

MARKETPLACE ASSISTER TOOLKIT

The Assister's Standard Operating Procedures Manual





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1.0 Introduction & Instructions for Use

1.1 Welcome

The Centers for Medicare & Medicaid Services (CMS) aims to ensure that all consumers have access to high-quality, affordable health coverage options through a Health Insurance Marketplace. Assisters play a critical role in meeting this goal, and CMS appreciates your support in this effort.

As an assister, you serve as a trusted resource to educate consumers and answer their questions about health coverage offered through the Marketplaces. Assisters help to ensure that consumers have positive and successful experiences as they complete Marketplace eligibility and enrollment activities.

1.2 Purpose of the Manual

The *Standard Operating Procedures Manual for Assisters* in the Federally-facilitated Marketplace, including State Partnership Marketplaces (Manual) is an instructional guide intended for assisters. In this Manual, the term “assisters” refers to certified application counselors (CACs), Navigators, and non-Navigator assistance personnel who help consumers with eligibility and enrollment activities in the Federally-facilitated Marketplace, including State Partnership Marketplaces. This Manual contains standard operating procedures (SOPs) for assister activities within the Federally-facilitated Marketplace for the individual market. The SOPs reflect requirements and policies contained within the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the Affordable Care Act), as well as CMS regulations and implementing guidance.

This Manual is not intended to take the place of the statutes, regulations, and formal policy guidance upon which it is based. It summarizes current policy and operations as of the date it was published. We encourage assisters to refer to these statutes, regulations, and interpretive guidance for complete and current information about the requirements that apply to them.

The instructions and information included in this Manual provide guidance on how to help consumers in the Federally-facilitated Marketplace for the individual market with activities such as:

- Preparing, completing, and updating Marketplace applications for health coverage;
- Enrolling in health coverage through a Marketplace;
- Understanding eligibility determinations for enrollment in health coverage through a Marketplace application;
- Resolving data-matching issues (DMIs);
- Renewing eligibility and enrollment for health coverage through a Marketplace; and
- Learning how to complete requests for exemptions and appeals.



1.3 Updates to the Manual

The Center for Consumer Information & Insurance Oversight (CCIIO) within CMS maintains this Manual in its entirety. CCIIO may alter, delete, suspend, or discontinue any part of the procedures in this Manual at any time. Procedural changes will be communicated to assisters through the Assister Newsletter and Assister Webinar, as well as through federal regulations and guidance. CCIIO will also periodically update the Manual as relevant regulations, guidance, or policies are released, and disseminate updated versions of the Manual to assister organizations. As an assister, you should refer to your assister organization's policies and guidelines for specific instructions on how to obtain new versions of the Manual. CMS plans to provide updated versions of the Manual on [Marketplace.CMS.gov](https://www.cms.gov/Marketplace).

1.4 Instructions for Use

The Manual can either be used as an electronic document or as a stand-alone paper document. Key features such as the Table of Contents, Index, and color-coding allow for easy navigation of the document in either format.

1.4.1 Electronic Document Use

When using the electronic version of the Manual, click on the hyperlinked words to navigate to a new section within the document or to open an external website. To identify hyperlinks in the body of the Manual, look for underlined words in blue font. In the Table of Contents, hyperlinks appear as normal text. In all instances, hovering over a hyperlink changes the mouse pointer to indicate the hyperlink's presence.

1.4.2 Paper Document Use

When using the paper version of the Manual, refer to the Table of Contents and the Index to navigate to the page containing the information you need. The Table of Contents provides an overview of the document by sections and subsections, while the Index catalogues a list of keywords and topics found within the document.



2.0 Consumer Protections

This section provides an overview of some of the consumer protections that apply when you help consumers, specifically:

- Privacy and security guidelines;
- Fraud prevention guidelines; and
- The complaint and grievance process.

2.1 Privacy & Security Guidelines

When you help consumers apply for health coverage through the Marketplace, they may provide personal information to you. Consumers should be able to trust you to handle their personal information with care. Some of this information will be personally identifiable information (PII). The term “personally identifiable information” refers generally to information used to distinguish or trace an individual's identity. Examples of PII include the consumer's name, Social Security number, date of birth, address, income, protected health information, and tax information. Another way to think about PII is that this information alone, or when combined with other personal information, can be linked to a specific individual.

Note: If you are working for a non-Navigator organization in a State Partnership Marketplace, please contact your state Marketplace for more information about what privacy and security standards apply to you.

2.1.1 Personally Identifiable Information

Review the guidelines in this section to understand your role in protecting consumers' PII and to be aware of situations in which you may come into contact with PII. Also review [How to Obtain a Consumer's Authorization before Gaining Access to Personally Identifiable Information \(PII\)](#) for more information on obtaining consumers' authorization prior to accessing their PII.

The guidance in this section supplements privacy and security standards that are specifically listed or incorporated in your or your organization's agreement with CMS, as required under 45 CFR § 155.260(b), and/or in your agreement with your organization. Additionally, under CMS regulations, you must obtain a consumer's authorization (also referred to in this document as consent) prior to accessing a consumer's PII (see [SOP-1, Receive Consent Before Accessing Consumer PII](#)). You are allowed to access, keep, and use consumer PII to carry out your assister “authorized functions,” which are listed in the privacy and security standards, as well as for any other purpose for which a consumer has provided specific consent, consistent with applicable law. In the event that you encounter a consumer's PII, you must adhere to all applicable privacy and security standards. Your responsibilities include:

- Knowing, understanding, and complying with the privacy and security standards in any grant, contract, or agreement between CMS and you and/or your assister organization, and/or in the terms and conditions of any contract or agreement between you and your assister organization.
- Recognizing and protecting consumers' private information, including PII, and any other sensitive information that belongs to consumers.
- Informing consumers how their PII will be secured.



2.0. Consumer Protections (continued)

- Obtaining consumers' authorization (or consent) prior to gaining access to their PII, and maintaining a record of such authorization for at least six years (unless a different and longer retention period has already been provided under other applicable federal law); and informing consumers that they can revoke this authorization at any time.
- Providing consumers with a written privacy notice statement that has been developed by your organization (or ensuring that your organization has provided consumers with this privacy notice statement) prior to collecting PII or other information from them in connection with carrying out your assister duties. However, the privacy notice statement doesn't need to be provided to consumers prior to collecting their name, physical address, email address or telephone number if that information is being used solely for making future contact with the consumer to carry out an authorized function, such as setting up an appointment, or to send them educational information directly related to your authorized functions.
- Only sharing consumers' PII with other individuals or organizations as authorized by the terms and conditions of any grant, contract, or agreement between CMS and you and/or your organization; the terms and conditions of any contract or agreement between you and your assister organization; or with a consumer's express consent.
- Maintaining an accounting of any and all disclosures of PII if you maintain and/or store PII, except for those disclosures that are necessary when carrying out your authorized functions. Your accounting should contain the date, nature and purpose of such disclosures, and the name and address of the person or agency to whom the disclosure is made. You should retain the accounting for at least six years after the disclosure, or the life of the record, whichever is longer. This accounting will need to be made available to CMS or the consumer who is the subject of the record, upon request.

You may come across consumers' PII when you:

- Obtain consumers' authorization to provide assistance;
- Assist consumers with creating an account through the Marketplace;
- Assist consumers with the eligibility application for Marketplace health coverage; and/or
- Assist consumers with an application for an exemption from the individual shared responsibility payment or with an eligibility appeal request.

Some requests or collections of PII are prohibited, however. For example, you and your organization are not permitted to:

- Request or require a Social Security number, information regarding citizenship, status as a U.S. national, or immigration status for any individual who is not seeking coverage for himself or herself on an application.
- Request information from or concerning any individual who is not seeking coverage for himself or herself, unless that information is necessary for the Marketplace eligibility application, or is required as part of a Small Business Health Options Program (SHOP) employer application. Examples of necessary information include contact information, addresses, tax filing status, income and deductions, access to employer-sponsored coverage, familial or legal relationship, American Indian or Alaska Native status, or pregnancy status for individuals who are in a consumer's tax household or who live with a consumer applying for coverage.
- Use consumers' PII to discriminate against them, such as by refusing to assist consumers who have significant or complex health care needs.

Exhibit 1 is a resource to answer common questions from consumers about assister use of PII in the Marketplace.



Exhibit 1 – Common Consumer Questions about Assister Use of PII

Why might you ask to see my PII?	What will happen with my PII?	What will NOT happen with my PII?
<ul style="list-style-type: none"> To help a consumer apply for eligibility for health coverage through a Marketplace To help a consumer apply for eligibility for programs to lower costs of health coverage To help a consumer identify qualified health plan (QHP) options available through a Marketplace To schedule appointments with consumers To provide assister services in a culturally and linguistically appropriate manner, and/or in a manner that is accessible to persons with disabilities 	<ul style="list-style-type: none"> Information will be used only for purposes related to the assister's authorized functions, or with the consumer's express consent At any time, consumers can limit or revoke their authorization for an assister to have access to their information Information will be retained by the assister in a manner that complies with privacy and security standards Information will be stored securely and used appropriately according to Marketplace guidelines. For example, assisters will retain a record of the consumer's authorization for at least six years 	<ul style="list-style-type: none"> Information will not be used for purposes unrelated to the assister's authorized functions or for purposes to which a consumer hasn't consented

2.1.2 Tips for Protecting PII

Here are some tips that will help you protect consumers' PII.

Handling PII

- You are required to keep or store any copies of documents containing a consumer's PII only in a manner that is consistent with the privacy and security standards that apply to you. If you need to keep a consumer's document containing PII to carry out an authorized function, it's a good idea to keep a copy and return the originals to the consumer.
- You may use or disclose PII only to carry out your authorized functions or subject to specific consumer consent.
- If you send information that may contain PII to other individuals or organizations, you may do so only to carry out your authorized functions or subject to specific consumer consent, and must do so in a manner that is consistent with the privacy and security standards that apply to you.
- It's not a good idea to leave files or documents containing PII where others could inadvertently see them. As a best practice, pick up documents that contain PII promptly from printers and fax machines, and secure any documents that contain PII before leaving your desk or workstation.
- When assisting consumers who will be mailing their PII (such as a hard copy Marketplace application), advise them that it's a good idea to use an opaque envelope or container, and, if possible, use a traceable delivery service.
- When assisting consumers who will be faxing PII, it's a good idea to double check that the recipient's fax number is correct and that someone is able to receive the faxed information promptly.
- Remind consumers they should keep their PII in a secure place that they will remember.
- If consumers mistakenly or accidentally leave behind PII at a facility or enrollment event, we recommend that you store the PII securely, and return it to consumers as soon as possible.



- If it is not possible to return PII to a consumer and the PII is not in the form of an original document (such as an original Social Security card or government-issued identification card), we recommend that you consider destroying the PII and maintaining a record of its destruction. If the PII is in the form of an original document like a Social Security card or government-issued identification card, we recommend that you return the document to the agency or entity that issued it and keep a record of its submission to that agency.
- Assisters should use e-mail accounts, websites, and mobile devices in a manner consistent with their organization's implementation of the privacy and security standards when collecting, transmitting, or accessing PII.
- As a best practice, clear your web browser history after using your browser to access PII, so that another person using the same computer and web browser does not inadvertently access the PII.
- Use passwords to protect electronic accounts that may contain PII, as well as any additional safeguards to protect electronic accounts, consistent with your organization's implementation of the privacy and security standards. Remind consumers to do the same.

Reporting a Breach of PII

- Your organization must have its own breach and incident handling procedures that are consistent with [CMS's Risk Management Handbook Standard 7.1 Incident Handling and Breach Notification](#). These procedures should identify the designated Privacy Official for the organization, and/or identify other personnel who are authorized or responsible for reporting and managing privacy and security incidents or breaches to CMS.
- You must comply with your organization's breach and incident handling procedures.
- Your organization's breach and incident handling procedures must address how to identify an "incident." Generally, an "incident" is the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data, and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.
- If an incident occurs, your organization's policies and procedures should be followed to determine if PII is involved in the incident.
- If you discover that a breach or potential breach of PII has occurred, you should immediately report this to your organization's designated Privacy Official and/or any other person who has been identified as responsible for reporting or managing a breach of PII.
- Your organization must report any incident or breach of PII to the CMS IT Service Desk by telephone at (410) 786-2580 or 1-800-562-1963 or via email notification at cms_it_service-desk@cms.hhs.gov within one hour of discovery of the incident or breach.
- In addition, your organization must complete a [CMS Security Incident Report](#).
- You and your organization must cooperate with CMS in resolving any incident or breach and provide details regarding identification, response, recovery, and follow-up of incidents and breaches. Your organization must also make its designated Privacy Official or other authorized personnel available to CMS upon request.



2.2 Fraud Prevention Guidelines

The Marketplace is committed to providing accurate information about health coverage options and providing enrollment assistance to consumers. As you assist consumers, you should be aware of potential instances of fraud and help consumers understand how to avoid it.

Consumers may make mistakes when completing their eligibility application or paying their premiums to health insurance companies. Fraud, however, can occur when someone falsifies information, for example on an eligibility application. Fraud can also occur if someone uses another person's personal information as their own to receive health coverage (this type of fraud is also known as "identity theft"). If you suspect or are aware of fraud, you should report it to your organization and refer to the resources listed in Exhibit 2 to report fraud.

Use these guidelines to help prevent fraud and identity theft from occurring, and to learn how to report fraud when you suspect it has occurred.

2.2.1 Preventing Fraud

To help prevent fraud from occurring, encourage consumers to:

- Accurately report all sources and amounts of income on eligibility applications;
- Accurately report their age, tobacco usage, and address on eligibility applications;
- Protect their Social Security numbers;
- Shred documents containing health information or other PII before throwing them away;
- Never give out information over the telephone or Internet unless the requestor has proven they have authority to have this information (e.g., a health insurance company, the Marketplace);¹
- Review charges, bills, and explanations of benefits to ensure all charges for services, equipment, and prescriptions are accurate;
- End any suspicious calls or visits immediately;
- Report suspicious calls or visits to the Marketplace Call Center; and
- Read [How Can I Protect Myself from Fraud in the Health Insurance Marketplace](#) for additional information on how they can protect themselves against Marketplace fraud.

2.2.2 Recognizing Fraud

Use these examples to help you recognize potentially fraudulent situations:

- Consumers who purposely underreport their income or fail to report all sources of income.
- Consumers who purposely do not report an accurate level of tobacco use to attempt to change the cost of health coverage.
- Consumers who use another person's information to get health coverage through the Marketplace.
- An agent, broker, or assister falsifies information to mislead a consumer into joining a health plan.

¹ Eligibility support staff from SERCO Inc. will make direct phone calls to consumers to verify information on consumers' eligibility applications. Inform consumers that SERCO Inc. will protect consumers' information if shared over the phone. For more information, including the phone numbers Marketplace representatives may be calling from and questions they might ask, visit: <https://www.HealthCare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/>.



- Someone who has made an unsolicited request for consumers’ personal information fraudulently claiming that they will enroll them in QHPs sold through the Marketplace.
- Someone claiming to be an agent, broker, or assister who sends a consumer an e-mail that asks for personal information.

2.2.3 Reporting Fraud

If you or a consumer thinks fraud may have occurred, use the following resources to report it:

Exhibit 2 – Resources to Report Fraud

Resource	Contact Information	Description
HHS Office of the Inspector General (OIG)	<ul style="list-style-type: none"> • Online: HHS OIG Fraud Hotline² • 1-800-HHS-TIPS (1-800-447-8477) • TTY: 1-800-377-4950 	To report that a consumer’s information was used to enroll someone else in the Marketplace
The Federal Trade Commission (FTC)	<ul style="list-style-type: none"> • Online: Secure Complaint Form³ • 1-877-ID-THEFT (1-877-438-4338); • TTY: 1-866-653-4261 	To report identity theft
State Department of Insurance (DOI)	<ul style="list-style-type: none"> • Your local State Department of Insurance 	To report agent/broker fraud
Federally-facilitated Marketplace Call Center	<ul style="list-style-type: none"> • 1-800-318-2596; • TTY: 1-855-889-4325 (all languages available) 	To report that a consumer received suspicious calls or visits, or to report fraudulent conduct by an assister

2.3 Complaint & Grievance Process

If consumers approach you about filing a complaint or grievance related to the conduct of Marketplace-approved assisters they have worked with during the eligibility and enrollment process, direct them to submit an e-mail to assistercomplaints@cms.hhs.gov. For example, consumers who are not pleased with the help they received from a Navigator can submit an e-mail detailing their complaint.

Additionally, if you have knowledge of assister misconduct, such as another assister requesting payment from a consumer in return for helping to enroll the consumer in a QHP, you should contact CMS. Navigators and non-Navigator assistance personnel who wish to file a complaint or grievance should contact their Project Officer or point of contact at CMS. All other assisters, including CACs, should direct their complaint or grievance to the CAC inbox at CACQuestions@cms.hhs.gov

² <https://forms.oig.hhs.gov/hotlineoperations/>

³ <https://www.ftccomplaintassistant.gov>



3.0 Individual Marketplace SOPs

The SOPs contained in this section provide guidance to help you assist individuals who select and purchase their health coverage through the Federally-facilitated Marketplace for the individual market. Individuals may request assistance with the process to apply for Medicaid or the Children’s Health Insurance Program (CHIP); identify, compare, and select QHPs; or complete a number of other eligibility and enrollment activities.

Each SOP adheres to the following general structure:

- A. Introduction:** Outlines general task(s) and describes the SOP topic.
- B. Procedures:** Provides step-by-step instructions, tables, and graphics to guide assisters as they help consumers complete Marketplace activities.
- C. Next Steps:** Identifies next steps or associated SOPs that assisters can reference to further assist consumers with Marketplace activities.

Use the Table of Contents below to navigate to the SOP needed to provide consumer assistance:

SOP-1. Receive Consent Before Accessing Consumer PII 10

SOP-2. Assess Consumers’ Knowledge & Needs 14

SOP-3. Create an Account 17

SOP-4. Verify Identity..... 21

SOP-5. Apply for Health Coverage 26

SOP-6. Review Eligibility Results..... 36

SOP-7. Lower Costs of Coverage 41

SOP-8. Compare, Save, & Select Health Plans..... 48

SOP-9. Pay Health Plan Premium 58

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SOP-1. Receive Consent Before Accessing Consumer PII

A. Introduction

As an assister, you must receive a consumer's consent (referred to in CMS regulations as authorization) before accessing his or her PII, and must inform consumers of the functions and responsibilities of your assister type (Navigator, non-Navigator assistance personnel, or CAC). This is an essential step to ensure that consumers are making an informed decision to share their PII with assisters. As a best practice, to ensure that you receive informed consent from consumers, first have a conversation with consumers about your roles and responsibilities as an assister, including all the consumer protection standards that apply to your assister type through CMS regulations, such as conflict of interest requirements, rules about accepting payment and providing gifts, etc.

Next, ask consumers to provide consent by completing a consumer consent form. A model consumer consent form for [Navigator grantees](#) and [CAC-designated organizations](#) is available at Marketplace.CMS.gov and can be used to obtain written consent from each consumer you assist. Your organization might have a consumer consent form that you can use each time you assist a consumer. If you obtain consent verbally, you should keep a written record of the consent as described in procedures below. These forms are also available in Spanish at: <https://Marketplace.CMS.gov/technical-assistance-resources/assister-programs/guidance-regulations-on-assister-programs.html>.

You must follow the privacy and security standards that apply to your assister type; these are contained in the terms and conditions of the grant, contract, or agreement between CMS and you and/or your organization; and/or the terms and conditions of the contract or agreement between you and your assister organization. You must also comply with these and other applicable standards or policies, including your organization's privacy and security policies, when collecting and storing consent forms. Note that all assister organizations are federally required to store written consumer consent forms and other records of consumer authorization for at least six years, unless a different and longer retention period has already been provided under other applicable federal law. For more information on obtaining consumers' authorization to access their PII, see the guidance available at Marketplace.CMS.gov/technical-assistance-resources/obtain-consumer-authorization.pdf.

The remainder of this SOP provides guidance on how to receive informed consent before assisting consumers.

B. Procedures

1. Inform Consumers of Your Assister Roles and Responsibilities

Inform consumers of the functions and responsibilities that apply to your specific assister type (e.g., Navigator, CAC), including all the consumer protection standards that apply through CMS regulations to your assister type, such as:

- a. The requirement to provide information and services in a fair, accurate, and impartial manner;
- b. Conflict of interest requirements;
- c. Rules about accepting payment and providing gifts;
- d. Rules about unsolicited direct contact with consumers, including "robo-calls;" and



- e. Rules about nondiscrimination and providing culturally and linguistically appropriate services and services accessible to consumers with disabilities.

2. Review Methods of Protecting PII

Step 1. Assisters are strongly encouraged to review with consumers the privacy and security standards required under the terms and conditions of the grant, contract, or agreement between CMS and you and/or your assister organization; and/or the terms and conditions of the contract or agreement between you and your assister organization. Explain to the consumer:

- a. PII is information which can be used to distinguish or trace an individual's identity, such as their name, Social Security number, and biometric records, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name;
- b. Assisters and assister organizations are required to follow privacy and security standards to protect consumers' PII;
- c. What your authorized functions are, as set forth in the terms and conditions of the grant, contract, or agreement between CMS and you and/or your assister organization; and/or the terms and conditions of the contract or agreement between you and your assister organization; and
- d. Assisters might access their PII, such as their names, dates of birth, financial information, and Social Security numbers when the assisters carry out their authorized functions.

Step 2. Explain the methods you will use to protect consumers' PII.

- a. CMS permits you to access, keep, and use consumer PII only to carry out your authorized functions, or with a consumer's specific consent. In the event that you encounter a consumer's PII, you must adhere to all applicable privacy and security standards. If you are authorized to share consumers' PII with individuals or entities, you will share only the minimum necessary consumer information.
- b. You will take precautions while handling consumers' PII to protect their confidentiality.
- c. When disposing of physical or electronic copies of consumers' PII, you will adhere to all privacy and security standards that apply to you.

Step 3. Answer consumers' questions about the privacy and security of the PII they share with you. If needed to answer consumers' questions, refer to the model consumer consent form; your organization's Privacy Notice Statement; or the terms and conditions of your Navigator organization's grant, non-Navigator assistance personnel contract, the agreement between you and your CAC organization, or your CAC organization's agreement with CMS.

3. Discuss Consumers' Responsibilities

Step 1. Assisters are strongly encouraged to remind consumers that they have certain responsibilities when applying for health coverage through the Marketplace.



SOP-1. Receive Consent Before Accessing Consumer PII

- a. Consumers must provide complete and accurate information on the Marketplace eligibility application.
- b. Consumers must accurately report all required sources and amounts of income.
- c. Consumers should not ask assisters to misrepresent consumers' information while applying for health coverage.
- d. Consumers must notify the Marketplace of any inaccurate information included on their eligibility application.

4. Obtain Consumers' Consent

Step 1. You can obtain a consumer's consent orally and/or in writing, or use the model form provided by CMS. At a minimum, the consent should include the following:

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

We also recommend that the authorization include:

- d. An explanation of what PII includes and examples of the kinds of PII you may request from the consumer;
- e. An acknowledgment that the consumer is not required to provide you with any PII;
- f. An explanation that the help you provide is based only on the information the consumer provides, and that if the information given is inaccurate or incomplete, you might not be able to offer all the help that is available for the consumer's situation;
- g. An acknowledgment that you will ask only for the minimum amount of PII necessary for you to carry out your functions and responsibilities; and
- h. Any applicable specific consents to obtain access to consumer PII for CMS-approved purposes that are not already captured in the list of purposes set forth in the terms and conditions of your Navigator organization's grant, non-Navigator assistance personnel contract, the agreement between you and your CAC organization, or your CAC organization's agreement with CMS.

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



5. Check Consumers' Understanding and Complete Consent Form

- Step 1.** Ask consumers if they have any questions about the information and/or form you have shared with them, and answer their questions. It's a good idea to have the consumer verbally confirm that they understand what you have told them before they sign the form.
- Step 2.** Ask consumers to read and sign your organization's consumer consent form before proceeding with consumer assistance. When you obtain consent verbally (e.g., over the phone), explain to the consumer the consent components (as described above), obtain consent, and make a written record of the consent.⁴ The record of the consumer's consent should contain, at a minimum, the consumer's name (and, if applicable, the name of the consumer's authorized representative); the date the consent was given; your name and/or the name of the assister to whom the consent was given (and the names of any other assisters that the consumer authorized to access his/her PII); notes regarding limitations, if any, the consumer makes on the scope of the consent provided; and notes recording all acknowledgments and consents obtained from the consumer, including any applicable specific consents to access consumer PII for CMS-approved purposes that are not already captured in the list of purposes set forth in your agreement with CMS and/or your organization.
- Store a signed copy of the consumer consent form or record of authorization (paper or electronic) for at least six years and in a secure manner in accordance with your agreement with CMS and/or your organization. If any changes are later made to the consent, including if and when a consumer revoked the consent, or any part thereof, this should be included with the original record.
 - It is strongly recommended that you provide the consumer with a copy of the signed consumer consent form (or, if applicable, the record of a verbally given consent).

C. Next Steps

- Proceed to [SOP-2 Assess Consumers' Knowledge & Needs](#) to assess the type of assistance consumers require.
- For more help answering consumers' specific questions, see the [Frequently Asked Questions \(FAQs\) related to SOP-1 Receive Consent to Access Consumer Information](#).

⁴ You may obtain consumers' consent verbally by reading them your organization's standard written consent form or a script that contains, at a minimum, the required elements of the authorization that are summarized above. You must record in writing that the consumer's consent was obtained. The record of the authorization must include at a minimum, the required components summarized in Item 5, Step 2. Assisters are strongly encouraged to create a record of the authorization as it is being provided, and then read back the content of the record to the consumer once it is complete, so that the consumer can confirm that the record is accurate and complete, and correct it if it is not. Assisters are also strongly encouraged to provide a copy of the record to the consumer at the earliest available opportunity.



SOP-2. Assess Consumers' Knowledge & Needs

A. Introduction

After receiving consumers' consent and before providing assistance, it is a best practice to walk through the steps outlined below to assess consumers' knowledge of health coverage, the Affordable Care Act, and the Marketplace, as well as to understand their needs. This assessment will also help you understand the type of support consumers require so that you can tailor your assistance to their needs.

B. Procedures

1. Assess Consumers' Knowledge

Step 1. Have a conversation with consumers to gauge their knowledge of health coverage, the Affordable Care Act, and the Marketplace. The *Knowledge Checks* and *Sample Questions* listed in Exhibit 3 provide ideas to help you start a conversation to assess consumers' understanding.

Exhibit 3 – Knowledge Assessment Guide

Knowledge Category	Knowledge Checks	Sample Questions
Health Coverage	<p>Determine if consumers:</p> <ul style="list-style-type: none"> Understand the basics of health coverage. Know that for individual market health insurance, consumers and insurance companies pay for health care. Understand key terms, such as premiums, deductibles, coinsurance, and copayments. Know that insurance companies contract with different networks of doctors, and that the consumer's health care provider may not be included in some insurance companies' networks. 	<ul style="list-style-type: none"> What questions do you have about health coverage? How have you managed your health care costs in the past? Do you understand how premiums, deductibles, coinsurance, and copayments function? Do you have a doctor you see regularly? How would you feel if you had to see a new or different doctor?



