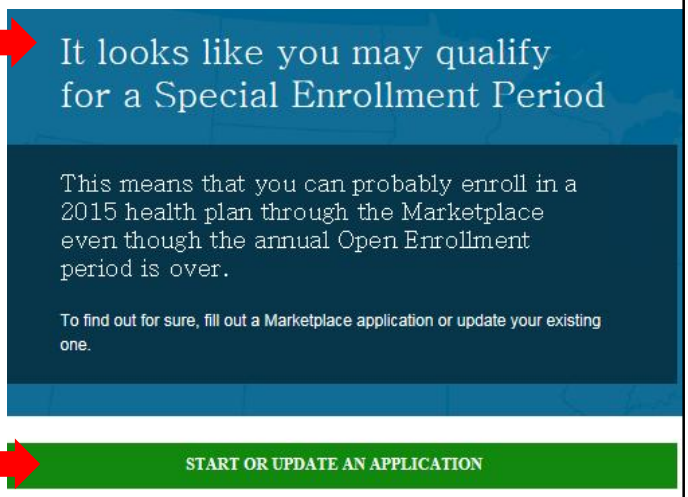
Are you a member of a federally recognized tribe, or an Alaska Native corporation shareholder?

YES NO

SEE IF YOU QUALIFY FOR A SPECIAL ENROLLMENT PERIOD

Start or Update an Application

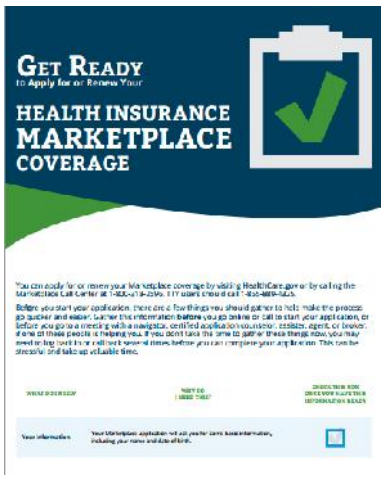
If it looks like you may qualify, update your old application if you have one, or start a new one if you don't.



Gather Important Information

Download or print this checklist so you know what information may be needed to apply for coverage

marketplace.cms.gov/outreach-and-education/apply-for-or-renew-coverage.pdf



General Process for Other Circumstances Special Enrollment Periods (SEPs)

- Call the Marketplace Call Center to request an SEP at 1-800-318-2596 (TTY 1-855-889-4325)
- Call Center asks questions to determine if you're eligible
- If granted, the Call Center activates the SEP
- You can enroll online or through the Call Center
- If your SEP request is denied, you can appeal

4 Ways to Get Marketplace Coverage

How the Marketplace Works

Create an account

First provide some basic information. Then choose a user name, password, and security questions for added protection.

Apply

Next you'll enter information about you and your family, including your income, household size, other coverage you're eligible for, and more.

Visit HealthCare.gov to get a checklist to help you gather the information you'll need.

Pick a plan

Next you'll see all the plans and programs you're eligible for and compare them side-by-side.

You'll also find out if you can get lower costs on monthly premiums and out-of pocket costs.

Enroll

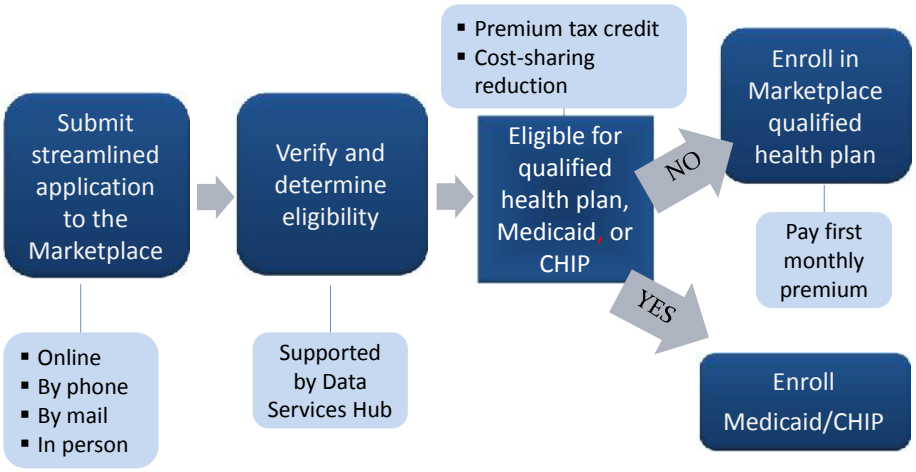
Choose a plan that meets your needs and enroll!

May apply or change plan during Special Enrollment Period due to certain life changing events.

Health Insurance Marketplace
HealthCare.gov
1-800-318-2596

CMS Product No. 11671
October 2013

Application and Eligibility



The Coverage Application

- Available electronically and on paper in English and Spanish
- Federally-facilitated Marketplace Application form
  - Dynamic online version asks only relevant questions based on your responses
  - Streamlined paper version
- State-based Marketplaces may have own version
- Help is available to complete application

Premium Payment

- You must pay the first month's premium by the insurer's deadline
- Issuers must accept at least these payment methods
  - Paper check
  - Cashier's check
  - Money order
  - Electronic fund transfer (EFT)
  - Pre-paid debit card
- Some issuers may also accept online, credit card, or debit card payments (check with the plan)

Enrollment Assistance

- Help is available in the Marketplace
  - Marketplace Call Center
  - SHOP Call Center for employers
  - Marketplace in-person help is available

Marketplace Call Center

- Services consumers in Federally-facilitated and State Partnership Marketplaces
  - 1-800-318-2596 (TTY 1-855-889-4325)
- Customer service representatives available 24/7
- Help with eligibility, enrollment, and referrals
- Assistance in English and Spanish
  - Language line for 240+ additional languages
- State-based Marketplaces have own call centers

SHOP Call Center

- For questions about SHOP for small employers with 50 or fewer employees
  - 1-800-706-7893 (TTY 711)
- Customer service representatives available Monday – Friday from 9 a.m. to 7 p.m. EST
- Small business employees with SHOP questions can also call the SHOP Call Center

In-Person Assistance

- Marketplace in-person help is available
  - Navigators
  - Non-Navigator assistance personnel
  - Certified application counselors
  - Issuer application assisters
  - Enrollment assistance contractor
  - Agents and brokers
  - To find help in your area, go to Localhelp.HealthCare.gov

Visit Marketplace.cms.gov for information on your organization becoming a Champion for Coverage

Marketplace and People with Medicare

- Medicare isn't part of the Marketplace
- If you have Medicare you don't need to do anything related to the Marketplace
  - Your benefits don't change because of the Marketplace
  - No one can sell you a Marketplace plan
    - Except an employer through the Small Business Health Options Program (SHOP) if you are an active worker or dependent of an active worker
      - The SHOP employer coverage may pay first
      - No late enrollment penalty if you delay Medicare
      - Doesn't include COBRA coverage

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, wait until you're covered by Medicare to avoid a gap in coverage
  - Depending on your income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments
  - You may also be able to buy a Medigap (Medicare Supplement Insurance) policy or join a Medicare Advantage Plan (like an HMO or PPO)

Marketplace/Medicare Enrollment Considerations

- If you don't enroll in Medicare when you're first eligible (Initial Enrollment Period)
  - A late enrollment penalty may apply (lifetime)
  - You generally can't enroll until the Medicare General Enrollment Period (January 1 to March 31) and coverage won't start until July 1
- If your Marketplace plan isn't through your employer
  - And you must pay a premium for Part A, you would need to drop Part A and Part B to be eligible to get a Marketplace plan
  - However, if you are also receiving Social Security benefits, you would have to drop your Social Security if you drop Medicare

From Coverage to Care

Written materials and videos available in English and Spanish

Marketplace.cms.gov/c2c

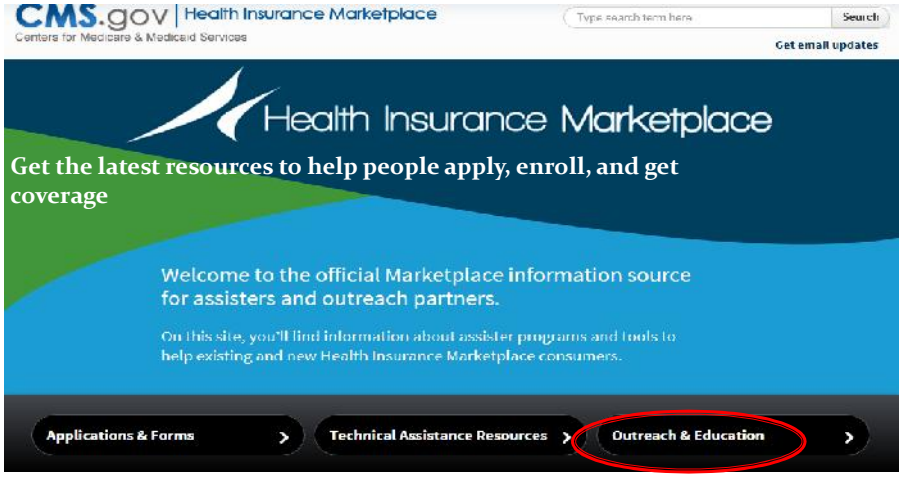
Marketplace Appeals

- If you don't agree with a decision made by the Health Insurance Marketplace, you may be able to file an appeal.
- You can appeal the following kinds of Marketplace decisions
  - Whether you're eligible to buy a Marketplace plan
  - Whether you can enroll in a Marketplace plan outside the regular open enrollment period
  - Whether you're eligible for lower costs based on their income
  - The amount of savings you're eligible for
  - Whether you're eligible for Medicaid or the Children's Health Insurance Program (CHIP)
  - Whether you're eligible for an exemption from the individual responsibility requirement

Key Points to Remember

- The Marketplace is a way for qualified individuals and families to find and buy health insurance
  - You may enroll or change plans during a Special Enrollment Period if you have certain life changing events
- Small employers can cover their employees through the SHOP
- States have flexibility to establish their own Marketplace
- Individuals and families may be eligible for lower costs on their monthly premiums and out-of-pocket costs
- There is help available
- If a you don't agree with a decision made by the Marketplace, you may be able to file an appeal

Marketplace.cms.gov



Want More Information about the Marketplace?

Stay connected

- Sign up to get email and text alerts at HealthCare.gov/subscribe
  - CuidadoDeSalud.gov for Spanish
- Updates and resources for organizations are available at Marketplace.cms.gov
- Twitter@HealthCareGov
- Facebook.com/HealthCare.gov

Medicare and the Marketplace

Information about the Marketplace for those who counsel people with Medicare

August 2015

The Marketplace and People with Medicare

- This presentation should help you explain the Marketplace to people
  - With Medicare
  - Aging into Medicare
  - Getting Social Security disability benefits
- When they may have coverage in the Marketplace, and when they can't
- Medicare Prescription drug coverage (Part D)
- Small Business Health Options Program

August 2015 Medicare and the Marketplace 2

Medicare and the Marketplace

- If you have Medicare you don't need to do anything related to the Marketplace
  - Your benefits don't change because of the Marketplace
- Medicare isn't part of the Marketplace
- Medicare Part A is considered minimum essential coverage
- The Marketplace doesn't offer
  - Medicare Supplement Insurance (Medigap) policies
  - Medicare Prescription Drug Plans (Part D)

If You Have Medicare

- No one can sell you a Marketplace plan
  - Even if you only have Medicare Part A or Part B
  - Except an employer through the Small Business Health Options Program (SHOP) if you're an active worker or dependent of an active worker
    - The size of the employer helps determine who pays first
    - No late enrollment penalty if you enroll anytime you have SHOP coverage, or within 8 months of losing that coverage Doesn't include COBRA coverage

Marketplace and Becoming Eligible for Medicare

- Sign up for Medicare during your Initial Enrollment Period (IEP)
  - The 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
  - If you enroll later, you may have to pay a late enrollment penalty
    - **For as long as you have Medicare**

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, wait until you're covered by Medicare to avoid a gap in coverage
  - Depending on your income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments
  - You may also be able to buy a Medigap (Medicare Supplement Insurance) policy or join a Medicare Advantage Plan (like an HMO or PPO)

Choosing Marketplace Instead of Medicare

- If you have an individual Marketplace plan
  - And you must pay a premium for Part A, you would need to drop Part A and Part B to be eligible to get a Marketplace plan
  - However, if you're also receiving Social Security benefits, you would have to drop your Social Security if you drop Medicare
- If you delay enrolling in Medicare after your Initial Enrollment Period (IEP) ends, a late enrollment penalty may apply
  - You'd **only** be able to enroll during the Medicare General Enrollment Period (January 1 to March 31, coverage starting July 1)
  - Pay a late enrollment penalty for as long as you have Medicare

Terminating Medicare for Marketplace Plan

- If you're enrolled in premium Part A and Part B, or Part B only
  - You can disenroll from Medicare and choose a Marketplace plan
  - You can qualify for advanced premium tax credit (APTC) or cost sharing reduction (CSR) if you meet eligibility requirements
- 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

Medicare for People with Disabilities and the Marketplace

- You may qualify for Medicare based on a disability
  - You must be entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
    - On the 25th month, you're automatically enrolled in Medicare Part A and B
- If you're getting SSDI, you can get a Marketplace plan to cover you during your 24–month waiting period
  - You may qualify for Medicaid or premium tax credits and reduced cost-sharing until your Medicare coverage starts

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
- If you don't sign up for Part B during the SEP
  - You may have to pay a late enrollment penalty for as long as you have Medicare
  - You can only enroll during the General Enrollment Period

The Marketplace and…

- Medicare prescription drug coverage (Part D)
  - Prescription drug coverage in Marketplace plans (including SHOP) isn't required to be creditable
    - Plan is required to let you know each year, in writing
    - You may have to pay a late enrollment penalty for Part D if you enroll after your Initial Enrollment Period and haven't had creditable drug coverage since first eligible for Medicare (any 63 day gap in creditable coverage)
- Dental coverage for adults
  - Covered by some Marketplace plans
  - Stand-alone dental plans
    - People with Medicare generally can't join a stand-alone Marketplace dental plan unless in a State-based Marketplace and the state allows you to join (check with your state)

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Check Your Knowledge—Scenario 1

Jim has Medicare Part A only. He didn't enroll in Part B during his Initial Enrollment Period (IEP). He signed up for Part B in January 2015, during the General Enrollment Period, and his coverage began on July 1.

Could he have enrolled in a Marketplace plan while he waited for his Part B to take effect?

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Scenario 1—Discussion

No. Medicare Part A is considered minimum essential coverage. Jim couldn't get a Marketplace plan since he already had minimum essential coverage.

Remember, it's illegal for anyone to sell you a Marketplace plan if you have Medicare.

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Check Your Knowledge—Scenario 2

Barbara works part-time and isn't getting Social Security retirement benefits yet. Her employer doesn't offer health coverage, so she enrolled in a Marketplace plan. Her Medicare Initial Enrollment Period ends next month, but she decided to keep her Marketplace plan and wait to sign up for Medicare

- Will Barbara have a late enrollment penalty when she signs up for Medicare Part B?
- What about Part D?
- What else should you tell her?

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Scenario 2—Discussion

Barbara can choose Marketplace coverage if she's eligible for Medicare but hasn't enrolled in it (because she'd have to pay a premium, or because she's not collecting Social Security benefits)

Before making this choice, there are 2 important points for Barbara to consider:

1. Generally she can enroll in Medicare **only** during the Medicare General Enrollment Period (from January 1 to March 31). Her coverage won't begin until July 1 of that year
2. If she enrolls in Medicare after her Initial Enrollment Period ends, she may have to pay a late enrollment penalty for as long as she has Medicare

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Scenario 2—Discussion Continued

If her Marketplace plan's prescription drug coverage isn't creditable, she may also have to pay a late enrollment penalty (LEP) for Medicare Part D coverage if she waits to enroll until after her Initial Enrollment Period.

Barbara should consider enrolling in Medicare to be sure she doesn't get an LEP for Part B and/or Part D. She can also choose to keep Marketplace coverage and also enroll in Medicare. In either case, Barbara won't be eligible for tax credits and there's no coordination of benefits, but it's her choice.

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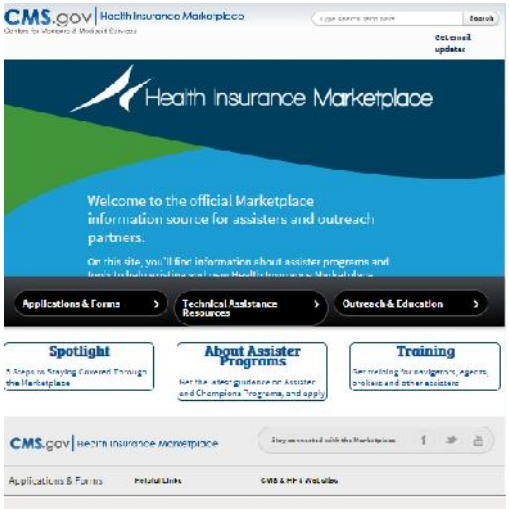
Marketplace.cms.gov

Get the latest resources to help people apply, enroll, and get coverage



Ways to Connect with the Marketplace

1. Sign up for updates at HealthCare.gov/subscribe/ or CuidadoDeSalud.gov/es/subscribe/
2. Twitter.com/HealthCareGov – Follow @HealthCareGov
3. Facebook.com/Healthcare.gov
4. Youtube.com/HealthCareGov
5. The Health Insurance Blog: HealthCare.gov/blog/
6. Federal training for agents and brokers, Navigators, in-person assisters, and Certified Application Counselors:
7. Marketplace.medicarelearningnetworklms.com
8. Facebook.com/Medicare.gov

CMS National Training Program

To view all available NTP training materials, or to subscribe to our email list, visit

CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html

For questions about training products email training@cms.hhs.gov

How to Access the Online Resource Library for Assisters

To join the online community, complete the following 3 steps:

Step 1: Create an account for the CMS Enterprise Portal.

