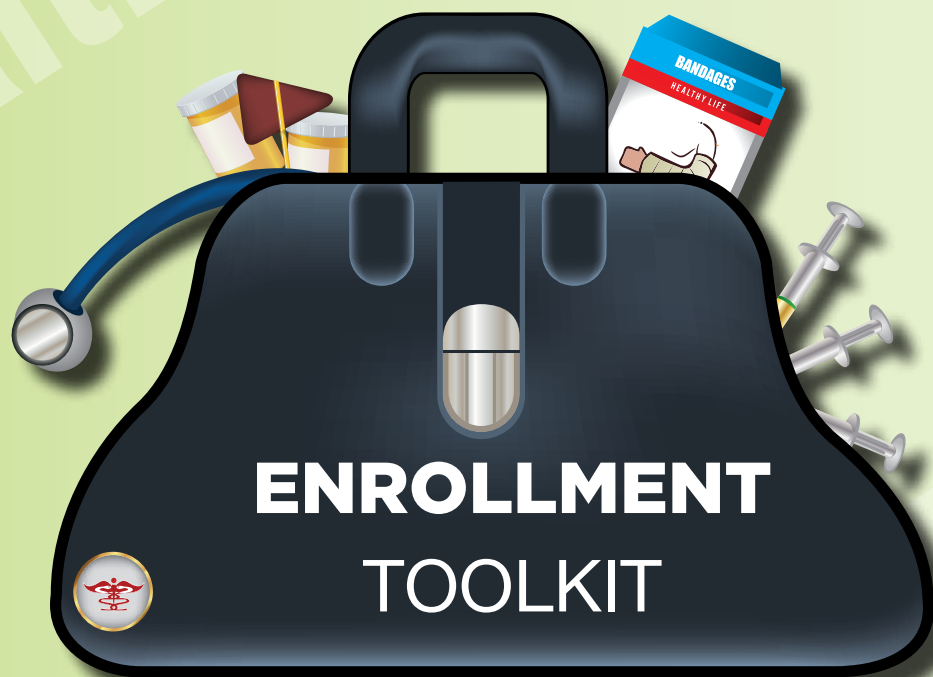


FROM COVERAGE TO CARE



**Helping Consumers Choose
the Health Plan
That's Right for Them**

Quick Start Guide to This Toolkit

Every year, consumers can enroll in health insurance coverage (coverage) or change their health insurance plan (plan). People may be overwhelmed by their choices. They may not know **how to choose the plan that meets their needs or how to use their coverage to get the care they need.**

This Toolkit is for community partners, assisters, and other people who help consumers enroll in coverage or change their plan. Sections start with a few questions consumers might have. There are key messages for you to emphasize at the top of each page. At the end of the section there are links to more resources for you and consumers on each topic.

You may be helping someone get covered for the first time, helping them re-enroll, or explaining coverage options so consumers can enroll on their own. You can use the information and resources here and in the **From Coverage to Care Roadmap to Better Care and a Healthier You** to help consumers get the coverage that's right for them and help them move **From Coverage to Care.**

The **Roadmap** and other **From Coverage to Care (C2C)** resources are available at:

<https://marketplace.cms.gov/c2c>.



▶ LET'S BEGIN

Personalize It.

To make the most of your time with consumers, look for ways to personalize this information to each person. Before you begin, ask if consumers have questions. Their answers will help you navigate this Toolkit to meet their needs.

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1



WHY CONSUMERS SHOULD SIGN UP FOR HEALTH COVERAGE

If the consumer you're working with isn't sure why he or she should get coverage, talk about the points below, and make it personal. For example, you could ask if there was a time when they thought they should go to a doctor but didn't, or if this happened to a family member. Was it because they couldn't afford the visit? Were they afraid of finding a problem and how much it would cost to treat it? Let consumers know that having coverage means they can get the care they need, and that there is a limit to the amount they will have to pay towards the cost of their care. Tell them that together you can find a plan that meets their health care needs and budget.