Knowledge Category	Knowledge Checks	Sample Questions
Affordable Care Act	<p>Determine if consumers:</p> <ul style="list-style-type: none"> • Are aware of the effects of the Affordable Care Act on their health coverage. • Are aware of the preventive services available to them without cost sharing when they have non-grandfathered coverage. • Understand that there are now limits on the amount they will pay in cost sharing for essential health benefits each year under non-grandfathered coverage. • Are aware that they can no longer be denied coverage or charged more for having a pre-existing medical condition. • Understand the individual shared responsibility payment. • Know the exemptions available from the individual shared responsibility payment and how to apply for an exemption if they think they might be eligible. 	<ul style="list-style-type: none"> • What have you heard about the Affordable Care Act? • What questions do you have about the effects of the Affordable Care Act on you and your family? • Do you understand the consequences for consumers who do not meet the requirement to have health coverage? • Are you aware that some consumers may be exempt from the requirement to obtain health coverage?
Marketplace	<p>Determine if consumers:</p> <ul style="list-style-type: none"> • Understand the eligibility requirements for health coverage, tax credits, and cost savings available through the Marketplace. • Are aware of the key dates for the Marketplace's annual Open Enrollment period, during which any consumer can apply for health coverage. • Are aware of the different health coverage options. • Are aware of the available programs to lower the costs of health coverage. • Understand the essential health benefits covered by all QHPs offered through the Marketplace. 	<ul style="list-style-type: none"> • What questions do you have about applying for and enrolling in health coverage through the Marketplace? • Are you aware of the start and end dates for the Marketplace's annual Open Enrollment period? • How can I help you apply for health coverage? • What questions do you have about the health coverage available through the Marketplace? • What are your concerns about paying for coverage? • Are you aware of the types of services covered by health coverage available through the Marketplace?

2. Assess Consumers' Needs

Step 1. Have conversations with consumers to learn about their health coverage status, any questions they might have about the enrollment process, and problems they might have with completing their Marketplace applications. During this discussion, find out:

- Whether consumers have existing health coverage and, if so, whether that coverage continues to meet their needs (e.g., if it is ending, benefits are changing, costs are changing);
- Who is in need of health coverage (e.g., consumers and/or family members);



- c. Whether consumers have started the Marketplace eligibility application process, and if they have, what stage in the application process they have reached (e.g., submitted the application, received an eligibility determination, ready to select a QHP);
- d. How consumers intend to pay for the coverage (e.g., with advance payments of the premium tax credit, with personal income); and
- e. What additional information, if any, consumers need to know about the Affordable Care Act, health coverage, or the Marketplace (e.g., how to apply for an exemption to the individual shared responsibility payment, how to make changes to their account profile).

C. Next Steps

1. If consumers require additional information about health coverage, the Affordable Care Act, or the Marketplace, refer to the appropriate section in the [Marketplace Background Guide](#) before proceeding with eligibility and enrollment activities.
2. If consumers are ready to begin eligibility and enrollment activities, proceed to the appropriate SOP(s) in this Manual.
3. For more help answering consumers' specific questions, see the [Frequently Asked Questions \(FAQs\) related to SOP-2 Assess Consumers' Knowledge & Needs](#).



SOP-3. Create an Account

A. Introduction

As an Assister, you can help consumers create an account to access the Marketplace online, submit an application for health coverage, and select a QHP. This SOP provides guidance on how to assist a consumer in creating an account.

B. Procedures

1. Create an Account

To assist consumers with creating an account, complete the following required steps:

Step 1. Assist consumers with entering the following information as shown on the screenshots below:

- a. An example of the screen consumers will see when creating their accounts is shown in Exhibit 4. Assist consumers with entering the following information on the screen:
 - i. First name (required to create an account);
 - Ensure that consumers use their given first name and not a nickname to be consistent with their Marketplace applications.
 - ii. Middle name;
 - iii. Last name (required to create an account);
 - iv. E-mail address, which will also be the consumer's username (required to create an account); and
 - v. Password (required to create an account).
- b. Explain to consumers that they must answer three security questions to protect their accounts from unauthorized access. Assist consumers with selecting security questions to protect their account.

Things You Should Know

- Consumers may change their Marketplace account passwords at any time, but consumers cannot change their usernames. If consumers need additional password or username assistance, direct them to the Marketplace Call Center.



Exhibit 4 – Marketplace Account Creation Screenshot

Create an account

Create an account to apply for and manage your Marketplace coverage.

If you already have an account, [log in](#). Don't create another account. [Get help if you're having trouble logging into your account.](#)

First name Last name

Your email address will also be your username when you log in.

Email address

Use: 8-20 characters Upper & lowercase letters Number(s)

Password

Retype password

We need you to pick a few questions that only you'll be able to answer. If you ever forget your password, we'll ask you these questions to verify your identity.

Pick a question

Answer

Pick a question

Answer

Pick a question

Answer

I understand and agree with the HealthCare.gov [privacy policy](#).

The Marketplace will automatically send you email with important information, updates and reminders about Marketplace enrollment. You can opt out of these communications at any time. To do this, click on the "unsubscribe" link in the footer of any Marketplace email.

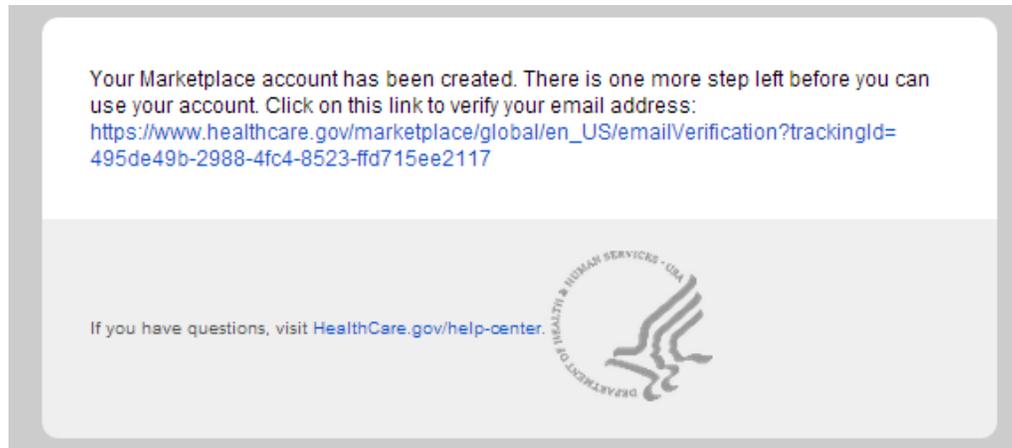
CREATE ACCOUNT

I ALREADY HAVE AN ACCOUNT

- Step 2.** Once consumers click “Create Account,” a “Check your e-mail” message will display on the same page with a reminder to click the verification link found in the consumer’s e-mail inbox to continue his/her application. Consumers cannot proceed with applying for coverage through the Marketplace before verifying their e-mail address and activating their account.
- Once consumers check their e-mail, they will see an e-mail from the sender “Health Insurance Marketplace;” the subject line of the e-mail will read “Marketplace account created.”

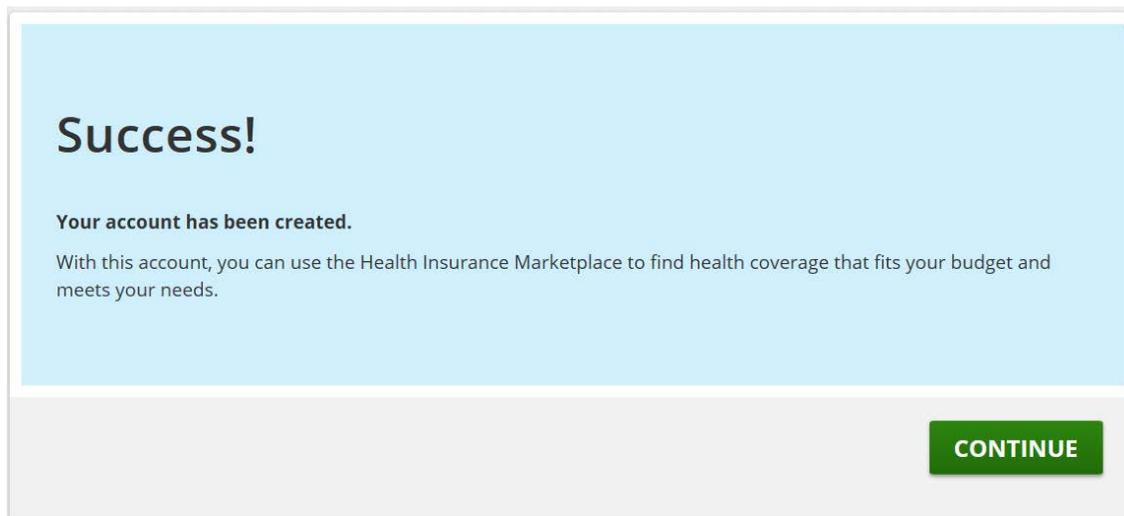


Exhibit 5 – Marketplace Account Verification E-mail



- b. Instruct consumers to click the link in the e-mail to verify their e-mail address. When they click the link, they will see the “Please wait” screen while the Marketplace finishes creating the account, and then, the account will be processed. Once consumers successfully verify their account, they will see the screen shown in Exhibit 6.

Exhibit 6 – Marketplace Account Created Screenshot





2. Troubleshooting

Consumers may receive error messages during the account creation process. Exhibit 7 provides reasons for errors encountered and steps to assist consumers in resolving the errors.

Exhibit 7 –Account Errors and Action Items

Error/Condition	Explanation & Discussion	Action Items
A profile already exists for that user	<ul style="list-style-type: none"> Explain that if consumers have previously created an account, it is stored in the Marketplace and consumers can access the account with the correct login information. Consumers can only create one account. Explain that consumers may have mistakenly entered information that belongs to another consumer's account. 	<ul style="list-style-type: none"> Assist consumers with ensuring that login information is correct and that they do not have an existing account. Consumers should contact the Marketplace Call Center or use the system prompts on HealthCare.gov to retrieve login information if an account already exists.
An account cannot be created with the information entered	<ul style="list-style-type: none"> Explain that the Marketplace requires consumers to enter information in a valid format. Explain that the system identifies each piece of information it deems missing or invalid so consumers can correct the information. Explain that consumers have the option to cancel the account creation activity. 	<ul style="list-style-type: none"> Walk consumers through each piece of information that the system has deemed missing or invalid. Help consumers correct the information or show them how to cancel the entire account creation activity.

C. Next Steps

1. If consumers would like to submit a Marketplace application or select a QHP, proceed to [SOP-54 Verify Identity](#) to complete the identity verification process required before beginning these eligibility and enrollment activities.
2. If consumers would like to perform account maintenance activities (e.g., reset password), proceed to [SOP-12 Updated Account Profile](#).
3. For more help answering consumers' specific questions, see the [Frequently Asked Questions \(FAQs\) related to SOP-3 Create an Account](#).



SOP-4. Verify Identity

A. Introduction

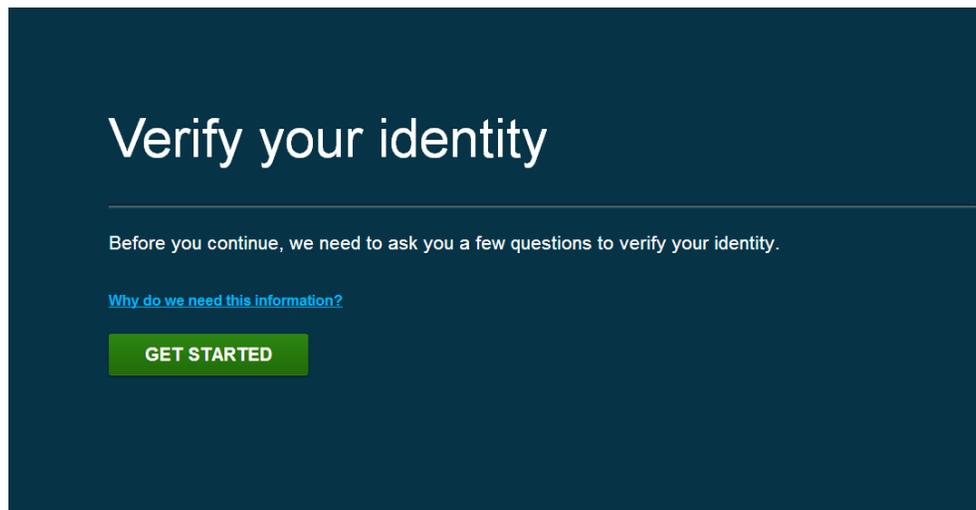
As an assister, you can help consumers verify their identities so that they are able to complete eligibility and enrollment activities such as submitting a Marketplace application or selecting a QHP. This SOP provides guidance on how to assist consumers with identity verification.

B. Procedures

1. Verify Identity

Step 1. If consumers would like to complete identity verification, assist them with logging in to HealthCare.gov and navigating to the screen shown in Exhibit 8.

Exhibit 8 – Verify Your Identity Screenshot



Step 2. After selecting the “Get Started” button, assist consumers with entering the following additional information, as shown in Exhibit 9:

- a. First name (no nicknames)
- b. Last name
- c. Phone number
- d. Date of birth (required to process an eligibility application)



SOP-4. Verify Identity

- e. Address (required to process an eligibility application)
 - i. Street
 - ii. Apartment number (if applicable)
 - iii. City
 - iv. State
 - v. ZIP code
- f. Social Security number (SSN)

Note: Although providing an SSN for the application filer can help expedite the identity proofing process, application filers who are not applying for coverage for themselves and who are not the tax filer for the household, and all individuals who do not have an SSN, are not required to provide one to the Marketplace.

As a reminder, later in the application process it will be important and strongly encouraged for non-applicants listed on the application to include an SSN if they have one, as this can help the Marketplace match applicants' information with trusted data sources to verify identity and avoid having to provide more information later.

Exhibit 9 – Marketplace Contact Information Screenshot

VERIFY YOUR IDENTITY

- 1 Contact information
- 2 Identity questions

Contact information

Tell us about yourself. Use your complete name, as it appears on legal documents (like your Social Security card).

All fields are required unless they're marked optional. Don't enter any letters with special characters, like accents, tildes, etc.

First name	Middle <i>optional</i>
<input type="text" value="Julie"/>	<input type="text"/>
Last name	Suffix <i>optional</i>
<input type="text" value="Smith"/>	<input type="text" value="Select..."/>
Date of birth	Social Security number (SSN) <i>optional</i>
<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="XXX-XX-XXXX"/>
Email address	

Step 3. Assist consumers with answering identity questions on the same page. Once consumers click “Questions Loaded” on the Verify Your Identity and Contact Information page, a set of four questions will display. Consumers must answer these questions to verify their identity and help protect their PII.



SOP-4. Verify Identity

Note: Consumers will be asked questions about their identity based on information in their consumer report maintained by Experian, a consumer reporting agency. Some of these questions may be based on a consumer's personal and financial history, so it may be helpful to prepare consumers to expect questions about their loans and other finances. Consumers must select the correct answer from a list of possible choices. Their answers will be compared with the information in their consumer report. Once consumers answer enough questions correctly, they will be able to proceed with their Marketplace application.

Note: Because identity proofing is based, in part, on a consumer's financial history, consumers may see an "inquiry" on their credit report. This will not affect their credit score.

- Step 4.** Once consumers are finished answering the questions, they need to click the "Verify My Identity" button. If they pass the identity proofing process, they will be taken to the Your Identity has been Verified page.

Note: The Privacy & Use of Your Information page lets consumers know how the information they entered will be used, and that data from other sources will be accessed to verify their information. Integrated systems will check applicants' eligibility by retrieving information from other federal agencies including the Social Security Administration (SSA) and the Department of Homeland Security (DHS). If they applied for help paying for coverage through insurance affordability programs, these integrated systems will also retrieve information from certain additional agencies, including the Internal Revenue Service (IRS), state Medicaid and CHIP agencies, and other trusted data sources.

- Step 5.** Consumers need to check the box to indicate they agree to have their information used and retrieved from the trusted data sources to verify the information provided on their applications. Then, they need to click the "Take Me to the Application" button.
- Step 6.** If online identity verification is successful, proceed to [SOP-5 Apply for Health Coverage](#) to assist consumers with beginning the application process. If online identity verification is unsuccessful, continue with Step 7.
- Step 7.** Consumers will receive a code, or reference number, on the response screen from their online application indicating that their identity verification attempt was unsuccessful. Refer consumers to the Experian Help Desk for assistance with identity proofing. Experian will need consumers' reference number from their online application. If a consumer only makes one attempt to identity proof, they may not receive their reference number until they make a second attempt. If the reference number was generated, but consumers cannot remember it when they call the Experian Help Desk, they can log back into their account and pull up their reference number. Inform consumers that they must verify their identity before they can submit an application online and receive a final eligibility determination. Direct a consumer to contact the Experian Help Desk, as shown in Exhibit 10, if the consumer's identity was not verified.



Exhibit 10 – Marketplace Identity Verification Screenshot

VERIFY YOUR IDENTITY

- 1 Contact information
- 2 Identity questions

Contact information

Important: Your attempt to verify your identity was unsuccessful. Review your information, and try again.

Tell us about yourself. Use your complete name, as it appears on legal documents (like your Social Security card).

All fields are required unless they're marked optional. Don't enter any letters with special characters, like accents, tildes, etc.

First name Middle *optional*

- If identity verification with Experian over the phone is successful, they can click the “I have verified my identity over the phone” button on HealthCare.gov, and then the consumer can submit updated contact information and click “Continue.” Proceed to [SOP-5 Apply for Health Coverage](#) to help consumers begin the application process.

If identity verification over the phone is unsuccessful, consumers will also need to click the “I have verified my identity over the phone” button and then enter in their contact information again. If the identity proofing process is unsuccessful after an additional two attempts, HealthCare.gov will display a screen for consumers to upload documents for manual verification of their identity. Please proceed to the [Submit Supporting Documentation section](#) in this manual to submit additional information to the Marketplace. (If for some reason the “Upload” button does not appear or is not working, the consumer should mail in documentation and contact the Marketplace Call Center to report the issue.) If consumers were unable to verify their identity over the phone, inform them that they must upload supporting documentation to HealthCare.gov or submit copies of supporting documentation by mail to complete the identity verification process.⁵ Consumers will be asked to submit a document with a picture ID from a list of documents which can be found in the [HealthCare.gov “Identity” section](#), and are also listed below.

Consumers can submit one of the following:

- Driver’s license issued by a state or territory;
- School identification card;
- Voter registration card;
- U.S. military card or draft record;
- Any identification card issued by the federal, state, or local government;

⁵ Consumers should mail all copies (not originals) of supporting documentation to Health Insurance Marketplace, 465 Industrial Blvd., London, KY 40750-0001. Consumers should be sure to follow the steps outlined in the Submitting Supporting Documentation section of [SOP-5. Apply for Health Coverage](#)



SOP-4. Verify Identity

- vi. U.S. passport or U.S. passport card;
- vii. Certificate of naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561);
- viii. Permanent Resident Card or Alien Registration Receipt Card (Form I-551);
- ix. Employment Authorization Document that contains a photograph (Form I-766);
- x. Military dependent identification card;
- xi. American Indian Tribal document;
- xii. U.S. Coast Guard Merchant Mariner card; or
- xiii. Foreign passport, or identification card issued by a foreign embassy or consulate that contains a photograph.

If consumers cannot provide one document with a picture ID from the list above, then the consumers must submit two documents from the list below:

- i. Birth certificate;
- ii. Social Security card;
- iii. Marriage certificate;
- iv. Divorce decree;
- v. Employer identification card;
- vi. High school or college diploma; or
- vii. Property deed or title.

Note: If a consumer is unable to successfully verify his or her identity, this does not prevent the consumer from completing an application and enrolling in coverage. Consumers who have gone through the steps above and continue to have issues verifying their identity should call the Marketplace Call Center and complete the online application with a Call Center Representative.

For more information about submitting documents, see the presentation on "[Tips for Submitting Supporting Documents to the Health Insurance Marketplace.](#)"

C. Next Steps

1. If consumers would like to begin the eligibility application process, proceed to [SOP-5 Apply for Health Coverage.](#)
2. For more help answering consumers' specific questions, see the [Frequently Asked Questions \(FAQs\) related to SOP-4 Verify Identity.](#)



SOP-5. Apply for Health Coverage

A. Introduction

As an assister, you can help consumers apply for health coverage through the Marketplace. When consumers apply, the Marketplace will consider the application for eligibility for a number of things. If consumers apply for help paying for coverage, the Marketplace will check for their eligibility for advance payments of the premium tax credit, cost-sharing reductions, and Medicaid or CHIP. Consumers can apply for enrollment in QHPs with or without advance payments of the premium tax credit and cost-sharing reductions. For more information on applying for health coverage through the Marketplace, refer to the [Marketplace Background Guide](#). This SOP provides guidance on how to assist consumers in completing their applications.

Things You Should Know

- Encourage consumers to use the electronic application feature to receive their eligibility determinations faster.

B. Procedures

1. Complete Online Application

To assist consumers with their online eligibility application, complete the following steps:

- Step 1.** If consumers do not yet have a HealthCare.gov account, proceed to [SOP-3 Create an Account](#) to assist consumers with account creation. If consumers have a HealthCare.gov account, proceed to Step 2.
- Step 2.** Help consumers go to their account to determine if they have previously started their Marketplace application online.
- If consumers have previously started and saved their Marketplace application, they should proceed to the section of the application where assistance is required. Ensure that consumers complete all required fields accurately.
 - If consumers do not have an existing Marketplace application, assist them with starting the application process.
- Step 3.** Guide consumers through the application process by following the application prompts to gather consumers' responses for each section of the application.
- Refer to Exhibit 11 to educate consumers on the information collected in each section of the eligibility application.



Exhibit 11 – Information Collected on the Eligibility Application (if Applying for Financial Assistance)

Section	Information Collected
Before You Get Started	<ul style="list-style-type: none"> • Marital Status – Applicants must disclose if they are legally married, whether to a spouse of the opposite sex or the same sex. Married couples must file taxes jointly to qualify for the premium tax credit and cost-sharing reductions. • Number of Dependents – Applicants must disclose the number of dependents they will claim on their next tax return. • Income Range – Applicants may disclose their income range, which will help determine whether they are eligible for help paying for coverage. • Help Paying for Coverage – Applicants must indicate whether they are interested in help paying for coverage through the Marketplace. If they are not interested in getting help paying for coverage, they will not be asked any additional income information during the application process.
Answer Some Questions	<ul style="list-style-type: none"> • Screening Questions – How applicants respond to these screening questions determines whether they complete the shorter, streamlined application, or go through the more detailed, traditional application.
Continue Your Application	<ul style="list-style-type: none"> • Contact Information <ul style="list-style-type: none"> ○ Name ○ Home address ○ Mailing address ○ Email address ○ Phone number ○ Preferred spoken language ○ Preferred written language ○ Preferred method of communication (e.g., text, e-mail, mail) ○ Race and ethnicity (optional) • Help Applying for Coverage – Applicants should be encouraged to indicate whether they are receiving help from an assister or agent/broker by inserting the assister's ID number or the agent/broker's National Producer Number (NPN) on the application
Income Information*	<ul style="list-style-type: none"> • Income – When applying for help paying for coverage, applicants must enter information about the monthly and annual income (e.g., job-based income, Social Security benefits, unemployment, and investments income) for everyone in the tax household even if other household members are not applying for coverage. <p>* Applicants are only required to complete the Income section if they would like to see their options to lower health plan costs or be evaluated for Medicaid or CHIP eligibility.</p>
Additional Questions	<ul style="list-style-type: none"> • Additional Questions – The series of additional questions on this page helps applicants determine whether they may have special circumstances that may qualify them for Medicaid. Specifically, they can indicate whether they have a physical disability or mental health condition that limits their ability to function on a daily basis, whether they need help with daily activities or live in a medical facility or nursing home. The system also asks whether they needed help paying medical bills in the last three months.
Additional Information	<ul style="list-style-type: none"> • Current Health Coverage Information – When applying for help paying for coverage, applicants must enter information on whether they are enrolled in or eligible for certain other coverage, and if so, information about the existing coverage. Additional questions are included to see whether applicants may be eligible for a special enrollment period to enroll in a Marketplace plan outside of open enrollment.



- b. Assist consumers with entering the information collected on the “Before you get started” section of the application, shown in Exhibit 12.

Exhibit 12 – HealthCare.gov Application: Before You Get Started Screenshot

- c. Assist consumers with entering the information collected on the “Family & household” section of the application, shown in Exhibit 13. (The “Family & household” section of the application must be completed in one sitting.)

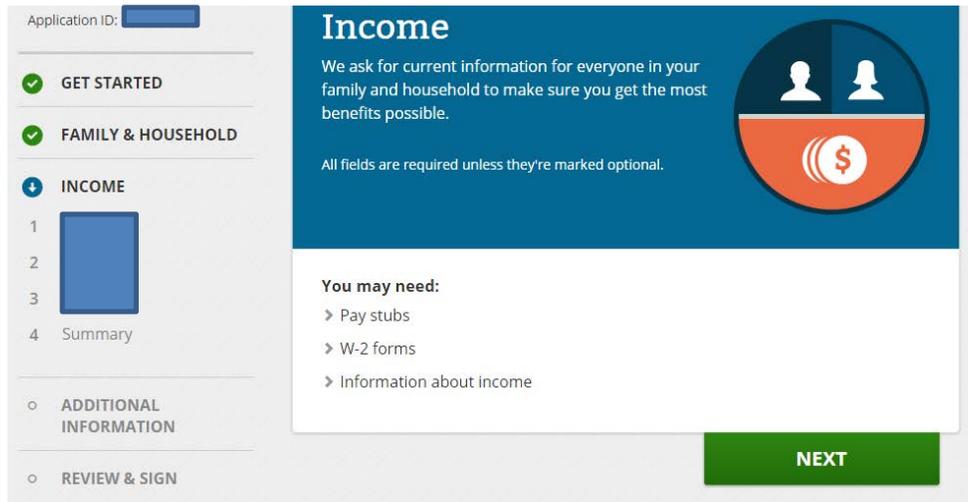
Exhibit 13 – HealthCare.gov Application: Family & Household Screenshot



SOP-5. Apply for Health Coverage

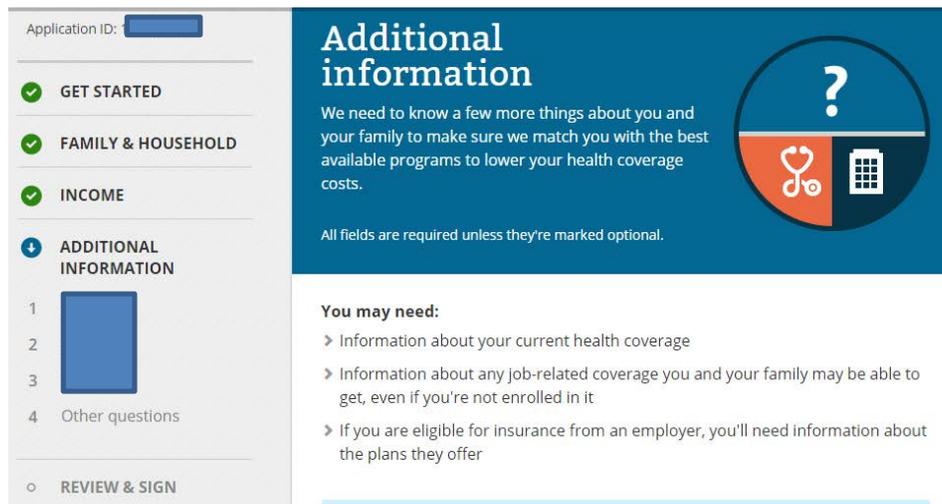
- d. Assist consumers with entering the information collected on the “Income” section of the application, shown in Exhibit 14.