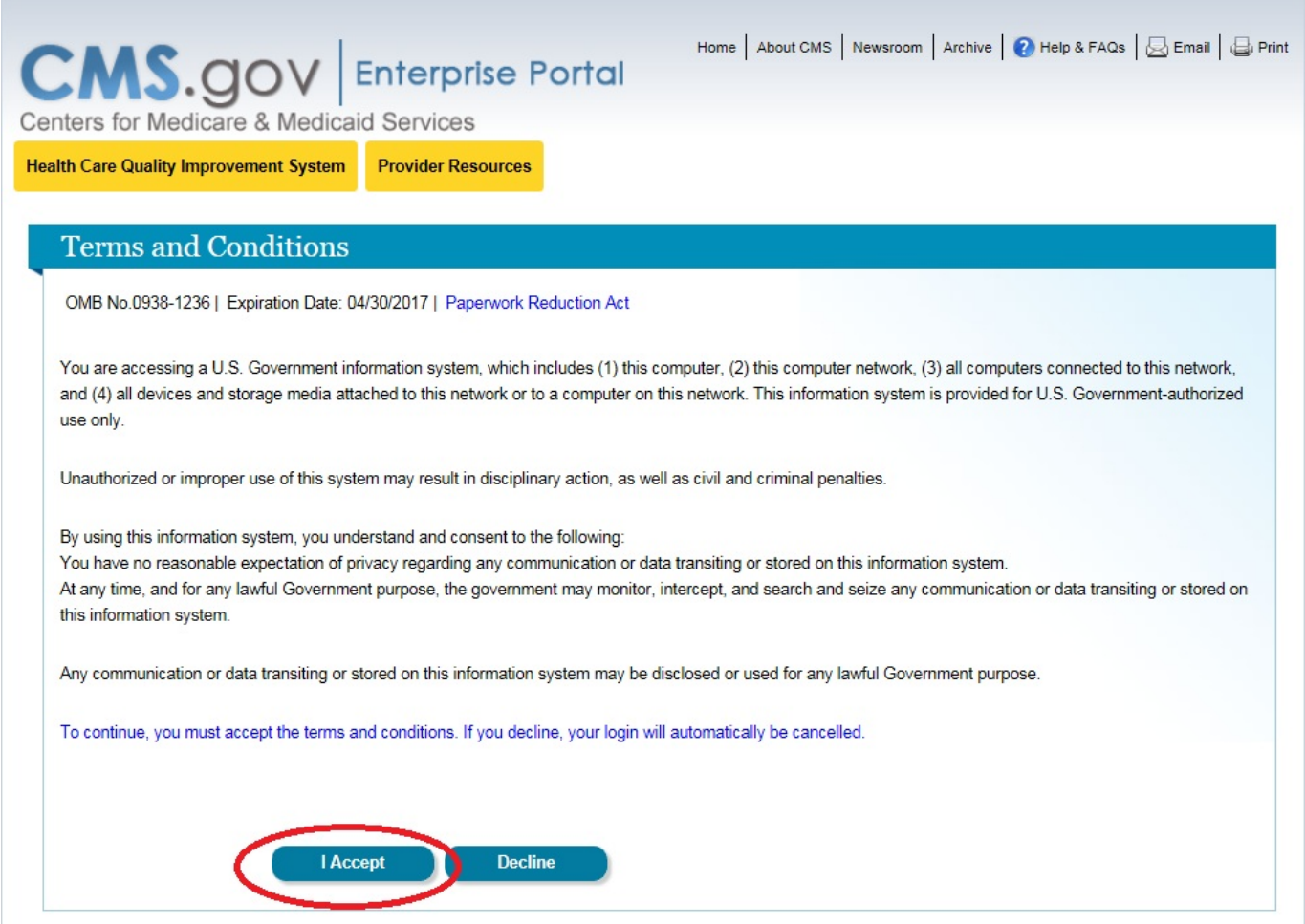
The CMS Enterprise Portal is the secure password-protected gateway that allows the public to access systems related to CMS programs. Assisters may already have an Enterprise Portal account and may request access to CMSzONE using their existing account. If assisters already have an Enterprise Portal account, skip to Step 2. If assisters do not already have an Enterprise Portal account, here is how to create one:

- Go to https://portal.cms.gov/wps/portal/unauthportal/home/
- Click on the box with the padlock marked "Login to CMS Secure Portal."

Exhibit 1: Screen Shot of CMS Enterprise Portal Home Page

- You will be prompted to accept the terms and conditions of the Enterprise Portal by clicking “I Accept.”

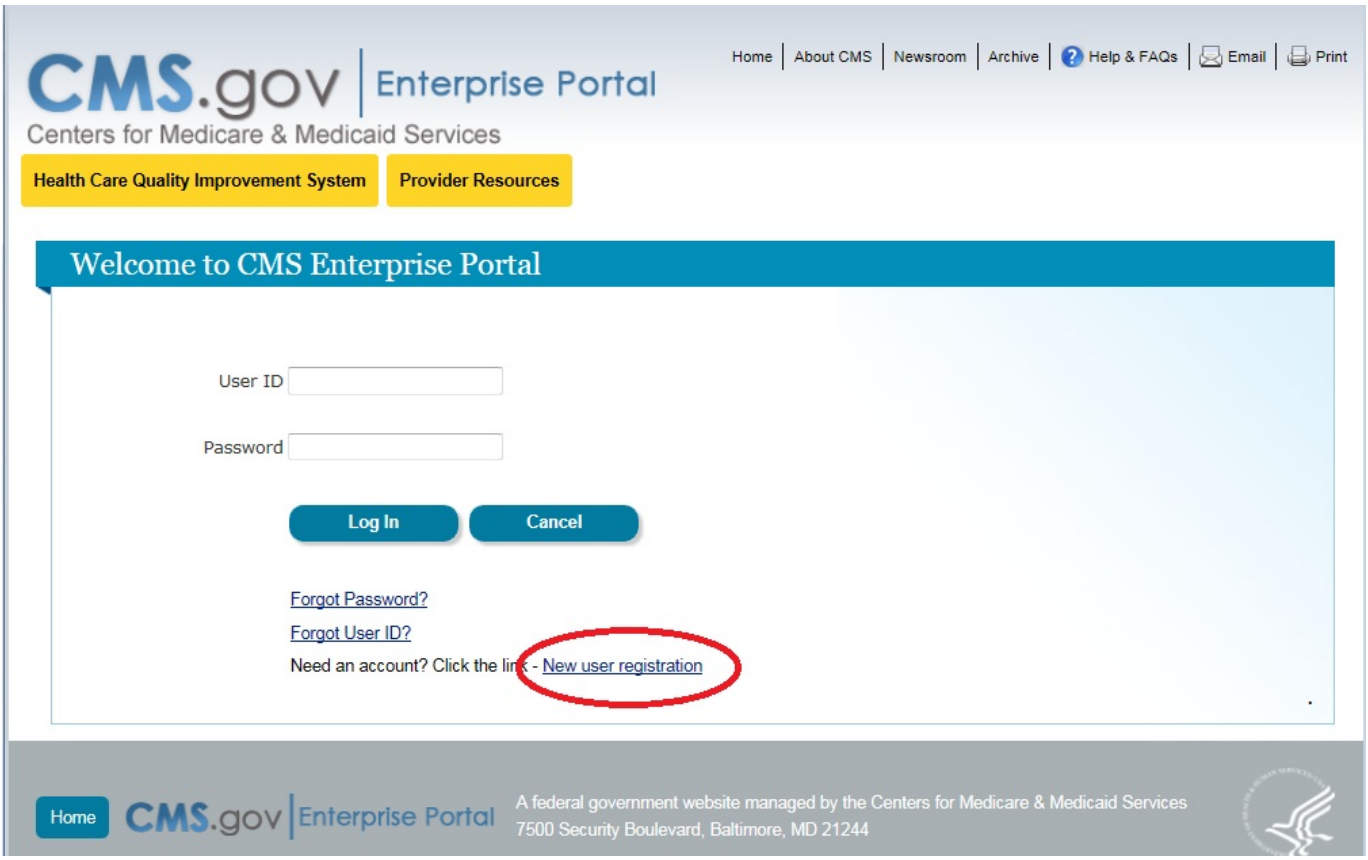
Exhibit 2: Screen Shot of Terms and Conditions Page



- This step will direct you to a login page. If you are a new user, click the “New user registration” link to create an account. You will be directed to a Terms and Conditions page, where you should read and, if you accept the terms, click the “I agree to the terms and conditions” box at the bottom of the page. Then, click the “Next” button. You will be directed to a page where you are asked to fill in basic contact information. When you have finished, click the “Next” button. You will then be directed to a page where you will be asked to create a username and password, and provide answers to 3 challenge questions to be used in the event that you forget your password.

Once your CMS Enterprise Portal account has been created, you can login to request access to CMSzONE.

Exhibit 3: Screenshot of New User Registration Page

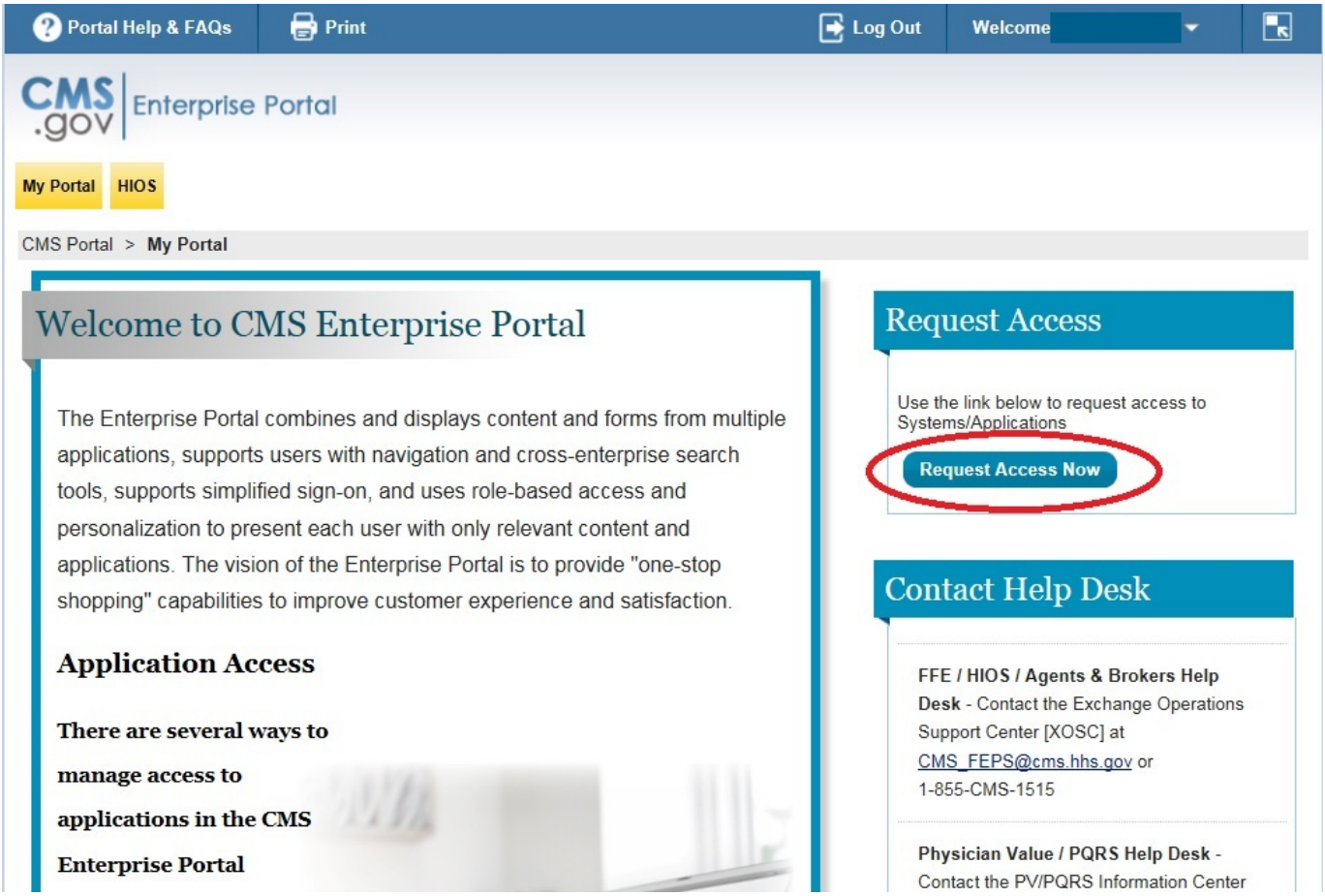


Step 2: Obtain access to CMSzONE.

Assisters request access to CMSzONE through their CMS Enterprise Portal account. Here is how to get access to CMSzONE once you have an Enterprise Portal account:

- When you login to the CMS Enterprise Portal, you will be directed to the Welcome Page.
- Click on “Request Access Now” button.

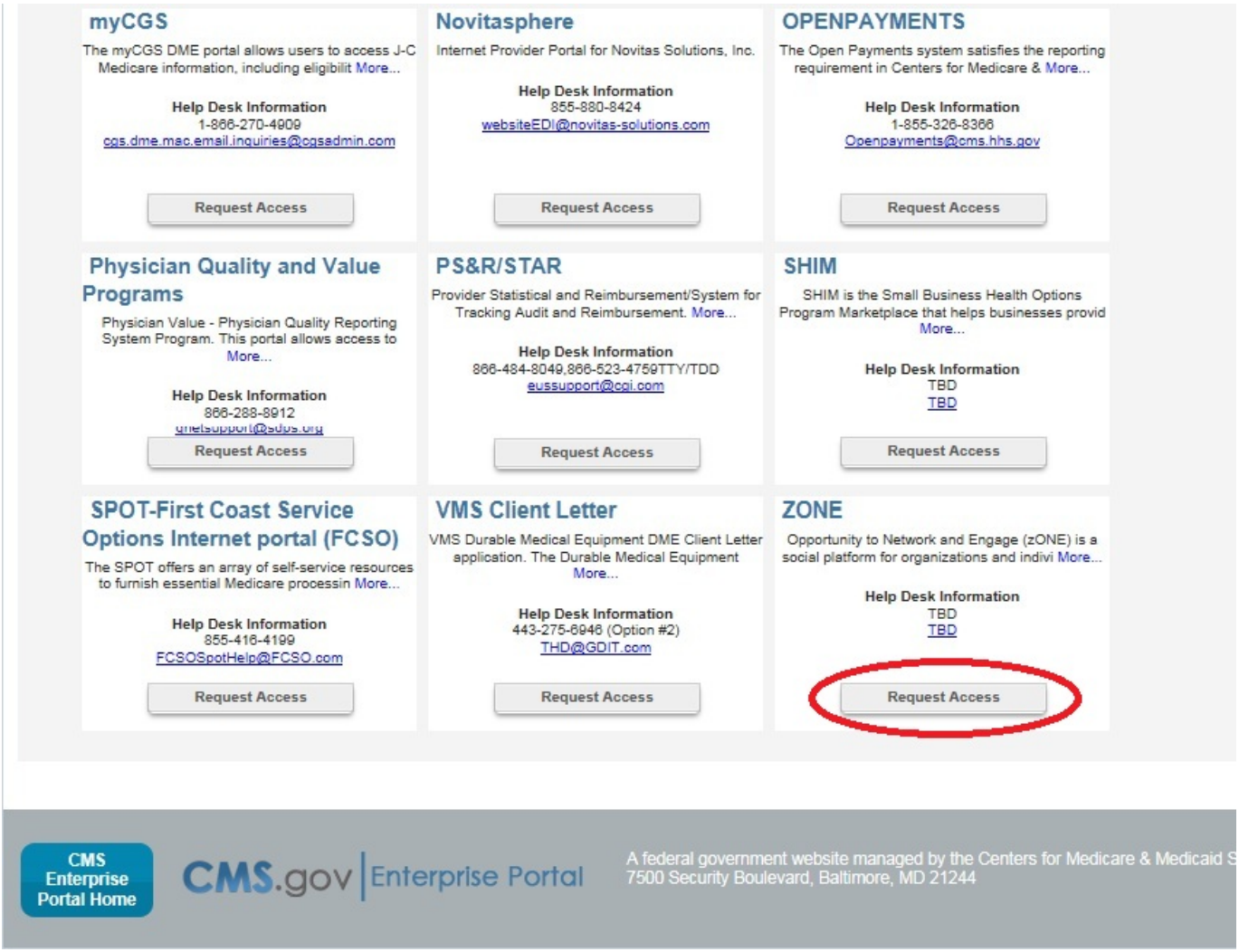
Exhibit 1: Screen Shot of Welcome Page with "Request Access Now" Button



You will be directed to a My Portal Access Catalog page.

- On the Access Catalog page find "ZONE."
- Click on "Request Access" button.

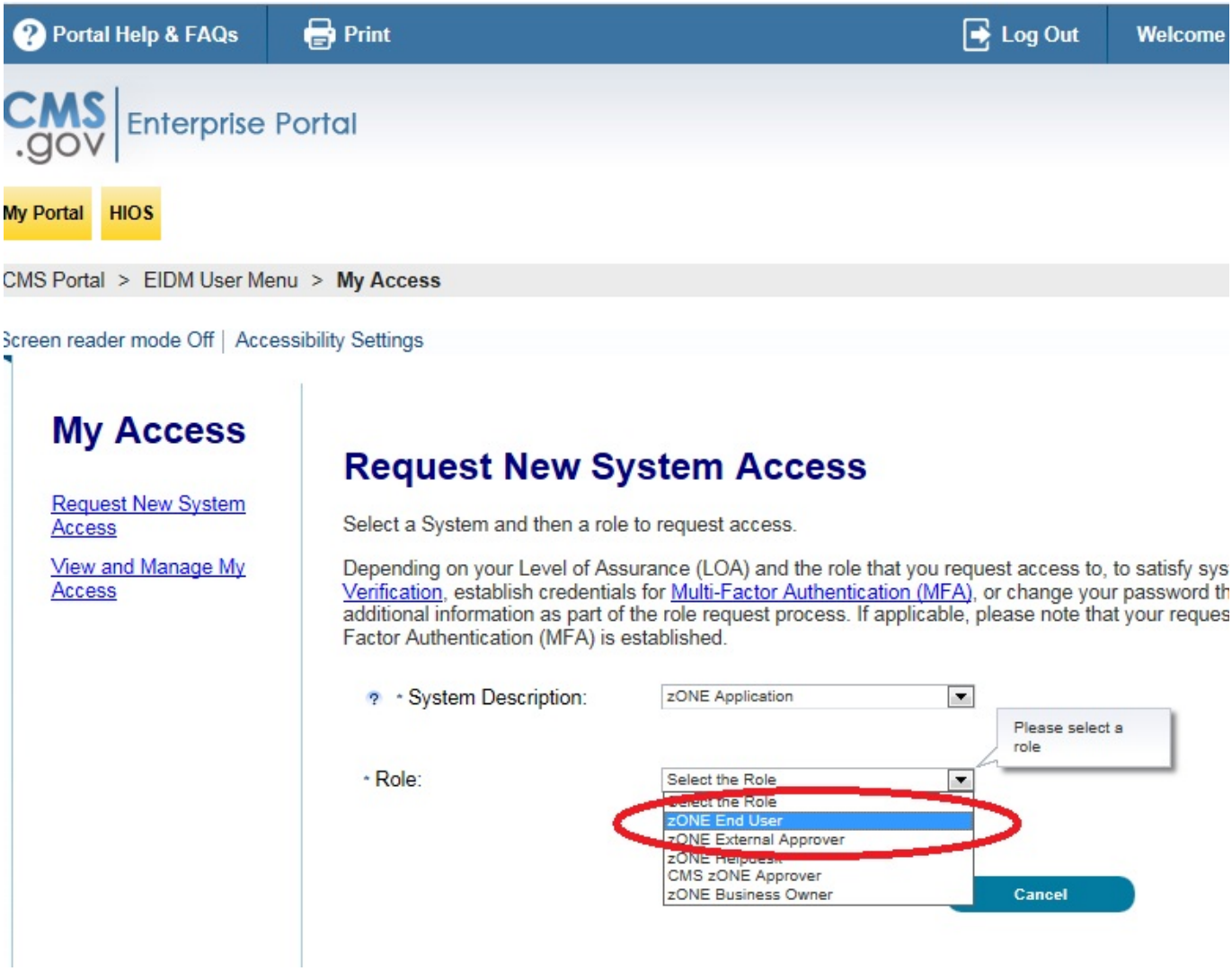
Exhibit 2: Screen Shot of Request Access



You will be prompted to select a role in that system.

- On the drop down menu select “zONE End User.”