When we say "coverage"... we mean a legal entitlement consumers have to payment or reimbursement for their health care costs. It is generally offered through:

Health Insurance Company

Group health plan offered in connection with employment

OR

A government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)

ARE THERE QUESTIONS ABOUT ...

BENEFITS
OF COVERAGE?

GO TO
3

AFFORDABILITY?

GO TO
4

EXEMPTIONS OR
FEE FOR NOT
HAVING
COVERAGE?

GO TO
5

1. Coverage Is Security.

Even if they're uninsured, most consumers use health care when they are sick. This may involve waiting until a health condition is unbearable, then going to an emergency department or clinic for care.

Explain that coverage can relieve some of the stress about using health care by providing a set of health care services they know will be covered (known as Essential Health Benefits, explained more on page 10).

Having coverage can also help relieve the stress of not knowing how much health care will cost if you get sick and get a high bill. With coverage, consumers know the portion of health care costs they're responsible for, and what their plan will pay. They also get access to free or low cost preventive care, which can keep people healthy and help them avoid more expensive medical problems in the future.

PERSONALIZE THE CONVERSATIONS FOR ...

- **Someone with a chronic condition (like diabetes, hypertension, depression, or cancer):** Ask consumers to think about their health and their family's health. For example, high blood pressure, diabetes or heart disease may run in their family. Explain that they can use their coverage to find out if they have a condition, then get treatment to manage it if they do. You could provide an example of the cost of a vial of a prescription drug like insulin. Without insurance, it could cost them \$300 but with coverage they would only pay a copayment – like \$10 or \$20.

To explain more about how total costs are different from what they'll pay when they're covered, refer to the Cost Tables in the

From Coverage to Care Roadmap. There is an example Cost Table for “Costs of Type 2 Diabetes” on page 15.

- **A young adult:** Young adults are sometimes called “young invincibles” because they think they can't get sick or injured. They might not see the value of coverage right away. Ask consumers if they've been to the emergency department recently – and if they know how much the visit cost. You can explain to them that without coverage, treating a broken arm can cost nearly \$7,700.

They may be thinking about starting a family. If so, let them know that having a baby can cost thousands of dollars. You can use the “Costs of Having a Baby” Cost Table in the **Roadmap** (on page 15) to show them an example of how having coverage could affect how much they'll pay.

Remind young consumers that they have options. They may be able to stay on their parents' plan until they're 26, get covered through their school's health plan, or enroll in Medicaid or a Marketplace plan with financial help. Having coverage will protect them from large health care costs if they get sick. Plus, using coverage for preventive services can reduce their health care costs over time by keeping them healthy.

Share information about preventive services and screenings that may be covered without cost-sharing. There's a link to the **Roadmap** and other resources to help you work with young adults at the end of this section on page 8.

2. Coverage May Be More Affordable Than You Think.

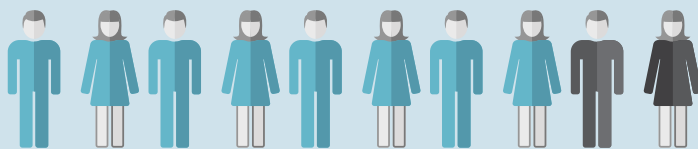
Eighty-five percent of individuals who selected a Marketplace plan last year qualified for financial help to lower their out-of-pocket costs. But many people didn't apply for coverage because they thought they couldn't afford it. Remind consumers that they will only find out whether they qualify for help paying for coverage if they apply to the Marketplace or their state Medicaid agency.

Consumers can select "See plans & prices" on **HealthCare.gov** and enter some basic information to get an estimate of their costs to use as a guide. If you can, show consumers an estimate of their costs by window shopping on the site with them, but let them know their costs and the exact amount of financial help they'll get is only available once they apply. Applying is free and it may save the consumer out-of-pocket costs.