Exhibit 14 – HealthCare.gov Application: Income Screenshot



- e. Assist consumers with entering the information collected on the “Additional information” section of the application, shown in Exhibit 15.

Exhibit 15 – HealthCare.gov Application: Additional Information Screenshot



Inform consumers that they can save and resume their eligibility application at a later date during the enrollment period by logging into their account again prior to submission. If consumers would like to submit their eligibility application, proceed to Step 4.



- Step 4.** Consumers should review their application content, verify accuracy of information provided, electronically sign, and submit the application. Before submitting their applications, consumers can review and edit any information provided on the application using the Application Summary page.
- Consumers must attest to the accuracy of the information provided in their applications before submission. On the Agreements & Signatures page, consumers will read a series of statements and confirm that they have read and understood each statement.
 - On the Agreements & Signatures page, consumers must input their electronic signatures before clicking the “Submit Application” button to submit their eligibility application. Exhibit 16 shows the screen consumers will see when it is time to electronically sign and submit their applications.

Exhibit 16 – Marketplace Electronic Signature Screenshot Screenshot

Application ID:

- ✓ GET STARTED
- ✓ FAMILY & HOUSEHOLD
- ✓ INCOME
- ✓ ADDITIONAL INFORMATION
- ➔ REVIEW & SIGN
 - 1 Review application
 - 2 Sign & submit

Review & sign

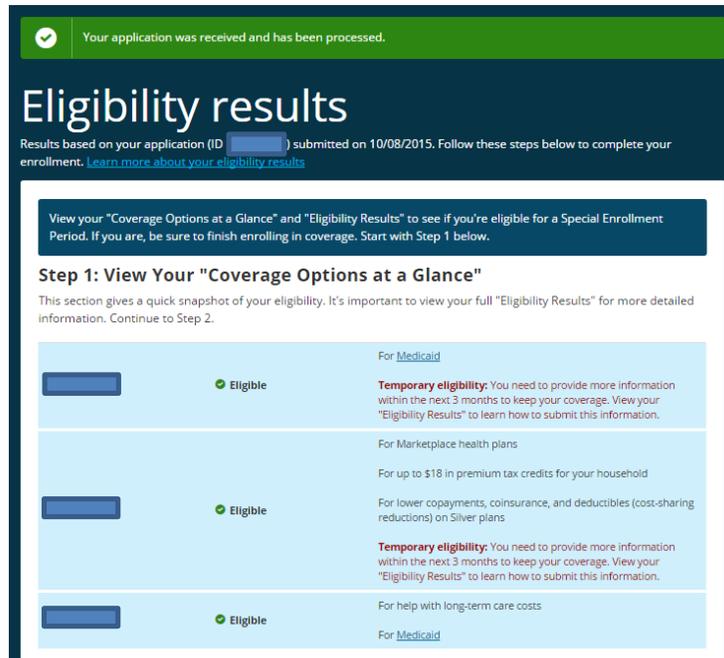
Take a few minutes to review the information you gave us. This is your chance to go back and make changes before you submit your final application.

NEXT

- Step 5.** If consumers receive an immediate eligibility determination, proceed to [SOP-6 Review Eligibility Results](#) to help consumers review their eligibility notice.
- Assist consumers with reviewing their eligibility notice in their online accounts, as shown in Exhibit 17. The eligibility notice will notify consumers if they need to submit supporting documentation or perform additional activities to complete the application process.
 - If consumers are asked to submit supporting documentation and have the necessary supporting documentation with them, assist them with scanning and uploading the documents. Be sure to return all original documents to consumers and to delete or erase all electronic copies of consumers' documents from all of your electronic devices (e.g., printers, scanners).
 - If consumers do not have the supporting documentation with them, but they need to submit supporting documents, explain their options to provide the documentation within the specified timeframe, which include:
 - Scanning and uploading documents from home;
 - Returning to the assister office with the supporting documents to scan and upload them with the assister's help; or
 - Mailing the documents to the Marketplace.

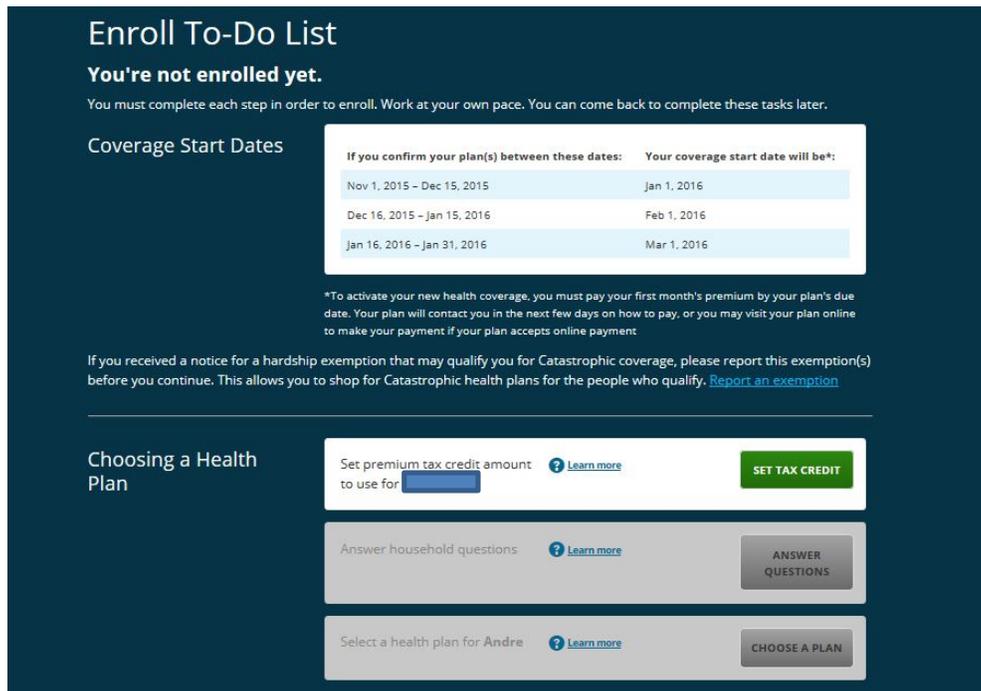


Exhibit 17 – Eligibility Results Screenshot



Step 6. After consumers review their eligibility results, and select “Continue to Enrollment,” the Enroll To-Do list will appear as shown in Exhibit 18.

Exhibit 18 – HealthCare.gov Enroll To-Do List Screenshot





2. Complete Paper Application

To assist consumers with paper applications, complete the following steps:

Step 1. Determine if consumers have previously started their applications.

- a. If consumers have previously started applications, proceed to the section where assistance is required.
- b. If consumers do not have existing paper applications, encourage them to complete electronic applications.
- c. If consumers would still like to complete paper applications, follow the format provided.

Things You Should Know

- Encourage consumers to transfer their paper application to the electronic format to help ensure enrollment in the most timely and efficient manner.

Step 2. Assist consumers with submitting their applications to the Marketplace.

- a. Provide consumers with the address to mail the application. Consumers should mail applications to:

Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001

Things You Should Know

- If consumers prefer the paper application, pre-printed eligibility applications may be useful to expedite the assistance process.

3. Submit Supporting Documentation

The Marketplace reviews consumers' application information and verifies it using a service called the Federal Data Services Hub (the Hub) to verify that the information entered in an application is correct. The Hub connects the Marketplace with federal agencies, such as SSA, IRS, and DHS, as well as state agencies and certain private trusted data sources. The Marketplace compares consumers' application information against their information through the Hub to verify its accuracy. Inconsistencies, also called data-matching issues (DMIs), may occur when the Hub's trusted data sources do not have a consumer's most up-to-date information. For example, a consumer's information may be flagged as potentially inaccurate if the consumer had a recent name change due to marriage. In this case, the consumer could receive a notice from the Marketplace asking for documents to prove the recent name change.

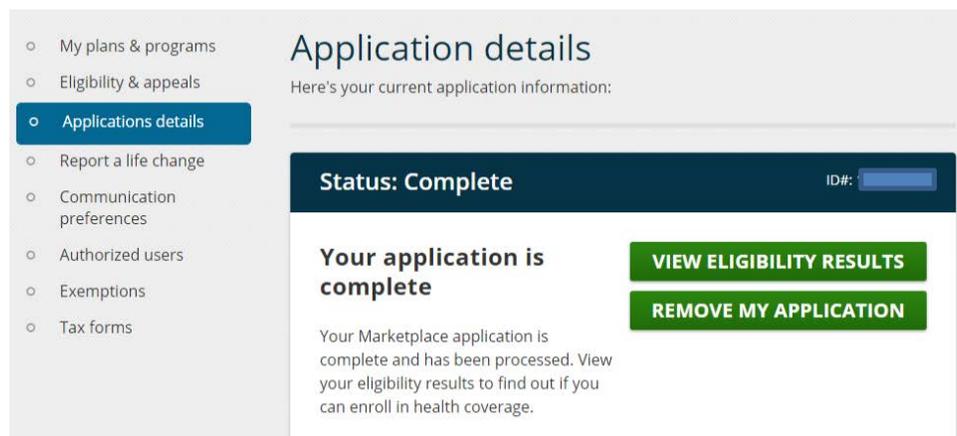
If consumers' application information cannot be confirmed through the Hub, they will receive a notice from the Marketplace notifying them of an inconsistency with their application. The notice will specify the timeframe to provide the documentation. The supporting documentation will help the Marketplace verify the application information and make a final eligibility determination. If consumers applied for Medicaid or CHIP and experienced an inconsistency due to citizenship, immigration status, income or residency, consumers will receive a notice telling them they may be eligible for Medicaid or CHIP and that their case has been sent to the state Medicaid agency. The state Medicaid agency will then contact them if they need further information to complete the application.



To assist consumers with uploading or mailing supporting documentation to resolve inconsistencies preventing them from enrolling in a Marketplace QHP, complete the following steps:

- Step 1.** If consumers receive a notice instructing them to send the Marketplace more information, explain to consumers why they may have received this notice and the process that the Marketplace uses to verify consumers' application information.
- Step 2.** If consumers wish to scan and upload the requested documentation to HealthCare.gov, complete the following steps. If consumers wish to mail copies of the requested documentation, proceed to Step 3.
- Help consumers review their eligibility notice to determine what type(s) of supporting documentation is needed.
 - Assist consumers with logging in to their account on HealthCare.gov.
 - Instruct consumers to navigate to My Applications & Coverage, and then select the relevant application.
 - Help consumers navigate to the Application Details page where they should click the "Verify" button for each application inconsistency, as shown in Exhibit 19.

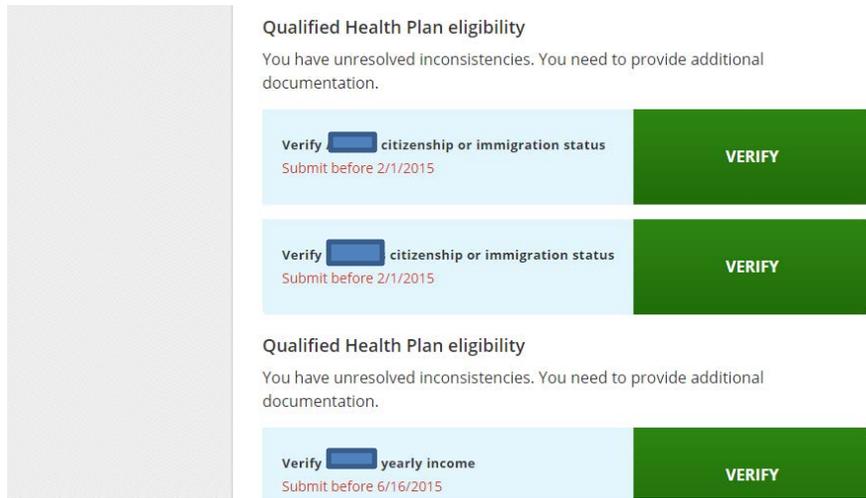
Exhibit 19 – Application Details Page on HealthCare.gov Screenshot



- Assist consumers with selecting the appropriate document type and uploading a scanned image of the document to HealthCare.gov, as shown in Exhibit 20. The document must be a .pdf, .jpeg, .jpg, .gif, .xml, .png, .tiff, or .bmp., and cannot be bigger than 10 MB. The file name can't include a colon, semicolon, asterisk, or any other special character.
- If a red box error message appears, make sure the consumer uploaded the right type of document (e.g., PDF not Excel file).



Exhibit 20 – Uploading Supporting Documentation to HealthCare.gov Screenshot

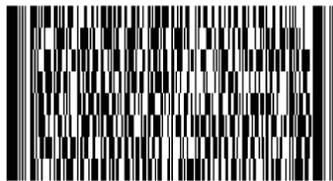


Step 3. If consumers wish to mail copies of the requested documentation, complete the following steps:

- a. Help consumers review their eligibility notice to determine what type(s) of supporting documentation is needed.
- b. Assist consumers with making copies of all supporting documentation. Consumers should retain originals of any documents sent to the Marketplace.
- c. Advise consumers to include the barcode page from their eligibility notice, (shown in Exhibit 21) in the envelope when they mail their supporting documentation to the Marketplace. If consumers do not have the page with the barcode, write the application ID number of the consumer who has the inconsistency, as well as his or her date of birth and SSN (if applicable) on the copies of supporting documents.

Exhibit 21 – Barcode Page from Eligibility Notice

Important: If you mail in your documentation, please also include this page in the same envelope, which includes a barcode, along with any documents. This page helps the Marketplace make sure your documents can easily be associated with your application.



PA,105991722



- d. Instruct consumers to mail copies of their supporting documentation to:

Health Insurance Marketplace
465 Industrial Blvd.
London, KY 40750-0001

C. Next Steps

1. If consumers are not ready to submit their eligibility applications, explain that they may save their online application to their account and resume the applications at a later point in time.
2. If consumers receive an immediate eligibility determination and are eligible to enroll in QHPs through the Marketplace, proceed to [SOP-6 Review Eligibility Results](#) and [SOP-8 Compare, Save, & Select Health Plans](#).
3. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-5 Apply for Health Coverage](#).



SOP-6. Review Eligibility Results

A. Introduction

As an assister, you can help consumers review their Marketplace eligibility determinations. This SOP provides guidance on how to assist consumers in understanding their eligibility determinations.

B. Procedures

1. Review Eligibility Results

To assist consumers with reviewing eligibility determinations, complete the following steps:

- Step 1.** Confirm with consumers that they have received an eligibility notice.
- Step 2.** Review the notices with consumers.
- Step 3.** Explain the eligibility results to consumers. Use Exhibit 22 to help consumers navigate the different sections of an eligibility notice.

Exhibit 22 – Eligibility Results

Section of Eligibility Notice	Information Displayed
What are the results of my application?	List of whether applicant(s) are eligible for purchasing coverage through the Marketplace (including, if applicable, a catastrophic plan), advance payments of the premium tax credit/cost-sharing reductions, a special enrollment period, and are or may be eligible for Medicaid/CHIP. Explain the eligibility results, including information about each program, to the individual. This information will be unique for each household application.
What should I do next?	Instructions and key deadlines for submitting any necessary supporting documentation. This information will be unique for each household application.
What are the coverage benefits?	Information about coverage benefits and potential cost sharing. For those eligible for Medicaid and CHIP, explain to individuals that more information about coverage and cost sharing will come separately through a letter from the state Medicaid agency.
When will coverage begin?	Information about coverage effective dates. This information will be unique for each household application.
What if information from my application changes during the year?	Information about the process and effect of reporting changes. This information will be the same for all consumers.
Why don't I qualify for other programs?	Information about why the applicant(s) did not qualify for other programs (e.g. Medicaid). This information will be the same for all consumers that did not qualify for Medicaid.



Section of Eligibility Notice	Information Displayed
What should I do if I think my eligibility results are wrong?	Instructions and important information to know about requesting an appeal of an eligibility determination. This information will be the same for all consumers.
Continuing your Medicaid or CHIP application	Information about applying for Medicaid/CHIP if the Marketplace application found the applicant(s) ineligible for Medicaid/CHIP based on their income, but the applicant(s) think they may qualify for other reasons. This information will be the same for all consumers that did not qualify for Medicaid/CHIP.
Does Medicaid cover special health care needs?	Information about how applicant(s) may be eligible for Medicaid coverage for special health care needs in addition to their other coverage. This information will be the same for all consumers.
Where can I find more information?	Contact information for the Marketplace and, if applicable, state Medicaid/CHIP agencies. This information will be the same for all consumers.
Additional information	Information on tax credits, lowering out-of-pocket costs, Medicaid, and getting help in a language other than English. This information will be the same for all consumers.

Note, if the eligibility notice states that additional supporting documentation is necessary, the indicated applicant(s) has an inconsistency, and this eligibility notice is not a final eligibility determination. You should help the applicant(s) with the inconsistency by completing the steps listed on the eligibility notice. Until the inconsistency is resolved, this eligibility notice is not final and cannot be appealed.

Proceed with Sections 1.1 through 1.4 to explain eligibility results.

1.1 Options to Lower Health Plan Costs

If consumers are eligible for advance payments of the premium tax credit and cost-sharing reductions, discuss the differences in the two programs. Refer to [SOP-7 Lower Costs of Coverage](#) and the [Marketplace Background Guide](#) for more information on these financial assistance options.

1.2 Medicaid/CHIP Eligibility

Depending on the state in which consumers reside, the Marketplace may either determine consumers' eligibility for Medicaid or CHIP, or make an initial assessment of eligibility for those programs and have the state make the final determination. On a Marketplace application, any applicant who meets their state's income, residency, immigration, and other requirements will be transferred to the state Medicaid or CHIP agency. If it appears a consumer may be eligible for Medicaid on another basis or if the consumer requests a full Medicaid eligibility determination, the Marketplace will transfer the consumer's application to the state agency for a final determination. This means that the notices to individuals when Marketplace provides an assessment of eligibility will tell the consumer they "may be eligible" for Medicaid or CHIP and that the state agency will make the final determination on their eligibility. The eligibility results do not indicate whether the consumer lives in an assessment state or a determination state; a list of assessment and determination states is available at: [Medicaid and CHIP Marketplace Interactions](#).

***Transferring consumer information to the state Medicaid and CHIP Agency***

There are several reasons the Marketplace may transfer a consumer's information to the Medicaid or CHIP agency. For example, on a Marketplace application, any applicant who meets their state's income, residency, immigration status, and other requirements for Medicaid or CHIP will have their account and information transferred to the state Medicaid or CHIP agency. Also, if it appears a consumer may be eligible for Medicaid on another basis (such as through special health care needs or a disability) the Marketplace will transfer the consumer's application to the state agency for a final determination. Consumers who reside in a state for which the Marketplace provides an assessment of eligibility can request to continue their applications with the state agency; if they do so, the Marketplace will transfer their information to the state agency. In this scenario, the Marketplace may have said that the consumer "may not be eligible" for Medicaid and CHIP in the initial assessment. However, since the state agency provides the final determination, consumers can request to continue their application with the state so that state agency can review their application.

- **Assessed as Potentially Eligible:** If the consumer resides in a state in which the Marketplace provides an initial eligibility assessment for Medicaid or CHIP and the Marketplace assesses a consumer "potentially eligible for Medicaid or CHIP", the consumer's application is transferred to the state Medicaid or CHIP agency for a final eligibility determination. It is important to remember that the consumer's determination of eligibility for coverage is not yet done. The state agency will provide a final decision on eligibility. The final decision may provide that the consumer is eligible for Medicaid or CHIP. However, there may be instances where state agency says the consumer is not eligible for Medicaid or CHIP, even if they were initially assessed as potentially eligible by the Marketplace.
- **Determined Eligible:** If the consumer resides in a state in which the Marketplace provides a final eligibility determination for Medicaid or CHIP and the Marketplace determines that a consumer is eligible, the consumer's determination of eligibility for coverage is complete. The consumer's application will be transferred to the state Medicaid or CHIP agency and the consumer will be enrolled in Medicaid or CHIP coverage. Consumers' state Medicaid/CHIP agency will notify them about next steps, including benefit and potential cost-sharing information.

Exhibit 23 highlights the differences between an assessment and a determination of eligibility.

Review whether consumers are assessed potentially eligible or determined to be eligible for Medicaid or CHIP.

Things You Should Know

- Medicaid/CHIP eligibility is determined on an individual basis and might be available to children, but not their parents.



Exhibit 23 – Eligibility Assessment vs. Determination

Consumers Who are <u>Assessed</u> by the Marketplace as Potentially Eligible for Medicaid/CHIP	Consumers Who are <u>Determined</u> by the Marketplace to be Eligible for Medicaid/CHIP
<ul style="list-style-type: none"> • The state Medicaid or CHIP agency will make a final Medicaid/CHIP eligibility determination. • Consumers' state Medicaid/CHIP agency may follow up with them to collect additional information. • Consumers' state Medicaid/CHIP agency will notify them about the results of the final determination and next steps. • Medicaid/CHIP coverage will be effective back to the date of application; Medicaid coverage may be effective up to three months prior to the month of application in certain states. 	<ul style="list-style-type: none"> • Consumers are enrolled directly in Medicaid or CHIP coverage in most cases. • Consumers' state Medicaid/CHIP agency will notify them about next steps, including benefit and potential cost-sharing information. • Medicaid/CHIP coverage will be effective back to the date of application; Medicaid coverage may be effective up to three months prior to the month of application in certain states.

If consumers who are determined eligible for Medicaid or CHIP indicate that they would rather enroll in a QHP, explain that they may do so; however, they will not be eligible for advance payments of the premium tax credit and/or cost-sharing reductions for enrollment in a QHP through the Marketplace. Ensure that consumers are aware of the cost associated with maintaining coverage through the Marketplace, when a consumer is eligible for Medicaid or CHIP. Use the following guidance when assisting consumers eligible for Medicaid or CHIP who want to enroll in a QHP through the Marketplace and pay the full cost:

Scenario 1: If everyone on an application is determined eligible for Medicaid/CHIP, they all want to enroll in a QHP through the Marketplace at full cost, and it is still during Open Enrollment or one or more people qualify for an SEP, assist them with starting a new application and indicating they do not want help paying for health coverage. Then, help them proceed through the rest of the application.

Scenario 2: If everyone on an application is determined eligible for Medicaid/CHIP and one or more applicants (but not all applicants) wants to enroll in a QHP through the Marketplace at full cost, assist the application filer with removing that applicant(s) from the application. They will need to be added as a non-applicant(s) if they are part of the tax household. The application filer should submit the application and continue through the Enroll To Do List. If it is still during Open Enrollment or the applicant(s) interested in QHP coverage qualifies for an SEP, they will need to create a separate application for QHP coverage without financial assistance to enroll in a QHP through the Marketplace.

1.3 Ineligibility

The Marketplace may find consumers ineligible to purchase coverage through the Marketplace or for programs to lower costs of health coverage. For example, consumers may be determined ineligible for advance payments of the premium tax credit or cost-sharing reductions if they do not meet the household income criteria for these programs. Consumers may be able to get low-cost health care at a community health center. For more information, visit findahealthcenter.hrsa.gov.



1.4 Eligible for Coverage Through the Marketplace Without Financial Assistance

Consumers who are ineligible for advance payments of the premium tax credit, cost-sharing reductions, or Medicaid or CHIP may still enroll in QHPs through the Marketplace if they are qualified. These consumers would receive an eligibility determination stating the reason they are not eligible and/or the reason they were denied eligibility for advance payments of the premium tax credit.

C. Next Steps

1. If an applicant is found ineligible and thinks this is due to an error, discuss the following options:
 - Making an account update; see [SOP-12 Update Account Profile](#).
 - Filing an eligibility appeal; see [SOP-10 Request an Eligibility Appeal](#).
 - Requesting to continue their application with the state Medicaid and CHIP agency if the Marketplace provided an assessment of eligibility.
2. If an applicant is found eligible for advance payments of the premium tax credit or cost-sharing reductions, proceed to [SOP-7 Lower Costs of Coverage](#).
3. If an applicant is found eligible to purchase coverage through the Marketplace, proceed to [SOP-8 Compare, Save, & Select Health Plans](#).
4. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-6 Review Eligibility Determination](#).



SOP-7. Lower Costs of Coverage

A. Introduction

When consumers who apply for help lowering the costs of coverage receive their eligibility results, the Marketplace will inform them of their eligibility for options to lower their health plan costs through advance payments of the premium tax credit and/or cost-sharing reductions. If eligible, consumers can choose whether to apply advance payments of the premium tax credit to the cost of their health plans. When comparing plans, consumers select the amount of advance payments of the premium tax credit for which they are eligible that they want paid on their behalf to their insurance provider. The amount of advance payments of the premium tax credit for which a consumer is eligible is based on the consumer's projected household income and other factors. Consumers can also select health plans that apply cost-sharing reductions if they are eligible.

While assisting consumers with selecting the amount of advance payments of the premium tax credit or viewing a plan's cost-sharing reductions, remind consumers that they must accurately represent their household income information. Consumers generally are required to report all forms of household income, although Supplemental Security Income (SSI) and certain other items are not included in household income.⁶ This SOP provides guidance on how to assist consumers with understanding advance payments of the premium tax credit and cost-sharing reductions.

B. Procedures

1. Select Advance Payments of the Premium Tax Credit

If consumers are eligible for advance payments of the premium tax credit, they have the option of using all, some, or none of the amount for which they are eligible to reduce their monthly premium cost. Before helping them make changes to their Marketplace accounts, make sure that consumers understand advance payments of premium tax credit. Exhibit 24 provides information to help answer questions about advance payments of the premium tax credit available through the Marketplace.

⁶ Don't include child support payments, SSI, gifts, veteran's disability payments, worker's compensation, or proceeds from loans, such as student loans.



Exhibit 24 – Common Premium Tax Credit Questions and Answers

Question	Answer
<p>What is the premium tax credit?</p> <p>What are advance payments of the premium tax credit?</p> <p>How do advance payments of the premium tax credit affect individuals' tax returns?</p>	<ul style="list-style-type: none"> • A tax credit that helps low- and moderate-income individuals afford health insurance. • Individuals who meet certain eligibility criteria at the time of enrollment in a QHP may choose to have advance payments of the premium tax credit made to their insurance provider to lower the cost of their monthly premiums. Consumers may choose to have some, none, or all of the advance payments of the premium tax credit for which they are eligible made on their behalf. • Then, when they file their tax return for the year and compute the actual premium tax credit they are allowed, they must reconcile or compare their advance payments of the premium credit with the premium tax credit they are allowed. Consumers whose advance payments of the premium tax credit exceed their actual premium tax credit must increase their tax liability by all or a portion of the difference. Consumers whose premium tax credit is more than their advance payments of the premium tax credit lower their tax liability or get a refund for the difference.
<p>Who is eligible for a premium tax credit and advance payments of the premium tax credit?</p>	<p>To be eligible for a premium tax credit:</p> <ul style="list-style-type: none"> • A consumer or a family member, such as his or her spouse or dependent, must be enrolled in a QHP through the Marketplace for one or more months in which he or she was not eligible for other minimum essential coverage (MEC), such as Medicaid, CHIP, TRICARE, or affordable employer-sponsored coverage that meets the minimum value standard; • The consumer must file joint tax return if married, unless the consumer is a victim of domestic abuse or spousal abandonment, and not be claimed as a dependent on another taxpayer's tax return;[†] and • The consumer must have household income between 100% and 400% of the federal poverty level (FPL) (see Appendix C: Federal Poverty Guidelines);* and • Note that a premium tax credit is only allowed for months in which the consumer pays his or her share of the premium by the due date of the consumer's tax return.