Exhibit 3: Screen Shot of Select the Role Drop Down Menu



- **You will be notified via email from CMS when your request has been approved.**

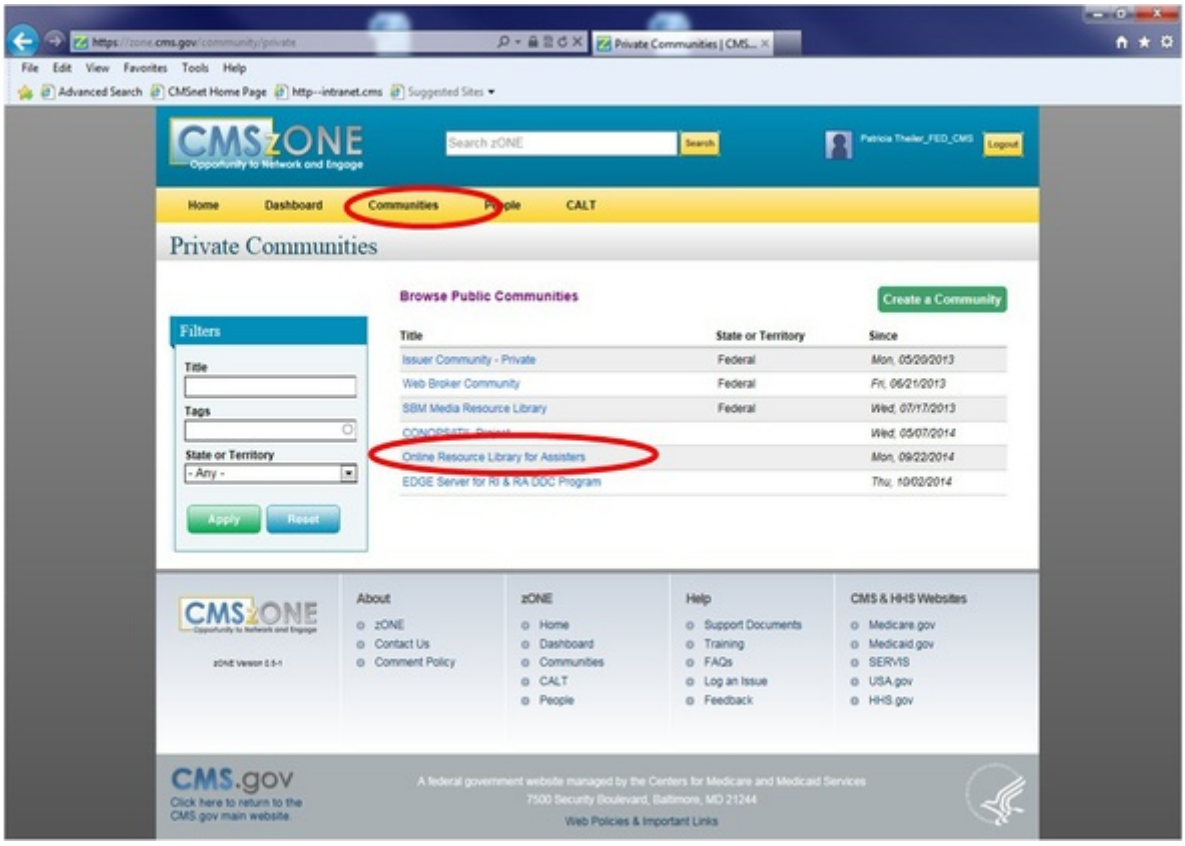
Step 3: Request access to the CMS Online Resource Library Community.

Once you receive an email granting you access to CMSzONE, follow these instructions for obtaining access to the CMS Online Resource Library Community for Assisters.

- Go to https://zone.cms.gov/
  You will be prompted to login to your CMS Enterprise Portal Account after clicking on the "accept" the terms and conditions page.

- On the CMS Zone home page, go to the Communities tab and click “browse private communities.” Click on “Online Resource Library for Assisters.”

Exhibit 1: Screen Shot of Browse Public Communities Page



- Complete the request for access to the community form, including the reason why you want to join the community. **All assisters should include their Navigator or CAC ID number in the paragraph description section as well as the name of the organization you represent.**

- **You will be notified via email by CMS when you are granted access to the community. You should also receive a welcome email from assisterlibrary@cms.hhs.gov.**

Additional Questions:

Assisters who have questions about the online assister resource library should send questions to: assisterlibrary@cms.hhs.gov.

If you are having technical issues with joining the CMS Enterprise Portal or CMSzONE, you should call 855-267-1515 or email CMS_FEPS@cms.hhs.gov.

CENTERS FOR MEDICARE & MEDICAID SERVICES

QUICK REFERENCE GUIDE: PLAN YEAR 2016
FFM REGISTRATION AND TRAINING STEPS FOR ASSISTERS

The purpose of this document is to provide a quick overview for Assisters on how to access and register in the Marketplace Learning Management System (MLMS). The MLMS is specifically designed to provide both one-time and continuous on-line training. When completing the initial registration process, pay close attention to the navigation provided in this guide. Open a web browser in Internet Explorer 10, Firefox 35.0.1, or Chrome.

1 1st Time NAV and Federal IPA Registration Process

- Navigate to CMS Enterprise Portal at https://portal.cms.gov/
  - **Create CMS Portal ID**
    - Click **"New User Registration"** link
    - Read and check the box to signify agreement with **"Terms and Conditions"** – Click **"Next"**
    - Complete all fields on "Your Information Page" Click **"Next"**
    - Create a User ID and Password
    - Select **"Challenge Question 1"** (Choose a question and provide an answer in **"Answer 1" -** repeat for Questions and Answers 2 and 3)
    - Click **"Next"**
    - Account Successfully Created – Click **"OK"**

2 1st Time CAC, State IPA or Other Registration Process

- Navigate to CMS Enterprise Portal at https://portal.cms.gov/
  - **Create CMS Portal ID**
    - Click **"New User Registration"** link
    - Read and check the box to signify agreement with **"Terms and Conditions"** – Click **"Next"**
    - Complete all fields on "Your Information Page" Click **"Next"**
    - Create a User ID and Password
    - Select **"Challenge Question 1"** (Choose a question and provide an answer in **"Answer 1" -** repeat for Questions and Answers 2 and 3)
    - Click **"Next"**
    - Account Successfully Created – Click **"OK"**

3 Enrolling in a Curriculum

- Navigate to CMS Enterprise Portal at https://portal.cms.gov/
  - **Request Access to MLMS**
    - Click **"Login to CMS Secure Portal"**
    - Read **"Terms and Conditions"** – Click **"I Accept"**
    - Enter User ID and Password
    - Click **"Log In"**
    - Click **"Request Access Now"**
    - Type **"FFM"** in the Access Catalog search box
    - Click **"Request Access"**
    - Select **"Assisters"** from the list of roles – Click **"Submit"**
    - Successful Completion! – Click **"OK"**
  - **Access the MLMS**
    - Click **"Login to CMS Secure Portal"**
    - Read "Terms and Conditions" – Click **"I Accept"**
    - Click **"MLMS"** then **"Training"**
    - Complete the necessary fields based on your Assister type
    - If changes were made – Click **"Save/Update"**, If no changes were made – Click **"Next"**
  - **You are at the "Learner's Landing Page"**
    - Under **"Training Options" -** Hover over the **"Actions"** link
    - Click **"Enroll"**
    - Click **"Complete Enrollment"** – this takes you to the **"Registration Confirmation Page"**
    - Click **"Learning"**

Note: *Required training is identified in red with an asterisk. If additional training is available for your role it is identified in black and is optional - you are encouraged to complete these.*

  - **Complete all courses and Complete curriculum - Print certificate.**
    - Click "**Current Learning**"
    - Click **"Launch"** - next to the first offering
    - Complete this and all other courses

Note*: When Curriculum is completed you will be taken back automatically to the MLMS home page.*

4 Updating MLMS Profile Information

- Navigate to CMS Enterprise Portal at https://portal.cms.gov/
  - Log In to MLMS
  - From the learner landing page click on your name at the top of the screen
  - Click "**My Profile**"
  - Add/change the appropriate information

  ***Note**: Fields in gray cannot be edited.*
  - Click **"Save"**

> ***Quick Tip:***
> *It is necessary to complete all additional required fields on the Profile Landing Page before continuing to the next step.*

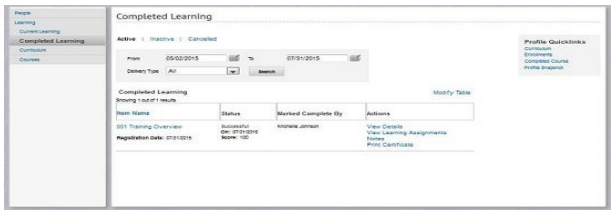
5 Printing a Curriculum/Course Certificate (Assisters)

- Navigate to CMS Enterprise Portal at https://portal.cms.gov/
  - Log in to MLMS
  - Under **"Completed Learning**
  - Click **"Print Certificate"**
  - Select **"Print Certificate"** from the certificate that appears

> ***Quick Tip:***
> *A certificate may be printed with the completion of each course; however, the final Curriculum Completion Certificate is the one that will be required.*

6 Printing a Federal Certificate (Navigators and Federal IPAs)

- Navigate to CMS Enterprise Portal at https://portal.cms.gov/
  - Log in to MLMS
  - Under **"Completed Learning**
  - Click **"Print Certificate"**
  - Select **"Print Certificate"** from the certificate that appears



7 Updating Your Contact Information on Find Local Help

- Navigate to CMS Enterprise Portal at https://portal.cms.gov/
- From the Assister Landing Page click on "**Update Profile Contact"**
  - Enter your new **"Business/Professional Contact Information"**
  - Click "**Save"** button at the bottom of the screen

***Note**: It may be necessary to complete all the additional required fields on the **Profile Landing Page** before continuing.*

Additional Resources for Assisters in the Health Insurance Marketplaces

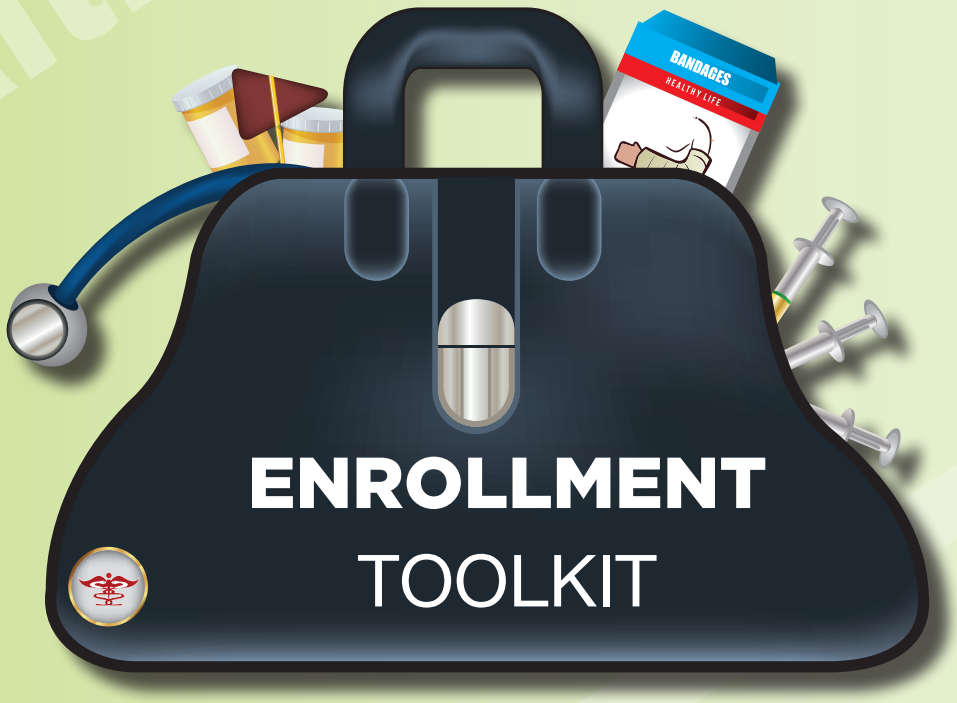
https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html

Contacts:

For questions/comments about the FFM application and enrollment: 1-800-318-2596 (TTY: 1-855-889-4325) available 7 days a week, 24 hours a day

For questions/comments about logging into CMS, contact the Exchange Operations Support Center at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515

FROM COVERAGE TO CARE



Helping Consumers Choose the Health Plan That's Right for Them

Quick Start Guide to This Toolkit

Every year, consumers can enroll in health insurance coverage (coverage) or change their health insurance plan (plan). People may be overwhelmed by their choices. They may not know **how to choose the plan that meets their needs or how to use their coverage to get the care they need.**

This Toolkit is for community partners, assisters, and other people who help consumers enroll in coverage or change their plan. Sections start with a few questions consumers might have. There are key messages for you to emphasize at the top of each page. At the end of the section there are links to more resources for you and consumers on each topic.

You may be helping someone get covered for the first time, helping them re-enroll, or explaining coverage options so consumers can enroll on their own. You can use the information and resources here and in the **From Coverage to Care Roadmap to Better Care and a Healthier You** to help consumers get the coverage that's right for them and help them move **From Coverage to Care.**

The Roadmap and other **From Coverage to Care** (C2C) resources are available at:

https://marketplace.cms.gov/c2c.

LET'S BEGIN

Personalize It.

To make the most of your time with consumers, look for ways to personalize this information to each person. Before you begin, ask if consumers have questions. Their answers will help you navigate this Toolkit to meet their needs.

TABLE OF CONTENTS

1 **Why consumers should sign up for health coverage (page 2)**
- Benefits of coverage
- Affordability
- Exemptions or fee for not having coverage

2 **What consumers should know before enrolling in a plan (page 9)**
- What services are covered
- Costs of coverage
- How to get help paying for coverage
- Re-enrollment reminders

3 **What consumers should know when picking a plan (page 20)**
- Plan categories (Bronze, Silver, Gold, Platinum)
- Provider networks
- Prescription drugs & formularies
- Dental & vision coverage

4 **What consumers should do after they get coverage (page 30)**
- Completing enrollment
- How to know what's covered
- Picking or changing providers
- Ongoing treatment & prescription drugs

5 **What consumers with special circumstances should know about enrolling in coverage (page 35)**
- American Indians & Alaska Natives
- Limited English proficiency
- Immigrants
- Resources for other populations

1 WHY CONSUMERS SHOULD SIGN UP FOR HEALTH COVERAGE

If the consumer you're working with isn't sure why he or she should get coverage, talk about the points below, and make it personal. For example, you could ask if there was a time when they thought they should go to a doctor but didn't, or if this happened to a family member. Was it because they couldn't afford the visit? Were they afraid of finding a problem and how much it would cost to treat it? Let consumers know that having coverage means they can get the care they need, and that there is a limit to the amount they will have to pay towards the cost of their care. Tell them that together you can find a plan that meets their health care needs and budget.

When we say "coverage"… we mean a legal entitlement consumers have to payment or reimbursement for their health care costs. It is generally offered through:

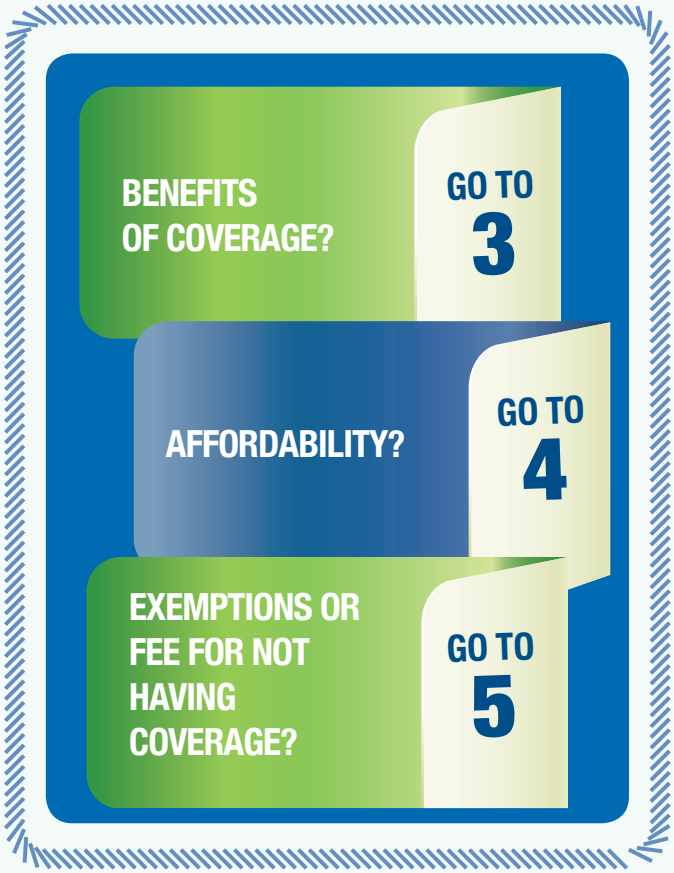
Health Insurance Company

Group health plan offered in connection with employment

OR

A government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)

ARE THERE QUESTIONS ABOUT …



1. Coverage Is Security.

Even if they're uninsured, most consumers use health care when they are sick. This may involve waiting until a health condition is unbearable, then going to an emergency department or clinic for care. **Explain that coverage can relieve some of the stress about using health care** by providing a set of health care services they know will be covered, including mental health and substance use disorder services (known as Essential Health Benefits, explained more on page 10).

Having coverage can also help relieve the stress of not knowing how much health care will cost if you get sick and get a high bill. With coverage, consumers know the portion of health care costs they're responsible for, and what their plan will pay. They also get access to free or low cost preventive care, which can keep people healthy and help them avoid more expensive medical problems in the future.

PERSONALIZE THE CONVERSATIONS FOR ...

- **Someone with a chronic condition (like diabetes, hypertension, depression, or cancer):** Ask consumers to think about their health and their family's health. For example, high blood pressure, diabetes or heart disease may run in their family. Explain that they can use their coverage to find out if they have a condition, then get treatment to manage it if they do. You could provide an example of the cost of a vial of a prescription drug like insulin. Without insurance, it could cost them $300 but with coverage they would only pay a copayment – like $10 or $20.

  To explain more about how total costs are different from what they'll pay when they're covered, refer to the Cost Tables in the **From Coverage to Care Roadmap.** There is an example Cost Table for "Costs of Type 2 Diabetes" on page 15.

- **A young adult:** Young adults are sometimes called "young invincibles" because they think they can't get sick or injured. They might not see the value of coverage right away. Ask consumers if they've been to the emergency department recently – and if they know how much the visit cost. You can explain to them that without coverage, treating a broken arm can cost nearly $7,700.

  They may be thinking about starting a family. If so, let them know that having a baby can cost thousands of dollars. You can use the "Costs of Having a Baby" Cost Table in the **Roadmap** (on page 15) to show them an example of how having coverage could affect how much they'll pay.

  Remind young consumers that they have options. They may be able to stay on their parents' plan until they're 26, get covered through their school's health plan, or enroll in Medicaid or a Marketplace plan with financial help. Having coverage will protect them from large health care costs if they get sick. Plus, using coverage for preventive services can reduce their health care costs over time by keeping them healthy.

  Share information about preventive services and screenings that may be covered without cost-sharing. There's a link to the **Roadmap** and other resources to help you work with young adults at the end of this section on page 8.

2. Coverage May Be More Affordable Than You Think.

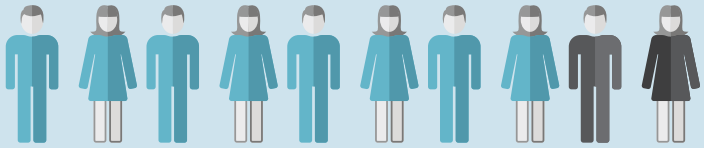
Eighty-five percent of individuals who selected a Marketplace plan last year qualified for financial help to lower their out-of-pocket costs. But many people didn't apply for coverage because they thought they couldn't afford it. Remind consumers that they will only find out whether they qualify for help paying for coverage if they apply to the Marketplace or their state Medicaid agency.