Section 2 has more information on how to see plans and prices on **HealthCare.gov** and there's a cheat sheet on page 14 so you can quickly tell whether a consumer might qualify for help based on their income. Remind consumers these are only estimates and the Marketplace and state Medicaid agencies will make final determinations when they apply for health coverage.

————— //// —————
SEE PLANS & PRICES AT:
<https://www.healthcare.gov/see-plans/>
————— //// —————

80% Or 8 out of 10 Consumers



can get coverage for **\$100** or less
per month after any applicable tax credits in 2015.



3. Avoid The Fee For Not Having Coverage.

Minimum Essential Coverage is what consumers must have to avoid paying the Individual Shared Responsibility Payment – a fee for going without coverage for part or all of the year. Qualified Health Plans in the Marketplace plans meet this standard. So does TRICARE, the Veteran's health care program, Medicare Part A, Medicaid, coverage for Peace Corps Volunteers, and job-based coverage.

Minimum Essential Coverage doesn't include coverage that only provides limited benefits. For example, coverage for just vision or dental care, and Medicaid just for certain benefits like family planning, workers' compensation or disability, don't meet this standard.

For more information or to find out what coverage qualifies, visit: <https://www.healthcare.gov/fees-exemptions/plans-that-count-as-coverage/>

Consumers who don't enroll in coverage may have to pay a fee when they file taxes (also called the Individual Shared Responsibility Payment). Make sure consumers know the fee for not enrolling in coverage goes up every year. Some consumers are exempt from this requirement if any of these apply them:

- Uninsured for less than 3 months of the year
- Lowest-priced coverage available would cost more than 8% of their household income

- Don't have to file a tax return because their income is too low
- Member of a federally recognized tribe or eligible for services through an Indian Health Services provider
- Member of a recognized health care sharing ministry
- Member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- Incarcerated (either detained or jailed), and not being held pending disposition of charges
- Not lawfully present in the U.S.
- Qualify for a hardship exemption

Encourage consumers to apply for coverage even if they are going to apply for an exemption. Once they see that they can get affordable coverage, they may decide they want the peace of mind and access to affordable health care services that they get when they're covered. There are more resources at the end of this section on page 8 to help you explain what qualifies for an exemption and how consumers can apply.

////

FIND OUT WHAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE:
[www.irs.gov/AffordableCare-Act/](http://www.irs.gov/AffordableCare-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage)
Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage

////

3. Avoid The Fee For Not Having Coverage (Continued).

If you don't enroll in Minimum Essential Coverage for 2015 (or have an exemption), the applicable taxpayer will pay whichever cost is higher when they file their 2015 income taxes:

- **Method 1:** Percentage of yearly income. 2% of their yearly household income (above the minimum tax threshold of \$10,150)

OR

- **Method 2:** Flat fee per person, \$325 for each adult and \$162.50 per child under 18 (up to a total maximum of \$975 per family for 2015)

For a single person living alone, earning \$35,000 per year that's...

METHOD 1: Percentage of yearly income

STEP 1

$$\text{\$35,000} - \text{\$10,150} = \text{\$24,850}$$

Annual Income	Minimum Filing Threshold	Fee Income
------------------	--------------------------------	------------

STEP 2

$$\text{\$24,850} \times 2\% = \text{\$497}$$

Fee	%	What the taxpayer owes
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METHOD 2: Flat fee per Person