[†]Consumers who are married but living apart from their spouse and are unable to file a joint income tax return because of a case of spousal abandonment or domestic abuse can obtain advance payments of the premium tax credit and cost-sharing reductions—as long as they are otherwise eligible. For more information, see the guidance available at: [CMS.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf).

*Adult consumers generally must have a household income between 138% and 400% of the FPL if they live in a state that has expanded Medicaid.

2. Select the Amount of the Advance Payments of the Premium Tax Credit

If consumers are eligible for advance payments of the premium tax credit, the Marketplace will notify them of the maximum dollar amount available to them. Consumers can choose to apply the entire amount to their monthly health plan premiums or a lesser amount of their choice, including zero. Be sure to point out that the advance payments of the premium tax credit are not their premium tax credit.

Advance payments of the premium tax credit are based on an estimate of the premium tax credit they may be allowed to claim when they file their tax return. Their eligibility for the premium tax credit and the amount of the credit they are allowed is not determined until they file their tax return.

Also point out that, when they file their tax return for the year, they must reconcile or compare their advance payments of the premium tax credit with the premium tax credit they are allowed. Consumers whose advance



payments of the premium tax credit exceed their actual premium tax credit must increase their tax liability by all or a portion of the difference. Consumers whose premium tax credit is more than their advance payments of the premium tax credit will lower their tax liability or get a refund for the difference. You can help consumers select the amount of advance payments of the premium tax credit to apply to their monthly premiums during plan selection after the initial application or when reporting a life change to the Marketplace.

To help consumers select the amount of advance payments of the premium tax credit they would like to have paid on their behalf, complete the following steps:

Step 1. Help consumers review the amount of advance payments of the premium tax credit for which they are eligible. The amount of advance payments of the premium tax credit for which consumers are eligible can be found in the *What are the results of my application?* table on their eligibility notice, as shown in Exhibit 25. Explain that the amount shown on the table represents the amount of the advance payments of the premium tax credit for the entire family, not just the individual, on that particular row of the chart. For example, if a married couple is eligible for \$400 of advance payments of the premium tax credit, the eligibility results table will have \$400 after the husband's name and \$400 after the wife's name. Even though the amount of \$400 appears twice, the couple is not eligible for \$800.

Exhibit 25 – What are the Results of my Application?

Family Member(s)	Results	Next Steps
Andre Hill	<ul style="list-style-type: none"> Eligible to purchase health coverage through the Marketplace, but more information is needed Eligible for advance payments of the premium tax credit (\$300 each month, which is \$3,600 for the year), but more information is needed 	<ul style="list-style-type: none"> Send the Marketplace more information
Bridget Hill	<ul style="list-style-type: none"> Eligible to purchase health coverage through the Marketplace, but more information is needed Eligible for advance payments of the premium tax credit (\$300 each month, which is \$3,600 for the year), but more information is needed 	<ul style="list-style-type: none"> Send the Marketplace more information

Step 2. Explain to consumers that adjusting the amount of advance payments of the premium tax credit affects the cost to them of their QHP monthly premiums.

Step 3. Describe the effects of adjusting advance payments of the premium tax credit amount, including:

- a. Premium amount paid by consumers; and
- b. Tax consequences (see [Section 2.1 Tax Consequences](#)).

Step 4. Explain when the advance payments of the premium tax credit take effect.

- a. If consumers adjust advance payments of the premium tax credit between the 1st and 15th of the month, the

Things You Should Know

- Remind consumers that they must file taxes in the upcoming year if advance payments of the premium tax credit are paid on their behalf. Also inform consumers that they will be ineligible for advance payments of the premium tax credit in future years if advance payments of the premium tax credit are paid on their behalf but they do not file a federal tax return for the year.



change in premium takes effect on the first of the next month (e.g., if the change is made on December 8, the change in premium takes effect on January 1).

- b. If consumers adjust advance payments of the premium tax credit between the 16th and the last day of the month, the change in premium takes effect on the first of the month following the next month (e.g., if the change is made on December 17, the change in premium takes effect on February 1).

Step 5. Help consumers select the amount of advance payments of the premium tax credit they would like to apply towards their monthly premium payments. Note that the default setting is 100% of the eligible amount. However, a consumer's maximum amount of the advance payments of the premium tax credit cannot be more than the cost of his or her monthly premiums. The tool consumers can use to select the amount of advance payments of the premium tax credit they would like to apply towards their monthly premium payments is shown in Exhibit 26.

Exhibit 26 – Selecting the Amount of Advance Payments of the Premium Tax Credit Screenshot

Set premium tax credit amount for

Andre is currently eligible for **\$300 each month** (\$3,600 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 \$300 premium tax credit each month?

YES **NO**

USE THIS AMOUNT

IMPORTANT: The consumer should continue through Plan Compare, select the plan in which the consumer is enrolled, and continue to the Review and Confirm Plan Selection page to have the new advance payments of the premium tax credit applied to the consumer's plan.



Exhibit 27 – Review and Confirm Plan Selection Screenshot

Confirm your plan choices

You must confirm your plan choices below in order to enroll.

To change the tax credit amount you want to use each month, return to the [To-Do List](#) and select "change" next to the set premium tax credit task.

Avera MyPlan \$3,500

Plan ID: [REDACTED]

Health plan for [REDACTED]

Estimated effective date
02/01/2016

Health plan monthly premium	\$492.53
Premium tax credit	\$300.00
Health plan monthly premium	\$192.53

[Is someone helping you select a plan and enroll?](#)

Total \$192.53
Monthly premium total (with tax credit)

I understand that I'm not eligible to get a premium tax credit if I'm found eligible for other minimum essential coverage, like Medicaid. I also understand that if I'm eligible for other minimum essential coverage, I must contact the Marketplace to end my Marketplace coverage and premium tax credit. If I don't, the person who files taxes in my household may need to pay back my premium tax credit.

CONFIRM

2.1 Tax Consequences

Explain to consumers that the amount of the advance payments of the premium tax credit paid on their behalf will affect the amount they owe or the amount of their refund when they file their federal income tax return. Consumers for whom advance payments of the premium tax credit payments are made must file a tax return and reconcile or compare their advance payments of the premium tax credit with the premium tax credit they are allowed on that return.

Consumers whose advance payments of the premium tax credit are more than their actual premium tax credit must increase their tax liability by all or a portion of the difference. Consumers whose premium tax credit is more than their advance payments of the premium tax credit will lower their tax liability or get a refund for the difference.

The amount of the advance payments of the premium tax credit for which consumers are eligible depends on their projected household income and family size. However, consumers use their actual household income and family size when they file their tax return to compute the premium tax credit. If a consumer's actual household



incomes differ from the projected household income amount, then this may affect the amount that the consumer will pay or receive as a refund when filing his or her federal income tax return.

If a consumer's actual household income is more than the projected household income used to compute advance payments of the premium tax credit, and the consumer chose to have all of the advance payments of the premium tax credit for which he or she was eligible paid to the insurance provider, it is likely that the consumer's advance payments of the premium tax credit will be more than his or her premium tax credit. These are called excess advance credit payments. In that case, the consumer must repay all or a portion of the excess advance credit payments when filing his or her federal income tax return. Choosing less than the full amount of advance payments of the premium tax credit for which the consumer is eligible reduces the likelihood that the consumer will have a tax liability as a result of excess advance credit payments.

If a consumer's actual household income is less than the projected household income used to compute advance payments of the premium tax credit, or if the consumer chose to have less than all of the advance payments of the premium tax credit for which he or she was eligible paid to the insurance provider, it is likely that the consumer's premium tax credit will be more than his or her advance payments of the premium tax credit. In that case, the consumer will, when he or she files a tax return for the year, reduce their tax liability or get a refund for the difference between the actual premium tax credit and the advance payments of the premium tax credit.

3. Select Plans with Cost-Sharing Reductions

If consumers have household income between 100% and 250% of the FPL or are members of a federally recognized Indian tribe, they may be eligible for plans with cost-sharing reductions. Plans with cost-sharing reductions reduce the amount that consumers have to pay out of pocket for health care (e.g., deductibles, copayments, and coinsurance). The Marketplace will determine if consumers are eligible for cost-sharing reductions based on projected household income and family size. Exhibit 28 provides information to help answer questions about cost-sharing reductions.

Exhibit 28 – Common Cost-Sharing Reductions Questions and Answers

Question	Answer
What is a cost-sharing reduction?	A discount that lowers the amount a consumer has to pay for deductibles, coinsurance, and copayments.
Who is eligible for cost-sharing reductions?	To be eligible for and utilize cost-sharing reductions, a consumer must: <ul style="list-style-type: none"> • Have a projected household income between 100% and 250% of the FPL (see Appendix C: Federal Poverty Guidelines) †; or an Indian with household income under 300% of the FPL. • Enroll in a Silver category QHP* through the Marketplace; and • Be eligible for the premium tax credit.

†Members of federally recognized tribes who have a household income below 300% of the FPL are exempt from cost-sharing and do not have to pay out-of-pocket costs for health coverage.

*Members of federally recognized tribes may take advantage of cost-sharing reductions at any health plan metal level.

If consumers are eligible for cost-sharing reductions, discuss the following topics.

Topic 1: Explain to consumers that they must choose a Silver category plan to take advantage of the cost-sharing reduction. (There is one exception to this rule: members of a federally recognized tribe may take advantage of cost-sharing reductions at any health plan metal level.)



Topic 2: Explain that cost-sharing reductions may decrease the following costs:

- Deductibles;
- Coinsurance; and/or
- Copayments.

Topic 3: Explain that cost-sharing reductions **will not** decrease the following costs:

- Monthly premiums;
- Balances billed by non-network providers; nor
- Amounts spent on non-covered services.

Topic 4: Explain that consumers need to be aware of their responsibility to notify the Marketplace of any changes in their household income level or other application information that may affect their eligibility for cost-sharing reductions.

C. Next Steps

1. If consumers would like to compare plans or make plan selections, proceed to [SOP-8 Compare, Save, & Select Health Plans](#).
2. If consumers need to report changes that affect their eligibility results, proceed to [SOP-13 Report Life Changes](#).
3. If consumers believe that they are eligible for more advance payments of the premium tax credit or cost-sharing reductions, proceed to [SOP-10 Request an Eligibility Appeal](#).
4. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-7 Lower Costs of Coverage](#).



SOP-8. Compare, Save, & Select Health Plans

A. Introduction

The Marketplace allows consumers to compare the full range of QHP options, including estimated premiums and other health care costs. Even if consumers have not created a Marketplace account and prefer to apply by calling the Marketplace Call Center or using a paper application, they can view and compare some Marketplace QHP options. However, until they submit an application and are determined eligible for enrollment through the Marketplace, the premiums they see will simply be estimates, and they will not be able to select health plans for enrollment.

Consumers without a Marketplace account may:

- View key plan details (e.g., premiums, deductibles) using the “[See Plans and Prices](#)” feature on HealthCare.gov.
- View, download, or print the plan’s Summary of Benefits and Coverage.
- View the plan’s provider directory.

If consumers choose to proceed without an online account, explain that the health plan and cost options that they receive are only estimates based on consumers’ responses to a few general questions. More consumer-specific information on available plans and costs can be viewed after consumers complete an application and are determined eligible for enrollment through the Marketplace.

If consumers are interested in more detailed information about plans available to them, or believe they may be eligible for other coverage programs or options to lower their costs (i.e., Medicaid, CHIP, advance payments of the premium tax credit, and cost-sharing reductions), encourage them to create an online account and complete an eligibility application. To create an account, proceed to [SOP-3 Create an Account](#).

The remainder of this SOP provides guidance on how to assist consumers with Marketplace accounts who have been determined eligible for enrollment through the Marketplace to compare QHPs, save plan information, and make a final QHP selection.

B. Procedures

1. Selecting Advance Payments of the Premium Tax Credit Amount

Consumers who are determined to be eligible for advance payments of the premium tax credit may choose to use all, some, or none of that amount to lower their monthly premiums. If consumers are eligible for advance payments of the premium tax credit, the system will prompt them to set the amount of advance payments of the premium tax credit that they would like to apply to their monthly premiums before viewing their QHP options, as shown in Exhibit 29.



Exhibit 29 – Setting the Amount of Advance Payments of the Premium Tax Credit Screenshot

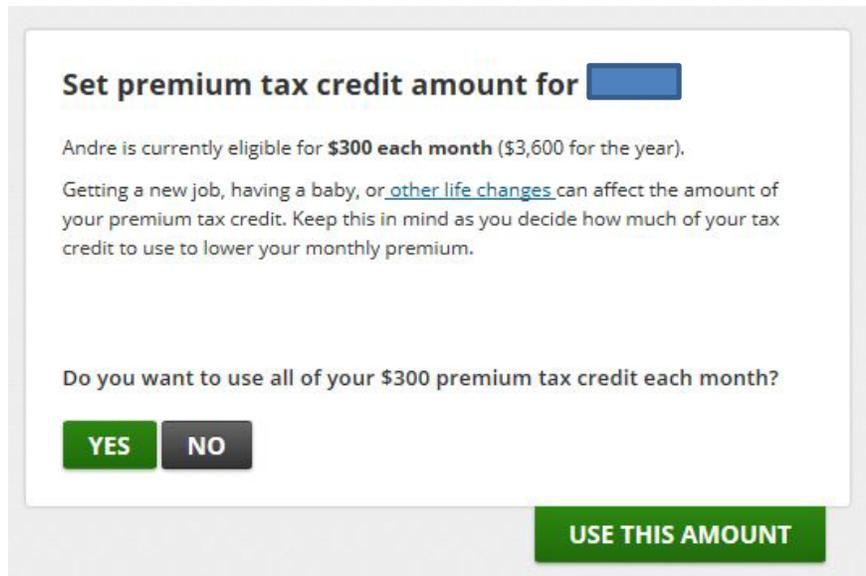
Step 1. Consumers who are eligible for advance payments of the premium tax credit will see the screen shown in Exhibit 30 that gives them three different options on how to use the advance payments of the premium tax credit for which they are eligible. Consumers can generally use all, some or none of the amount for which they are eligible. The three scenarios show how the options affect the consumer's monthly premium cost and, potentially, their tax liability when they file their tax return. After reviewing, the consumer will select "I have reviewed" in the bottom right corner.

Exhibit 30 – Advance Payments of the Premium Tax Credit



Step 2. You can help consumers use the advance payments of the premium tax credit amount selection tool shown in Exhibit 31 to set the amounts of advance payment of the premium tax credit they would like to apply to their premium each month. Note that the default setting for the advance payments of the premium tax credit is 100% of the eligible amount.

Exhibit 31 – Selecting the Amount of Advance Payments of the Premium Tax Credit Screenshot



The setting that consumers choose at this stage is not permanent; however, when consumers view and compare QHPs, the Marketplace will reduce premium amounts displayed according to the amount of advance payments of the premium tax credit they select. At any time before enrolling in a plan, consumers may adjust the amount of advance payments of the premium tax credit that they would like to use. (Consumers will also be able to change the amount of advance payments of the premium tax credit they select after enrolling in a plan, but the time at which that change takes effect will depend on the calendar date on which the change is made.)

Step 3. You can help consumers select the amount of advance payments of the premium tax credit that they would like to have made on their behalf. Exhibit 32 provides an explanation of the tax consequences that consumers might encounter.

Exhibit 32 – Tax Consequences for Advance Payments of the Premium Tax Credit

Scenario	Tax Consequence
Consumers elect <i>lower</i> advance payments of the premium tax credit than the maximum for which they are eligible AND/OR their annual household income is <i>less than</i> projected for the tax year or their household size <i>increases</i> .	Consumers' tax liability might decrease, and they might get a tax refund if the premium tax credit for which they are eligible at tax time exceeds the advance payments of the premium tax credit that they received during the year.
Consumers elect the <i>maximum</i> advance payments of the premium tax credit for which they are eligible AND/OR their annual household income is <i>more than</i> projected for the tax year or their household size <i>decreases</i> .	Consumers' tax liability might increase, and they might owe money at tax time if the premium tax credit for which they are eligible at tax time is less than the advance payments of the premium tax credit that they received during the year.



Step 4. It is important to remind consumers that they are required to report certain income and household –related changes to the Marketplace as soon as possible because it may affect the amount of premium tax credit and/or cost-sharing reductions for which they are eligible, and they may wish to adjust the amount of advance payments of the premium tax credit they apply to their monthly premiums if the amount for which they are eligible changes.

Things You Should Know

- While you can help consumers compare plans based on the applicant and his or her family members' unique coverage needs, you should never advise consumers to choose specific plans.

2. Comparing QHPs

This section provides information on different criteria (e.g., cost, benefits covered) by which consumers may wish to compare and evaluate QHPs.

Step 1. Explain to consumers the factors that might affect their available QHP options and the costs of the QHPs. The following are factors that affect the plans and/or costs that consumers are able to view and compare:

- a. Place of residence;
- b. Age;
- c. Family size;
- d. Tobacco use; and
- e. Eligibility for advance payments of the premium tax credits or cost-sharing reductions.

Step 2. You can assist consumers with comparing health plans using the “Metal Table” which summarizes plans by metal level, displaying premium ranges (after application of advance payments of the premium tax credit), and cost-sharing (e.g., deductibles) for all the plans that are available based on information entered in their application.

- a. Once the consumer is on the plan results page, summary information about individual plans is presented, including the cost of premiums.

Step 3. You can assist consumers with filtering and sorting QHPs to find the one that best meets their needs.

- a. The Marketplace initially sorts plans from the lowest to highest premium amount. However, consumers may filter and view QHPs by other sorting criteria, such as alphabetically by QHP name or by maximum out-of-pocket costs.
- b. Consumers may also filter QHPs to narrow the results to display only plans that meet selected criteria. Exhibit 33 specifies the various filtering options available to consumers for customizing their QHP lists and lists examples of when to use each filtering option. It may be helpful to review the chart with consumers and identify the filtering options that are most important to them.



Exhibit 33 – Filtering Options

Filtering Option	Examples of Consumer Scenarios	Description of Filtering Option
Health Plan Categories	Consumers want to view only those plans that can be expected to cover, on average, 70% or more of their health care costs (i.e., a Silver-level plan or higher).	<ul style="list-style-type: none"> Assignment of plan categories designated by metal level: Bronze, Silver, Gold, Platinum, and Catastrophic (e.g., a Platinum category plan, on average, will cover a higher percentage of costs of care than a Bronze category plan, but will generally have a higher premium).
Cost-Sharing Reduction Plans	Consumers are interested in viewing only those plans that can offer cost-sharing reductions.	<ul style="list-style-type: none"> Silver Plans with cost-sharing reductions.
Premium Range	Consumers are concerned about monthly premium costs.	<ul style="list-style-type: none"> Price range that consumers pay monthly for their QHPs.
Yearly Deductible	Consumers want to view only those plans that have a deductible amount within a certain range.	<ul style="list-style-type: none"> The required amount consumers must pay before their health coverage begins to cover most health care costs.
Out-of-Pocket Maximum	Consumers receive a lot of health care each year and are concerned about their costs.	<ul style="list-style-type: none"> The maximum amount consumers will have to pay for most services under a health plan per year.
Dental Coverage	Consumers are seeking to enroll in a plan that offers dental coverage.	<ul style="list-style-type: none"> Adult and/or child dental care is covered under the health plan.*
Health Plan Network Types	Consumers are concerned with flexibility of access to providers inside and outside of a network or are interested in coverage in multiple states.	<ul style="list-style-type: none"> Types of provider access, such as Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point of Service (POS), and multi-state or national provider networks.
Health Savings Account (HSA) Eligible	Consumers are considering enrolling in a high deductible health plan (HDHP).	<ul style="list-style-type: none"> Tax-advantaged medical savings account available to consumers who are enrolled in an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit.
Medical Management Programs	Consumers have chronic medical conditions that require coordinated management.	<ul style="list-style-type: none"> The medical management programs (e.g., asthma, diabetes) covered by each QHP.

**Under the Affordable Care Act, dental insurance is treated differently for adults and children 18 and under. Dental coverage for children is an essential health benefit. All qualified dental plans offered through the Marketplace must cover the pediatric dental essential health benefit, but are not required to cover adult dental services.*

- Step 4.** Once consumers identify QHPs in which they are interested in enrolling, consumers may make direct plan-to-plan comparisons using the side-by-side function.
- a. To select QHPs for comparison, consumers can click the “Compare” box listed next to the QHP name. Next, select the “Compare Plans” button at the top of the page. See Exhibit 34 for an illustration of this process.



Exhibit 34 – Select a QHP for Plan Comparison Screenshot

Advantage Silver
\$3,250/\$10 - Partner Network

Plan ID: [Redacted]
 EPO | Silver | Reduced costs

Compare [View](#)
 Save

DETAILS
ENROLL

Monthly premium	Deductible	Out-of-pocket maximum	Copayments / Coinsurance
\$206.80 /mo. was \$261.80	\$850	\$2,250	\$5 Primary doctor \$25 Specialist doctor \$4 Generic prescription

Dental: Child

Doctors: 0 of 0
 Prescriptions: 0 of 0
 Facilities: 0 of 0

[Plan Brochure](#)
[Summary of Benefits](#)
[Provider directory](#)

Show more + **VIEW ALL +**

- b. The side-by-side comparison, shown in Exhibit 35, allows consumers to compare QHPs' monthly premiums and annual deductibles, medical and prescription drug benefits, and other key information.

Exhibit 35 – Side-by-Side Plan Comparison Screenshot

Advantage Silver \$3,250/\$10 - Partner Network	Advantage Silver \$1,750/\$30 - Partner Network
Plan ID: [Redacted] <input type="checkbox"/> Save	Plan ID: [Redacted] <input type="checkbox"/> Save
Doctors: 0 of 0 Prescriptions: 0 of 0 Facilities: 0 of 0 VIEW ALL +	Doctors: 0 of 0 Prescriptions: 0 of 0 Facilities: 0 of 0 VIEW ALL +
DETAILS ENROLL	DETAILS ENROLL
General Information	
Monthly premium \$206.80 /mo. was \$261.80	Monthly premium \$211.10 /mo. was \$266.10
Deductible \$850	Deductible \$500
Out-of-pocket maximum \$2,250	Out-of-pocket maximum \$2,250
<input checked="" type="checkbox"/> Reduced costs <input checked="" type="checkbox"/> Dental: Child only Summary of Benefits Plan Brochure Provider directory	<input checked="" type="checkbox"/> Reduced costs <input checked="" type="checkbox"/> Dental: Child only Summary of Benefits Plan Brochure Provider directory



Step 5. Remind consumers to make sure their doctors or other health providers are in-network for the specific plan they are considering before they enroll. The best way for consumers to ensure a provider participates in the specific plan they are selecting 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. If consumers request a plan that includes their health provider(s) or specific prescription drugs in the plan’s formulary, direct them to the following external resources for additional information about the QHPs:

- Plan websites.
- Individual plan provider directories.
- [Summaries of Benefits & Coverage \(SBCs\)](#). This information may be found by clicking on the “Details” link for the plan on HealthCare.gov.

3. Saving QHP Selections

Step 1. If a consumer would like to return to review certain QHPs at a later time, the consumer may save the QHPs to his or her account by clicking the “Save” box, as shown in Exhibit 36. The consumer may view these QHPs at a later time by logging in to his or her account and clicking the “Saved Plans” button also shown in Exhibit 36.

Exhibit 36 – Save QHP Screenshot

The image shows two screenshots from the Marketplace Assister Toolkit. The left screenshot displays the details for an 'Advantage Silver \$3,250/\$10 - Partner Network' plan. It includes a 'Compare' button, a 'Save' button with a checkmark, and an 'ENROLL' button. Below the plan name, it lists 'Plan ID', 'EPO', 'Silver', and 'Reduced costs'. A table shows financial details: Monthly premium (\$206.80/mo., was \$261.80), Deductible (\$850), Out-of-pocket maximum (\$2,250), and Copayments / Coinsurance (\$5 Primary doctor, \$25 Specialist doctor, \$4 Generic prescription). It also notes 'Dental: Child' and provides links for 'Plan Brochure', 'Summary of Benefits', and 'Provider directory'. The right screenshot shows the 'Saved Plans' section of the interface, listing the same 'Advantage Silver' plan as one of the '2 Eligible Saved Health Plans'. It includes a 'PRINT' button and a message: '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.'

4. Selecting a QHP

Step 1. After consumers have reviewed and compared their available QHP options, they may select plans in which to enroll for themselves and/or family members included on their application. After clicking “Enroll,” different warnings may appear that indicate the consumer may have missed the opportunity to participate in a plan with cost-sharing reductions (for example, if the consumer 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. Consumers will be asked to confirm their plan selection, as shown in Exhibit 37.



Exhibit 37 – Confirm Plan Selection Screenshot

Confirm your plan choices

You must confirm your plan choices below in order to enroll.

To change the tax credit amount you want to use each month, return to the [To-Do List](#) and select "change" next to the set premium tax credit task.

Advantage Silver \$3,250/\$10 - Partner Network

Plan ID: [REDACTED]

Health plan for [REDACTED]

Estimated effective date
01/01/2016

Health plan monthly premium	\$261.80
Premium tax credit	\$55.00
Health plan monthly premium	\$206.80

CHANGE SELECTION

[Is someone helping you select a plan and enroll?](#)

Total \$206.80
Monthly premium total (with tax credit)

I understand that I'm not eligible to get a premium tax credit if I'm found eligible for other minimum essential coverage, like Medicaid. I also understand that if I'm eligible for other minimum essential coverage, I must contact the Marketplace to end my Marketplace coverage and premium tax credit. If I don't, the person who files taxes in my household may need to pay back my premium tax credit.

CONFIRM

5. Dental Coverage

- Step 1.** Some medical plans include child and/or adult dental coverage. Once the consumer has selected a QHP, the consumer has the option to select a separate dental plan. If no separate dental plan is desired, the consumer can skip directly to the "Review and Confirm" task. If the consumer wishes to select a separate dental plan, proceed to Step 2.
- Step 2.** You can help the consumer indicate that they are interested in separate dental coverage. The process will proceed similarly to the major medical plan compare and selection process. Once available dental plans appear, you can assist the consumer in enrolling in a dental plan.
- If a consumer wishes to enroll in a dental plan, Marketplace operations require that he or she enroll in a Marketplace health plan at the same time. In other words, a dental plan cannot be purchased alone or selected separately from QHP enrollment.
 - Consumers can enroll in a supplemental dental plan through the Marketplace even after they have already enrolled in health coverage as long as it is still Open Enrollment, or if they have an SEP. To do so, Marketplace operations require that consumers return to the Marketplace, re-select their Marketplace health plan, and then select a dental plan at the same time to add a dental plan. Assisters helping consumers in this situation can remind consumers that the coverage effective date of their dental plan will depend on the date that they enroll, not on the date when they originally selected health coverage.



Step 3. Once a consumer 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,” as shown in Exhibit 38.

Exhibit 38 – Confirming Dental Plan Selection Screenshot

The screenshot shows a confirmation window titled "Confirm your dental plan selection". It includes a warning icon and text: "If you confirm your plan today, your coverage start date will be 01/01/2016." Below this, it states "Andre will be enrolled in the following dental plan:". A light blue box contains the plan details: "PPO Basic Plan for Families", "Plan ID: [redacted]", and "Monthly premium \$11.99/mo.". At the bottom, there is a note: "If you want to enroll in this plan, select 'Confirm.' If you don't want to enroll in this plan, select 'Cancel' and choose a new plan." Two buttons are visible: "CANCEL" and "CONFIRM".