Consumers can select "See plans & prices" on **HealthCare.gov** and enter some basic information to get an estimate of their costs to use as a guide. If you can, show consumers an estimate of their costs by window shopping on the site with them, but let them know their costs and the exact amount of financial help they'll get is only available once they apply. Applying is free and it may save the consumer out-of-pocket costs.

Section 2 has more information on how to see plans and prices on **HealthCare.gov** and there's a cheat sheet on page 14 so you can quickly tell whether a consumer might qualify for help based on their income. Remind consumers these are only estimates and the Marketplace and state Medicaid agencies will make final determinations when they apply for health coverage.

SEE PLANS & PRICES AT:
https://www.healthcare.gov/see-plans/

80% **Or 8 out of 10 Consumers**



can get coverage for **$100** **or less**
per month after any applicable tax credits in 2015.

3. Avoid The Fee For Not Having Coverage.

Minimum Essential Coverage is what consumers must have to avoid paying the Individual Shared Responsibility Payment – a fee for going without coverage for part or all of the year. Qualified Health Plans in the Marketplace plans meet this standard. So does TRICARE, the Veteran's health care program, Medicare Part A, Medicaid, coverage for Peace Corps Volunteers, and job-based coverage.

Minimum Essential Coverage doesn't include coverage that only provides limited benefits. For example, coverage for just vision or dental care, and Medicaid just for certain benefits like family planning, workers' compensation or disability, don't meet this standard.

For more information or to find out what coverage qualifies, visit: **https://www.healthcare.gov/fees-exemptions/plans-that-count-as-coverage/**

Consumers who don't enroll in coverage may have to pay a fee when they file taxes (also called the Individual Shared Responsibility Payment). Make sure consumers know the fee for not enrolling in coverage goes up every year. Some consumers are exempt from this requirement if any of these apply them:

- Uninsured for less than 3 months of the year
- Lowest-priced coverage available would cost more than 8% of their household income
- Don't have to file a tax return because their income is too low
- Member of a federally recognized tribe or eligible for services through an Indian Health Services provider
- Member of a recognized health care sharing ministry
- Member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- Incarcerated (either detained or jailed), and not being held pending disposition of charges
- Not lawfully present in the U.S.
- Qualify for a hardship exemption

Encourage consumers to apply for coverage even if they are going to apply for an exemption. Once they see that they can get affordable coverage, they may decide they want the peace of mind and access to affordable health care services that they get when they're covered. There are more resources at the end of this section on page 8 to help you explain what qualifies for an exemption and how consumers can apply.

FIND OUT WHAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE:
www.irs.gov/AffordableCare-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage

3. Avoid The Fee For Not Having Coverage (Continued).

If you don't enroll in Minimum Essential Coverage for 2015 (or have an exemption), the applicable taxpayer will pay whichever cost is higher when they file their 2015 income taxes:

- **Method 1**: Percentage of yearly income. 2% of their yearly household income (above the minimum tax threshold of $10,150)

OR

- **Method 2:** Flat fee per person, $325 for each adult and $162.50 per child under 18 (up to a total maximum of $975 per family for 2015)

For a single person living alone, earning $35,000 per year that's…

METHOD 1: Percentage of yearly income

STEP 1

$35,000 - $10,150 = $24,850

Annual Income	Minimum Filing Threshold	Fee Income

STEP 2

$24,850 x 2% = $497

Fee	%	What the taxpayer owes

METHOD 2: Flat fee per Person

$325 for 1 person

The consumer will pay $497 in 2015 since that is the higher amount.

4. Your Coverage Pays For Preventive Care That Can Keep You Healthy.

Consumers may have had a provider recommend vaccines, screenings, or tests to them or a family member, but they may not have known why they needed it, or the value of knowing the results. Explain that screenings and test results help providers monitor patients' health and make sure they're on the right track. And most preventive services, like screenings, tests and vaccines, are available at no cost to the enrollee (no copayments or deductibles). Explain to consumers that if they're diagnosed with a health condition or illness, catching it early could be life-saving. Many serious health conditions can be treated or managed.

Consumers may have also heard statistics, like: 1 in 8 women will develop breast cancer in their lifetime, or 1/3 of all people have heart disease. People with a family history of a certain illness or health condition may have heard that they're more likely to get sick. They may even think that they can't avoid it, and may be afraid to see a provider. Talk about how consumers can be proactive and get regular health care to prevent illness or to catch it early.

ONCE CONSUMERS HAVE COVERAGE, THEY CAN TALK WITH A PROVIDER ABOUT HOW TO USE IT TO STAY HEALTHY.

Do Consumers Need Help Enrolling?

Call the Marketplace Call Center:

- 1-800-318-2596
- TTY: 1-855-889-4325
- Available 24 hours a day, 7 days a week in more than 150 languages

Find local in-person help, visit: https://localhelp.healthcare.gov/

RESOURCES

From Coverage to Care resources
(Partner/Consumer)

https://marketplace.cms.gov/c2c

Incomes that qualify for lower costs
(Partner/Consumer)

https://www.healthcare.gov/qualifying-for-lower-costs-chart/

How to estimate income for the Marketplace (Partner/Consumer)

https://www.healthcare.gov/income-and-household-information/

How health coverage affects 2014 taxes (Partner/Consumer)

https://www.healthcare.gov/taxes/marketplace-health-plan/

Where and how to get an exemption
(Partner/Consumer)

http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions

Qualifying for a hardship exemption
(Partner/Consumer)

https://www.healthcare.gov/fees-exemptions/hardship-exemptions/

Questions & answers on the Individual Shared Responsibility Payment and exemptions
(Partner/Consumer)

http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision - Exemptions

Health coverage for young adults
(Partner/Consumer)

https://www.healthcare.gov/young-adults/

Myhealthfinder web app for personalized preventive care recommendations (Consumer)

healthfinder.gov/myhealthfinder/

Mental health and substance use disorder services treatment locator and resources (Consumer)

http://www.mentalhealth.gov/

2 WHAT CONSUMERS SHOULD KNOW BEFORE ENROLLING IN A PLAN

People enrolling in health coverage for the first time may not understand common health insurance coverage terms. Misconceptions and knowledge gaps can make shopping for coverage difficult. Use this section and the **From Coverage to Care Roadmap, Step 2** to discuss key coverage terms and consumers' concerns about costs.

Emphasize the four topics below, and get the **Roadmap** at:

https://marketplace.cms.gov/c2c

ARE THERE QUESTIONS ABOUT ...

WHAT SERVICES ARE COVERED? GO TO 10

COSTS OF COVERAGE? GO TO 11

HOW TO GET HELP PAYING FOR COVERAGE? GO TO 14

RE-ENROLLMENT REMINDERS? GO TO 18

1. All Marketplace Plans Must Cover Doctor Visits, Preventive Services, Prescription Drugs, Mental Health Care, Hopitalization, And More.

Consumers may be hesitant to enroll in coverage because they are unclear on what is covered and afraid to pick the wrong plan. They may have had a bad experience in the past, been denied coverage, had their coverage cancelled, or thought a treatment was covered when it wasn't, which may contribute to their hesitation. Reassure consumers that although each plan is different, Marketplace plans must meet certain minimum standards, including covering the ten Essential Health Benefits listed to the right. Plans also cover many preventive services like screenings and vaccines without out-of-pocket costs to the consumer, like copayments, coinsurance, or deductibles.

Talk to consumers about which services they may need. Ask if there are other things that they don't see listed in the box to the right. Write them down and refer back to the list when comparing available plans.

WHAT ARE ESSENTIAL HEALTH BENEFITS?

A set of health care service categories that Marketplace plans must be covered by plans sold through the Marketplace.

1. **Outpatient care** is care a person gets without being admitted to the hospital as an inpatient
2. **Emergency services**
3. **Treatment in the hospital for inpatient care**
4. **Care before and after a baby is born**
5. **Mental health and substance use disorder services**
6. **Prescription drugs**
7. **Services and devices** to help you a person recover if they're injured or have a disability or chronic condition, or that help you gain function (called habilitative and rehabilitative services)
8. **Lab tests and services**
9. **Preventive services** including counseling, screenings, and vaccines to keep people healthy and manage a chronic disease
10. **Pediatric Services** - services tailored to the needs of children to ensure they grow up and develop properly, including dental and vision care for kids

ONE IN THREE CONSUMERS DON'T UNDERSTAND WHAT A PREMIUM IS.

2. Once You Understand Key Terms, You Can Compare Costs For Plans.

Consumers may not understand common health care terms, including deductible, premium, copayments, and coinsurance.

Below are some key pieces of information to point out:

Premiums are payments generally made every month to maintain coverage. Explain that consumers will pay their premium to their insurance plan, regardless of whether they use any health care services. Remind them that it's important to pay their premiums in order to keep their coverage.

Copayment (or Copay) is the fixed amount a consumer pays for a covered health care service or supply. Copayments are usually a set amount, for example $15 for primary care visits and $35 for specialty care visits. Point out the copayment amounts for each service. With some types of coverage (like Medicaid) there may not be a copayment. Mention that copayments could differ based on the type of care or service they receive (for example, primary care, specialist, emergency department, and brand-name and generic prescription drugs may have different copayments).

Go to **Section 3** for more information about talking with consumers about the costs of prescription drug coverage.

Coinsurance is the consumer's share of the costs of a covered health care service. It's different from a copayment because it is a percent of the total allowed amount for the service, not a set dollar amount. For example: if the cost of a visit to a specialist is $180, and the consumer is responsible for paying 20% coinsurance, he or she would pay $36.

SAMPLE: WHAT YOU PAY WITH COINSURANCE

$180 x .20 = $36

Specialist cost x 20% coinsurance = Patient cost

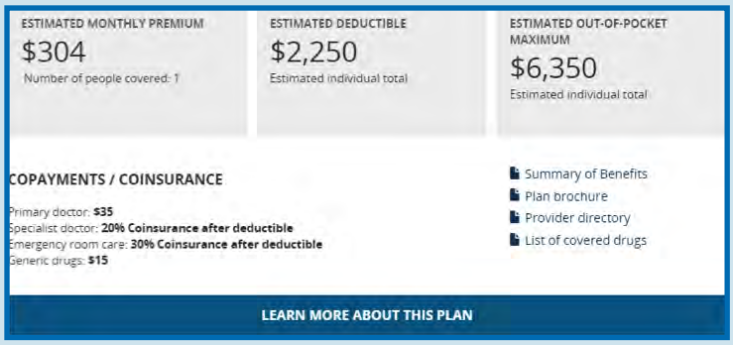
Deductible is the dollar amount consumers have to pay for health care services before their plan will start paying for their care. The deductible may not apply to all health care services. For example, in all Marketplace plans, coverage for preventive services is not subject to the deductible. Other plans may not have a deductible for primary care or prescription drugs. Different plans may have different deductibles for specific services, so consumers should know the deductibles before they pick a plan. Let them know their insurance company will keep track of how much they've paid toward their deductible, but they should keep track as well.

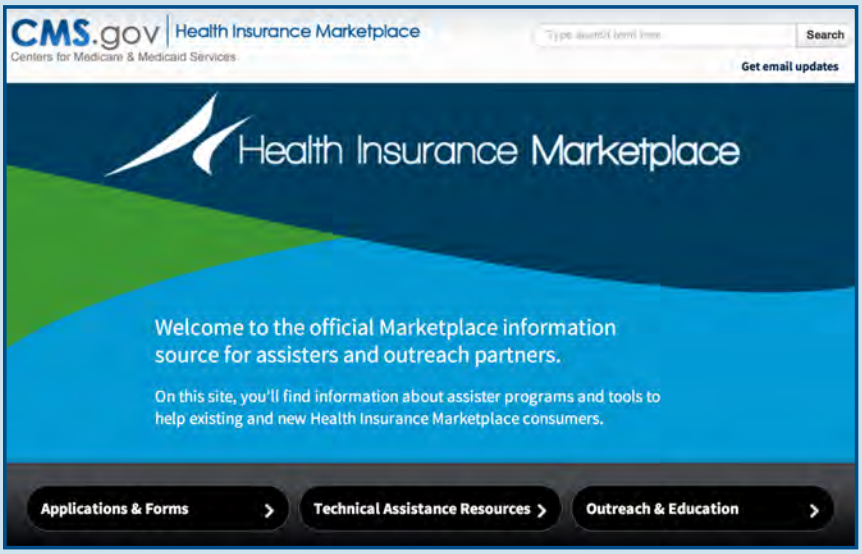
2. Once You Understand Key Terms, You Can Compare Costs For Plans (Continued).

Out-of-pocket limit is the maximum amount consumers will have to pay for covered health care services for the year. One of the benefits of having coverage is that consumers are protected from paying very high costs because of the out-of-pocket limit. Once they reach this limit, their plan will pay for 100% of the rest of the covered health care they need. Each plan sets its own out-of-pocket limit, but it can't be more than **$6,600 for an individual** (or **$13,200 for 2 or more people**) in 2015. This may still be unaffordable for some consumers.

Remind consumers they may qualify to get a cost-sharing reduction that lowers their maximum out-of-pocket expenses even more. There's more information about how to apply in this section.

Have consumers go to **www.healthcare.gov/see-plans**/ and answer a few basic questions. They will see a display like this one for the available plans with estimated costs and some of the financial help they may get. Write down the costs for the plans they're considering, then select a few on the website and print.

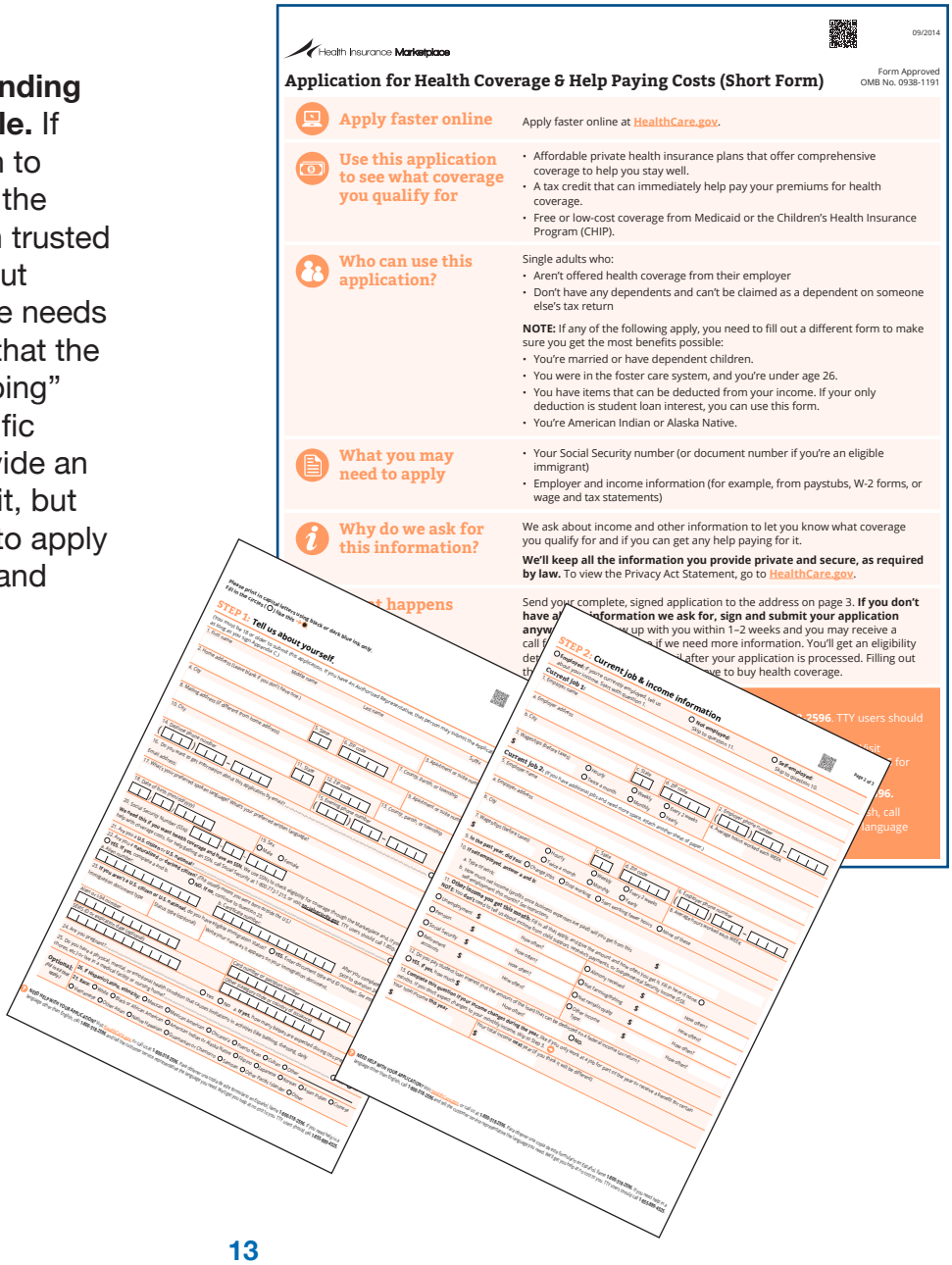




Talk about the different costs to get a sense of the consumer's preferences. Some people may prefer to pay a smaller amount each month, even if their copayments when they get care are a little higher. Consumers can filter plans by plan category, premiums, or out-of-pocket costs to find one that meets their needs. For example, if a low premium is the most important thing, consumers can see plans sorted from lowest premium prices to the highest.

Discuss monthly budget or spending and which options are affordable. If consumers aren't sure which plan to enroll in, encourage them to take the information home and to talk with trusted family and friends, if needed, about which plan meets their health care needs and budget. Remind consumers that the information in the "window shopping" feature may not reflect their specific costs or savings – it will only provide an estimate of the premium tax credit, but not other help. Consumers need to apply to know exactly what their costs and financial assistance will be.

TALK TO CONSUMERS ABOUT THEIR MONTHLY BUDGET AND WHICH COVERAGE OPTIONS ARE AFFORDABLE.



Health Insurance Marketplace

09/2014

Application for Health Coverage & Help Paying Costs (Short Form)

Form Approved
OMB No. 0938-1191

Apply faster online

Apply faster online at HealthCare.gov.

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Who can use this application?

Single adults who:

- Aren't offered health coverage from their employer
- Don't have any dependents and can't be claimed as a dependent on someone else's tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're American Indian or Alaska Native.

What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.

We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to HealthCare.gov.

happens

Send your complete, signed application to the address on page 3. **If you don't have a information we ask for, sign and submit your application anyw** up with you within 1–2 weeks and you may receive a call if we need more information. You'll get an eligibility det after your application is processed. Filling out th e to buy health coverage.

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3. Financial Assistance May Be Available, But You Must Apply To Learn What You Qualify For.

Many people don't think they can afford coverage, and don't realize that financial assistance may be available. Talk to consumers about tax credits, cost-sharing reductions, Medicaid and the Children's Health Insurance Program (CHIP), and protections for American Indian and Alaska Natives and members of federally recognized tribes and ANCSA shareholders. Let people know that help is available for eligible people and families with lower household incomes. See below for a cheat sheet from **HealthCare.gov** to match up their income to the federal poverty level (FPL). The amounts below are 2014 numbers and used for calculating eligibility for Medicaid and the Children's Health Insurance Program (CHIP). 2014 numbers are used to calculate eligibility for savings on private insurance plans for 2015.