\$325 for 1 person

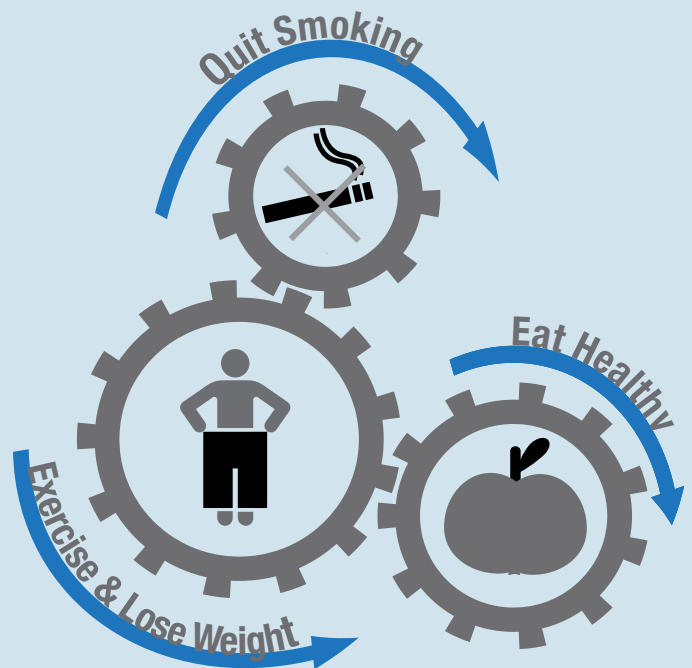
The consumer will pay \$497 in 2015 since that is the higher amount.

4. Your Coverage Pays For Preventive Care That Can Keep You Healthy.

Consumers may have had a provider recommend vaccines, screenings, or tests to them or a family member, but they may not have known why they needed it, or the value of knowing the results. Explain that screenings and test results help providers monitor patients' health and make sure they're on the right track. And most preventive services, like screenings, tests and vaccines, are available at no cost to the enrollee (no copayments or deductibles). Explain to consumers that if they're diagnosed with a health condition or illness, catching it early could be life-saving. Many serious health conditions can be treated or managed.

Consumers may have also heard statistics, like: 1 in 8 women will develop breast cancer in their lifetime, or 1/3 of all people have heart disease. People with a family history of a certain illness or health condition may have heard that they're more likely to get sick. They may even think that they can't avoid it, and may be afraid to see a provider. Talk about how consumers can be proactive and get regular health care to prevent illness or to catch it early.

**ONCE CONSUMERS HAVE COVERAGE,
THEY CAN TALK WITH A PROVIDER
ABOUT HOW TO USE IT TO STAY
HEALTHY.**



Do Consumers Need Help Enrolling?

Call the Marketplace Call Center:

- 1-800-318-2596
- TTY: 1-855-889-4325
- Available 24 hours a day, 7 days a week in more than 150 languages

Find local in-person help, visit:

<https://localhelp.healthcare.gov/>

RESOURCES

From Coverage to Care resources (Partner/Consumer)

<https://marketplace.cms.gov/c2c>

Incomes that qualify for lower costs (Partner/Consumer)

<https://www.healthcare.gov/qualifying-for-lower-costs-chart/>

How to estimate income for the Marketplace (Partner/Consumer)

<https://www.healthcare.gov/income-and-household-information/>

How health coverage affects 2014 taxes (Partner/Consumer)

<https://www.healthcare.gov/taxes/marketplace-health-plan/>

Where and how to get an exemption (Partner/Consumer)

<http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions>

Qualifying for a hardship exemption (Partner/Consumer)

<https://www.healthcare.gov/fees-exemptions/hardship-exemptions/>

Questions & answers on the Individual Shared Responsibility Payment and exemptions (Partner/Consumer)

[http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision - Exemptions](http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision-Exemptions)

Health coverage for young adults (Partner/Consumer)

<https://www.healthcare.gov/young-adults/>

Myhealthfinder web app for personalized preventive care recommendations (Consumer)

healthfinder.gov/myhealthfinder/



2



WHAT CONSUMERS SHOULD KNOW BEFORE ENROLLING IN A PLAN

People enrolling in health coverage for the first time may not understand common health insurance coverage terms. Misconceptions and knowledge gaps can make shopping for coverage difficult. Use this section and the **From Coverage to Care Roadmap, Step 2** to discuss key coverage terms and consumers' concerns about costs.