6. Review and Confirm

- Step 1.** After confirming his or her dental plan, the consumer will be brought back to the Enroll To-Do List page where he or she can select “Review and confirm your coverage.”
- Step 2.** On the Attestation page, the consumer must attest to his or her acceptance of eligibility for advance payments of the premium tax credit (if applicable) by agreeing to file a federal income tax return in the upcoming year for the current tax year and/or by attesting to the filing of a joint income tax return with his or her spouse by the end of the current tax year (if married). The consumer is also attesting that no one else can claim him or her as a dependent for the current tax year on a federal income tax return. After selecting “Agree” or “Disagree,” the consumer needs to click “Save & Continue.”
- Step 3.** You can help the consumer review the selected health and dental (if applicable) plans and confirm his or her choices. The consumer must also check the box acknowledging what happens to his or her options for lowering the costs of their Marketplace coverage if the Marketplace determines that the consumer has become eligible for other coverage during the year, as shown in Exhibit 39.



Exhibit 39 – Review and Confirm Screenshot

Confirm your plan choices

You must confirm your plan choices below in order to enroll.

To change the tax credit amount you want to use each month, return to the [To-Do List](#) and select "change" next to the set premium tax credit task.

Advantage Silver \$3,250/\$10 - Partner Network

Plan ID: [REDACTED]
Health plan for [REDACTED]

Estimated effective date
01/01/2016

Health plan monthly premium	\$261.80
Premium tax credit	\$55.00
Health plan monthly premium	\$206.80

CHANGE SELECTION

PPO Basic Plan for Families

Plan ID: [REDACTED]
Dental plan for [REDACTED]

Estimated effective date
01/01/2016

Dental Plan Monthly Premium	\$11.99
-----------------------------	---------

CHANGE SELECTION

[Is someone helping you select a plan and enroll?](#)

Total \$218.79
Monthly premium total (with tax credit)

I understand that I'm not eligible to get a premium tax credit if I'm found eligible for other minimum essential coverage, like Medicaid. I also understand that if I'm eligible for other minimum essential coverage, I must contact the Marketplace to end my Marketplace coverage and premium tax credit. If I don't, the person who files taxes in my household may need to pay back my premium tax credit.

CONFIRM

C. Next Steps

1. If consumers wish to pay their health plan premium, proceed to [SOP-9 Pay Health Plan Premium](#).
2. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-8 Compare, Save, & Select Health Plans](#).



SOP-9. Pay Health Plan Premium

A. Introduction

This SOP provides guidance on how to assist consumers with making premium payments once they have selected a QHP. After the consumer has selected a QHP, the Marketplace will redirect the consumer to the QHP website, or will instruct the consumer to contact the QHP issuer directly to make premium payments. Online premium payment is optional, and not every health insurance company will accept online payments. Consumers should contact their health insurance company with any specific questions about acceptable methods or deadlines for premium payment.

Before assisting consumers when they are making a payment, it's important to understand that consumers' financial payment information (e.g., bank account, debit cards, credit cards) must be kept private and secure, just like all consumer PII that you may encounter while helping a consumer. Exhibit 40 specifies appropriate and inappropriate activities related to assisting consumers with information about premium payments:

Exhibit 40 – Premium Payment Assistance Do's and Don'ts

Do	Don't
<ul style="list-style-type: none"> Assure consumers that the assister will protect any financial information they share with the assister, and that the Marketplace does not collect their financial information, because they will make their payments directly to the issuer with which they have selected a QHP. Keep any financial information that consumers give you private and secure. Turn computers to face consumers to keep information private. Ask consumers to enter their own financial information. 	<ul style="list-style-type: none"> Use consumers' financial information for personal gain. Enter consumers' payment methods (e.g., credit card information) on their behalf.

B. Procedures

1. Make a Premium Payment

If a consumer understands the requirement to make a premium payment and the available payment options, you can proceed with the following steps to help the consumer submit a premium payment:

Step 1. Assist consumers with navigating to their Enroll To-Do List on HealthCare.gov to view their selected QHP.

Step 2. Help consumers select how they would like to make payments:

- Pay online/electronically, if available as an option.



b. Mail payments to the appropriate insurance company.

Step 3. If consumers wish to make electronic payments, they may click the “Pay for Health Plan” button (if available) to be redirected to their QHP issuer’s website, as shown in Exhibit 41.

Exhibit 41 – Pay for Health Plan Screenshot



Step 4. Once consumers have navigated to their QHP issuer's website, you can complete the following steps to assist consumers:

- a. Explain to consumers that their enrollment in a QHP is not complete until the insurance company receives the first premium payment.
- b. Explain that consumers can follow the prompts on the insurance company's website to complete electronic payments, if available. Consumers should be sure to follow their insurance company's payment policies.
- c. Encourage consumers to contact their insurance company's call center with questions about billing.
- d. Remind consumers that to protect their PII, they should log out of the insurance company's website after making their premium payments.

Things You Should Know

- Insurance companies must accept methods of payment that include options for consumers that do not have bank accounts or credit cards.

Step 5. If consumers wish to pay their premiums by mail, you can complete the following steps:

- a. Explain to consumers that enrollment in their QHP is not complete until the insurance company receives the first premium payment.
- b. Direct consumers to the insurance company's call center if they need additional billing information. Consumers should note that it may take a day or two before their QHP selection shows up in the insurance company's system.
- c. Encourage consumers to contact their insurance company's call center with questions about billing.

C. Next Steps

1. If consumers do not have their payment information with them (e.g., credit card or bank account routing info), they should access their insurance company's website or contact the insurance company's call center to make a payment at a later time.
2. If consumers have further questions or issues about premium payments, they should contact their insurance company's call center.
3. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-9 Pay Health Plan Premium](#).



SOP-10. Request an Eligibility Appeal

A. Introduction

This SOP provides guidance on how to assist consumers with submitting a request for a Marketplace eligibility appeal. The Marketplace allows consumers to request an appeal of the following:

- Eligibility or redetermination of eligibility to purchase a Marketplace QHP (including eligibility to purchase a QHP that is a catastrophic plan).
- Eligibility for an SEP.
- Eligibility or redetermination of eligibility for advance payments of the premium tax credit or cost-sharing reductions, including the amount of advance payments of the premium tax credit and cost-sharing reductions for which the consumer was determined or re-determined eligible.
- Eligibility for an exemption from the individual shared responsibility payment.
- Eligibility for Medicaid or CHIP.⁷
- A Marketplace application that has not been acted on with reasonable promptness that precluded timely notice of an eligibility determination.
- The appeal decision of a state-based appeals entity or the refusal of a state-based appeals entity to vacate dismissal of an appeal request (that is, to reinstate the appeal).

⁷ Consumers may file appeals from Medicaid and CHIP determinations with FFM only under limited circumstances.

(i) MAGI-related Medicaid denials by the FFM.

a. The following states have delegated MAGI-related Medicaid determinations to the FFM – AL, AR, LA (only through September 30, 2015), MT, NJ, ND, OR, TN, WV, WY (for MAGI-related Medicaid, not CHIP). When the FFM denies MAGI-related Medicaid to residents of those states who apply to the FFM, they may appeal those denials to the Federal Marketplace Appeals Entity (Marketplace Appeals Center). There is one exception – OR has delegated MAGI-Medicaid and CHIP determinations to the FFM, but has not delegated appeals from those determinations to the Marketplace Appeals Center. Oregonians who are denied MAGI-related Medicaid should request their appeal through the OR Fair Hearing process.

b. Option to Transfer to State Entity. Consumers in these states have a right to have their state Fair Hearing entity conduct a Medicaid Fair Hearing. They may request their MAGI-related Medicaid appeal through the Marketplace Appeals Center, but can ask that their Fair Hearings be held by their state by checking the appropriate box on their appeal request, or otherwise asking for this option. Marketplace Appeals Center will transfer such appeals to the applicable state Medicaid agency Fair Hearing entity. This option does not exist for CHIP appeals.

(ii) Appeals in Assessment States. For consumers in all other states, the FFM assesses eligibility for MAGI-related Medicaid and CHIP. The state Medicaid agency makes the final eligibility determination and aggrieved consumers may appeal through their state's Fair Hearing process.

(iii) Non-MAGI-Related Appeals. The FFM does not render eligibility determinations for non-MAGI-related Medicaid. If a state Medicaid agency denies non-MAGI Medicaid, aggrieved consumers may appeal through their state's Fair Hearing process. Consumers whose eligibility is determined on a non-MAGI basis include the aged, blind, or disabled, as well as the medically needy, present or former foster youth, consumers with long-term care needs, and some others.



SOP-10. Request an Eligibility Appeal

A consumer who disagrees with an eligibility determination made by the FFM may appeal to the Federal Marketplace Appeals Entity (Marketplace Appeals Center) within 90 days of the date of his or her eligibility notice. Upon receipt, the Marketplace Appeals Center will review the appeal request and validate the appeal based on whether it was submitted within the 90-day timeframe and whether it concerns a matter over which the Marketplace Appeals Center has jurisdiction. For example, if the appeal request is about a matter where no jurisdiction exists, such as a dispute the consumer has with a QHP issuer over a claim denial, the consumer will receive a notice explaining why the appeal request was invalid and what other options the consumer may have.

Once an appeal has been validated, the Marketplace Appeals Center will review the appeal, including all documentation provided by the consumer and available in the consumer's Marketplace eligibility record. The consumer may be asked in writing to submit additional information or contacted by phone to discuss the appeal. In many cases, the Marketplace Appeals Center will work with the consumer to resolve the appeal informally. If the consumer is satisfied with the informal resolution, a decision will be sent in the mail. Conversely, if the consumer is not satisfied with the informal resolution, the consumer can request a hearing of the appeal before a federal hearing officer, which is conducted by telephone. After the hearing, the consumer will receive a final appeal decision in the mail. If the appeal decision holds that the contested eligibility determination was incorrect, the consumer will be able to choose for the appeal decision to be effective prospectively, or retroactively to the coverage effective date associated with the incorrect eligibility determination.

The following rights are afforded to consumers as part of the appeals process:

- Consumers can ask for an expedited appeal review if they believe that they have an immediate need for health services and a delay could seriously jeopardize their health.
- Consumers may have an authorized representative to help them with their appeal. An authorized representative is a person who has the permission of the consumer to talk with the Marketplace Appeals Center about their appeal, see their information, and act for them on matters related to their appeal, including getting information about them and signing their appeal request on their behalf.
- Consumers also can have someone help them with their appeal, including at the hearing, like a friend, relative or lawyer. This person does not have to be formally designated as an authorized representative, but if they are not, they will not be allowed to act for the consumer on matters related to the consumer's appeal.
- Consumers who are appealing a redetermination of eligibility resulting in a loss or reduction of eligibility for advance payments of the premium tax credit, and if applicable, cost-sharing reductions, can request a continuation of the previous level of benefits pending their appeal. This is sometimes called "aid-paid-pending." If they do not prevail in their appeal, they would be liable for any advance payments of the premium tax credit that they had received during the appeal, which would be reconciled when they file their taxes.
- Consumers can ask the Marketplace Appeals Center to provide them a copy of their appeal record free of charge.
- Consumers can bring witnesses to testify.
- Consumers may request an auxiliary aid or service and language assistance services to make the appeals process accessible to them.

The sections that follow in this SOP provide guidance on how to assist consumers with requesting an appeal.



B. Procedures

All consumer eligibility determination notices contain instructions on how consumers may request an appeal. Consumers can mail or fax their appeal requests to the Marketplace. The appeal request may either be in the form of a letter or consumers may send a completed and signed appeal request form. Depending on consumers' preferred method for requesting an appeal, see the corresponding section below.

1. Complete and Mail or Fax an Appeal Request Form to the Marketplace

Step 1. If consumers choose to complete an appeal request form, they can find the correct appeal request form for their state by visiting [HealthCare.gov/Marketplace-Appeals](https://www.healthcare.gov/marketplace-appeals).

Step 2. Consumers should complete their state's appeal request form, and then mail or fax their completed form, a copy of the eligibility notice they would like to appeal, and copies of any supporting documentation to:

Health Insurance Marketplace
465 Industrial Blvd.
London, KY 40750-0061
Fax line: 1-877-369-0129

2. Write and Mail or Fax a Letter to the Marketplace

Step 1. If consumers choose to write a letter to the Marketplace to request an appeal, they should include the following information:

- a. Name;
- b. Address;
- c. Reason for appeal request;
- d. Name of the person (or people) on the application who is (are) appealing their eligibility determination(s); and
- e. Copy of the eligibility notice (optional, but encouraged).

Step 2. Consumers may also include copies of any supporting documentation, such as pay stubs or W2 forms to demonstrate household income. If they do not choose to submit documents with the appeal request, the Marketplace Appeals Center will notify the consumer about what, if any, information or documents it needs to adjudicate the appeal. Consumers should never send original documents, but should be sure the copies they send to the Marketplace are legible.



Step 3. The consumer should either mail or fax his or her completed letter to:

Health Insurance Marketplace
 Dept. of Health and Human Services
 465 Industrial Blvd.
 London, KY 40750-0061
 Fax line: 1-877-369-0129

Things You Should Know

- Consumers should be sure to include the ZIP code extender (the “0061”) when mailing documents or letters to the Marketplace.

3. Additional Information

Consumers may receive various notices during the appeals process. Exhibit 42 lists sample notices commonly used throughout the appeals process and their corresponding descriptions.

Exhibit 42 – Appeals Notices

Notice Type	Description
Acknowledgment of Your Marketplace Eligibility Appeal	Notice explaining the appeal request has been received
Notice of Informal Resolution	Notice explaining how CMS proposes to resolve the appeal informally, without a hearing
Notice of Hearing	Notice explaining a hearing request has been received and details on the hearing (e.g., format, date, and time)
Appeals Decision Notice	Notice explaining the outcome of the hearing
Notice of Marketplace Eligibility Appeal Dismissal	Notice explaining why the appeal has been dismissed. This notice includes a form to use if the consumer disagrees with the dismissal and wants to request that the appeal be reopened
Notice Granting (or Denying) Request to Vacate an Appeal Dismissal	Notice explaining whether an appellant demonstrated ‘good cause’ to reopen an appeal that has been dismissed

For more information on appeals, assisters and consumers can visit [HealthCare.gov/Marketplace-Appeals](https://www.healthcare.gov/marketplace-appeals).

C. Next Steps

1. If consumers require further assistance with the appeals process, consider referring them to the Consumer Assistance Program or legal services program available in their state.⁸
2. For more help answering consumers’ specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-10 Request an Eligibility Appeal](#).
3. Appellants with questions about their eligibility appeals may call the Marketplace Appeals Center at 1-855-231-1751 (TTY: 1-855-739-2231). The call center is available 7:30 AM to 8:45 PM (EST) Monday through Friday, and 10:00 AM to 5:30 PM (EST) Saturday.

⁸ For more information on Consumer Assistance Programs, visit [www.CMS.gov/CCIIO/Resources/Consumer-Assistance-Grants](https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants). For more information on legal services, visit www.lsc.gov/find-legal-aid.



SOP-11. Apply for Exemption

A. Introduction

The Affordable Care Act allows consumers to apply for an exemption from the individual shared responsibility payment. The Affordable Care Act requires applicable individuals to either have minimum essential coverage (MEC), pay a fee when filing a federal income tax return, or obtain an exemption from the requirement to maintain MEC or the fee. Refer to Exhibit 43 to learn more about the various exemptions for which consumers may qualify. Additional information on exemptions can also be found in [Appendix E: Exemptions Information](#).

Exhibit 43 – Description of Exemptions

Exemption	Description
Consumers who experienced a short coverage gap (a person who doesn't have MEC for less than three consecutive months of the year)	This exemption applies to applicable individuals who go without MEC for less than three consecutive months. Consumers can only claim this exemption when filing their federal income tax return. If an applicant has more than one short coverage gap during a year, the short coverage gap exemption only applies to the first gap.
Consumers who cannot afford coverage (affordability through tax filing)	<p>This exemption is for consumers who cannot afford coverage (based on <i>actual</i> annual household income determined when the year is over). It is only available through the federal tax filing process. Consumers may qualify for this exemption if the lowest-priced coverage available to them would cost more than 8.05% of their actual household income. It is also available when there is more than one working member of a tax household that has affordable self-only coverage, but for whom the total cost of coverage for the household is unaffordable.</p> <p>This exemption differs from the lack of affordable coverage hardship exemption, which is granted <i>prospectively</i> by the Marketplace and based on projected household income, and is applied for through the Marketplace hardship exemption application.</p>
Consumers who don't have to file a tax return because their gross income or household income is below the filing threshold	This exemption applies to consumers whose gross income or household income is below the filing threshold. This exemption is not available through the Marketplace. Consumers who don't have to file a federal income tax return are automatically exempt from the individual shared responsibility payment. However, consumers whose incomes are below the filing threshold but who choose to file a federal income tax return anyway can claim the exemption through the tax filing process.
Consumers who are members of a federally recognized Indian tribe or are Indians eligible for services through the Health Service, tribes and tribal organizations, and urban Indian organizations	This exemption applies to each consumer in a household who is a member of a federally recognized Indian tribe, or Alaska Native Shareholder Corporation; or who is eligible for health services through the Indian Health Service, tribes or tribal organizations, or urban Indian health organizations. These exemptions may be obtained by applying through the Marketplace or by claiming them on an annual federal income tax return. If the consumer is granted this exemption, he/she can keep it for future years without submitting another application as long as the membership in the federally recognized tribe, or eligibility for services from an Indian health care provider, remains unchanged.



SOP-11. Apply for Exemption

Exemption	Description
Consumers who are members of a health care sharing ministry	This exemption applies to each consumer in a household who is a member of a health care sharing ministry. A health care sharing ministry is a non-profit organization whose members have similar religious or ethical beliefs and share the expenses of one another's health care. This exemption may be obtained by applying through the Marketplace (only if the health care sharing ministry has been recognized by CMS/ Department of Health & Human Services [HHS]) or on the individual's annual federal income tax return. To verify eligibility, the Marketplace will refer to a list of known ministries that were recognized by CMS/HHS. The Marketplace can only provide this exemption retrospectively prior to 12/31 of the tax year.
Consumers who are members in a recognized religious sect with religious objections to insurance, including Social Security and Medicare (religious conscience)	This exemption applies to each consumer in a household who is a member of a religious sect that is recognized as being conscientiously opposed to the acceptance of benefits of any private or public insurance that makes payments in the event of death, disability, old age, or retirement, or makes payments towards the cost of, or provides services for, medical care (including Medicare or Medicaid). This exemption may be obtained only by applying through the Marketplace. Consumers must attest to the name of the religious sect, and the sect must be recognized by the SSA. These individuals are generally Amish or Mennonite.
Consumers who were incarcerated, other than being held pending disposition of charges	This exemption applies to each consumer in a household who was in a jail, prison, or similar penal institution, or correctional facility, other than pending disposition of charges. This exemption may be obtained by applying through the Marketplace or on the individual's federal income annual tax return. The consumer must attest to the dates they were incarcerated. The Marketplace can only provide this exemption retrospectively prior to 12/31 of the tax year.
Consumers who aren't citizens or U.S. nationals and who aren't lawfully present in the U.S.	Consumers who aren't citizens or nationals of the U.S. and are not lawfully present in the U.S. are exempt. Many consumers do file a return despite this immigration status. The consumers who do file federal income tax returns should apply for this exemption when filing their federal income tax returns.
Consumers who are experiencing a hardship	<p>This exemption applies to consumers who experienced an event that kept them from obtaining coverage under a QHP. Hardship exemptions are defined in 45 CFR 155.605(g). The length of the hardship exemption varies depending on the type, but is usually granted for one month prior to, one month after, and during the hardship event. In most cases, this exemption may be obtained by applying through the Marketplace. Consumers who are ineligible for Medicaid based on a state's decision not to expand Medicaid may apply for this exemption when filing their federal income tax returns.⁹</p> <p>Consumers who are granted a hardship exemption can purchase catastrophic health coverage through the Marketplace even if they are over 30 years of age.</p>

*

⁹ Additional information can be found at: <https://www.CMS.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Hardship-Exemption-Guidance-3-20-15-FINAL.pdf>. This updated guidance addresses CHIP Buy-in Programs and Elite Athlete Health Insurance, which do not qualify as MEC.



Consumers may apply for an exemption through the Marketplace at any time during the year. Incarceration, religious conscience and health care sharing ministry exemption requests for a given year must be submitted by December 31 of that year. Exemptions available through the federal tax filing process may be claimed when applicants file their federal income taxes for the year. The exemption for unaffordable coverage processed by the Marketplace is available prospectively ONLY. After the tax year ends, the consumer must claim this exemption via his or her tax return.

The sections that follow in this SOP provide guidance on how to assist consumers with completing their exemption application.

B. Procedures

1. Hardship Exemptions to Purchase Catastrophic Coverage

Consumers may be eligible for an exemption based on financial or other circumstances that prevented them from obtaining coverage in a QHP. If a consumer qualifies for and receives one of these hardship exemptions, he or she may enroll in a catastrophic plan.

Step 1. Consumers should download and fill out the appropriate application for either an [affordability exemption](#)¹⁰ or a [hardship exemption](#),¹¹ depending on the consumer's specific situation. Consumers should mail the application to:

Health Insurance Marketplace – Exemption Processing
465 Industrial Blvd.
London, KY 40741

Step 2. The Marketplace will review the exemption application and determine consumers' eligibility for an exemption. The Marketplace may request more information or documentation from consumers as part of this review.

Step 3. The Marketplace will mail consumers a notice of the exemption eligibility result. If consumers are granted an exemption, the Marketplace notice will include their unique exemption certificate number (ECN).

Step 4. Consumers should read and understand the notice. The notice will direct consumers to view [Catastrophic Plan Information](#) or call the Marketplace Call Center at 1-800-318-2596 for assistance with shopping for a plan, if they're interested in purchasing coverage.

Step 5. Assist consumers with contacting the health insurance company of their choice to enroll, if preferred.

¹⁰ <https://Marketplace.CMS.gov/applications-and-forms/affordability-ffm-exemption-2015.pdf>

¹¹ <https://Marketplace.CMS.gov/applications-and-forms/hardship-exemption.pdf>



2. Hardship Exemptions to Purchase Catastrophic Coverage for Consumers Who Receive Policy Cancellation Notices

If a consumer has been notified that his or her health plan has been cancelled due to lack of compliance with Affordable Care Act standards, and the consumer believes that the QHP options available through the individual market in the Marketplace in the area are unaffordable, the consumer may be eligible for a hardship exemption and may be able to enroll in catastrophic coverage if available in his or her area.¹² Consumers whose coverage was cancelled may enroll using the steps in the section immediately above, or they can choose to enroll in a catastrophic plan directly with the insurer of their choice by following the steps outlined below. For information, QHP options, and insurer contact numbers, visit [Catastrophic Plan Information](#) or call 1-866-837-0677, a special phone number for people whose plans have been canceled.¹³

- Step 1.** Consumers should download and fill out the form for a [hardship exemption](#).¹⁴ Consumers should be sure to answer that their reason for applying is that the consumer's individual policy was canceled and they do not feel available coverage is affordable.
- Step 2.** Consumers can view a list of catastrophic plans available through HealthCare.gov.
- Step 3.** The consumer should submit the completed hardship exemption form to an insurance company that sells catastrophic plans to show that they qualify to buy one. The consumer should also submit a copy of the cancellation notice to the insurance company.
- Step 4.** The health insurance company may send the form to the Marketplace to confirm that the consumer is eligible for a hardship exemption. However, consumers may buy catastrophic coverage right away.

3. Other Exemptions

Depending on the type of exemption, consumers may apply for an exemption via the Marketplace or claim it when filing their federal tax returns. Use the information and instructions below to help consumers with applying for exemptions.

- Step 1.** If consumers have not yet started an application for an exemption, they should determine the appropriate exemption application (see [Appendix E: Exemptions Information](#)), download the application with the link provided, and determine what information is required to complete the application. If consumers have brought a previously started exemption application, they should proceed to the section in the application where assistance is required.
- Step 2.** The following guidance may be helpful to consumers completing exemption applications:
 - a. In Step 1 of the application, consumers input their name, address, phone number, preferred language, and other personal information, as shown in Exhibit 44.

¹² Catastrophic plans are not available in all states.

¹³ 9 AM – 7 PM EST Monday – Friday and 9 AM – 5 PM EST Saturday – Sunday

¹⁴ <https://Marketplace.CMS.gov/applications-and-forms/hardship-exemption.pdf>



Exhibit 44 – Step 1 of Exemption Application

STEP 1: Tell us about yourself.

(The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information even if the adult doesn't need the exemption.)

Form with fields for: Give your legal name (First, Middle, Last, Suffix), Home address, Apartment or suite number, City, State, ZIP code, County, parish, or township, Mailing address, Daytime phone number, Evening phone number, and preferred spoken/written language.

- b. In Step 2 of the application, consumers input the information required for the specific exemption application, such as information about members of the applicant's tax household (e.g., Social Security number, demographic information, financial information). Be sure to complete a Step 2 page for every person in the consumer's tax household.

Exhibit 45 – Step 2 of Exemption Application

STEP 2: Tell us about your tax household.

Who do you need to include on this application?

You need to complete Step 2 for every person in your household who is on the same federal income tax return. If the person doesn't want an exemption, just answer questions 1-7 of Step 2.

For Person 1:

Person 1 must be an adult who files a federal income tax return in your household, even if they don't want an exemption.

For Person 2:

Person 2 can be either:

- A spouse who files taxes jointly with Person 1.
- Anyone that Person 1 claims as a dependent on the same tax return.

Who not to include:

- A spouse who files taxes separately. Spouses who file separately need to fill out a separate application for themselves and for each person they claim on their tax returns.
- Anyone who lives with you but who isn't listed on your tax return. Each person who needs an exemption must be on an application with the person who lists them on a tax return.

If you don't plan to file taxes, you don't need to apply for an exemption.

You'll get an eligibility determination letter in the mail after your application is processed. If you get this exemption, we'll give you an Exemption Certificate Number (ECN) with your approval letter. Keep the letter for your records. You'll need to put this number on your federal income tax return at the time you file taxes.

We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for an exemption.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov, or call us at 1-800-318-2596. Para obtener una copia de este formulario en Español, llame 1-800-318-2596. If you need help in a language other than English, call 1-800-318-2596 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-855-889-4325. HARDSHIP

- c. In Step 3 of the application, consumers should review the information provided, confirm that the answers they provided are accurate, and sign their application.



Exhibit 46 – Step 3 of Exemption Application

STEP 3: Read & sign this application



- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.

What should I do if I think the results of my exemption application are wrong?

If you don't agree with the results of your exemption application, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you make an appeal request or participate in your appeal. This is optional.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, visit HealthCare.gov/marketplace-appeals/. Or call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. The person who signs this application must be the person who files a federal income tax return and is an adult over the age of 18.

<p>Signature</p>	<p>Date signed (mm/dd/yyyy)</p>
<p>_____</p>	<p>____/____/____</p>

- d. In Step 4 of the application, consumers should review the instructions for mailing their completed application and copies of any supporting documentation. Documentation is required for most exemptions.
- e. Depending on the type of exemption application, consumers may need assistance completing additional steps, inputting information in the appendices of the application, or gathering any required supporting documentation. You can provide consumer assistance as needed.