PREMIUM TAX CREDIT-ELIGIBLE: This is 100% - 400% FPL in 2014

PRIVATE MARKETPLACE HEALTH PLANS

Number of people in household..	1	2	3	4	5	6
You may qualify for lower premiums **AND** lower out-of-pocket costs for Marketplace insurance if your yearly income is between...	$11,670 - $46.680	$15,730 - $62,920	$19,790 - $79,260	$23,850 - $95,400	$27,910 - $111,640	$31,910 - $127,880
You may qualify for lower premiums **AND** lower out-of-pocket costs for Marketplace insurance if your yearly income is between...	$11,670 - $29,175	$15,730 - $39,325	$19,790 - $49,475	$23,850 - $59,625	$27,910 - $69,775	$31,970 - $79,925

COST SHARING ELIGIBLE: This is 100% - 250% FPL in 2014

MEDICAID ELIGIBLE: This is 138% FPL in 2014

MEDICAID COVERAGE

Number of people in household..	1	2	3	4	5	6
If your state is expanding Medicaid: You may qualify for Medicaid coverage if your yearly income is below...	$16,101	$21,707	$27,310	$32,930	$38,516	$44,119
If your state isn't expanding Medicaid: You may not qualify for any Marketplace savings programs if your yearly income is below....	$11,670	$15,730	$19,790	$23,850	$27,910	$31,970

This is 100% FPL in 2014

NOTE: INCOMES THAT QUALIFY FOR LOWER COSTS ARE HIGHER IN ALASKA & HAWAII.

Persons in Household	2014 FPL	Alaska 2014 FPL	Hawaii 2014 FPL
1	$11,670	$14,580	$13,420
2	$15,730	$19,660	$18,090
3	$19,790	$24,740	$22,760
4	$23,850	$29,820	$27,430
5	$27,910	$34,900	$32,100
6	$31,970	$39,980	$36,770
7	$36,030	$45,060	$41,440
8	$40,090	$50,140	$46,110

Types of Financial Assistance

Premium tax credit is for people with household incomes between 100% - 400% FPL who are not eligible for certain other coverage. Lower incomes are eligible for a larger credit. The credit reduces monthly premium payments. Consumers can apply the credit before they pay their premium so they pay less per month, or when they file taxes to get money back at the end of the year.

Cost-sharing reductions provide additional financial assistance for eligible consumers with incomes between 100% - 250% FPL who also qualify for premium tax credits. Let consumers know that this reduction lowers the amount they will have to pay for out-of-pocket for deductibles, coinsurance, and copayments, but they must enroll in a specific category of plan (Silver, and we'll talk about the categories in **Section 3**).

American Indians and Alaska Natives (AI/AN) and members of federally recognized tribes and ANCSA shareholders have special protections and cost-sharing. **Section 5** has more information.

3. Financial Assistance May Be Available, But You Must Apply To Learn What You Qualify For (Continued).

Premium tax credits: Talk to consumers about how coverage will affect their income taxes when they file their federal income tax returns. People may not realize they could get a premium tax credit, even if they earn more than $40,000 a year. Advance payments of the premium tax credit can lower monthly premium costs. If they qualify for a tax credit, consumers can decide how much of the credit to apply to their premium each month up to their maximum credit amount. They can apply the credit when their coverage starts and pay less per month or claim the credit when they file their taxes.

Let consumers know they must file their federal taxes to get this subsidy, whether they apply it up front as advance payment of the premium tax credit or when they file their taxes. When the individual files their annual federal income tax return, the amount of premium tax credit they received during the year will be reconciled with their eligibility for the premium tax credit based on their actual household income for the year. If the individual received excess premium tax credit than what they are eligible for, they may have to repay the excess amount.

Cost-sharing reductions: In addition to the premium tax credit, eligible consumers enrolling in Marketplace plans with incomes whose household income is between 100% - 250% of FLP and who don't qualify for Medicaid can get cost-sharing reductions if they enroll in a Silver plan. This subsidy is different from the premium tax credit in these ways: it is only for Silver plans, it reduces the consumer's out-of-pocket costs when they use health care services, and it applies to their deductibles, copayments and coinsurance.

- **Without the cost-sharing subsidy**, a consumer's total out-of-pocket maximum can be no higher than $6,600 for an individual and $13,200 for 2 or more people.

- **With the cost-sharing subsidy**, a consumer's out-of-pocket maximum can be no higher than $2,250-$5,200 for an individual or $4,500-$10,400 for a family depending on where their household income falls between 100% - 250% FPL.

A plan can change how it combines its charges for copayments, coinsurance, and deductibles, but consumers will never pay more than these out-of-pocket maximum amounts for covered health care services. If you're serving consumers who are members of a federally recognized tribe, are ANCSA shareholders, or are American Indian or Alaska Native, let them know they could be eligible for additional cost-sharing reductions. Go to **Section 5** for more information.

Paying for coverage and care may seem expensive, but having coverage actually makes using health care more affordable. Explain that coverage can be like having a coupon – plans negotiate a lower payment rate with health care providers who participate with their plan so consumers pay a reduced rate for services. Coverage is also like having a gift card – when consumers use their coverage, their plan generally pays part of the covered services, so consumers' payments (or out-of-pocket costs) are lower. If consumers are uninsured they might be billed a higher amount for the same services **and** have to pay the full cost of their care.

Medicaid and the Children's Health Insurance Program (CHIP)

Medicaid and CHIP provide comprehensive benefits for people at no cost or low cost so talk with eligible consumers about enrolling. In states that have expanded eligibility, more adults qualify than ever before – but children and adults may qualify even if your state has not expanded eligibility. People also may not know they can enroll any time of the year if they qualify. Let them know that if they're eligible for Medicaid but choose to enroll in a Marketplace or other private plan, they can't get the premium tax credits and cost-sharing reductions.

If your state chose not to expand its Medicaid program and consumers are not eligible for Medicaid, adults below 100% FPL may not have access to cost-sharing reductions or premium tax credits. Medicaid expansion is a state choice and some states did not increase the eligibility threshold. If you are working with low-income consumers who are not eligible for Medicaid, they also may not be able to afford Marketplace coverage. Be sensitive to their circumstances and let them know they can't get federal help paying for coverage for a Marketplace plan. If possible, connect them to any local or state resources that might help cover the costs of their care. Additionally, notify these individuals that they may qualify for a hardship exemption. Go to **Section 1** for more information on exemptions and use resources on page 8 to help eligible consumers apply.

Job-Based Coverage & Financial Assistance

In general, if an employer offers a consumer a plan that's affordable and meets the minimum value standard for plans in the Marketplace, the consumer won't qualify for financial help if they purchase Marketplace coverage – even if they meet the income threshold. If the employer plan doesn't meet these two standards, consumers can qualify for premium tax credits in the Marketplace.

- The health plan has to be affordable: cost of coverage for one person is less than 9.5% of the individual's household income.
- The health plan has to meet minimum value standards.

Most job-based coverage will meet the minimum standards. If a consumer thinks their coverage doesn't qualify, have them bring the **Employer Coverage Tool** to their employer to fill out. You can help them apply for a determination to see whether they're eligible for help paying for coverage.

Employer Coverage Tool: **https://www.healthcare.gov/downloads/employer-coverage-tool.pdf**

4. If You're Already Enrolled In A Marketplace Plan, Review Current Plan Options To Make Sure Your Coverage Still Meets Your Needs And Update Your Information.

Encourage consumers to log in to **HealthCare.gov** to review and update their income and report life changes, including information about changes like a birth, adoption, marriage, divorce, or change of address. This information will be used to determine eligibility for premium tax credits and cost-sharing reductions.

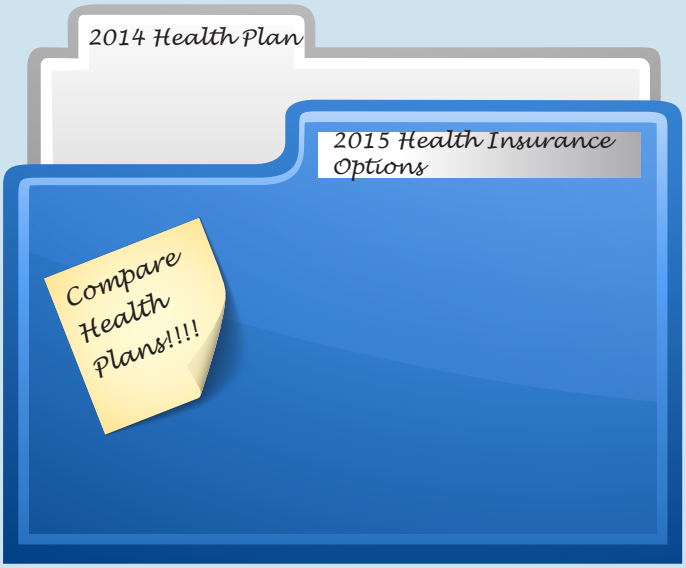
Reporting changes will help consumers avoid getting a smaller refund or owing money they didn't expect to owe on their federal tax return. If you're working with consumers who are claiming the premium tax credit for 2014, you may want to remind them that they must file a federal tax return in order to get it. If they are married, they generally must file taxes jointly with their spouse.

When consumers file their annual federal income taxes, the IRS will match up the information they report with the premium tax credit they received. The IRS may adjust the amounts consumers owe or are due if:

- The amount of advance payments of the premium tax credit that consumer got is less than the premium tax credit due. **Consumers will receive the difference as a refund.**

OR

- A consumer's advance payment of the premium tax credit for the year is more than the amount of the premium tax credit due. **Consumers will have to repay the excess with their tax return, subject to statutory repayment limits.**



Health plans will be different this year. Let consumers know that every year health insurance plans may change benefits and how they cover certain services, prescription drugs, or include particular providers in their networks. Teach them how to review their coverage this year – and every year. Let them know they could find a more affordable plan, or one with better choices and value, if they go back to the Marketplace and look at their options during open enrollment.

RESOURCES

Helping consumers compare and select a plan (Partner)

http://marketplace.cms.gov/technical-assistance-resources/plan-compare-walk-through.pdf

Essential Health Benefits covered in the Marketplace (Consumer)

https://www.healthcare.gov/blog/10-health-care-benefits-covered-in-the-health-insurance-marketplace/

How to estimate your income for the Marketplace (Consumer)

https://www.healthcare.gov/income-and-household-information/

Videos with facts about the Premium Tax Credit (Consumer)

http://www.irs.gov/uac/The-Premium-Tax-Credit

Qualifying for Marketplace cost-sharing reductions (Consumer)

https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/

Find and compare plans in your area (Consumer)

https://www.healthcare.gov/see-plans/

HealthCare.gov employer-provided coverage tool (Consumer)

https://www.healthcare.gov/downloads/employer-coverage-tool.pdf

MEDICAID & CHIP

To find out information about specific State Medicaid programs (Partner)

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State

Information on Medicaid programs (Partner/Consumer)

http://www.medicaid.gov/

Information on Children's Health Insurance Programs (Partner/Consumer)

http://www.insurekidsnow.gov/

3 WHAT CONSUMERS SHOULD KNOW BEFORE ENROLLING IN A PLAN

ARE THERE QUESTIONS ABOUT ...

PLAN CATEGORIES? GO TO 21

PROVIDER NETWORKS? GO TO 23

PRESCRIPTION DRUGS & FORMULARIES? GO TO 26

DENTAL & VISION COVERAGE? GO TO 28

Once consumers have a basic understanding of health coverage and cost-sharing, they're ready to find the health plan that best meets their health care needs and budget. Explain that different plans and provider networks have different costs and benefits. For example: some plans may have very low premiums, but limited provider and hospital networks and high out-of-pocket costs. Other plans may have higher premiums but a bigger selection of providers and hospital facilities, and lower out-of-pocket costs like deductibles, copayments, and coinsurance.

This section has discussion-starters and diagrams to help you explain the benefits of different plans. If you haven't already, ask which things are most important to each individual you're helping so you can personalize your assistance.

1. Choosing Your Plan Category Generally Means Balancing Monthly Premium Costs With Costs When You Get Health Care Services.

Plans sold in the Marketplace are divided into four different categories: Bronze, Silver, Gold, and Platinum. The main difference between metals, or plan categories, is the proportion of a consumer's health care costs that their plan will pay. Another difference will be how much cost-sharing the consumer will be responsible for. In general, there is a trade-off between premiums and costs at the time of care: **lower premiums usually come with higher out-of-pocket costs.** Make sure consumers understand this. Consumers should also be aware that no matter which category they choose, all plans cover the 10 Essential Health Benefits discussed in **Section 2**. Let consumers know that the plan categories only apply to certain health insurance plans, and not Medicaid, CHIP, or other coverage types.

Consumers under 30 (and certain individuals who qualify for an exemption from the individual shared responsibility fee) may want to consider a Catastrophic plan. These plans have low premiums and require consumers to meet a high deductible before their coverage starts, except for coverage for certain preventive services and a limited number of primary care visits (three visits, generally). Consumers who do not plan on using much health care during the year and who only want protection against very high costs in case of a serious accident or illness may want to consider this type of plan.

As with all Marketplace plans, the maximum amount consumers with a Catastrophic plan will pay during a policy year is $6,600 for an individual plan and $13,200 for a family plan in 2015. After that, the plan covers 100% of the cost of the covered Essential Health Benefits. Without any coverage, a serious accident or illness could cost a consumer thousands of dollars in health care bills. Let consumers know that premium tax credits can't be used to discount premiums on Catastrophic plans.

1. Choosing Your Plan Category Generally Means Balancing Monthly Premium Costs With Costs When You Get Health Care Services (Continued).

Cost-sharing reductions are available for **Silver Plans** if you are eligible.

	BRONZE	SILVER	GOLD	PLATINUM
What You Pay Each Month (Premium*)	$	$$	$$$	$$$$
What You Pay When You Go For Care (Out of Pocket Costs, including Deductible, Copays & Coinsurancce)	$$$$	$$$	$$	$
Percent of Total Average Costs of Care Your Plan Will Cover (Actuarial Value)	60% Your Plan 40% You	70% Your Plan 30% You	80% Your Plan 20% You	90% Your Plan 10% You
Might Be Good For You If You...	don't plan to need a lot of health care serives for the year.	need to balance your monthly premium with your out of pocket costs.	want to keep your out of pocket costs low, but can afford a higher monthly premium.	plan to use a lot of health care services.

The **actuarial value** of your plan is the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actual value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total cost of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

* Note: These numbers are not real and give an idea of different premium costs. Check the plans in your area for exact costs. You may find a lower premium on a higher metal level plan.

2. Aside From Choosing A Plan Category, Decide What Type of Provider Network Helps You Balance the Providers You Can See With How Much You'll Pay For A Visit.

A plan's provider network is the list of providers, facilities, and suppliers a health insurer or plan has contracted with to provide health care services. The **From Coverage to Care Roadmap, Step 2** introduces the provider network concept to consumers. Explain that plans negotiate lower rates for consumers with providers who are "in-network" for a plan. These providers can be called "preferred providers" or "participating providers." So, in-network providers will usually cost consumers less than out-of-network providers. With some plans, out-of-network care will not be covered, meaning the consumer will pay the full cost.

Each consumer has different priorities, so as you talk about provider network types, **discuss whether they would be willing to pay more to have a larger pool of providers**. Some plans keep premiums low by contracting with a smaller, "tighter" network of providers. Emphasize the key differences between networks, like:

- Costs of care inside and outside the network
- Size of the network
- Specialists in the network

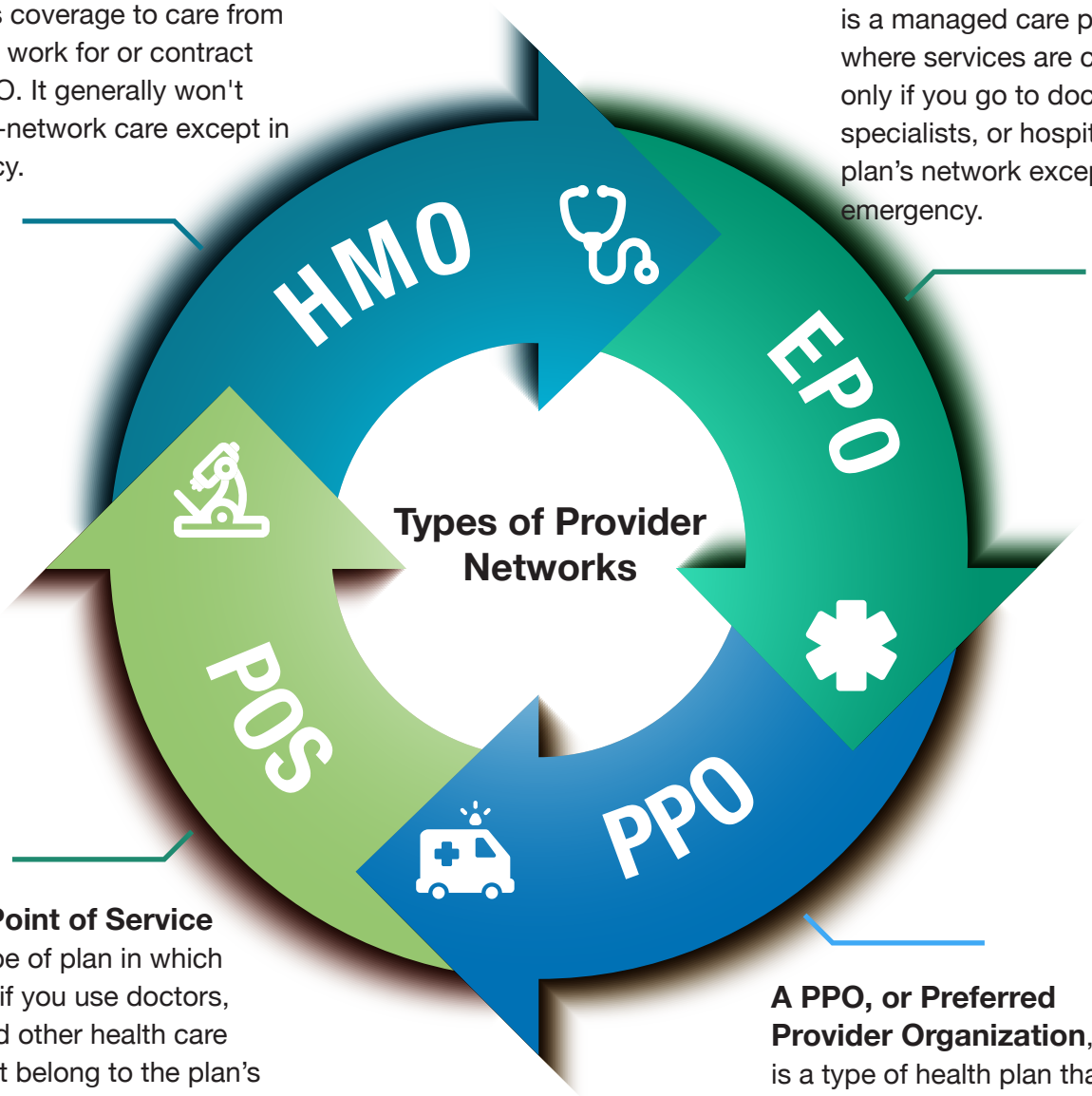
Use **HealthCare.gov's** "window shopping" feature and the Summary of Benefits and Coverage to show differences between provider networks. Point out how plans vary in provider networks and how services are covered by out-of-network/non-participating providers versus in-network/participating providers. As you compare Marketplace plans

on **HealthCare.gov**, consumers can look at each plan's provider directory and search for a specific provider or hospital they want to continue using. **You may want to emphasize that for HMOs and EPOs, the plan may not pay anything for out of network services, but with PPOs and POS networks the plan will generally provide some coverage.** Refer to the definitions below and talk about each type of network. Have consumers look at a specific plan's Summary of Benefits and Coverage to understand how that plan covers in-network versus out-of-network services.