Emphasize the four topics below, and get the **Roadmap** at:

<https://marketplace.cms.gov/c2c>

ARE THERE QUESTIONS ABOUT ...



1. All Marketplace Plans Must Cover Doctor Visits, Preventive Services, Prescription Drugs, Mental Health Care, Hospitalization, And More.

Consumers may be hesitant to enroll in coverage because they are unclear on what is covered and afraid to pick the wrong plan. They may have had a bad experience in the past, been denied coverage, had their coverage cancelled, or thought a treatment was covered when it wasn't, which may contribute to their hesitation. Reassure consumers that although each plan is different, Marketplace plans must meet certain minimum standards, including covering the ten Essential Health Benefits listed to the right. Plans also cover many preventive services like screenings and vaccines without out-of-pocket costs to the consumer, like copayments, coinsurance, or deductibles.

Talk to consumers about which services they may need. Ask if there are other things that they don't see listed in the box to the right. Write them down and refer back to the list when comparing available plans.

WHAT ARE ESSENTIAL HEALTH BENEFITS?

A set of health care service categories that Marketplace plans must be covered by plans sold through the Marketplace. Many plans also cover additional benefits as well.

- 1 **Outpatient care** is care a person gets without being admitted to the hospital as an inpatient
- 2 **Emergency services**
- 3 **Treatment in the hospital for inpatient care**
- 4 **Care before and after a baby is born**
- 5 **Mental health and substance use disorder services**
- 6 **Prescription drugs**
- 7 **Services and devices** to help you a person recover if they're injured or have a disability or chronic condition, or that help you gain function (called habilitative and rehabilitative services)
- 8 **Lab tests and services**
- 9 **Preventive services** including counseling, screenings, and vaccines to keep people healthy and manage a chronic disease
- 10 **Pediatric Services** - services tailored to the needs of children to ensure they grow up and develop properly, including dental and vision care for kids

ONE IN THREE CONSUMERS DON'T UNDERSTAND WHAT A PREMIUM IS.

2. Once You Understand Key Terms, You Can Compare Costs For Plans.

Consumers may not understand common health care terms, including deductible, premium, copayments, and coinsurance.

Below are some key pieces of information to point out:

Premiums are payments generally made every month to maintain coverage. Explain that consumers will pay their premium to their insurance plan, regardless of whether they use any health care services. Remind them that it's important to pay their premiums in order to keep their coverage.

Copayment (or Copay) is the fixed amount a consumer pays for a covered health care service or supply. Copayments are usually a set amount, for example \$15 for primary care visits and \$35 for specialty care visits. Point out the copayment amounts for each service. With some types of coverage (like Medicaid) there may not be a copayment. Mention that copayments could differ based on the type of care or service they receive (for example, primary care, specialist, emergency department, and brand-name and generic prescription drugs may have different copayments).

Go to **Section 3** for more information about talking with consumers about the costs of prescription drug coverage.

Coinsurance is the consumer's share of the costs of a covered health care service. It's different from a copayment because it is a percent of the total allowed amount for the service, not a set dollar amount. For example: if the cost of a visit to a specialist is \$180, and the consumer is responsible for paying 20% coinsurance, he or she would pay \$36.

SAMPLE: WHAT YOU PAY WITH COINSURANCE

$$\text{\$180} \times .20 = \text{\$36}$$

Specialist cost x 20% coinsurance = Patient cost

Deductible is the dollar amount consumers have to pay for health care services before their plan will start paying for their care. The deductible may not apply to all health care services. For example, in all Marketplace plans, coverage for preventive services is not subject to the deductible. Other plans may not have a deductible for primary care or prescription drugs. Different plans may have different deductibles for specific services, so consumers should know the deductibles before they pick a plan. Let them know their insurance company will keep track of how much they've paid toward their deductible, but they should keep track as well.