Step 3. Consumers should mail their exemption application and any supporting documentation to:

Health Insurance Marketplace – Exemption Processing
 465 Industrial Blvd
 London, KY 40741

C. Next Steps

1. After consumers submit their exemption application, the Marketplace will notify them about any additional supporting documentation needed and the status of their exemption application.
2. If consumers receive an exemption, they will be assigned an ECN. Consumers will need their ECN:
 - If they qualify for a hardship exemption and plan to enroll in a catastrophic health plan in the Marketplace.
 - If they plan to file a federal income tax return, so the IRS knows that they have an exemption. The federal income tax return will include instructions for where consumers should provide their ECN in their federal income tax return forms.
3. If consumers do not receive an exemption, you can assist them with applying for health coverage by referring to [SOP-3 Create an Account](#).
4. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-11 Apply for Exemption](#).



SOP-12. Update Account Profile

A. Introduction

Consumers can update their Marketplace account information through the Account Settings tab. In general, the Marketplace uses the consumer's contact information and preferences to send Marketplace communications such as notices. However, the consumer's plan only receives consumer information that is provided on the application, either initially at enrollment or through a reported life change. Some changes, such as those made to communication preferences or a consumer's account password will have no effect on a consumer's eligibility determination. Other updates to application information (which can be made using the "Report a life change" function), such as updating a state of residence or a change in income, may affect a consumer's eligibility to obtain coverage through the Marketplace or for help paying for coverage. This SOP provides guidance on how to assist consumers in updating their account profiles.

B. Procedures

1. Update Account Profile

Consumers updating their account profiles should complete the following steps:

Step 1. Consumers can log in to their accounts on HealthCare.gov and select the My Profile tab.

Step 2. The following information can be changed on the My Profile tab:

- a. Password;
- b. E-mail address;
- c. Phone number;*
- d. Address;*
- e. State in which the consumer lives;* and
- f. Security questions.

Things You Should Know

- Consumers can find this information on the My Profile screen or by viewing current applications on the Current Applications & Coverage screen.

**To update addresses to a new ZIP code, county, or state, consumers must report a life change. This address change may affect consumers' eligibility. The consumer's plan will only receive the phone number and email address if the consumer confirms enrollment on that application by continuing all the way through Plan Compare.*

2. Update Communication Preferences

Consumers updating their communication preferences should complete the following steps:

Step 1. Consumers can log in to their accounts and select the My Applications & Coverage tab, then select the application for which they would like to update communication preferences.



Step 2. Consumers should select the Communication Preferences tab, as shown in Exhibit 47.

Exhibit 47 – Communication Preferences Screenshot

The screenshot shows the HealthCare.gov website interface. At the top, there are navigation tabs for "Individuals & Families" and "Small Businesses". The user is logged in as "Andre" and can click "Logout" or "Español". The main header shows "Pennsylvania" and a "HELP" button. Below the header, there is a breadcrumb trail: "2016 application for Individuals & Families (ID#: [redacted])" and a "View all applications" link. The main content area is titled "Communication preferences" and includes a sidebar with a list of options: "My plans & programs", "Eligibility & appeals", "Applications details", "Report a life change", "Communication preferences" (which is highlighted), "Authorized users", and "Exemptions". The main content area contains the text: "All fields are required unless they're marked optional. You can make changes to the way you get Marketplace information. Information shown here comes from your application." Below this text is a form field for "Email address" with an "EDIT" button next to it.

Step 3. The following information can be changed on the Communication Preferences tab:

- a. E-mail address;
- b. Phone number;
- c. Second phone number;
- d. Notifications (i.e., prefer to receive via text message or e-mail);
- e. Notices (i.e., prefer to receive electronic or paper notices*);
- f. Preferred spoken language; and
- g. Preferred written language.

**Consumers may also edit the address to which they would like paper notices sent. To update addresses to a new ZIP code, county, or state, consumers must report a life change. This life change may affect consumers' eligibility if the change is being made to their home address.*

3. Remove an Authorized User

Step 1. Consumers can log in to their accounts and select the My Applications & Coverage tab, then select the application from which they would like to remove an authorized user.

Step 2. Consumers should select the Authorized Users tab, as shown in Exhibit 48.



Exhibit 48 – Authorized Users Screenshot

2016 application for Individuals & Families (ID#: [redacted]) View all applications

- My plans & programs
- Eligibility & appeals
- Applications details
- Report a life change
- Communication preferences
- Authorized users**
- Exemptions
- Tax forms

Authorized users

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “Authorized user.” You can remove an authorized user at any time.

People authorized to access this application

You have chosen to authorize this person to access this application and act on your behalf.

Name:	Type:	Status:	Helps With	Action:
[redacted]	Navigator	Active	Application	REMOVE

Step 3. On this screen, consumers may remove any authorized users whom they designated during the initial application process. If consumers wish to add an authorized user, refer to [SOP-13 Report Life Changes](#).

C. Next Steps

1. When life changes happen, consumers should return to the Marketplace and update their account information as soon as possible. If consumers want to update their applications because of new life events (e.g., birth of a child, income increase), proceed to [SOP-13 Report Life Changes](#).
2. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-12 Update Account Profile](#).



SOP-13. Report Life Changes

A. Introduction

This SOP provides guidance on how to assist consumers with updating their eligibility application information. Consumers may experience life changes (e.g., marriage, relocation, birth of a child, or change in income, citizenship or immigration status) during the year. The Marketplace strongly recommends that consumers update their account information as soon as possible when life changes happen. Consumers must report changes to their application information within 30 days of the change, and the Marketplace will redetermine consumers' eligibility after any changes are reported, and will notify consumers of any resulting changes in eligibility and next steps.

B. Procedures

1. Reporting Life Changes

To assist consumers with updates to reflect new life changes, proceed with the following steps:

- Step 1.** Consumers should log in to their accounts and select the My Applications & Coverage tab, then select the application for which they would like to report life changes.
- Step 2.** Consumers should select the Report a Life Change tab, as shown in Exhibit 49.



Exhibit 49 – Report a Life Change Screenshot

The screenshot shows a web interface for reporting a life change. At the top, there is a navigation bar with a back arrow, a user ID '2016 application for Individuals & Families (ID#: [redacted])', and a link 'View all applications'. A left sidebar contains a menu with options: 'My plans & programs', 'Eligibility & appeals', 'Applications details', 'Report a life change' (highlighted in blue), 'Communication preferences', 'Authorized users', 'Exemptions', and 'Tax forms'. The main content area is titled 'Report a life change' and includes a sub-header 'Some changes may qualify you or your dependents for a Special Enrollment Period.' Below this is a section 'What kind of changes should I report?' with a paragraph explaining that household income and size affect program eligibility. A list of 'Examples of changes to report:' includes: household income changes, household size changes (marriage, divorce, new baby, moving out), new coverage needs, getting new coverage, citizenship/immigration status changes, and preferences for information delivery and tax filing status. An 'Important' note states that income information should be checked frequently for eligibility. A final section 'After you report a change:' lists: receiving new eligibility results, finding out about help costs, and checking enrollment details. A green button at the bottom reads 'REPORT A LIFE CHANGE'.



Step 3. Review the types of possible life changes, listed in Exhibit 50, with consumers.

Exhibit 50 – Life Changes

Life Event	Potential Updates
Citizenship/Immigration Status Change	<ul style="list-style-type: none"> Change in citizenship or immigration status for a household member needing coverage
Residency Changes	<ul style="list-style-type: none"> Report a new residential address
Incarceration Status Change	<ul style="list-style-type: none"> Claim current incarceration (in detention or jail) for household member Claim end of incarceration period for household member
Tax Filing Status Change	<ul style="list-style-type: none"> Claim new tax filing status (e.g., married, single, divorced) Add, remove, or change tax dependents
Pregnancy Status Change	<ul style="list-style-type: none"> Claim current pregnancy status Claim end of pregnancy status
Household Member Change	<ul style="list-style-type: none"> Add or remove member of household (including through birth, adoption or placement of child for adoption) Change household members' names Update household contact Update marital status or other family relationships Report that a household member has a physical disability or mental health condition that limits their ability to work, attend school, or take care of daily needs Remove member of household from coverage
Change in Request to Lower Health Plan Costs	<ul style="list-style-type: none"> Request advance payments of the premium tax credit and cost-sharing reductions End request for advance payments of the premium tax credit and cost-sharing reductions
Income Change	<ul style="list-style-type: none"> Increase or decrease in income
Employer-Sponsored MEC Change	<ul style="list-style-type: none"> Changes to employer-sponsored coverage (e.g., changes to premiums, coverage no longer offered by employer) Changes to employment status
Other MEC Changes	<ul style="list-style-type: none"> Gained or lost health coverage (e.g., Medicaid, CHIP, Medicare) in the last 60 days Will gain or lose health coverage in the next 60 days Gained eligibility for Medicare coverage on 65th birthday or receives disability benefits

Step 4. Assist consumers with selecting the type of change they would like to report from the options menu.

Confirm that the consumer wants to report one of the life changes listed in Exhibit 50.

Assist consumers as they update their application to account for any life changes. Remind consumers that their eligibility results may change as a result of the life change and how this may affect their coverage options.

Things You Should Know

- The system returns a list of the supporting documents required depending on the life changes reported. Consumers will see both their previously-uploaded documents and those that they still need to upload.

Step 5. Help consumers submit any required supporting documentation and review updated eligibility results.



C. Next Steps

1. If consumers receive a new eligibility determination after reporting life changes, proceed to [SOP-6 Review Eligibility Determination](#).
2. For more help answering consumers' specific questions, see Appendix A for [Frequently Asked Questions \(FAQs\) related to SOP-13 Report Life Changes](#).



SOP-14. Renew Health Coverage

A. Introduction

As an assister, you can help consumers renew their enrollment in QHPs through the Marketplace. The process for renewal of health coverage begins with the Marketplace's annual eligibility redetermination process for all consumers who were determined eligible for enrollment in a QHP in the previous year. Consumers are responsible for notifying the Marketplace within 30 days of any changes in their application information during the year. This helps ensure an accurate redetermination of eligibility. Any changes in coverage or eligibility as a result of the annual eligibility redetermination will be effective on January 1 of the next year.

If a consumer requested help paying for health coverage, agreed to allow the Marketplace to re-check their tax return information on an annual basis, and has properly reconciled any advance payments of the premium tax credit received for the 2014 benefit year with the IRS, the Marketplace will then check the consumer's income data from the IRS and use it to redetermine his or her eligibility for help paying for health coverage. For consumers covered by Medicaid or CHIP, their states' Medicaid or CHIP agencies will generally redetermine their eligibility for these programs on an annual basis.

The Marketplace will send consumers a Marketplace Open Enrollment Notice by November 1, 2015, for the coming year. Every consumer is encouraged to come back to the Marketplace or log into his or her HealthCare.gov account to update their application information and compare plan options to be sure they are receiving the correct amount of help paying for coverage and will enroll in 2016 coverage that works best for them.

If a consumer did not agree to allow the Marketplace to re-check his or her tax return information on an annual basis at the time that the consumer filed his or her eligibility application, the Marketplace will still send the consumer a notice, but the notice will tell the consumer that if he or she wants to receive, or continue to receive, advance payments of the premium tax credit or income-based cost-sharing reductions for 2016, the consumer must contact the Marketplace or go to HealthCare.gov to update his or her information. Otherwise, any help paying for coverage the consumer may be receiving will end on December 31, 2015. Similarly, if enrollees failed to reconcile 2014 advance payments of the premium tax credit by filing taxes with completed IRS Form 8962 for the 2014 tax year, enrollees will lose any help paying for coverage after December 31, 2015.

The majority of current Marketplace enrollees will be automatically enrolled in coverage for the next benefit year under the reenrollment guidelines established for the Marketplaces if they don't do anything. However, if consumers don't return to the Marketplace and select 2016 coverage by December 15, 2015, they could miss out on better deals and cost savings for coverage starting on January 1, 2016. That's why CMS is advising assisters to strongly encourage all consumers – even those who plan to reenroll in their same plan – to come back to the Marketplace to review their plan options, as well as their application information.

In addition to the Marketplace Open Enrollment Notices, all consumers who are enrolled in a QHP and whose coverage can be renewed through the Marketplace will get a notice from their health insurance company before November 1, 2015, informing them of either the eligibility amount for financial assistance for 2016 coverage or an estimated amount based on 2015 financial assistance. If the health insurance company's renewal letter estimated 2016 eligibility for financial assistance instead of indicating the actual amount, the company must



notify the enrollee through either the January 2016 bill and/or a separate notice of the actual 2016 financial assistance once it is available from the Marketplace.

The plan's renewal letter will also identify the enrollee's 2016 plan, if available. The plan notice will describe any changes to the enrollee's QHP. If the QHP will be discontinued or non-renewed, the issuer will send a notice that will inform consumers which plan, if any, the consumers will be enrolled in for 2016. For the 2016 coverage year, consumers whose QHPs are being discontinued or non-renewed may be enrolled automatically into a different plan offered by the insurance company, unless these consumers return to the Marketplace and select new QHPs.

The remainder of this SOP provides guidance on how to assist consumers with their annual eligibility redeterminations and completing the renewal process.

B. Procedures

Step 1. All consumers who are currently enrolled in a QHP through the Marketplace for plan year 2015 will be sent a Marketplace Open Enrollment Notice by November 1 that contains the following information:

- a. A note that the Open Enrollment period begins November 1, 2015, and ends January 31, 2016.
- b. A description of the annual eligibility redetermination and renewal process.
- c. The requirement to report changes to information affecting eligibility and the timeframe and channels through which changes can be reported.
- d. The key dates for ensuring coverage is effective on January 1, 2016.
- e. The reconciliation process for consumers receiving advance payments of the premium tax credit and/or cost-sharing reductions.
- f. Special instructions for those consumers receiving advance payments of the premium tax credit or cost-sharing reductions. For more information on these instructions, see Step 4.

Step 2. Assist consumers with reviewing their Marketplace Open Enrollment Notice.

Step 3. Explain to consumers that they should update their eligibility application with any new or changed information about themselves or their households.

Step 4. Assist consumers with reporting any changes or new information (e.g., annual household income, household size) to the Marketplace. Keep in mind the guidance below based on different consumer scenarios:

- a. If consumers who applied for but were determined ineligible for advance payments of the premium tax credits or income-based cost-sharing reductions contact the Marketplace to report any changes or select a new QHP, they will receive an updated eligibility determination based on updated thresholds and criteria (e.g., federal poverty levels) for the upcoming plan year.
- b. If consumers who are not receiving advance payments of the premium tax credit or income-based cost-sharing reductions do not contact the Marketplace within the specified timeframe, generally, the Marketplace will automatically reenroll them in the coverage for the next benefit year under



the reenrollment guidelines established for the Marketplaces for the 2016 benefit year, without advance payments of the premium tax credit or cost-sharing reductions.

- c. Consumers who are receiving advance payments of the premium tax credit or cost-sharing reductions and agreed to allow the Marketplace to re-check their tax return information on an annual basis and have reconciled any previous advance payments of the premium tax credit with the IRS for the 2014 plan year should be aware of the following key points about their annual eligibility redetermination and renewal process:
- If consumers have provided updated eligibility information to the Marketplace, the eligibility redetermination notice will be based on their most recent eligibility information on file.
 - If consumers have not provided updated eligibility information, the notice will encourage them to contact the Marketplace to get an updated eligibility determination by December 15, 2015.
 - If consumers do not update their information, the Marketplace generally will renew their QHP enrollment for the next calendar year into coverage for the next benefit year under the reenrollment guidelines established for the Marketplaces, with the same level of help selected in the previous year, but applied to the updated amount of income-based cost-sharing reductions and advance payments of the premium tax credit based on the newest income and household size data available to the Marketplace, updated FPL tables, and 2016 benchmark plan premiums.^{15,16}
- d. Consumers who are receiving advance payments of the premium tax credit or cost-sharing reductions and did not agree to allow the Marketplace to re-check their tax return information on an annual basis should be aware of the following key points about their annual eligibility redetermination and renewal process:
- The Marketplace Open Enrollment Notice will ask consumers to contact the Marketplace to get an updated eligibility determination.

¹⁵ The amount of premium tax credits consumers will receive in the new plan year depends on the amount consumers elected to receive in the previous plan year and the amount of consumers' premiums for the new plan year. For consumers who were determined eligible for advance payments of the premium tax credit, the same percent of premium tax credit that consumer elected to apply toward his or her total premium amount for the previous benefit year will be applied as the updated advance payments of the premium tax credit for the new plan year.

¹⁶ Exceptions to this rule include: (1) if the redetermination reveals a household income in excess of 500% of the FPL, (2) if the consumer did not select the option to allow for the Marketplace to conduct a redetermination review and access updated tax return information for the eligibility redetermination process, and/or (3) if the tax filer in the consumer's household has not filed a tax return and reconciled the advance payments of the premium tax credit received during that tax year. In these cases, see the special notice information here: <https://www.CMS.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.pdf>.



- If consumers do not contact the Marketplace by December 15, their financial assistance (advance payments of premium tax credit or cost-sharing reductions) will end on December 31.
 - If consumers are still eligible for QHP coverage, the Marketplace generally will renew their coverage for the next benefit year under the reenrollment guidelines established for the Marketplaces, but without financial assistance to help lower costs. Applicable regulations specify the hierarchy of plans that the Marketplace will use to determine which QHP the consumer will be automatically enrolled in for 2016 coverage.¹⁷
- e. For consumers who are receiving advance payments of the premium tax credit or cost-sharing reductions and did not file a tax return and reconcile the premium tax credit for the 2014 coverage year, advance payments of the premium tax credit and/or cost-sharing reductions will end on December 31, 2015. Here are key points about their annual eligibility redetermination and renewal process:
- The Marketplace Open Enrollment Notice will ask consumers to take action to ensure they file a 2014 tax return and then return to the Marketplace to update their application and attest to having filed a tax return. If consumers attest to having filed a tax return by December 15, the Marketplace generally will renew their coverage for the next benefit year under the reenrollment guidelines established for the Marketplace with financial assistance.
 - If consumers do not return to the Marketplace to attest to having filed a tax return and get an updated eligibility determination by December 15, their financial assistance will end on December 31, 2015.

Step 5. If consumers are unsure if they agreed to allow the Marketplace to re-check their tax return information on an annual basis, inform consumers that they may return to the Marketplace to provide this authorization when they update their 2016 eligibility and plan selection.

Step 6. Enrollment.

Changes submitted on a 2016 application generally don't take effect unless consumers complete the process by continuing to enrollment and select a plan. If returning consumers want to keep their Marketplace plan for next year, they should select "Saved Plans" at the top of the plan results in Plan Compare.

Even if the consumer is satisfied with his or her 2015 plan, it is still a good idea for the consumer to compare plans to see what's covered, whether desired providers and prescription drugs are still in the plan, and compare costs.

¹⁷ See 45 C.F.R. § 155.335(a)(2).



C. Next Steps

1. If consumers receive updated eligibility notices, proceed to [SOP-6 Review Eligibility Determination](#).
2. If consumers would like to file an appeals request, proceed to [SOP-10 Request an Eligibility Appeal](#).
3. If consumers would like to complete an exemption application, proceed to [SOP-11 Apply for Exemption](#).
4. For more help answering consumers' specific questions, see the [Frequently Asked Questions \(FAQs\) related to SOP-14 Renew Health Coverage](#).



Appendices

Appendix A: Frequently Asked Questions (FAQs)

Assisters may encounter questions while helping consumers. The FAQs in this section are organized by topic area and may serve as an aid to the assister throughout the consumer assistance process.

SOP-1 Receive Consent to Access Consumer Information

The FAQs below are designed to help assisters answer consumers' specific questions on giving consent. For more information on this topic, see [SOP-1 Receive Consent Before Accessing Consumer PII](#) .

FAQ 1. Why are you asking me to provide consent?

- Answer: Your consent is an important step in the consumer assistance process. It ensures that you are aware of your rights and responsibilities within the Individual Marketplace, understand the role of assisters, and are making an informed decision to share your personal information with an assister.

SOP-2 Assess Consumers' Knowledge & Needs

The FAQs below are designed to help assisters answer consumers' specific questions on how assisters assess consumers' knowledge of and needs within the Individual Marketplace. For more information on this topic, see [SOP-2 Assess Consumers' Knowledge & Needs](#).

FAQ 2. Why do assisters ask questions to assess my knowledge and needs before helping me with eligibility and enrollment activities in the Individual Marketplace?

- Answer: For an assister to help you make the most informed choices about your health coverage, an assister needs to understand how much you know about health coverage, the Affordable Care Act, and the Marketplace. You might also have specific health needs that should be taken into consideration when you are comparing health coverage options. Therefore, assisters want to understand your needs to tailor their assistance to meet your unique circumstances.

FAQ 3. How do assisters assess my knowledge and needs?

- Answer: Assisters will have an informal conversation with you and ask you a number of questions designed to evaluate your knowledge and needs for health coverage. For example, an assister might ask if you have concerns about paying for coverage and whether you know that you may be eligible for help paying for coverage. They may also ask you whether you understand how premiums, deductibles, coinsurance, and copayments work.



SOP-3 Create an Account

The FAQs below are designed to help assisters answer consumers' specific questions on creating an eligibility account through the Individual Marketplace. For more information on this topic, see [SOP-3 Create an Account](#).

FAQ 4. Why do I need an account?

- Answer: An account allows you to electronically submit your application, compare and select QHPs, view the status of your application, and complete other Marketplace-related activities.

FAQ 5. Can I set up multiple accounts?

- Answer: No, you are only able to create one account.

FAQ 6. What if I do not have an e-mail account?

- Answer: You may create an e-mail account with an e-mail service provider of your choice or choose to submit a paper application to participate in the Marketplace.

FAQ 7. What if my password is not accepted?

- Answer: If you are still unable to create a password after confirming you have followed the requirements, contact the Marketplace Call Center for further assistance.

FAQ 8. What if my username is not accepted?

- Answer: You cannot select a username if it is already in use by another applicant. You should try another username, or contact the Marketplace Call Center for further help.

FAQ 9. Can I still set up an online account after I mail in my paper application?

- Answer: If you have submitted a paper application and wish to set up an online account, you should contact the Marketplace Call Center to obtain an application ID number after you receive your eligibility notice in the mail, if available. You should then go to the HealthCare.gov website and click on "Find my application" on the login screen of the MyAccount page and then enter your application ID number and create an online account that is linked to the paper application you submitted. Please remember that all information - first name, last name, city, state, and zip code - for the person listed as **the household contact** on the original application must be an exact match for the contact information used for identity proofing when creating an account on HealthCare.gov. From here, you will be able to view your eligibility determinations and continue with the enrollment process.

FAQ 10. Should I make sure to remember or keep a secure record of my username, password, and application ID once they are created?

- Answer: Yes. You will need your username and password each time you log in to HealthCare.gov and you may need your application ID for certain Marketplace activities (e.g., submitting supporting documentation, filing an appeal).



SOP-4 Verify Identity

The FAQs below are designed to help assisters answer consumers' specific questions on identity verification in the Individual Marketplace. For more information on this topic, see [SOP-4 Verify Identity](#).

FAQ 11. Why do I need to verify my identity?

- Answer: To protect your personal information, you have to take a few steps to verify your identity before you can finish creating a Marketplace account and completing an application online. Without this process, an unauthorized person could create an account and apply for health coverage in your name without your knowledge.

FAQ 12. How does HealthCare.gov verify my identity?

- Answer: HealthCare.gov compares your responses to identity verification questions with information from your Experian consumer report.

FAQ 13. Why was my identity verification unsuccessful?

- Answer: Identity verification uses specific information contained in your Experian consumer report. Sometimes this information has not been recently updated or the information is inaccurate. For example, you may have recently paid off a loan that has not yet been reported to Experian. Other times, Experian may not have enough information about you in its systems to successfully verify your identity.

FAQ 14. Will identity verification affect my credit score?

- Answer: No. If you check your credit report, you may see an inquiry from CMS. CMS uses consumer reporting agencies like Experian to verify the information you use to create an account. Your credit score will not be affected by inquiries from CMS.

FAQ 15. If my identity verification is unsuccessful, will I be unable to enroll in a Marketplace plan?

- Answer: If you are unable to verify your identity successfully, you should call the Marketplace Call Center. They will be able to assist you with the identity verification process as well as with completing an application and submitting a plan selection.

SOP-5 Apply for Health Coverage

The FAQs below are designed to help assisters answer consumers' specific questions on eligibility applications in the Individual Marketplace. For more information on this topic, see [SOP-5 Apply for Health Coverage](#).

FAQ 16. Do I have to enter my SSN to apply for health coverage?

- Answer: If you have an SSN and you are applying for health coverage for yourself, you must provide your SSN. If you do not have a SSN or you are not applying for coverage for yourself, you are not required to enter one, unless you are the tax filer whose tax return information is used to determine eligibility for an applicant. However, even if you are not applying for coverage for yourself or are not the tax filer, entering your SSN may allow the Marketplace to more quickly determine applicants' eligibility for coverage. It may also help to prevent a request from the Marketplace for additional documentation.



FAQ 17. Why do I need to submit supporting documentation?

- Answer: The Marketplace may request supporting documentation to verify the information you provided on your application. The Marketplace verifies information to ensure only eligible individuals obtain coverage through the Marketplace and/or eligibility for help paying for coverage.

FAQ 18. How do I convert my paper application to the electronic format if I have not yet submitted the application?

- Answer: If you have not yet submitted your application, you will need to follow a manual process to convert your paper application to an electronic format. You may create an account online and complete identity proofing. Enter the information you have collected on the paper application in the fields provided by the Marketplace portal.

FAQ 19. I want to change or remove an eligibility application that I previously started. How can I do this?

- Answer: Log in to your account to view any eligibility applications that you previously submitted or that are still in progress. To remove an application, click the "Remove" button listed under the application's ID number. To edit information on an application that is still in-progress, click on the application you would like to edit then select the Continue Application link.

FAQ 20. How do I know when the Marketplace receives the documents I scanned and uploaded from home?

- Answer: You can log in to your account and verify whether the Marketplace has received your documents.

FAQ 21. If the document I am scanning has multiple pages, can I upload each page separately?

- Answer: Yes, you may upload pages separately.

FAQ 22. Why do you need to know if I currently have health coverage?

- Answer: If you already have health coverage that meets MEC requirements other than individual market coverage, then you will not be eligible to receive the benefit of advance payments of the premium tax credit or cost-sharing reductions (although you may be eligible to purchase coverage through the Marketplace without financial assistance). However, if you have job-based coverage but it is not considered affordable for you or it does not meet minimum value standards, you might still be eligible to receive advance payments of the premium tax credit and cost-sharing reductions to lower the cost of your QHP through the Marketplace (see definition of minimum value standards in Appendix B).

FAQ 23. Can I see the plans I might be able to purchase before I finish my application?

- Answer: Yes, on the HealthCare.gov homepage, you may select the See Plans and Prices link. After providing basic information including age, location, and the type of plan desired, consumers can view a list of plans and estimated premiums. All premium prices and other costs shown will be estimates, as consumers must complete their eligibility application to receive exact information about what their costs will be.



FAQ 24. Will I be able view, compare, and select QHPs while the Marketplace verifies my application information?

- Answer: Yes, you will be able to view, compare and select a QHP. You will also be able to see the eligibility that you will be provided while the Marketplace processes any supporting documentation that may be needed from you, if applicable.

FAQ 25. Should I upload **and** mail my supporting documentation?

- Answer: No. This will not expedite the process. Please choose one method to submit the information. Your documents will be processed more quickly if you upload them.

FAQ 26. How can I check on the status of the supporting documentation I submitted to the Marketplace?

- Answer: If you would like to follow up with the Marketplace for a status update on the supporting documentation you submitted via upload or mail, you can contact the Marketplace Call Center. The Call Center will ask for some information, such as your name, date of birth, and application ID number.