There are links at the end of this section on page 29 to a sample Summary of Benefits and Coverage and other resources to help you talk with consumers about provider network types.

An HMO, or Health Maintenance Organization, is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

An EPO, or Exclusive Provider Organization, is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network except in an emergency.



A POS, or Point of Service Plan, is a type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

A PPO, or Preferred Provider Organization, is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

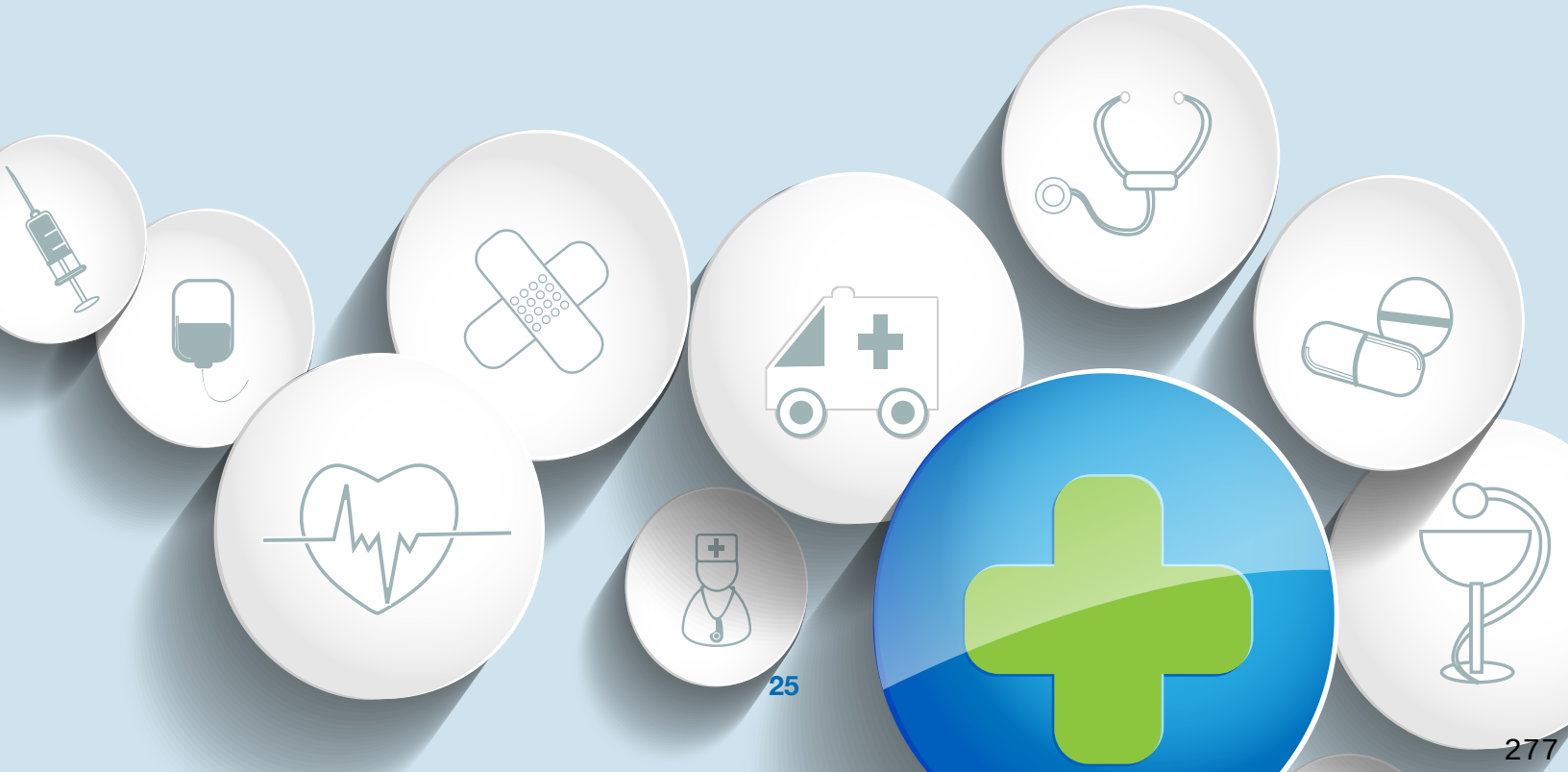
3. Check For Your Providers Before Enrolling.

Ask if the consumer has a provider they would like to continue seeing. If a consumer wants to keep his or her provider, show how to check to see if the provider is “in-network” for the plan under consideration. You can use the provider directories linked on **HealthCare.gov**, or show consumers how to look up their provider by name on a particular plan’s website. However, since providers can change the plans they contract with at any time, encourage consumers to call their provider's office directly to confirm their participation in a plan’s network before enrolling and, if possible, before seeking care.

If the provider they’re looking for isn’t in one plan’s network, a consumer may want to select a different plan to continue seeing the same provider. They can also look at the providers who are “in-network” and see if there are other options that meet their needs.

ENCOURAGE CONSUMERS TO CALL THEIR PROVIDER'S OFFICE TO CONFIRM THEIR PLAN PARTICIPATION.

Consumers may not be familiar with mental health parity, or they may want to know if mental health services are covered in a particular plan. Explain that there's a law that generally prevents health plans from limiting access to mental health and substance use disorder services any more than they restrict access to medical and surgical services. If consumers want to locate a treatment provider, suggest they use the provider locator on **MentalHealth.gov.** As with their primary care provider, remind consumers to check whether the provider they're thinking about is in their network before they get care.



CHECK A PLAN'S FORMULARY FOR EXPENSIVE PRESCRIPTION DRUGS.

4. Know What Prescription Drugs Are Covered And What They'll Cost.

A plan's formulary is a list of prescription drugs that are covered by a plan. Ask consumers if they're currently taking any prescription drugs. Consumers, especially those with a chronic condition, need to understand how much they'll pay. Help consumers see how much their drugs will cost by showing them how to find and read a plan's formulary. Consumers with Medicaid and CHIP generally have to pay some money for prescription drugs, but it's not a lot. Marketplace plans' formularies are posted on HealthCare.gov and consumers can see lists of covered drugs as they compare plans.

Some drugs cost more than others. Formularies are usually divided into categories, or tiers. They tell you how much drugs in each category cost for the health plan and for the consumer. The tiers are usually called:

- Generics (often the lowest cost for consumers)
- Preferred brands
- Non-preferred brands
- Specialty drugs (often the highest cost)

If a consumer takes an expensive prescription drug or fills several prescriptions, they should check the plan's formulary for these particular prescription drugs to see if they're covered. Some people may want to choose a Gold or Platinum plan because although the monthly premium may cost more, if their prescription drugs or treatments are covered their care would cost less over the year.

For example, if a consumer is prescribed a drug to manage their cholesterol, the cost would depend on: 1) how the plan classifies that drug in its formulary, and 2) what level of coverage the plan provides for each type of drug. Also explain to the consumer that they can talk to their provider about switching from a particular brand to the generic brand for the same drug, which may cost less. Use the table below as an example of how a plan might cover different prescription drugs in its formulary.

SAMPLE CONSUMER COST TABLE

Bronze vs. Gold Plan for 30 day supply of a prescription drug

	BRONZE	GOLD
Generic Drugs	$20 copay	$10 copay
Preferred Brand Drugs	$45 copay	$35 copay
Non-Oreffered Brand or Generic Drugs	$75 copay	$70 copay
Specialty Drugs	40% coinsurance	30% coinsurance

Some drugs have special rules. Most health plan formularies have rules, or restrictions, on certain prescription drugs. These rules can include:

- Requiring prior authorization
- Limiting the amount of a drug a person can get over a certain period of time
- Requiring a consumer to use a cheaper drug that has been proven effective before covering the more expensive drug if the first option doesn't work (also known as "step therapy")

Talk to consumers about any restrictions in the formularies for the plans they're considering since this could impact their care. Reassure consumers that they can work with their provider and their plan to get the care they need.

Re-enrolling? Remind consumers that health plans update their formularies regularly and can change which drugs are covered, add new generic drugs, or change their costs. If there are changes that could affect their care, consumers may want to consider switching plans or talking with their provider about changing to another covered prescription drug instead.

Prescription drugs still too expensive?

Even with coverage, consumers may still be concerned about the cost of their prescription drugs. National and local patient assistance groups such as the Partnership for Prescription Assistance may be able to help qualifying patients get their prescription drugs for very low or no cost.

Go to sites like this one for help:

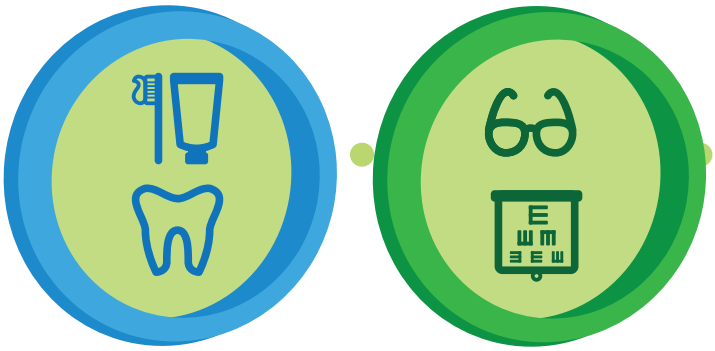
https://www.pparx.org/

5. Not All Plans Cover Dental And Vision Care.

Individuals and families who are new to coverage may assume that enrolling in a Marketplace plan will give them coverage for dental or vision care automatically. Ask consumers if they want dental or vision coverage. **All Marketplace plans are required to cover pediatric dental care for consumers who are 18 and under, and pediatric vision care.** This is not true for adults. Insurers do not have to offer adult dental coverage. If adult dental or vision coverage is important to them, check the Summary of Benefits and Coverage for a particular plan to see if it's included. If it is, let consumers know they'll pay one monthly premium for everything – the premium shown for the plan on **HealthCare.gov** includes both health and dental coverage.

If the plan they're considering doesn't cover adult dental or if they want different dental coverage, consumers can compare the stand-alone dental plans that may be available using the "window shopping" feature of **HealthCare.gov**. If they choose a separate dental plan, consumers will pay a separate, additional premium. If dental plans aren't available, or if consumers would like to enroll in other coverage like a stand-alone vision plan that is not offered in the Marketplace, talk about how to find a stand-alone plan in your state, including contacting your state's Department of Insurance or a local agent or broker.

INSURERS ARE NOT REQUIRED TO OFFER ADULTS DENTAL AND VISION BENEFITS. BE SURE TO SHOP AROUND IF YOU WANT THIS TYPE OF COVERAGE.



RESOURCES

Marketplace background guide for Federally Facilitated Marketplace and Partnership states (Partner)

https://marketplace.cms.gov/technical-assistance-resources/marketplace-background-guide.pdf

Explaining a Summary of Benefits and Coverage (Partner)

http://marketplace.cms.gov/technical-assistance-resources/summary-of-benefits-and-coverage.pdf

FAQs on coverage for young invincibles (Consumer)

https://www.healthcare.gov/young-adults

Marketplace coverage and metal levels (Consumer)

https://www.healthcare.gov/choose-a-plan/plans-categories/

How to find information on health care providers (Consumer)

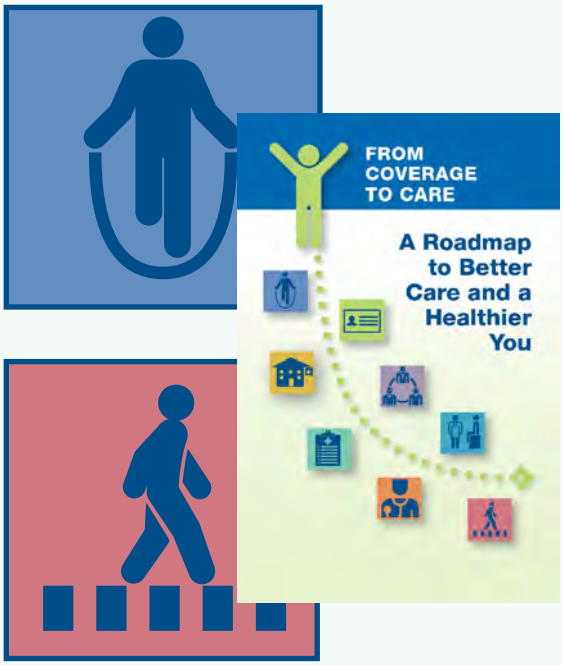
https://www.healthcare.gov/choose-a-plan/find-provider-information/

Health insurance coverage of mental health and substance use disorder services (Partner/Consumer)

http://www.mentalhealth.gov/get-help/health-insurance/index.html/

4 WHAT CONSUMERS SHOULD DO AFTER THEY GET COVERAGE

After enrolling, many consumers may be unsure what they should do next. Let consumers know that getting coverage is the first step in their journey to better health. Use the **From Coverage to Care Roadmap** and the messages in this section to help consumers understand how to use their coverage to live a long and healthy life.



ARE THERE QUESTIONS ABOUT ...

COMPLETING ENROLLMENT? GO TO 31

HOW TO KNOW WHAT'S COVERED? GO TO 32

PICKING OR CHANGING PROVIDERS? GO TO 32

ONGOING TREATMENT OR PRESCRIPTION DRUGS? GO TO 33

1. Confirm You're Covered.

After consumers complete the enrollment process, they should receive information from their plan about benefits and paying their premiums. Let consumers know there are ways to confirm they're covered if they don't hear from their plan or they aren't sure they've finished the enrollment process. They can:

- **Log in to their account on HealthCare.gov** and click on their application. Consumers will see a summary on the "My Applications & Coverage" page where they can find more details about their enrollment and plan benefits.
- **Call the Customer Service Center of their new plan**, using the listing and instructions on **HealthCare.gov.** Consumers can confirm whether they're enrolled and whether they've paid their first month's premium. Go to: **https://marketplace.cms.gov/outreach-and-education/contact-health-plan.pdf.**
- If they are still having trouble, **call the Marketplace Call Center** at 1-800-318-2596 (TTY: 1-855-889-4325).

2. Pay Your Monthly Premium To Keep Your Coverage.

Consumers who are new to health coverage may not realize they have to pay their premiums every month. Tell them they need to do this even if they don't use any services in the month. Let people know that once they are enrolled, they must pay their first premium directly to the insurance company – not to the Marketplace. They should follow any instructions from their insurer about how and when to make their premium payment. **Consumers who don't pay their premiums risk losing their coverage and having to pay for 100 percent of the cost of their health care.** It may also mean they have to pay the fee for not having coverage. Remind consumers that staying covered is as important as getting covered.

3. Review Plan Materials And Learn About Your Benefits.

Suggest to consumers that they review their plan materials and coverage documents and store them in a safe place right after they enroll. They'll get the most out of their coverage if they know what's covered and what their costs will be. If they have questions, encourage them to call their health plan (or state Medicaid or CHIP office, if they are eligible for those programs) for answers.

4. Talk With A Provider About How To Improve Your Health And Well-Being.

While the consumer was enrolling in coverage, you probably talked about whether he or she already has a provider. If they don't, explain that having a regular provider is an important first step to getting the primary care and preventive services they need. Some consumers may have been assigned to a provider by their plan. If they want to change, show them how to contact their plan to do so.

You've picked a provider, now schedule an appointment. As soon as coverage begins, consumers can see a provider to learn about their health needs, and start working with them toward better health.

The **Roadmap, Steps 4, 5, and 6** help you talk with consumers about finding a provider, and how to scheduling and preparing for their first appointment.

The **Roadmap, Step 7** helps you guide the consumer to find the provider that's right for them.

Know where to go for care. Consumers who are new to coverage may have used the emergency department for care in the past. Remind them that they should only use the emergency department when they have a life-threatening illness or injury. Encourage them to use their primary care provider for other situations.

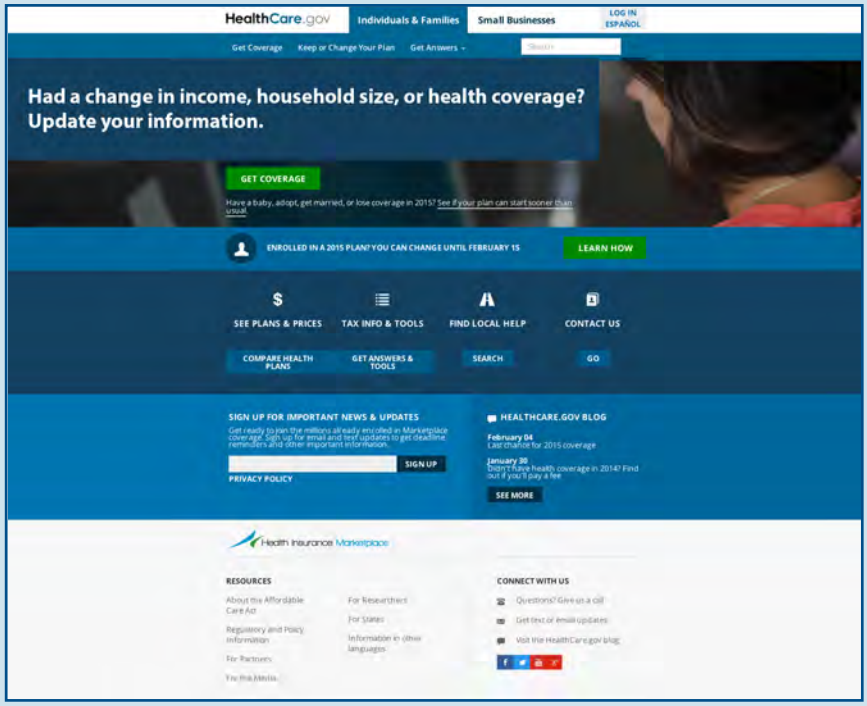
The **Roadmap, Step 3** helps you talk about where to go for care and the differences between primary care and the emergency department.

5. Keep Getting The Prescription Drugs And Treatment You Need.

You probably talked about consumers' ongoing treatment or prescription drugs earlier in the enrollment process. Remind individuals that they'll need to take action to keep getting care while their coverage changes. If a consumer needs ongoing treatment for a chronic condition or needs to fill a prescription regularly, urge them to talk with their provider immediately to see what needs to be done under their new plan. Let the consumer know that if their new plan has restrictions on certain prescription drugs or services, sometimes these can be waived if their provider and plan work together. If their treatment is denied they always have the right to appeal that decision. Talk about where to look for their plan's appeals process, and remind them that their provider can help them appeal a decision. There are links to more information about the appeals process at the end of this section on page 34.

6. Keep Your Information Current On Healthcare.gov.

The information consumers enter into their Marketplace application on **HealthCare.gov** (for example, family size and household income level) is used to calculate their premium tax credit. **Remind consumers about the importance of keeping their information current so they receive the right amount of financial assistance and don't end up owing money when they file their taxes.** Encourage them to update their information on **HealthCare.gov** when there is a change within 30 days of the change. In addition to keeping their records accurate, consumers may become eligible for a Special Enrollment Period if they have a major life event like a birth, adoption, marriage, or job loss, and they may want to choose a new plan that meets their changing health care needs.