2. Once You Understand Key Terms, You Can Compare Costs For Plans (Continued).

Out-of-pocket limit is the maximum amount consumers will have to pay for covered health care services for the year. One of the benefits of having coverage is that consumers are protected from paying very high costs because of the out-of-pocket limit. Once they reach this limit, their plan will pay for 100% of the rest of the covered health care they need. Each plan sets its own out-of-pocket limit, but it can't be more than **\$6,600 for an individual** (or **\$13,200 for 2 or more people**) in 2015. This may still be unaffordable for some consumers.

Remind consumers they may qualify to get a cost-sharing reduction that lowers their maximum out-of-pocket expenses even more. There's more information about how to apply in this section.

Have consumers go to **www.healthcare.gov/see-plans/** and answer a few basic questions. They will see a display like this one for the available plans with estimated costs and some of the financial help they may get. Write down the costs for the plans they're considering, then select a few on the website and print.

ESTIMATED MONTHLY PREMIUM \$304 Number of people covered: 1	ESTIMATED DEDUCTIBLE \$2,250 Estimated individual total	ESTIMATED OUT-OF-POCKET MAXIMUM \$6,350 Estimated individual total
COPAYMENTS / COINSURANCE Primary doctor: \$35 Specialist doctor: 20% Coinsurance after deductible Emergency room care: 30% Coinsurance after deductible Generic drugs: \$15		<ul style="list-style-type: none">Summary of BenefitsPlan brochureProvider directoryList of covered drugs
LEARN MORE ABOUT THIS PLAN		



Talk about the different costs to get a sense of the consumer's preferences. Some people may prefer to pay a smaller amount each month, even if their copayments when they get care are a little higher. Consumers can filter plans by plan category, premiums, or out-of-pocket costs to find one that meets their needs. For example, if a low premium is the most important thing, consumers can see plans sorted from lowest premium prices to the highest.

Discuss monthly budget or spending and which options are affordable. If consumers aren't sure which plan to enroll in, encourage them to take the information home and to talk with trusted family and friends, if needed, about which plan meets their health care needs and budget. Remind consumers that the information in the "window shopping" feature may not reflect their specific costs or savings – it will only provide an estimate of the premium tax credit, but not other help. Consumers need to apply to know exactly what their costs and financial assistance will be.

TALK TO CONSUMERS ABOUT THEIR MONTHLY BUDGET AND WHICH COVERAGE OPTIONS ARE AFFORDABLE.

Health Insurance Marketplace

Application for Health Coverage & Help Paying Costs (Short Form)

Apply faster online at HealthCare.gov.

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Who can use this application?

Single adults who:

- Aren't offered health coverage from their employer
- Don't have any dependents and can't be claimed as a dependent on someone else's tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're American Indian or Alaska Native.

What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.

We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to HealthCare.gov.

What happens

Send your complete, signed application to the address on page 3. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll contact you if we need more information. You'll get an eligibility determination after your application is processed. Filling out this application may help you decide if you want to buy health coverage.

STEP 1: Tell us about yourself

STEP 2: Current job & income information

3. Financial Assistance May Be Available, But You Must Apply To Learn What You Qualify For.

Many people don't think they can afford coverage, and don't realize that financial assistance may be available. Talk to consumers about tax credits, cost-sharing reductions, Medicaid and the Children's Health Insurance Program (CHIP), and protections for American Indian and Alaska Natives and members of federally recognized tribes and ANCSA shareholders. Let people know that help is available for eligible people and families with lower household incomes. See below for a cheat sheet from **HealthCare.gov** to match up their income to the federal poverty level (FPL). The amounts below are 2014 numbers and used for calculating eligibility for Medicaid and the Children's Health Insurance Program (CHIP). 2014 numbers are used to calculate eligibility for savings on private insurance plans for 2015.