FAQ 27. I am a shareholder of an Alaska Native Claims Settlement Act corporation or member of a federally recognized Indian tribe. When can I apply for and enroll in health coverage through the Marketplace?

- Answer: Members of federally recognized tribes and Alaska Native corporation shareholders can apply for and enroll in Marketplace coverage at any time of year. There is no requirement to wait for an open enrollment period and you can change plans as often as once per month.

SOP-6 Review Eligibility Determination

The FAQs below are designed to help assisters answer consumers' specific questions on eligibility determinations received through the Individual Marketplace. For more information on this topic, see [SOP-6 Review Eligibility Results](#).

FAQ 28. What if I did not receive my eligibility results?

- Answer: If you have an account, you should log in to your account and confirm that you have not received an electronic notice in your Message Center. If you are waiting for a paper notice, you may reach out to the Marketplace Call Center to receive further assistance.

FAQ 29. If I think I am eligible for higher advance payments of the premium tax credit or cost-sharing reductions than I received, what can I do?

- Answer: You may file an appeal if you think you are eligible for a higher advance payments of the premium tax credit and/or cost-sharing reductions, or if you disagree with certain other eligibility determinations. For more information on appeals, see [SOP-10 Request an Eligibility Appeal](#).



- FAQ 30. How much do my assets matter in determining my eligibility for advance payments of the premium tax credit and cost-sharing reductions?
- Answer: The Marketplace does not consider your assets to determine your eligibility for advance payments of the premium tax credit and cost-sharing reductions.
- FAQ 31. How much does my household income matter in determining my eligibility to enroll in a QHP through the Marketplace?
- Answer: Your household income is not a factor in determining your eligibility to enroll in a QHP through the Marketplace. If you decide to apply with financial assistance, your household income is only used to help determine your eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as your eligibility for Medicaid and CHIP. If you decide to submit an application without requesting financial assistance, the Marketplace will not ask for your income.
- FAQ 32. Is the Marketplace application different from the regular Medicaid application?
- Answer: In all states, you can use the Marketplace application to apply for Medicaid and CHIP, as well as for advance payments of the premium tax credit and cost-sharing reductions. In some states, and for some individuals whose eligibility is based on factors such as age, disability, or the need for long-term care services, the Medicaid agency may require an additional, different Medicaid application or ask for additional information.
- FAQ 33. How much do my assets matter in determining my eligibility for Medicaid and CHIP?
- Answer: For many applicants, your assets won't matter in determining your eligibility for Medicaid and CHIP. There are still some populations for whom assets do matter – specifically, individuals who are seeking Medicaid coverage because they are age 65 or over, disabled, or some individuals in need of long-term care services. The Marketplace will not ask you for information about assets, and your state Medicaid agency will let you know if this information is necessary.
- FAQ 34. How much does my income matter in determining my eligibility for Medicaid and CHIP?
- Answer: Medicaid and CHIP eligibility standards consider household size and income. See [Appendix C: Federal Poverty Guidelines](#) to estimate if you are potentially eligible for Medicaid/CHIP. Please note that there are other non-financial eligibility requirements for Medicaid and CHIP.
- FAQ 35. Can I find out if I qualify for Medicaid without completing the Marketplace application?
- Answer: Assisters may provide an estimate by referencing [Appendix C: Federal Poverty Guidelines](#) and factoring in consumers' household size and income. However, in some states only the state Medicaid or CHIP agency can make final eligibility determinations, and in other states, the Marketplace can. In addition, in many states you can choose to complete only the state's Medicaid application and not the Marketplace application.



FAQ 36. How do I contact my state Medicaid or CHIP agency?

- Answer: If your eligibility results refer you to your local state Medicaid or CHIP agency, specific contact information will be included in the notice. Assisters can reference [Appendix D: State Medicaid & CHIP Program Information](#) for more information to share with consumers.

FAQ 37. What if I currently have Medicaid/CHIP, but would like a QHP instead?

- Answer: If you are eligible for Medicaid or CHIP but would rather purchase coverage through the Marketplace, you may be eligible to do so if it is still during Open Enrollment or you are eligible for an SEP. However, you won't qualify for the premium tax credit or cost-sharing reductions to help pay the costs for coverage through the Marketplace.

FAQ 38. How long does it take for my state Medicaid or CHIP agency to make a final eligibility determination? And how will the agency notify me?

- Answer: Determination periods vary from state to state. You should contact your local state Medicaid or CHIP agency for detailed information.

FAQ 39. Do I have to go to my state Medicaid or CHIP agency in person to receive assistance?

- Answer: No, you can contact your state Medicaid or CHIP agency in person, via phone or through the state's website to request assistance. Many states also have electronic applications.

SOP-7 Lower Costs of Health Plan

The FAQs below are designed to help assisters answer consumers' specific questions on options to lower health plan costs available through the Individual Marketplace. For more information on this topic, see [SOP-7 Lower Costs of Coverage](#).

FAQ 40. Can I adjust the amount of my advance payments of the premium tax credit I receive?

- Answer: Yes, you can adjust the amount of your advance payments of the premium tax credit, up to the maximum amount for which you are eligible, at any point during the year, including during the Open Enrollment period.

FAQ 41. Can I adjust the amount of income-based cost-sharing reductions I receive?

- Answer: No. If you are eligible for income-based cost-sharing reductions and enroll in a Silver-level plan, you will receive the fixed amount of cost-sharing reductions for which you are eligible based on your household income. You may not choose a different amount or level of cost-sharing reductions, but you may choose to enroll in a plan without cost-sharing reductions.

FAQ 42. Can I adjust the amount of my advance payments of the premium tax credit I receive to more than I am eligible for?

- Answer: No, the Marketplaces determine the amount advance payments of the premium tax credit for which you are eligible. If you feel that you are eligible for a higher amount of advance payments of the premium tax credit, you may file an appeal.



FAQ 43. I think I am eligible for more advance payments of the premium tax credit or cost-sharing reductions. What do I do?

- Answer: You may file an appeal if you believe you are eligible for more advance payments of the premium tax credit or cost-sharing reductions, or if you aren't satisfied with certain other eligibility determinations.

FAQ 44. If I lose my job, will I qualify for advance payments of the premium tax credit and cost-sharing reductions?

- Answer: You must report this change to the Marketplace and complete an eligibility application to determine whether you are eligible for advance payments of the premium tax credit and cost-sharing reductions. If you were previously ineligible because of household income or because affordable employer-sponsored coverage that meets the minimum value standard was available to you, you may become eligible for help paying for coverage through the Marketplace as a result of decreased income or losing eligibility for this employer-sponsored coverage.

FAQ 45. How do I report changes in my household income?

- Answer: You may log in to your account, select the Report a Life Change tab, and follow the system instructions to enter any changes. You may also contact the Marketplace Call Center.

FAQ 46. How much does my household income matter in determining my eligibility for advance payments of the premium tax credit and cost-sharing reductions?

- Answer: Eligibility for advance payments of the premium tax credit and cost-sharing reductions depends, in part, on your family size and household income. The Marketplace will determine if your family size and household income qualifies you for these benefits. Please note that there are other non-financial eligibility requirements for advance payments of the premium tax credit and cost-sharing reductions. Visit HealthCare.gov for more information.

SOP-8 Compare, Save, & Select Health Plans

The FAQs below are designed to help assisters answer consumers' specific questions on comparing and selecting plans through the Individual Marketplace. For more information on this topic, see [SOP-8 Compare, Save, & Select Health Plans](#).

FAQ 47. How do I look at the different plans and compare them?

- Answer: You may view and compare plans by logging in to your HealthCare.gov account or using the See Plans and Prices tool on HealthCare.gov before you create an account.

FAQ 48. Can I browse health plans in the Marketplace without creating an account?

- Answer: Yes, you may browse and compare plans on the HealthCare.gov website. However, you may not see all details of QHPs, including the exact amounts of what your costs would be. You are encouraged to create an account and submit an application to see the full details of various QHPs.



FAQ 49. When can I select my health plan?

- Answer: During Open Enrollment or if you are eligible for an SEP, you may select an insurance plan after you have completed an eligibility application and received eligibility results indicating that you are eligible to enroll in a QHP through the Marketplace.

FAQ 50. May I select more than one health plan?

- Answer: You may only select one health plan for each individual. You may also select separate dental coverage, if available.

FAQ 51. Can I select a qualified dental plan?

- Answer: If you want to enroll in a qualified dental plan through the Marketplace, you must also enroll in a QHP through the Marketplace at the same time.

FAQ 52. Can I select a child-only plan?

- Answer: Yes, you may enroll a child in a child-only plan without enrolling yourself in coverage, but you must include yourself and other members of your tax household as non-applicants on your application if you select that you want to see if you can get help paying for coverage. However, it's important to remember that if you do not have MEC for yourself, you may be required to obtain an exemption or pay a fee when you file your annual federal income taxes.

FAQ 53. After I determine the filtering options for my plan comparison, how do I prioritize them?

- Answer: You will need to determine what factors are most important to you. Some factors that you may want to consider include costs and providers, like doctors, hospitals, and pharmacies, the health insurer or plan has contracted with to provide health care services (known as the "network").

FAQ 54. Who decides which health plans are QHPs?

- Answer: The Marketplace, with involvement from some states, determines which plans are QHPs.

FAQ 55. When do I see the cost of the health plans?

- Answer: You can see estimated costs of health plans before you apply. If you are determined eligible to enroll in a QHP through the Marketplace and for help paying for coverage, you will be able to view your exact plan costs, taking into account any advance payments of the premium tax credit or cost-sharing reductions for which you qualify.

FAQ 56. Are all QHP benefits the same despite different QHP costs?

- Answer: No, you will see differences within coverage categories and you may see additional benefits that only some plans offer. However, all QHPs provide coverage of the required essential health benefits, and all QHPs (other than qualified dental plans) are considered MEC.



SOP-9 Pay Health Plan Premium

The FAQs below are designed to help assisters answer consumers' specific questions on premium payments for QHPs selected through the Individual Marketplace. For more information on this topic, see [SOP-9 Pay Health Plan Premium](#).

FAQ 57. What financial information can I update in my Marketplace account?

- Answer: You can update household income information in your Marketplace account. However, you must visit your health insurance company's website to update payment information for your monthly premiums (e.g., bank account information, credit card information).

FAQ 58. How do I make payments?

- Answer: Your insurance company will inform you of the acceptable methods of payment. Generally, you can make payments through your health plan's website if the issuer makes online payments available, by phone if the issuer accepts payments by phone, or via mail directly to the health plan.

FAQ 59. Can I make payments by check? May I pay in cash?

- Answer: Your health insurance company will inform you of the acceptable methods of payment. Health insurance companies are required to have methods of payment that are available to consumers who do not have checking accounts or credit cards.

FAQ 60. What happens if I miss a payment? Does my coverage end?

- Answer: You will need to contact your health insurance company to confirm what happens after missing a payment. Coverage might not end immediately and your health insurance company may provide a grace period. Under Marketplace rules, QHP issuers must allow enrollees who receive advance payments of the premium tax credit and have previously paid at least one full month's premium since enrolling a three-consecutive-month grace period. They must also grant enrollees who do not receive advance payments of the premium tax credit a grace period in accordance with state laws. Assisters and consumers may want to contact their State Department of Insurance for more information on grace periods based on state rules.

FAQ 61. Does my premium amount include any advance payments of the premium tax credit I receive?

- Answer: Yes, the Marketplace automatically deducts any advance payments of the premium tax credit for which you are eligible and have chosen to apply from the monthly premium amount displayed for you to pay.



SOP-10 Request an Eligibility Appeal

The FAQs below are designed to help assisters answer consumers' specific questions on eligibility appeals through the Individual Marketplace. For more information on this topic, see [SOP-10 Request an Eligibility Appeal](#).

FAQ 62. How will I know when the Marketplace receives my appeal?

- Answer: You will receive a notice about your appeal request via mail or through your account in the Message Center. If you do not receive a notice, you can contact the Marketplace Call Center for assistance.

FAQ 63. How long will it take to receive a decision on my appeal?

- Answer: The time required to make a decision on your appeal will vary, based on factors including the reason for your appeal and whether you submit additional documentation to support your appeal.

FAQ 64. I cannot attend my hearing request date. Can I reschedule?

- Answer: Yes, you can reschedule if you have a conflict and cannot make the date and time scheduled for your eligibility appeal hearing. As soon as you know you have a conflict with when your hearing is scheduled, you should call the Marketplace Appeals Center to ask for a new date and time. The information on how to do this and the number to call is on your Notice of Hearing. Hearing Officers carefully prepare for hearings to be ready to appropriately conduct each appellant's hearing and then correctly decide the case. If you do not request a rescheduled hearing and fail to appear at your hearing, your appeal will be dismissed.

SOP-11 Apply for Exemption

The FAQs below are designed to help assisters answer consumers' specific questions on consumer exemptions through the Individual Marketplace. For more information on this topic, see [SOP-11 Apply for Exemption](#).

FAQ 65. How do I file for an exemption?

- Answer: Depending on the reason for the exemption, an exemption application will be mailed in to the Marketplace, or the exemption can be claimed during the federal tax filing process.

FAQ 66. How long will it take to know if my exemption application to the Marketplace was accepted?

- Answer: The time required to process your exemption application will vary based on the type of exemption for which you apply. You should receive a notice from the Marketplace after your application is accepted. Otherwise, you may contact the Marketplace Call Center to find out if your application was accepted.



FAQ 67. When does my exemption end?

- Answer: When the Marketplace grants you an exemption, the exemption period may vary in length. The Marketplace grants exemptions on a month-to-month basis, for a calendar year, or on a continuing basis until an individual reports a change related to the eligibility standards. Consumers may reference their exemption notice for further information. Consumers should note that most exemptions will end at the end of the plan year; thus, consumers will need to re-apply for an exemption each year in most cases.

FAQ 68. My household income is so low that I am not required to file a federal tax return. Do I qualify for an exemption?

- Answer: Consumers who are not required to submit federal income tax returns because they do not meet the filing threshold are automatically exempt from the shared responsibility payment for not maintaining MEC and do not need to do anything else to get an exemption. This is true even if the consumer files a tax return to get a refund. In that case, the consumer can claim the exemption through the tax filing process. Note, however, that consumers whose incomes are below the filing threshold but who file a federal income tax return for another reason must apply for an exemption if they do not have MEC.

SOP-12 Update Account Profile

The FAQs below are designed to help assisters answer consumers' specific questions on updating their online accounts through the Individual Marketplace. For more information on this topic, see [SOP-12 Update Account Profile](#).

FAQ 69. What account changes/updates will affect my eligibility to participate in the Marketplace or for help paying for coverage?

- Answer: Certain life changes, like gaining citizenship, marriage, or the birth of a child, may affect eligibility. However, account maintenance updates, like changing your password or e-mail, will not affect your eligibility.

FAQ 70. How do I change my account details (e.g., password, e-mail)?

- Answer: You may log in to your account, select the My Profile tab, and follow the system instructions in completing any account changes.

FAQ 71. If I've already mailed in my paper eligibility application, can I update my information later online?

- Answer: If you have submitted a paper application to the Marketplace, you can make changes to your application information online. You will need to create an account online, complete identity proofing, and then use the Find Application function to associate the application with the account. You will need to have your application ID number to retrieve your application. If you're not sure of your application ID number, you can contact the Marketplace Call Center.



SOP-13 Report Life Changes

The FAQs below are designed to help assisters answer consumers' specific questions on reporting life changes through the Individual Marketplace. For more information on this topic, see [SOP-13 Report Life Changes](#).

FAQ 72. What account changes/updates will affect my eligibility to participate in the Marketplace or for help paying for coverage?

- Answer: Certain life changes, like gaining citizenship, marriage, moving, or the birth of a child, may affect eligibility. However, account maintenance updates, like changing your password or e-mail, will not affect your eligibility.

FAQ 73. When should I report a life change?

- Answer: Changes to eligibility information must be reported within 30 days of the change, but consumers should report changes in circumstances as soon as they can to ensure the financial assistance being provided is correct and to help avoid potentially owing money related to advance payments of the premium tax credit when they file their federal income tax returns.

SOP-14 Renew Health Coverage

The FAQs below are designed to help Assisters answer consumers' specific questions on renewing their health coverage through the Individual Marketplace. For more information on this topic, see [SOP-14 Renew Health Coverage](#).

FAQ 74. How will I know if my current coverage is available for renewal?

- Answer: In addition to annual eligibility redetermination notices from the Marketplace, all consumers who are enrolled in a QHP through the Marketplace will receive a notice from their health insurance company before November 1, 2015. This notice either informs consumers of their ability to renew their coverage for 2016 (known as a renewal notice) or that their QHP is being discontinued (known as a discontinuance notice). The health insurance company generally must send a discontinuation notice at least 90 days in advance of the date the coverage will be discontinued.

FAQ 75. What happens if my current coverage is being discontinued for the upcoming benefit year?

- Answer: For the 2016 coverage year, if your QHP is being discontinued, and if state law allows, you will be enrolled automatically into a different QHP in accordance with a specified hierarchy of plans. You can also return to the Marketplace and select a new QHP.

FAQ 76. Why was I redetermined ineligible for coverage through the Marketplace?

- Answer: There are several reasons why consumers who were previously eligible for QHP enrollment may no longer be eligible when the Marketplace redetermines their eligibility, including incarceration or moving outside the service area of the Marketplace.



Appendix B: Acronyms & Definitions

The proceeding sections describe the commonly used acronyms and terms that appear throughout the Manual.

Frequently Used Acronyms

Acronyms	Descriptions
CAP	Consumer Assistance Program
CCIIO	Center for Consumer Information & Insurance Oversight
COBRA	Consolidated Omnibus Budget Reconciliation Act
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
DHS	Department of Homeland Security
DMI	Data-matching Issue
EHB	Essential Health Benefits
FAQ	Frequently Asked Questions
FFM	Federally-facilitated Marketplace
FPL	Federal Poverty Level
HDHP	High Deductible Health Plan
HHS	Department of Health & Human Services
HMO	Health Maintenance Organization
HAS	Health Savings Account
ID	Identification
IHS	Indian Health Service
IRS	Internal Revenue Service
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
PII	Personally Identifiable Information
QHP	Qualified Health Plan
SBC	Summary of Benefits and Coverage
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SOP	Standard Operating Procedure
SSI	Supplemental Security Income
SSN	Social Security Number
VA	Veterans Affairs
VHA	Veterans Health Administration



Definitions

The following is a list of terms from HealthCare.gov, CCIIO, and the Affordable Care Act explained in plain language that you may reference to assist consumers.

Actuarial Value: The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, a consumer would be responsible for 30% of the costs of all covered benefits. However, consumers could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on their actual health care needs and the terms of their insurance policy. (Reference: [HealthCare.gov/glossary/actuarial-value](https://www.healthcare.gov/glossary/actuarial-value))

Advance Payments of the Premium Tax Credit: The Affordable Care Act provides a new tax credit to help consumers afford health coverage purchased through the Marketplace. Consumers can use advance payments of the premium tax credit to lower their monthly premium costs. If consumers qualify, they may choose how much in advance payments of the premium tax credit to apply to their premiums each month, up to a maximum amount. If the amount of advance payments of the premium tax credit consumers get for the year is less than the premium tax credit they're due based on their annual household income, they'll get the difference as a refundable credit when they file their federal income tax return. If their advance payments of the premium tax credit for the year are more than the amount of the premium tax credit for which they are eligible, they may be required to repay the excess advance payments with their tax return. (Reference: [HealthCare.gov/glossary/advanced-premium-tax-credit](https://www.healthcare.gov/glossary/advanced-premium-tax-credit))

Affordable Care Act: The comprehensive health care reform law enacted in March 2010. Congress passed the law in two parts. The President signed the Patient Protection and Affordable Care Act into law on March 23, 2010, which was amended by the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. The name "Affordable Care Act" refers to the amended version of the law. (Reference: [HealthCare.gov/glossary/affordable-care-act](https://www.healthcare.gov/glossary/affordable-care-act))

Agent: When registered with the Marketplace, an individual or entity that helps individuals and businesses apply for and enroll in QHPs through the Marketplace, and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to agents to sell insurance in their respective jurisdictions and they may receive compensation from insurance companies with whom they have a contractual relationship to enroll consumers in a QHP or non-QHP. (Reference: Affordable Care Act §1312(e) and 45 CFR §155.20)

Applicant: With respect to the Marketplace for the individual market, an applicant is an individual seeking eligibility for him or herself through an application submitted to the Marketplace (or transmitted to the Marketplace by the state Medicaid or CHIP agency), except individuals seeking eligibility for an exemption from the individual shared responsibility payment. Applicants must be seeking eligibility for at least one of the following: enrollment in a QHP through the Marketplace (with or without advance payments of the premium tax credit and/or cost-sharing reductions), and enrollment in Medicaid or CHIP. (Reference: 45 CFR §155.20 and 42 CFR §435.4)

Authorized Representative: Someone who a consumer designates in writing to act on his or her behalf with the Marketplace, like a family member or other trusted person. (Reference: 45 CFR §155.227)

Benefits: The health care items or services covered under a health plan. The health plan's coverage documents define the coverage benefits and excluded services. In Medicaid or CHIP, the state program rules define covered benefits and excluded services. (Reference: [HealthCare.gov/glossary/benefits](https://www.healthcare.gov/glossary/benefits))



Benefit Year: A calendar year for which a health plan provides coverage for health benefits. The benefit year for individual market plans bought inside or outside the Marketplace generally begins January 1 of each year and ends December 31 of the same year. A consumer's coverage ends December 31 even if the coverage started after January 1. Any changes to benefits or rates to a health insurance plan are generally made at the beginning of the calendar year. (Reference: [HealthCare.gov/glossary/benefit-year](https://www.healthcare.gov/glossary/benefit-year))

Broker: When registered with the Marketplace, an individual or entity that helps individuals and businesses apply for and enroll in a QHP through the Marketplace, and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to brokers to sell insurance in their respective jurisdictions. They may receive compensation from an insurance company with whom they have a contractual relationship to enroll consumers into a QHP or non-QHP. (Reference: Affordable Care Act § 1312(e) and 45 CFR §155.20)

Catastrophic Health Plan: Health plans that meet all of the requirements applicable to other QHPs but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met and complies with the requirement to cover certain preventive services without cost sharing obligations. The premium amount consumers pay each month for health care is generally lower than for other QHPs, but the amounts for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, consumers must be under 30 years old at the time of enrollment OR get an exemption because the Marketplace determined that they're unable to afford health coverage or have certain other hardships. (Reference: [HealthCare.gov/glossary/catastrophic-health-plan](https://www.healthcare.gov/glossary/catastrophic-health-plan))

Center for Consumer Information & Insurance Oversight (CCIIO): A part of the Department of Health & Human Services that helps to implement many provisions of the Affordable Care Act, the historic health reform bill that became law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance. (Reference: [CMS.gov/CCIIO](https://www.cms.gov/CCIIO))

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, as well as the Federally-facilitated Marketplace. For more information, visit [CMS.gov](https://www.cms.gov). (Reference: [HealthCare.gov/glossary/centers-for-medicare-and-medicare-services](https://www.healthcare.gov/glossary/centers-for-medicare-and-medicare-services))

Certified Application Counselor (CAC): An individual (affiliated with an organization designated by CMS) who is trained and able to help consumers as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers. (Reference: [HealthCare.gov/glossary/certified-applicant-counselor](https://www.healthcare.gov/glossary/certified-applicant-counselor))

Certified Application Counselor Designated Organization (CDO): An organization designated by the Marketplace to certify its staff members or volunteers to act as certified application counselors. (Reference: 45 CFR §155.225)

Children's Health Insurance Program (CHIP): Program jointly funded by state governments and the federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. (Reference: [HealthCare.gov/glossary/childrens-health-insurance-program-chip](https://www.healthcare.gov/glossary/childrens-health-insurance-program-chip))

Claim: A request for payment that you, your authorized representative, or your health care provider submits to your health insurer when you get items or services you think are covered. (Reference: [HealthCare.gov/glossary/claim](https://www.healthcare.gov/glossary/claim))



Coinsurance: The consumer's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. Consumers pay coinsurance plus any deductibles they owe. For example, if the health insurance or plan's maximum allowed amount for a covered office visit is \$100 and the consumer has met the plan's deductible, the consumer's coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount. (Reference: [HealthCare.gov/glossary/coinsurance/](https://www.healthcare.gov/glossary/coinsurance/))

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law that may allow consumers to temporarily keep health coverage after their employment ends, they lose coverage as a dependent of the covered employee, or another qualifying event. If consumers elect COBRA coverage, they pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee. (Reference: [HealthCare.gov/glossary/cobra/](https://www.healthcare.gov/glossary/cobra/))

Copayment: Also referred to as a copay, this is a fixed amount (for example, \$15) a consumer pays for a covered health care service, usually when they receive the service. The amount can vary by the type of covered health care service. (Reference: [HealthCare.gov/glossary/co-payment/](https://www.healthcare.gov/glossary/co-payment/))

Cost-sharing Reduction: A discount that lowers the amount consumers have to pay out-of-pocket for deductibles, coinsurance, and copayments. Consumers are eligible for cost-sharing reductions if they get health insurance through the Marketplace, they meet household income requirements, and if they enroll in a health plan from the Silver plan category (See Health Plan Categories). Consumers may qualify for additional cost-sharing benefits if they are a member of a federally recognized tribe. (Reference: [HealthCare.gov/glossary/cost-sharing-reduction/](https://www.healthcare.gov/glossary/cost-sharing-reduction/))

Deductible: The amount consumers owe for covered health care services before their health insurance or plan begins to pay. For example, if a consumer's deductible is \$1,000, the plan won't pay anything for covered health care services subject to the deductible until the consumer has met the \$1,000 deductible. The deductible may not apply to all services. (Reference: [HealthCare.gov/glossary/deductible/](https://www.healthcare.gov/glossary/deductible/))

Eligibility Appeal: In the Individual Marketplace, a request by an individual for a reevaluation of a Marketplace eligibility decision, or an eligibility decision by a state Medicaid or CHIP agency. (Reference: [HealthCare.gov/can-i-appeal-a-marketplace-decision/](https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/))

Employer-sponsored Health Insurance Plan (Group Health Plan): A group health plan or health coverage offered by an employer which is a governmental plan or any other plan, or coverage offered in the small- or large-group marketplace within a state. (Reference: IRC §5000A(f)(2))

Enrollee: In the Individual Marketplace, an individual enrolled in a QHP through the Marketplace. (Reference: 45 CFR §155.20)

Essential Health Benefits (EHB): A set of health care service categories that certain plans must cover starting in 2014.

The Affordable Care Act ensures that non-grandfathered health insurance plans offered in the individual and small-group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following ten 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; and pediatric services, including oral and vision care.