RESOURCES

Confirming enrollment in coverage
(Partner/Consumer)

https://www.healthcare.gov/apply-and-enroll/complete-your-enrollment/

Contact your Marketplace health plan
(Partner/Consumer)

https://marketplace.cms.gov/outreach-and-education/contact-health-plan.pdf

From Coverage to Care resources
(Partner/Consumer)

https://marketplace.cms.gov/c2c

Helping a consumer with appealing a plan's decision not to cover (Partner)

http://marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf

Options for coverage outside of Open Enrollment (Partner/Consumer)

https://www.healthcare.gov/coverage-outside-open-enrollment/

Qualifying for a Special Enrollment Period (Consumer)

https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

5 WHAT CONSUMERS WITH SPECIAL CIRCUMSTANCES SHOULD KNOW ABOUT THEIR COVERAGE OPTIONS

Some consumers have special circumstances that affect their coverage options and enrollment. Three of these groups are discussed in this section, and there are resources on page 41 to help you work with these and other special populations. You may want to partner with others in your community to share resources, best-practices and tips to meet your consumers' needs.

ARE THERE QUESTIONS ABOUT ...

AMERICAN INDIANS & ALASKA NATIVES? GO TO 36

LIMITED ENGLISH PROFICIENCY? GO TO 38

IMMIGRANTS? GO TO 39

1. American Indians And Alaska Natives (Ai/An) May Have New Coverage Benefits And Protections.

Some benefits are available to members of federally recognized tribes or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders. Others are available to people of Indian descent or who are otherwise eligible for services from the Indian Health Service, a tribal program, or an urban Indian health program.

Based on their eligibility, talk to American Indian and Alaska Native consumers about limited and zero cost-sharing plans and Medicaid. Help them compare plans by window shopping at "See Plans & Prices" on **HealthCare.gov** to find one that works for them. Remind consumers they will have to pay their premiums if they enroll in a Marketplace plan. You should also help them check to see if they're eligible for premium tax credits (discussed in **Section 2**).

Financial Assistance for American Indians and Alaska Natives

Members of federally recognized Indian tribes and ANCSA Corporation shareholders (regional or village) may qualify for zero or limited cost-sharing plans or cost-sharing reductions based on their income. Let consumers know that they can enroll in a Marketplace plan any time during the year, not just during the yearly Open Enrollment period.

- **Household income is below $70,650 for a family of 4 ($88,320 in Alaska):** can enroll in a zero cost-sharing plan. Let them know they have no out-of-pocket costs like copayments, deductibles, or coinsurance.

- **Household income is above $70,650 for a family of 4 ($88,320 in Alaska):** Can enroll in a limited cost-sharing plan. Let people know they won't have to pay out-of-pocket costs when they get services from an Indian health care provider – or from another provider, if they have a referral from an Indian health care provider.

American Indians or Alaska Natives, and others eligible for services from the Indian Health Service, tribal program, or urban Indian Health program have additional opportunities for coverage:

- **May qualify for Medicaid or CHIP:** Let consumers know they have special cost and eligibility rules for Medicaid and CHIP that make it easier to qualify for these programs.

- **Don't pay out-of-pocket costs for Indian health programs**: regardless of their income, consumers won't have any out of pocket costs for items or services provided by the Indian Health Service, tribal programs, or urban Indian programs, including Contract Health Services.

- **Don't pay the penalty:** Consumers who do not enroll in coverage won't have to pay the fee that most other people without health insurance must pay, but do have to apply for an exemption.

For more information about coverage for American Indian and Alaska Natives, go to:
https://www.healthcare.gov/american-indians-alaska-natives/

Where do you go for care? Consumers who've been using tribal health care services may not know which other providers will take their new coverage. American Indian and Alaska Natives can use an Indian health care provider as a primary care provider or choose to use a provider in their new plan's network. If they get health care from an Indian health provider already, let them know that they can continue to see that Indian health provider and many others after they enroll in Marketplace coverage. They may also qualify for coverage with low or zero cost-sharing. If they don't have a provider, show them how to find one using the plan's provider directory posted on **HealthCare.gov** or the health plan's website, if they have one. Let consumers know that getting covered will give them more options when they need health care.

Enroll in coverage or apply for an exemption. Many American Indians and Alaska Natives get health care at various types of Indian health care providers, including Indian Health Services, tribal programs, and urban Indian programs (called ITUs). Although they have access to health care services, explain that this health care is not considered insurance for purposes of the individual shared responsibility requirement. Let them know that they still need to enroll in minimum essential coverage or apply for an exemption to avoid having to pay the individual shared responsibility fee.

You can use the **Tribal version of the Roadmap** and resources at the end of this section on page 41 to help you work with tribal populations. You'll find more information about help with costs, how American Indian and Alaska Native consumers can get an exemption, what documents are required, and how to access care.

HEALTH CARE SERVICES YOU GET AT IHS, URBAN INDIAN PROGRAMS, OR TRIBAL PROGRAMS DOESN'T COUNT AS MINIMUM ESSENTIAL COVERAGE.

2. Help Is Available If You Speak A Language Other Than English.

If you're helping someone who speaks a language other than English, there are resources in the box below for help that may be available in his or her preferred language. Some of these resources include interpreters, call center support, and print and web resources like a Uniform Glossary and Marketplace application guides. You can also use the "local help" feature on **HealthCare.gov** to find in-person support in your community.

Get In-Language Assistance

You can use these resources together, or consumers can access these services on their own.

The Marketplace Call Center has representatives available in English and Spanish-speaking representatives, and interpretation and translation services in 150 languages. These services are free.

For help in a language other than English, call **1-800-318-2596.**

Some In-person "assisters," like navigators, Certified Application Counselors, and others partner offer services in languages other than English. Consumers can get a list of local organizations with contact information, office hours, and types of help offered including non-English language support. **Visit https://localhelp.healthcare.gov/** and type enter a city and state or ZIP Code.

Online resources are available in many languages, with more being developed. You can find Marketplace application guides in 27 languages. For more information visit: **https://www.healthcare.gov/language-resource/.**

En Español: **https://www.cuidadodesalud.gov/es/**

3. Many Immigrants Can Enroll In Marketplace Plans, Medicaid, Or Chip, And May Be Eligible For Financial Assistance.

Non-U.S. citizens or members of their family may have questions about whether they can enroll in coverage and get help with costs. They may also wonder what documentation they need.

People with the following immigration status qualify for Marketplace coverage:

- Lawful Permanent Resident (LPR or Green Card Holder)
- Asylees
- Refugees
- Cuban and Haitian entrants
- Paroled to the U.S. for at least 1 year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children or parents
- Victims of trafficking or and their spouses, children, siblings or parents
- Granted withholding of deportation
- American Indian born in Canada
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
- Valid non-immigrant visas
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals)

See a full list of eligible immigration statuses eligible to use the Marketplace here: **https://www.healthcare.gov/immigrants/immigration-status/**

In general, Medicaid and CHIP require lawfully present immigrants to become lawful permanent residents, and to wait five years before they can enroll in coverage. During this five-year waiting period eligible individuals may be able to get coverage to treat an emergency medical condition. Lawful permanent residents who haven't completed the five-year waiting period can enroll in a Marketplace plan and may be eligible for premium tax credits and cost-sharing reductions during that time. Some states don't have the five-year waiting period for children and pregnant women. Use the resource below to see if your state is one of them.

DO THEY HAVE TO WAIT 5 YEARS?

Check whether your state allows children and/or pregnant women to enroll in Medicaid and CHIP with no five-year waiting period. Go to:

http://insurekidsnow.gov/professionals/eligibility/lawfully_residing.html

FOR A COMPLETE LIST OF DOCUMENTATION IMMIGRANTS CAN USE WHEN ENROLLING IN COVERAGE:

https://www.healthcare.gov/help/immigration-document-types/

Immigrants who aren't lawfully present aren't eligible to enroll for coverage through the Marketplace, get premium tax credits or cost-sharing reductions, or enroll in non-emergency Medicaid or CHIP. They can file a Marketplace application for their lawfully present children or family members. Family members who aren't applying for coverage for themselves will not have to give information about their immigration status, so they can help anyone in their family apply.

You may need documentation when you apply and enroll. The documents individuals need to enroll in Marketplace coverage will depend on their immigration status. Here are some of the documents immigrants may need:

- Permanent Resident Card, "Green Card" (I-551)
- Reentry Permit (I-327)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Temporary I-551 Stamp (on passport or I-94/I-94A)
- Arrival/Departure Record (I-94/I-94A)
- Arrival/Departure Record in foreign passport (I-94)
- Foreign Passport
- Certificate of Eligibility for Nonimmigrant Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor Status (DS2019)
- Notice of Action (I-797)
- Document indicating membership in a federally recognized Indian tribe or American Indian born in Canada
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Alien number (also called alien registration number or USCIS number) or 1-94 number

AMERICAN INDIANS AND ALASKA NATIVES

From Coverage to Care Roadmap – Tribal Version (Partner/Consumer)

https://marketplace.cms.gov/c2c

Tip sheet for Assisters working with AI/ANs (Partner)

https://marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf

Details on special Marketplace protections and benefits for AI/ANs (Consumer)

https://www.healthcare.gov/tribal

How to apply for an exemption (Consumer)

https://www.healthcare.gov/fees-exemptions/apply-for-exemption/

Information for tribal leaders and tribal health programs, National Indian Health Outreach and Education (NIHOE) (Partner/Consumer)

http://tribalhealthcare.org/

LIMITED ENGLISH PROFICIENCY

Glossary of health care terms for consumers with limited English proficiency (Partner/Consumer)

https://marketplace.cms.gov/technical-assistance-resources/plan-compare-and-plan-selection-help.html

Translated resources from Marketplace (Partner)

https://marketplace.cms.gov/outreach-and-education/other-languages.html

Videos in English and other languages for outreach and enrollment to diverse populations (Partner/Consumer)

https://www.youtube.com/playlist?list=PLBXgZMI_zqfRXt44Uk6YeMW0Npmbemc2h

Uniform Glossaries in other languages (Partner/Consumer)

https://marketplace.cms.gov/outreach-and-education/tools-and-toolkits.html

Marketplace Call Center instructions in other languages (Consumer)

https://marketplace.cms.gov/outreach-and-education/getting-help-in-a-language-other-than-english.pdf.

Find local enrollment help in other languages (Consumer)

https://localhelp.healthcare.gov/

HealthCare.gov resources in other languages (Consumer)

https://www.healthcare.gov/language-resource/

Spanish version of HealthCare.gov (Consumer)

https://www.cuidadodesalud.gov/es/

Help filing a complaint in other languages (Consumer)

http://www.hhs.gov/ocr/office/file/languageaccess.html

IMMIGRANTS

Overview of immigrant eligibility for affordable health coverage (Partner)

http://www.healthreformbeyondthebasics.org/wp-content/uploads/2014/09/CMS-Assister-Webinar-09.19.14-Immigrant-Eligibilty.pdf

Information on immigration status and the Marketplace (Consumer)

https://www.healthcare.gov/immigrants/immigration-status

OTHER VULNERABLE POPULATIONS

Helping special populations enroll (Partner)

https://marketplace.cms.gov/outreach-and-education/special-populations.html

Understanding health coverage needs of people with disabilities (Partner)

http://www.nationaldisabilitynavigator.org/wp-content/uploads/presentations/NDNRC_CMS_Nov-21-14.pdf

Coverage options for people with disabilities (Consumer)

https://www.healthcare.gov/people-with-disabilities/

Overview of assisting people with disabilities in the Marketplace (Partner)

https://marketplace.cms.gov/technical-assistance-resources/assisting-people-with-disabilities.pdf

Tools for working with consumers with HIV/AIDS (Partner/Consumer)

https://careacttarget.org/category/audience/consumers-and-community

Enrollment assistance for lesbian, gay, bisexual, and transgender communities (Partner)

http://store.samhsa.gov/product/PEP14-LGBTACAENROLL

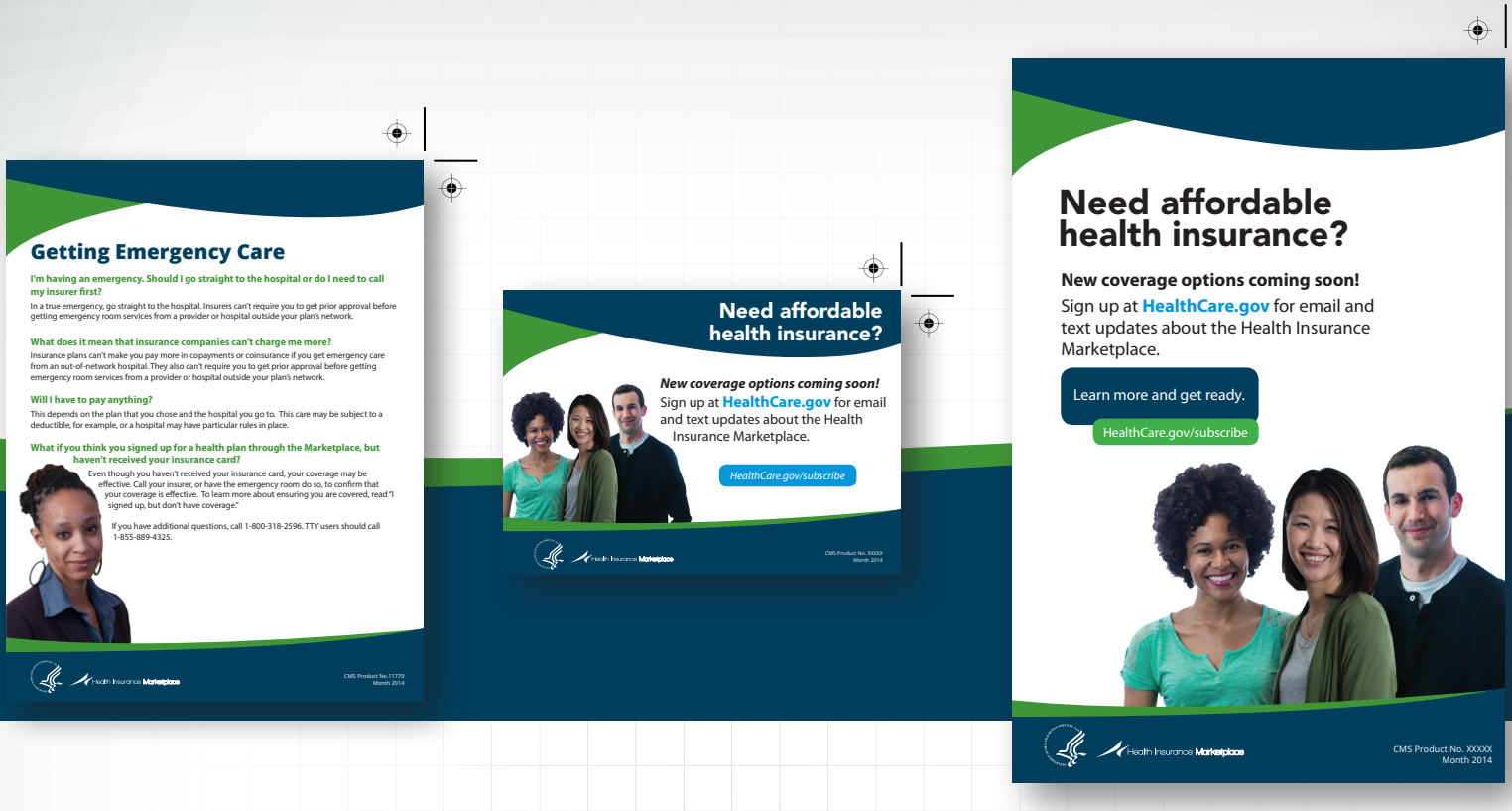
Health care toolkit for faith and community-based organizations (Partner)

http://www.hhs.gov/partnerships/aca_act_and_community/index.html

NOTES

CMS Product No. 11909
May 2015

marketplace.cms.gov/c2c



Health Insurance Marketplace

Brand Identity and Design Standards

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OVERVIEW

The Health Insurance Marketplace is a reliable destination for uninsured and non-group individuals and small businesses. It's the official, accessible place for people to learn about coverage options that fit their needs, apply for financial assistance, compare available health plans, and enroll in coverage. Ultimately, the Marketplace provides a path to security and peace of mind — ensuring access to health care when they need it and limiting unexpected expenses.

Why Do We Need Brand Identity and Design Standards?

System-wide brand identity and design standards are essential to building strong brands. Identity and design standards empower Health Insurance Marketplace partners to build from universal rules and conventions so that consumers have consistent experiences on a daily basis and across every touch point.

Who Should Use These Identity and Design Standards?

Anyone who creates material for print to market or educates consumers about the Marketplace should use these standards. Specifically, the Federally Facilitated Marketplace (FFM) is required to follow the standards described. The latest version of the brand standards is always available at **Marketplace.cms.gov**.

Design Principles

The two guiding design principles of the Marketplace design standards are to build trust and simplicity. We know that most of the uninsured want to get insured as quickly and easily as possible. We also know they're afraid of expense and complexity.

Using clean, uncomplicated design, we create products that are easy to see, read, and interact with. Presenting information consistently lets the audience know that the material they received is coming from a reliable source.

About the Health Insurance Marketplace Identity Mark

The Health Insurance Marketplace identity mark ("logo") was developed in January 2013 by the Department of Health and Human Services (DHHS). It's meant to unify the experiences and expectations associated with the Marketplace, and express them consistently through layout, color, typography, and graphic elements.

Health Insurance Marketplace Identity Guidelines

These guidelines provide standards related to the Health Insurance Marketplace identity mark and its use with other identity marks.

As all Health Insurance Marketplace materials are developed, updated, reprinted, reproduced, or otherwise modified, the identity mark should be used in accordance with these guidelines.

Authorized Users and Requests for the Identity Mark

The Health Insurance Marketplace identity mark is available for use by DHHS staff for official Marketplace products. It's also available for use by approved states for the Marketplace through the password-protected state resource web portal, without obtaining any additional approvals from DHHS. We encourage using this identity mark to promote and identify the Marketplace whenever possible.

Other entities who want to use this identity mark must get individual approval from the Centers for Medicare & Medicaid Services' Office of Communications by sending a request to **logos@cms.hhs.gov**. Requests will be considered on a case-by-case basis. The request must include the following information:

Requestor's name, address, phone number

Organization name

Does the organization have a current contract with CMS?

Project name (if applicable)

Contract number (if applicable)

Period of performance for CMS contract
(mm/dd/yyyy – mm/dd/yyyy) (if applicable)

CMS contact person (Contracting Officer's Representative)

Where and how will the mark be used?
(example or description)

How to Use the Identity Mark

These guidelines provide information and instructions on the appropriate use of the Health Insurance Marketplace identity mark. You shouldn't recreate the identity mark. Approved states can download it from the CALT website under Marketplace Branding and Logo Materials at **https://calt.cms.gov/sf/docman/do/listDocuments/projects.medicaid_state_collaborative_com/docman.root.marketplace_logo_and_branding_ma**. Other entities can request it as described on page 4.

States operating a State-based Marketplace (SBM) wanting to reproduce and distribute Health Insurance Marketplace materials developed by DHHS may remove the DHHS official seal and replace it with a state seal or identity mark. However, you can't remove the Health Insurance Marketplace identity mark. We also require FFMs to use the Health Insurance Marketplace name and identity mark on your websites, but placement is at the state's discretion. See examples on page 7 for recommended placement of identity marks.

States operating a State Partnership Marketplace (SPM) wanting to reproduce and distribute Health Insurance Marketplace materials developed by DHHS may add a state seal or identity mark to the materials, but may not remove the DHHS seal or Health Insurance Marketplace identity mark. We also require SPMs to use the Health Insurance Marketplace name and identity mark on your websites, with placement at the state's discretion. See examples on page 7 for recommended placement of identity marks. All other states can reproduce, but can't alter Health Insurance Marketplace materials developed by DHHS.