PRIVATE MARKETPLACE HEALTH PLANS

**PREMIUM TAX
CREDIT-ELIGIBLE:**
This is 100% - 400%
FPL in 2014

Number of people in household..	1	2	3	4	5	6
You may qualify for lower premiums AND lower out-of-pocket costs for Marketplace insurance if your yearly income is between...	\$11,670 - \$46,680	\$15,730 - \$62,920	\$19,790 - \$79,260	\$23,850 - \$95,400	\$27,910 - \$111,640	\$31,910 - \$127,880
You may qualify for lower premiums AND lower out-of-pocket costs for Marketplace insurance if your yearly income is between...	\$11,670 - \$29,175	\$15,730 - \$39,325	\$19,790 - \$49,475	\$23,850 - \$59,625	\$27,910 - \$69,775	\$31,970 - \$79,925

**MEDICAID
ELIGIBLE:**
This is 138%
FPL in 2014

**COST SHARING
ELIGIBLE:**
This is 100% - 250%
FPL in 2014

MEDICAID COVERAGE

Number of people in household..	1	2	3	4	5	6
If your state is expanding Medicaid: You may qualify for Medicaid coverage if your yearly income is below...	\$16,101	\$21,707	\$27,310	\$32,930	\$38,516	\$44,119
If your state isn't expanding Medicaid: You may not qualify for any Marketplace savings programs if your yearly income is below....	\$11,670	\$15,730	\$19,790	\$23,850	\$27,910	\$31,970

This is 100%
FPL in 2014

NOTE: INCOMES THAT QUALIFY FOR LOWER COSTS ARE HIGHER IN ALASKA & HAWAII.

	2014 FPL
1	\$11,670
2	\$15,730
3	\$19,790
4	\$23,850
5	\$27,910
6	\$31,970
7	\$36,030
8	\$40,090

Alaska 2014 FPL	Hawaii 2014 FPL
\$14,580	\$13,420
\$19,660	\$18,090
\$24,740	\$22,760
\$29,820	\$27,430
\$34,900	\$32,100
\$39,980	\$36,770
\$45,060	\$41,440
\$50,140	\$46,110

Types of Financial Assistance

Premium tax credit is for people with household incomes between 100% - 400% FPL who are not eligible for certain other coverage. Lower incomes are eligible for a larger credit. The credit reduces monthly premium payments. Consumers can apply the credit before they pay their premium so they pay less per month, or when they file taxes to get money back at the end of the year.

Cost-sharing reductions provide additional financial assistance for eligible consumers with incomes between 100% - 250% FPL who also qualify for premium tax credits. Let consumers know that this reduction lowers the amount they will have to pay for out-of-pocket for deductibles, coinsurance, and copayments, but they must enroll in a specific category of plan (Silver, and we'll talk about the categories in **Section 3**).

American Indians and Alaska Natives (AI/AN) and members of federally recognized tribes and ANCSA shareholders have special protections and cost-sharing. **Section 5** has more information.

3. Financial Assistance May Be Available, But You Must Apply To Learn What You Qualify For (Continue).

Premium tax credits: Talk to consumers about how coverage will affect their income taxes when they file their federal income tax returns. People may not realize they could get a premium tax credit, even if they earn more than \$40,000 a year. Advance payments of the premium tax credit can lower monthly premium costs. If they qualify for a tax credit, consumers can decide how much of the credit to apply to their premium each month up to their maximum credit amount. They can apply the credit when their coverage starts and pay less per month or claim the credit when they file their taxes.

Let consumers know they must file their federal taxes to get this subsidy, whether they apply it up front as advance payment of the premium tax credit or when they file their taxes. When the individual files their annual federal income tax return, the amount of premium tax credit they received during the year will be reconciled with their eligibility for the premium tax credit based on their actual household income for the year. If the individual received excess premium tax credit than what they are eligible for, they may have to repay the excess amount.