Insurance policies must cover these categories of benefits to be certified as qualified health plans that can be offered through the Health Insurance Marketplace, and alternative benefit plans offered under Medicaid state plans (which must be offered to the new adult population) must cover these services by 2014. (Reference: HealthCare.gov/glossary/essential-health-benefits)

Federal Poverty Level (FPL): FPL represents a threshold level of income used by the federal government to determine an individual's eligibility to participate in certain federal programs. (Reference: 45 CFR §155.300)

Health Coverage: Consumers' legal entitlement to payment or reimbursement for their health care costs for covered services or items, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or CHIP. (Reference: HealthCare.gov/glossary/health-coverage)

Health Insurance: A contract that requires a consumer's health insurer to pay some or all of the consumer's health care costs in exchange for a premium. (Reference: HealthCare.gov/glossary/health-insurance)

Health Insurance Issuer (Issuer): An insurance company, insurance service, or insurance organization that must have a license to engage in the business of insurance in a state and that is subject to state laws that regulate insurance. (Reference: 45 CFR §144.103)

Health Maintenance Organization (HMO): 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 HMO may require a consumer to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. (Reference: HealthCare.gov/glossary/health-maintenance-organization-HMO)

Health Plan Categories: The Individual Marketplace generally separates health plans into five health plan categories — Bronze, Silver, Gold, Platinum, or Catastrophic — based on the amount the plan can be expected to pay of the average overall cost of providing essential health benefits to members. The plan category a consumer chooses affects the total amount the consumer will likely spend for essential health benefits during the year. For the four metal category plans, the percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This is not the same as coinsurance, in which a consumer pays a specific percentage of the cost of a specific service. (Reference: HealthCare.gov/glossary/health-plan-categories)

High Deductible Health Plan (HDHP): A plan that features higher deductibles than traditional insurance plans. Consumers may combine high deductible health plans with a health savings account or a health reimbursement arrangement to allow them to pay for qualified medical expenses on a pre-tax basis. (Reference: HealthCare.gov/glossary/high-deductible-health-plan)

Health Savings Account (HSA): A medical savings account available to taxpayers who are enrolled in a HDHP. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Consumers must use funds to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if consumers do not spend them. (Reference: HealthCare.gov/glossary/health-savings-account-HSA)



Incarceration Status: A criterion for eligibility referring to whether an individual is required to be confined to a correctional institution. An applicant is not a qualified individual if he or she is incarcerated, other than pending the disposition of charges. (Reference: 45 CFR §155.305)

Indian Status: A criterion for eligibility for cost-sharing reductions or enrollment periods referring to whether an individual is a member of an Indian tribe as defined by section 4 of the Indian Self-Determination and Education Assistance Act. (Reference: 45 CFR §155.300)

Individual Marketplace: The Marketplace for individuals to purchase health insurance plans for themselves or their families other than through an employer-provided group health plan. (Reference: Affordable Care Act §1304(a)(2))

Individual Shared Responsibility Payment (also referred to as a “Fee”): Starting January 1, 2014, if an applicable individual doesn't maintain health coverage that qualifies as MEC or obtain an exemption, he or she may have to pay a fee, known as the individual shared responsibility payment, that increases every year, from 1% of household income (or \$95 per adult, whichever is higher) in 2014, 2.0% of household income (or \$325 per adult) in 2015, to 2.5% of household income (or \$695 per adult) in 2016. The fee for children is half the adult amount. If applicable, consumers will pay this fee on their annual tax return. People with very low incomes and others may be eligible for exemptions. (Reference: HealthCare.gov/glossary/fee)

In-network Providers: Doctors, hospitals, pharmacies, and other health care providers that have agreed to provide members of a certain insurance plan or certain issuer with services and supplies. Some plans will only cover a consumer's health care if the consumer gets it from in-network doctors, hospitals, pharmacies, and other health care providers. (Reference: Medicare.gov/glossary/i.html)

Insurance Affordability Program: A program that is one of the following: a Medicaid program, a CHIP program, a program that makes available QHPs with advance payments of the premium tax credit or cost-sharing reductions, and a Basic Health Program, if available. (Reference: 45 CFR §155.300)

Job-based Coverage: Also referred to as a job-based health plan, group health plan or employer-sponsored health insurance plan, coverage that an employer offers to employees (and may also offer to employees' family members). (Reference: HealthCare.gov/glossary/job-based-health-plan)

Marketplace: A marketplace for health insurance, also known as an “Exchange,” operated by a governmental agency or non-profit entity that meets applicable government standards. A Marketplace makes QHPs available to qualified individuals, and/or qualified employers. Unless otherwise identified, this term includes Marketplaces serving the individual market for qualified individuals and Small Business Health Options Program (SHOP) Marketplaces serving the small group market for qualified employers, regardless of whether the Marketplace is established and operated by a State or by HHS. (Reference: 45 CFR §155.20)

Marketplace Service Area: The geographic area in which the Marketplace is certified to operate. (Reference: 45 CFR §155.20)

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid varies state by state and may have a different name in your state. (Reference: HealthCare.gov/glossary/medicaid)



Medicare: A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). (Reference: HealthCare.gov/glossary/medicare)

Minimum Essential Coverage (MEC): The type of health coverage an individual needs to have to avoid having to make the individual shared responsibility payment (unless he or she qualifies for a coverage exemption) when he or she files a federal income tax return. Many types of coverage qualify as MEC, including qualified health plans offered through the Marketplace, job-based coverage, Medicare, Medicaid, CHIP, and TRICARE. (Reference: Section 5000A(f) of the Internal Revenue Code)

Minimum Value: A health plan meets this standard if it is designed to pay at least 60% of the total allowed cost of benefits under the plan. Individuals eligible for minimum essential coverage, including employer-sponsored coverage that provides minimum value and that is affordable, are not eligible to receive a premium tax credit. (Reference: 45 CFR §156.145)

Modified Adjusted Gross Income (MAGI): The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP applicants whose eligibility is based on MAGI. Generally, MAGI is an individual's adjusted gross income plus any tax-exempt Social Security, interest, or foreign income the individual has. (Reference: HealthCare.gov/glossary/modified-adjusted-gross-income-magi)

Navigator: An individual or organization that receives a grant from the Marketplace and that is trained and able to help consumers, and small employers and their employees as they look for health coverage options through the Marketplace, including completing the eligibility and enrollment process. These individuals and organizations are required to be unbiased. Their services are free to consumers. (Reference: HealthCare.gov/glossary/navigator)

Non-citizen: An individual who is not a citizen or national of the United States. (Reference: 45 CFR §155.305;)

Non-Navigator Assistance Personnel: Individuals or organizations that are trained and able to provide help to consumers, and small employers and their employees as they look for health coverage options through the Marketplace, including helping them complete the eligibility and enrollment process. These individuals and organizations are required to be unbiased. Their services are free to consumers. Also referred to as "in-person assisters." (Reference: HealthCare.gov/glossary/in-person-assistance-personnel-program)

Open Enrollment Period: The period of time during which individuals who are eligible to enroll in a QHP can enroll in a plan through the Marketplace. For coverage starting in 2016, the Open Enrollment period is November 1, 2015 – January 31, 2016. Individuals may also qualify for special enrollment periods if they experience certain events. Consumers can apply for Medicaid or CHIP at any time of the year. (Reference: HealthCare.gov/glossary/open-enrollment-period)

Out-of-pocket Costs: The expenses for health care services that insurance companies do not reimburse. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered. (Reference: HealthCare.gov/glossary/out-of-pocket-costs)

Plan Year: A consecutive twelve-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year. (Reference: 45 CFR §155.20)

Pre-existing Condition: A health problem you had before the date that new health coverage starts. (Reference: HealthCare.gov/glossary/pre-existing-condition)



Preferred Provider Organizations (PPOs): Types of health plans that contract with medical providers, such as hospitals and doctors, to create a network of participating providers. Consumers pay less in out-of-pocket costs if they use providers that belong to the plan's network. Consumers can use doctors, hospitals, and providers outside of the network for an additional cost. (Reference: [HealthCare.gov/glossary/preferred-provider-organization-PPO](https://www.healthcare.gov/glossary/preferred-provider-organization-PPO))

Premium: The amount that consumers or employers pay for a health insurance or job-based coverage. Premiums are paid by the consumer or employers on a monthly, quarterly, or yearly basis. (Reference: [HealthCare.gov/glossary/premium](https://www.healthcare.gov/glossary/premium))

Prevention: Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings. (Reference: [HealthCare.gov/glossary/prevention-glossary](https://www.healthcare.gov/glossary/prevention-glossary))

Point-of-service Plan (POS): A type of plan in which consumers pay less when they use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require consumers to get a referral from their primary care doctor to see a specialist. (Reference: [HealthCare.gov/glossary/point-of-service-plan-POS-plan](https://www.healthcare.gov/glossary/point-of-service-plan-POS-plan))

Qualified Health Plan (QHP): Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A QHP will have a certification by each Marketplace that offers that plan. (Reference: [HealthCare.gov/glossary/qualified-health-plan](https://www.healthcare.gov/glossary/qualified-health-plan))

Qualified Individual: An individual who has been determined eligible to enroll in a QHP through the Individual Marketplace. (Reference: 45 CFR §155.20)

Service Area: A geographic area where a health insurance plan accepts members if it limits membership based on where people live or work. For plans that limit which doctors and hospitals consumers may use, it is also generally the area where consumers can get routine (non-emergency) services. The plan may disenroll consumers if they move out of the plan's service area. (Reference: [HealthCare.gov/glossary/service-area](https://www.healthcare.gov/glossary/service-area))

Special Enrollment Period (SEP): A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace. For example, individuals who lose employer-provided health coverage, or who lose Medicaid coverage because of an increase in income, would be eligible for an SEP to enroll in a Marketplace plan, if they otherwise qualify. Other triggering events include marriage, divorce, and the birth or adoption of a child. (Reference: 45 CFR §155.20)

Summary of Benefits and Coverage (SBC): An easy-to-read summary that lets consumers make apples-to-apples comparisons of costs and coverage between health plans. Consumers can compare options based on price, benefits, and other features that may be important to them. Consumers will get the Summary of Benefits and Coverage when they shop for coverage on their own or through their job, renew or change coverage, or request an SBC from the health insurance company. (Reference: [HealthCare.gov/glossary/summary-of-benefits-and-coverage](https://www.healthcare.gov/glossary/summary-of-benefits-and-coverage))

Tax Dependent: A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their tax dependents. (Reference: [HealthCare.gov/glossary/dependent](https://www.healthcare.gov/glossary/dependent))



TRICARE: A health care program for active-duty and retired uniformed services members and their families. (Reference: [HealthCare.gov/glossary/tricare](https://www.healthcare.gov/glossary/tricare))

Veterans Affairs Health Benefits: Health coverage through the Veterans Health Administration (VHA) for eligible military veterans. For more information on how the Affordable Care Act affects VA health benefits, visit [VA.gov/aca](https://www.va.gov/aca). (Reference: [VA.gov](https://www.va.gov))



Appendix C: Federal Poverty Guidelines

Exhibit 51 – 2015 Annual Poverty Guidelines for All States (Except Hawaii and Alaska)

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250 %
1	11,770.00	14,124.00	15,654.10	15,889.50	17,655.00	20,597.50	21,774.50	23,540.00	29,425.00
2	15,930.00	19,116.00	21,186.90	21,505.50	23,895.00	27,877.50	29,470.50	31,860.00	39,825.00
3	20,090.00	24,108.00	26,719.70	27,121.50	30,135.00	35,157.50	37,166.50	40,180.00	50,225.00
4	24,250.00	29,100.00	32,252.50	32,737.50	36,375.00	42,437.50	44,862.50	48,500.00	60,625.00
5	28,410.00	34,092.00	37,785.30	38,353.50	42,615.00	49,717.50	52,558.50	56,820.00	71,025.00
6	32,570.00	39,084.00	43,318.10	43,969.50	48,855.00	56,997.50	60,254.50	65,140.00	81,425.00
7	36,730.00	44,076.00	48,850.90	49,585.50	55,095.00	64,277.50	67,950.50	73,460.00	91,825.00
8	40,890.00	49,068.00	54,383.70	55,201.50	61,335.00	71,557.50	75,646.50	81,780.00	102,225.00

*For family units with more than eight members, add \$4,160 for each additional family member.

Exhibit 52 – 2015 Annual Poverty Guidelines for Alaska Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	14,720.00	17,664.00	19,577.60	19,872.00	22,080.00	25,760.00	27,232.00	29,440.00	36,800.00
2	19,920.00	23,904.00	26,493.60	26,892.00	29,880.00	34,860.00	36,852.00	39,840.00	49,800.00
3	25,120.00	30,144.00	33,409.60	33,912.00	37,680.00	43,960.00	46,472.00	50,240.00	62,800.00
4	30,320.00	36,384.00	40,325.60	40,932.00	45,480.00	53,060.00	56,092.00	60,640.00	75,800.00
5	35,520.00	42,624.00	47,241.60	47,952.00	53,280.00	62,160.00	65,712.00	71,040.00	88,800.00
6	40,720.00	48,864.00	54,157.60	54,972.00	61,080.00	71,260.00	75,332.00	81,440.00	101,800.00
7	45,920.00	55,104.00	61,073.60	61,992.00	68,880.00	80,360.00	84,952.00	91,840.00	114,800.00
8	51,120.00	61,344.00	67,989.60	69,012.00	76,680.00	89,460.00	94,572.00	102,240.00	127,800.00

*For family units with more than eight members, add \$5,200 for each additional family member.

Exhibit 53 – 2015 Annual Poverty Guidelines for Hawaii Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,550.00	16,260.00	18,021.50	18,292.50	20,325.00	23,712.50	25,067.50	27,100.00	33,875.00
2	18,330.00	21,996.00	24,378.90	24,745.50	27,495.00	32,077.50	33,910.50	36,660.00	45,825.00
3	23,110.00	27,732.00	30,736.30	31,198.50	34,665.00	40,442.50	42,753.50	46,220.00	57,775.00
4	27,890.00	33,468.00	37,093.70	37,651.50	41,835.00	48,807.50	51,596.50	55,780.00	69,725.00
5	32,670.00	39,204.00	43,451.10	44,104.50	49,005.00	57,172.50	60,439.50	65,340.00	81,675.00
6	37,450.00	44,940.00	49,808.50	50,557.50	56,175.00	65,537.50	69,282.50	74,900.00	93,625.00
7	42,230.00	50,676.00	56,165.90	57,010.50	63,345.00	73,902.50	78,125.50	84,460.00	105,575.00
8	47,010.00	56,412.00	62,523.30	63,463.50	70,515.00	82,267.50	86,968.50	94,020.00	117,525.00

*For family units with more than eight family members, add \$4,780 for each additional family member.



Appendix D: State Medicaid & CHIP Program Information

While implementation of the Affordable Care Act brings with it the coordination of state Medicaid and CHIP programs with Health Insurance Marketplace, states must still have a single state agency to administer or supervise the administration of the Medicaid program. As an assister, you may be confronted with questions from consumers about specific Medicaid or CHIP eligibility requirements in their states. You may also encounter consumers who have been determined eligible for Medicaid or CHIP by the Marketplace and require assistance with enrollment. In these cases, you may reference Exhibit 54 for links to Medicaid and CHIP programs within the states participating in the FFM.¹⁸ Please refer consumers to these websites and agencies to help them find the information and assistance they need.

Exhibit 54 – State Medicaid & CHIP Program Contact Information

State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
Alabama	ALL Kids	www.adph.org/allkids	www.medicaid.alabama.gov
Alaska	Denali KidCare	www.dhss.alaska.gov/dhcs/Pages/denalikidcare	http://dhss.alaska.gov/dpa/pages/medicaid
Arizona	Arizona Health Care Cost Containment System (AHCCCS) KidsCare	www.azahcccs.gov/applicants/categories/KidsCare.aspx	www.azahcccs.gov
Arkansas	ARKids First!	www.arkidsfirst.com	www.medicaid.state.ar.us
Delaware	Delaware Healthy Children Program	www.dhss.delaware.gov/dss/dhcp.html	www.dmap.state.de.us
Florida	Florida KidCare	www.floridakidcare.org	www.fdhc.state.fl.us/Medicaid/index.shtml
Georgia	PeachCare for Kids	www.peachcare.org	http://dch.georgia.gov/medicaid
Idaho	Idaho CHIP	www.healthandwelfare.idaho.gov/?TabId=219	http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx
Illinois	All Kids	www.allkids.com	http://www2.illinois.gov/hfs/Pages/default.aspx
Indiana	Hoosier Healthwise Package C	http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise.aspx	www.in.gov/fssa/2408.htm
Iowa	Hawk-I	www.hawk-i.org	http://dhs.iowa.gov/ime/about
Kansas	HealthWave 21	http://www.kancare.ks.gov	https://cssp.kees.ks.gov
Louisiana	LaCHIP	http://new.dhh.louisiana.gov/index.cfm/page/222	www.dhh.louisiana.gov/index.cfm/subhome/1/n/331
Maine	MaineCare	www.state.me.us/dhhs/OIAS/services/cubcare/CubCare.htm	www.maine.gov/dhhs

¹⁸ SBMs are not included in this table since this Manual is designed to be used by assisters located in FFM states, including State Partnership Marketplaces.



Appendix D: State Medicaid & CHIP Program Information

State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
Michigan	MiChild	www.michigan.gov/mdch/1,1607,7-132-2943_4845_4931---,00.html	www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html
Mississippi	Mississippi Health Benefits CHIP	www.medicaid.ms.gov/programs/childrens-health-insurance-program-chip/	www.medicaid.ms.gov
Missouri	MO HealthNet for Kids	www.dss.mo.gov/mhk/index.htm	www.dss.mo.gov/mhd
Montana	Healthy Montana Kids	www.dphhs.mt.gov/hmk	http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices
Nebraska	Nebraska Kids Connection	http://dhhs.ne.gov/medicaid/Pages/med_CHIP.aspx	http://dhhs.ne.gov/medicaid/Pages/med_index.aspx
New Hampshire	New Hampshire CHIP	www.dhhs.nh.gov/ombp/medicaid/nhmedicaid-children.htm	www.dhhs.nh.gov/ombp/medicaid/index.htm
New Jersey	NJ Family Care	www.njfamilycare.org	www.state.nj.us/humanservices/dmahs/clients/medicaid
New Mexico	New MexiKids & New MexiTeens	www.insurenewmexico.state.nm.us/NewMexiKidsandTeens.htm	www.hsd.state.nm.us/mad/HMedicaid.html
North Carolina	NC Health Choice for Children	www.ncdhhs.gov/dma/healthchoice	www.ncdhhs.gov/dma/medicaid
North Dakota	Healthy Steps	www.nd.gov/dhs/services/medicalserv/chip	www.nd.gov/dhs/services/medicalserv/medicaid
Ohio	Healthy Start	http://medicaid.ohio.gov/FOROHIOANS/Programs/ChildrenFamiliesandWomen.aspx	http://medicaid.ohio.gov
Oklahoma	Oklahoma CHIP	www.okhca.org	www.okhca.org/individuals.aspx?id=52&menu=114&parts=11601_7453
Pennsylvania	Pennsylvania CHIP	www.chipcoverspakids.com	http://www.dhs.state.pa.us/foradults/healthcaremedicalassistance/index.htm
South Carolina	Partners for Healthy Children	www.scdhhs.gov/eligibility-groups/children-also-known-partners-healthy-children	www.scdhhs.gov
South Dakota	South Dakota CHIP	http://dss.sd.gov/medicalservices/chip	http://dss.sd.gov/medicaid/
Tennessee	Cover Kids	www.coverkids.com	www.tn.gov/tenncare
Texas	TexCare CHIP	www.chipmedicaid.org	http://www.hpsc.state.tx.us/medicaid
Utah	Utah CHIP	www.health.utah.gov/chip	http://health.utah.gov/medicaid/provhtml/general_info.html
Virginia	Family Access to Medical Insurance (FAMIS)	www.famis.org	www.dss.virginia.gov/benefit/medicalassistance/index.cgi



State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
West Virginia	West Virginia CHIP	www.chip.wv.gov	www.wvdhhr.org/bcf/family_assistance/medicaid.asp
Wisconsin	BadgerCare Plus	www.dhs.wisconsin.gov/badgercareplus/index.htm	www.dhs.wisconsin.gov/medicaid
Wyoming	Kid Care CHIP	http://health.wyo.gov/healthcarefin/chip	http://health.wyo.gov/healthcarefin/medicaideligibility/index.html



Appendix E: Exemptions Information

Exhibit 55 outlines the different types of exemptions. As an assister, you can use this chart to help consumers identify which exemptions to apply for, what documentation is needed for exemption applications, which exemption application form should be used for submission, and how to claim their exemptions depending on the exemption type.

Exhibit 55 – Exemptions Information

Type of Exemption: Membership in a health care sharing ministry			
When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption
Use this exemption application if consumers and/or anyone in their tax household is/was a member of a health care sharing ministry that is recognized by the Marketplace. A health care sharing ministry is an organization whose members share a common set of ethical and religious beliefs and share medical expenses among themselves in accordance with these beliefs.	<ul style="list-style-type: none"> Name and address of the health care sharing ministry of which they are a member SSNs, if they have them Information about people in their tax household 	Application for Exemption from the Shared Responsibility Payment for Members of a Health Care Sharing Ministry	Marketplace exemption application or claim on tax return



Exhibit 55 – Exemptions Information (continued)

Type of Exemption: Membership in a federally recognized Indian tribe or eligibility for services through an Indian health care provider			
When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption
<p>Use this exemption application if consumers and/or anyone in their tax household is:</p> <ul style="list-style-type: none"> • A member of an federally recognized Indian tribe; or • Eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations. 	<ul style="list-style-type: none"> • Documents showing membership in a federally recognized Indian tribe or eligibility for services from the Indian Health Service, a tribal health care provider, or an urban Indian health care provider • SSNs, if they have them • Information about people in their tax household 	<p>Application for Exemption for American Indians and Alaska Natives and Other Individuals who are Eligible to Receive Services from an Indian Health Care Provider</p>	<p>Marketplace exemption application or claim on tax return</p>

Type of Exemption: Incarceration			
When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption
<p>Use this exemption application if a consumer and/or anyone in their tax household is/was incarcerated (detained or jailed), other than being held pending disposition of charges.</p>	<ul style="list-style-type: none"> • Documents showing the name and address of the facility where the consumer was incarcerated, and the time periods of incarceration • SSNs, if they have them • Information about people in their tax household 	<p>Application for Exemption from the Shared Responsibility Payment for Individuals who are Incarcerated (Detained or Jailed)</p>	<p>Marketplace exemption application or claim on tax return</p>



Exhibit 55 – Exemptions Information (continued)

Type of Exemption: Coverage is unaffordable based on projected income			
When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption
Use this exemption application if a consumer's required contribution for coverage exceeds 8.05% percent of the individual's household income.	<ul style="list-style-type: none"> • SSNs, if they have them • Employer and income information for everyone in their family • Information about any job-related health insurance available to their family • Proof of yearly income for 2015 (examples of documents are found in the exemption application) 	Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in a State with a Federally Facilitated Marketplace	Marketplace exemption application or claim on tax return

Type of Exemption: Membership in a recognized religious sect whose members object to insurance			
When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption
Use this exemption application if consumers and/or anyone in their tax household is/was a member of an approved religious sect or division that is described in section 1402(g) (1) of the Internal Revenue Code, and an adherent of established tenets or teachings of such sect or division.	<ul style="list-style-type: none"> • Name and address of their religious sect • SSNs, if they have them • Copy of an approved IRS Form 4029 (Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits), if they have one 	Application for Exemption from the Shared Responsibility Payment for Members of Recognized Religious Sects or Divisions	Marketplace exemption application



Exhibit 55 – Exemptions Information (continued)

Type of Exemption: Hardship exemption			
When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption
<p>Use this exemption application if consumers and/or anyone in their tax household have experienced a hardship with respect to the capability to obtain coverage under a QHP. There are multiple types of categories of hardship exemptions. Eligibility will depend on particular facts and circumstance for each hardship category.</p>	<ul style="list-style-type: none"> • SSNs, if they have them • Information about people in their tax household • Documents that support their claim of hardship (see page 1 of the hardship exemption application). <p><i>*Note: If consumers can't obtain documents to support hardship, call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.</i></p>	<p>Application for Exemption from the Shared Responsibility Payment for Individuals who Experience Hardships</p>	<p>Marketplace exemption application or claim on tax return (in instances where consumers are determined ineligible for Medicaid based on a state's decision not to expand Medicaid)</p>



Appendix F: Support Resources

If consumers require assistance that is outside of assister activities, refer consumers to other organizations and resources as appropriate. Exhibit 56 provides a list of external resources.

Exhibit 56 – External Resources

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Center for Consumer Information & Insurance Oversight (CCIIO)	www.CMS.gov/ccio/index.html	This entity implements many provisions of the Affordable Care Act, the health reform bill signed into law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance.	<ul style="list-style-type: none"> To gather more information on the Affordable Care Act by referencing detailed fact sheets, FAQs, and other resources.
Experian Help Desk	1-866-578-5409	The Experian Help Desk assists consumers with verifying their identity over the phone so that they may proceed with eligibility and enrollment activities after creating an account on HealthCare.gov.	<ul style="list-style-type: none"> To verify their identity over the phone if they were unsuccessful in their attempt to verify their identity on HealthCare.gov. When necessary, the Marketplace will give consumers a unique identity verification code and instruct them to contact the Experian Help Desk.
Marketplace Call Center	1-800-318-2596 TTY: 1-855-889-4325 (all languages available)	The Marketplace Call Center provides assistance to consumers who need information or want to enroll in health coverage through the Marketplace.	<ul style="list-style-type: none"> To get answers to questions while applying for health coverage using the online or paper application. To apply for health coverage over the phone.
HealthCare.gov	www.HealthCare.gov	This website allows consumers to access information about the Affordable Care Act and to enroll in health coverage through the Marketplace.	<ul style="list-style-type: none"> To find out about health coverage options available through the Marketplace. To apply for health coverage online. To get real-time answers to questions using the online chat function.



Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Indian Health Service (IHS)	www.IHS.gov	This division of HHS is dedicated to providing federal health services to American Indians and Alaska Natives.	<ul style="list-style-type: none"> • To learn more about the Affordable Care Act provisions that apply to American Indians or Alaskan Natives. • To learn more about exemptions and lower health coverage costs available to American Indians or Alaskan Natives.
Internal Revenue Service (IRS)	www.IRS.gov	This federal agency collects taxes from individuals and businesses in the U.S.	<ul style="list-style-type: none"> • To learn more about the effects of the Affordable Care Act on consumers' tax returns.
Medicaid	www.Medicaid.gov	This state-administered health insurance program is for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state-by-state and may have a different name in your state.	<ul style="list-style-type: none"> • To find answers to questions about health coverage through Medicaid or CHIP. • To get further information about their state's Medicaid program and agency contact information.
Medicare	www.Medicare.gov	This federal program is run by CMS and provides health coverage to qualified individuals who are 65 years of age or older and/or have a disability.	<ul style="list-style-type: none"> • To learn more about eligibility for Medicare or apply for Medicare online. • To learn more about or make changes to existing Medicare benefits.
State Health Insurance Assistance Program (SHIP) Office	www.shiptacenter.org	This state-based program offers one-on-one counseling and assistance to people covered by Medicare and their families.	<ul style="list-style-type: none"> • To receive free in-person or telephone counseling on navigating the health care system and Medicare program.



Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Social Security Administration (SSA)	www.SSA.gov	This division of HHS administers Social Security, a social benefits program consisting of retirement, disability, and survivors' benefits.	<ul style="list-style-type: none">• To learn more about available social security benefits for which consumers might be eligible.• To apply for a Social Security number, which is necessary to apply for health coverage through the Marketplace (except for legal immigrants, who can provide a document number).
Veterans Affairs (VA) Health Benefits	www.VA.gov www.VA.gov/health/aca	This program is run by the Department of Veterans Affairs and provides health coverage through the Veterans Health Administration (VHA) for eligible military veterans.	<ul style="list-style-type: none">• To enroll in or manage VA health care benefits for consumers who are veterans of the U.S. armed forces.• To learn more about how the Affordable Care Act affects veterans' health care.



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