The Health Insurance Marketplace mark is composed of two components:

1. The stylized letter "H" on the far left
2. The words Health Insurance Marketplace

Health Insurance Marketplace

The elements are designed for use as a unit. Don't try to recreate the identity mark on your own. Always use reproducible art available electronically for download in EPS, JPG and PNG file formats upon request. Other file formats can be requested by sending a request to **logos@cms.hhs.gov**. The positive four-color version of the horizontal logo is the preferred and recommended version for use on products.

An optional stacked version is also available for use when needed, like on materials that have limited space available for logo placement.

Health Insurance
Marketplace

The Health Insurance Marketplace mark should always be clearly legible. The following guidelines will help you ensure that your products reflect the Marketplace brand standards.

Bleed-Edge Indicator

The mark may not bleed off any edge of an item. The mark should sit at least 1/8 inch inside any item's edges.

Clear Space Allocation

The clear space around the mark prevents any nearby text, image or illustration from interfering with the impact of the mark. Any type of graphic elements must be at least "x" distance from the logo as shown by the illustration below. The measurement "x" can be defined as approximately half the height of the mark.

Approved Colors

The four-color mark is the preferred version and is recommended for products that require 4/C-process production, like banners, billboard signage and digital printing. The Health Insurance Marketplace identity mark uses PMS 2925C blue and PMS 363C green. If only using one or two color spot printing, use the black positive logo.

All positive marks are to be used against white backgrounds and colors that are tonally lighter than 20% of the color. A negative mark, which is reversed out in white may also be used. When placing the mark on a photographic background, ensure that there's enough contrast between the mark and the image to be able to see it.

Use of the Health Insurance Marketplace Logo with Other Logos

If the Health Insurance Marketplace identity mark is used on the same page as the HHS seal and/or a state logo or seal, the Health Insurance Marketplace identity mark should be equal in size to the other logos.

Example of Use with the DHHS Logo

The DHHS logo should always be placed to the left of the Health Insurance Marketplace mark. The example below is the appropriate use of the Health Insurance Marketplace identity mark for a State Partnership Marketplace.

Example of Use with the DHHS Logo and State Seal

The HHS logo should always be placed to the left of the Health Insurance Marketplace mark. Any state seal or logo should be placed to the right of the Marketplace identity mark. The example below is the appropriate use of the Health Insurance Marketplace mark with a State-based Marketplace identity mark. The use of the DHHS logo is optional for a State-based Marketplace.

If a State-based Marketplace chooses not to include the DHHS logo, the state seal or logo should be placed to the right of the Health Insurance Marketplace mark within the clear space allocation measurement, as seen below.

A Spanish version of the Health Insurance Marketplace mark is also available. All of the provisions and specifications outlined in this brand guide apply to its use.

Using the Marketplace Design Standards

CMS has developed a series of standardized design elements and treatments to use when creating materials for the Marketplace. A Marketplace DIY Identity toolkit containing fillable PDFs for fact sheets, posters, and postcards is available for download and use at **marketplace.cms.gov/outreach-and-education/tools-and-toolkits.html**. Questions about how to use the toolkit can be sent to **DesignServices@cms.hhs.gov**.

All Health Insurance Marketplace products have four standard design elements:

- The HHS logo
- The Health Insurance Marketplace logo
- A header consisting of the dark blue primary color in a curved graphic with the secondary accent color of either green, yellow or light blue
- A footer consisting of the dark blue primary color in a curved line graphic with the secondary accent color of either green, yellow or light blue

The use of the secondary color palette as accent colors designates which audience the content is intended for. Green indicates the content is intended for consumers, yellow for assisters, and light blue SHOP employers or employees. Examples of each design are below:

Getting Emergency Care

I'm having an emergency. Should I go straight to the hospital or do I need to call my insurer first?

In a true emergency, go straight to the hospital. Insurers can't require you to get prior approval before getting emergency room services from a provider or hospital outside your plan's network.

What does it mean that insurance companies can't charge me more?

Insurance plans can't make you pay more in copayments or coinsurance if you get emergency care from an out-of-network hospital. They also can't require you to get prior approval before getting emergency room services from a provider or hospital outside your plan's network.

Will I have to pay anything?

This depends on the plan that you chose and the hospital you go to. This care may be subject to a deductible, for example, or a hospital may have particular rules in place.

What if you think you signed up for a health plan through the Marketplace, but haven't received your insurance card?

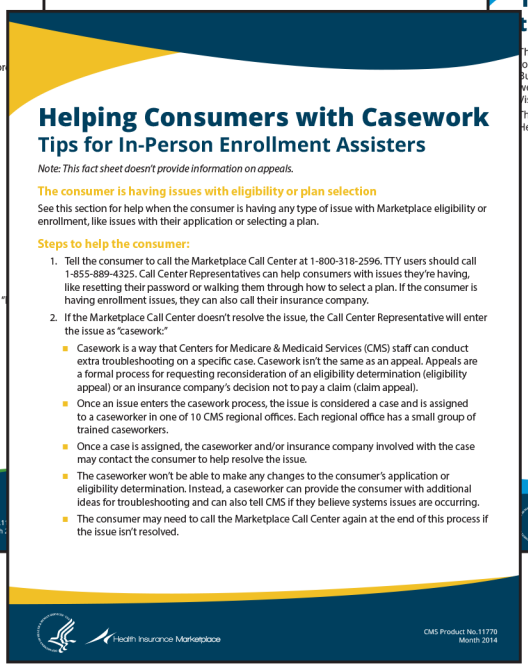
Even though you haven't received your insurance card, your coverage may be effective. Call your insurer, or have the emergency room do so, to confirm that your coverage is effective. To learn more about ensuring you are covered, read "signed up, but don't have coverage."

If you have additional questions, call 1-800-318-2596. TTY users should call 1-855-889-4325.

Health Insurance Marketplace

CMS Product No.1
Month

Consumer



Helping Consumers with Casework

Tips for In-Person Enrollment Assisters

Note: This fact sheet doesn't provide information on appeals.

The consumer is having issues with eligibility or plan selection

See this section for help when the consumer is having any type of issue with Marketplace eligibility or enrollment, like issues with their application or selecting a plan.

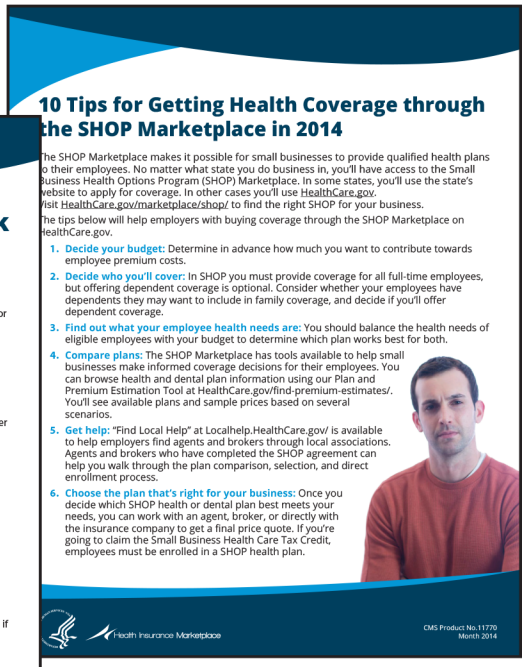
Steps to help the consumer:

1. Tell the consumer to call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. Call Center Representatives can help consumers with issues they're having, like resetting their password or walking them through how to select a plan. If the consumer is having enrollment issues, they can also call their insurance company.
2. If the Marketplace Call Center doesn't resolve the issue, the Call Center Representative will enter the issue as "casework:"
   - Casework is a way that Centers for Medicare & Medicaid Services (CMS) staff can conduct extra troubleshooting on a specific case. Casework isn't the same as an appeal. Appeals are a formal process for requesting reconsideration of an eligibility determination (eligibility appeal) or an insurance company's decision not to pay a claim (claim appeal).
   - Once an issue enters the casework process, the issue is considered a case and is assigned to a caseworker in one of 10 CMS regional offices. Each regional office has a small group of trained caseworkers.
   - Once a case is assigned, the caseworker and/or insurance company involved with the case may contact the consumer to help resolve the issue.
   - The caseworker won't be able to make any changes to the consumer's application or eligibility determination. Instead, a caseworker can provide the consumer with additional ideas for troubleshooting and can also tell CMS if they believe systems issues are occurring.
   - The consumer may need to call the Marketplace Call Center again at the end of this process if the issue isn't resolved.

Health Insurance Marketplace

CMS Product No.11770
Month 2014

Assister



10 Tips for Getting Health Coverage through the SHOP Marketplace in 2014

The SHOP Marketplace makes it possible for small businesses to provide qualified health plans to their employees. No matter what state you do business in, you'll have access to the Small Business Health Options Program (SHOP) Marketplace. In some states, you'll use the state's website to apply for coverage. In other cases you'll use HealthCare.gov. Visit HealthCare.gov/marketplace/shop/ to find the right SHOP for your business.

The tips below will help employers with buying coverage through the SHOP Marketplace on HealthCare.gov.

1. **Decide your budget:** Determine in advance how much you want to contribute towards employee premium costs.
2. **Decide who you'll cover:** In SHOP you must provide coverage for all full-time employees, but offering dependent coverage is optional. Consider whether your employees have dependents they may want to include in family coverage, and decide if you'll offer dependent coverage.
3. **Find out what your employee health needs are:** You should balance the health needs of eligible employees with your budget to determine which plan works best for both.
4. **Compare plans:** The SHOP Marketplace has tools available to help small businesses make informed coverage decisions for their employees. You can browse health and dental plan information using our Plan and Premium Estimation Tool at HealthCare.gov/find-premium-estimates/. You'll see available plans and sample prices based on several scenarios.
5. **Get help:** "Find Local Help" at Localhelp.HealthCare.gov/ is available to help employers find agents and brokers through local associations. Agents and brokers who have completed the SHOP agreement can help you walk through the plan comparison, selection, and direct enrollment process.
6. **Choose the plan that's right for your business:** Once you decide which SHOP health or dental plan best meets your needs, you can work with an agent, broker, or directly with the insurance company to get a final price quote. If you're going to claim the Small Business Health Care Tax Credit, employees must be enrolled in a SHOP health plan.

Health Insurance Marketplace

CMS Product No.11770
Month 2014

SHOP

Color Palette

The Health Insurance Marketplace design standards take a minimalist approach to the use of color. The primary colors used in Marketplace designs are blue, green, dark blue, and black. Blue has been specifically selected based on color theory to represent trust, confidence and sincerity. Blue is also used extensively to represent calmness and responsibility. Green was selected to represent new beginnings, growth and sustainment. These colors are part of the brand identity of the Marketplace and should be used as a design element that unifies multiple materials that support the Marketplace. Light blue, yellow and orange are predominantly used as secondary colors, although not a design standard requirement.

Below are the PMS and CMYK values for the Marketplace color palette:

PMS 2925	PMS 363	PMS 303	BLACK
C: 85 M: 24 Y: 0 K: 0	C: 68 M: 0 Y: 100 K: 24	C: 100 M: 11 Y: 0 K: 74	

PRIMARY COLORS

PMS 291	PMS 123	PMS 1665
C: 33 M: 3 Y: 0 K: 0	C: 4 M: 24 Y: 96 K: 0	C: 3 M: 74 Y: 81 K: 0

SECONDARY COLORS

Typography

The typography used in Marketplace communication material should be clean and simple, allowing the emphasis to be put on the content. All textual content should be as legible as possible. A san serif font is recommended for use in all material. There are many suitable and free san serif fonts readily available such as Arial, Avenir or Helvetica.

Photography

Select photos and graphics for use in Marketplace material from the point-of-view of the Marketplace consumer. Choose images featuring diversity in national origin, race, sex, age and gender. Be sure that you have the rights to use any chosen imagery in the products created for the Marketplace.

Fact Sheet Standards

Health Insurance Marketplace fact sheets should be designed using the solid white version of the HHS logo, 7/8" wide and tall, and the solid white Marketplace logo, 3" wide and 0.5" tall.

One page fact sheets should present the HHS logo with the Marketplace logo to it's immediate right in the lower left corner in the dark blue area of the footer. Multi-page fact sheets should present the HHS logo with the Marketplace logo to its immediate right in the lower left corner in the dark blue area of the footer on the last fact sheet page.

The standardized header should be present only on the first page of all fact sheets.

Getting Emergency Care

I'm having an emergency. Should I go straight to the hospital or do I need to call my insurer first?

In a true emergency, go straight to the hospital. Insurers can't require you to get prior approval before getting emergency room services from a provider or hospital outside your plan's network.

What does it mean that insurance companies can't charge me more?

Insurance plans can't make you pay more in copayments or coinsurance if you get emergency care from an out-of-network hospital. They also can't require you to get prior approval before getting emergency room services from a provider or hospital outside your plan's network.

Will I have to pay anything?

This depends on the plan that you chose and the hospital you go to. This care may be subject to a deductible, for example, or a hospital may have particular rules in place.

What if you think you signed up for a health plan through the Marketplace, but haven't received your insurance card?

Even though you haven't received your insurance card, your coverage may be effective. Call your insurer, or have the emergency room do so, to confirm that your coverage is effective. To learn more about ensuring you are covered, read "I signed up, but don't have coverage."

If you have additional questions, call 1-800-318-2596. TTY users should call 1-855-889-4325.

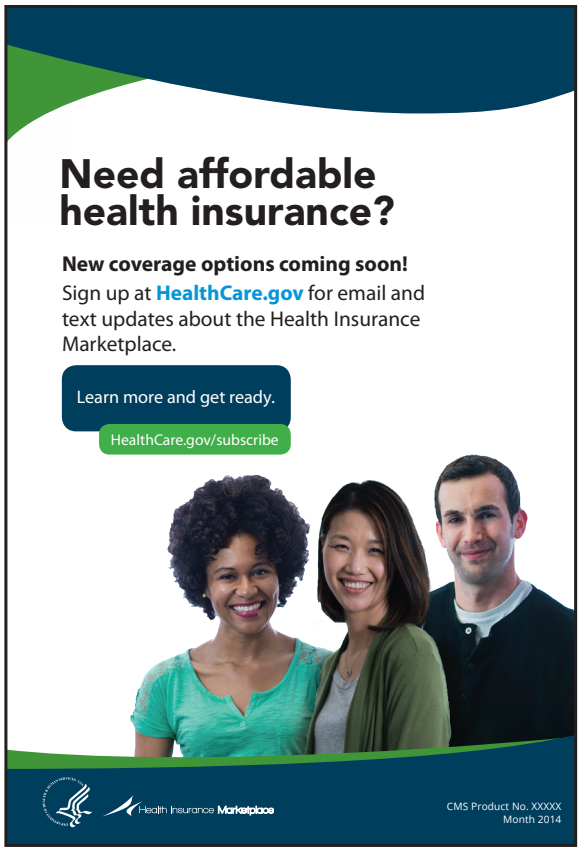
Health Insurance Marketplace

CMS Product No.11770
Month 2014

Fact sheet sample set up

Posters and Postcards Standards

Health Insurance Marketplace posters and postcards should be designed using the branded dark blue color and a secondary color in the header and footer area as well as the solid white version of the HHS logo, placed in the lower left corner in the dark blue area of the footer.



Poster sample set up

Postcard sample set up

Video Elements

Video files for download are available in several resolutions at:
http://marketplace.cms.gov/outreach-and-education/diy-video-files-480.zip
http://marketplace.cms.gov/outreach-and-education/diy-video-files-720.zip
http://marketplace.cms.gov/outreach-and-education/diy-video-files-1080.zip

These files can be used as introductions or closings on any Marketplace related video product.

The Health Insurance Marketplace
DIY DESIGN TOOLKIT

A one stop shop for do-it-yourself Marketplace branded marketing material

Become a Brand Champion

There are some communications materials that CMS must create and others you can create yourself following a few simple guidelines. The more we become “brand champions,” the better we’re able to define and differentiate the program from other programs run by CMS and from similar programs run by organizations outside of the federal government.

DIY PROJECTS

There are many internal-facing, short-term and/or quick-turnaround communications projects that you may prefer to create yourself. These include:

- **POSTERS**
- **FLYERS**
- **VIDEO GRAPHICS**
- **FACT SHEETS**
- **POSTCARDS**

Materials that you create yourself should reflect the Marketplace brand using the templates in this toolkit. If you need more guidance, you can download the complete **Marketplace brand guide here**.

PRINT AND PRESENTATION TEMPLATES

Following are some basic templates that you can use as a starting point to create your own promotional materials. Each template is branded to reflect the Health Insurance Marketplace brand guide and includes Department of Health and Human Services logo and the Health Insurance Marketplace logo.

Click on the links below to download zipped files that contain each of the product versions listed.

POSTER, 24” X 36” (FILLABLE ADOBE ACROBAT PDF)

- *African American/Female*
- *African American/Male*
- *Asian/Female*
- *Asian/Male*
- *Caucasian/Female*
- *Caucasian/Male*
- *Diverse Adult Group*
- *Indian/Female*
- *Latina/Female*

POSTER, 11” X 17” (FILLABLE ADOBE ACROBAT PDF)

- *African American/Female*
- *African American/Male*
- *Asian/Female*
- *Asian/Male*
- *Caucasian/Female*
- *Caucasian/Male*
- *Diverse Adult Group*
- *Indian/Female*
- *Latina/Female*

FLYER, 8.5” X 11” (FILLABLE ADOBE ACROBAT PDF)

- *African American/Female*
- *African American/Male*
- *Asian/Female*
- *Asian/Male*
- *Caucasian/Female*
- *Caucasian/Male*
- *Diverse Adult Group*
- *Indian/Female*
- *Latina/Female*

POSTCARD, 7” X 5” (FILLABLE ADOBE ACROBAT PDF)

- *African American/Female*
- *African American/Male*
- *Asian/Female*
- *Asian/Male*
- *Caucasian/Female*
- *Caucasian/Male*
- *Diverse Adult Group*
- *Indian/Female*
- *Latina/Female*
- *No Photos*

- FACT SHEET, 8.5” X 11” (CUSTOMIZABLE WORD DOCUMENT), NO PHOTOS
- HEADER AND FOOTER GRAPHICS

DIGITAL VIDEO TEMPLATES

Digital video graphic templates are available for download in a variety of resolutions. You can use the video slate files as introduction or closing graphics. You can use lower 3rd title graphics to present information to support video presentations.

To download static and animated video slates and lower 3rd graphics, click on the links below.

- 480 RESOLUTION
- 720 RESOLUTION
- 1080 RESOLUTION

DIY TOOLKIT FAQS

1. Who can I contact with questions about these templates?

You may contact CMS' Division of Design Services with any questions about the Marketplace brand and templates by e-mailing **DesignServices@cms.hhs.gov**.

2. How do I print these materials?

You have several options for printing your DIY project. You may use an office or personal printer or a local printing business. If you need a file with crops and bleeds for a professional printer, contact **DesignServices@cms.hhs.gov**. You may also share the file electronically via e-mail or by posting the file on the web.

3. How do I get started creating my own materials?

Download one of the templates and simply type your own content into the text boxes. Save the file as a PDF and print!

4. I don't have professional design software. Can I still create something to use?

Professional design software isn't required to use these downloadable templates. Posters, postcards and flyers are available as fillable PDFs. Fact sheet templates are available as Microsoft Word files.

5. Are these materials 508 compliant?

All Marketplace customizable PDFs created by CMS' Design Services are 508 compliant. Once you customize these files, you will be responsible for ensuring that they are 508 compliant, if required. More information about 508 compliance can be found at **www.section508.gov**.