Cost-sharing reductions: In addition to the premium tax credit, eligible consumers enrolling in Marketplace plans with incomes whose household income is between 100% - 250% of FLP and who don't qualify for Medicaid can get cost-sharing reductions if they enroll in a Silver plan. This subsidy is different from the premium tax credit in these ways: it is only for Silver plans, it reduces the consumer's out-of-pocket costs when they use health care services, and it applies to their deductibles, copayments and coinsurance.

- **Without the cost-sharing subsidy,** a consumer's total out-of-pocket maximum can be no higher than \$6,600 for an individual and \$13,200 for 2 or more people.
- **With the cost-sharing subsidy,** a consumer's out-of-pocket maximum can be no higher than \$2,250-\$5,200 for an individual or \$4,500-\$10,400 for a family depending on where their household income falls between 100% - 250% FPL.

A plan can change how it combines its charges for copayments, coinsurance, and deductibles, but consumers will never pay more than these out-of-pocket maximum amounts for covered health care services. If you're serving consumers who are members of a federally recognized tribe, are ANCSA shareholders, or are American Indian or Alaska Native, let them know they could be eligible for additional cost-sharing reductions. Go to **Section 5** for more information.



Paying for coverage and care may seem expensive, but having coverage actually makes using health care more affordable. Explain that coverage can be like having a coupon – plans negotiate a lower payment rate with health care providers who participate with their plan so consumers pay a reduced rate for services. Coverage is also like having a gift card – when consumers use their coverage, their plan generally pays part of the covered services, so consumers’ payments (or out-of-pocket costs) are lower. If consumers are uninsured they might be billed a higher amount for the same services **and** have to pay the full cost of their care.

Medicaid and the Children’s Health Insurance Program (CHIP)

Medicaid and CHIP provide comprehensive benefits for people at no cost or low cost so talk with eligible consumers about enrolling. In states that have expanded eligibility, more adults qualify than ever before – but children and adults may qualify even if your state has not expanded eligibility. People also may not know they can enroll any time of the year if they qualify. Let them know that if they’re eligible for Medicaid but choose to enroll in a Marketplace or other private plan, they can’t get the premium tax credits and cost-sharing reductions.

If your state chose not to expand its Medicaid program and consumers are not eligible for Medicaid, adults below 100% FPL may not have access to cost-sharing reductions or premium tax credits. Medicaid expansion is a state choice and some states did not increase the eligibility threshold. If you are working with low-income consumers who are not eligible for Medicaid, they also may not be able to afford Marketplace coverage. Be sensitive to their circumstances

and let them know they can’t get federal help paying for coverage for a Marketplace plan. If possible, connect them to any local or state resources that might help cover the costs of their care. Additionally, notify these individuals that they may qualify for a hardship exemption. Go to **Section 1** for more information on exemptions and use resources on page 8 to help eligible consumers apply.

Job-Based Coverage & Financial Assistance

In general, if an employer offers a consumer a plan that’s affordable and meets the minimum value standard for plans in the Marketplace, the consumer won’t qualify for financial help if they purchase Marketplace coverage – even if they meet the income threshold. If the employer plan doesn’t meet these two standards, consumers can qualify for premium tax credits in the Marketplace.

- The health plan has to be affordable: cost of coverage for one person is less than 9.5% of the individual’s household income.
- The health plan has to meet minimum value standards.

Most job-based coverage will meet the minimum standards. If a consumer thinks their coverage doesn’t qualify, have them bring the **Employer Coverage Tool** to their employer to fill out. You can help them apply for a determination to see whether they’re eligible for help paying for coverage.

Employer Coverage Tool: <https://www.healthcare.gov/downloads/employer-coverage-tool.pdf>

4. If you're already enrolled in a Marketplace plan, review current plan options to make sure your coverage still meets your needs and update you information.

Encourage consumers to log in to **HealthCare.gov** to review and update their income and report life changes, including information about changes like a birth, adoption, marriage, divorce, or change of address. This information will be used to determine eligibility for premium tax credits and cost-sharing reductions.

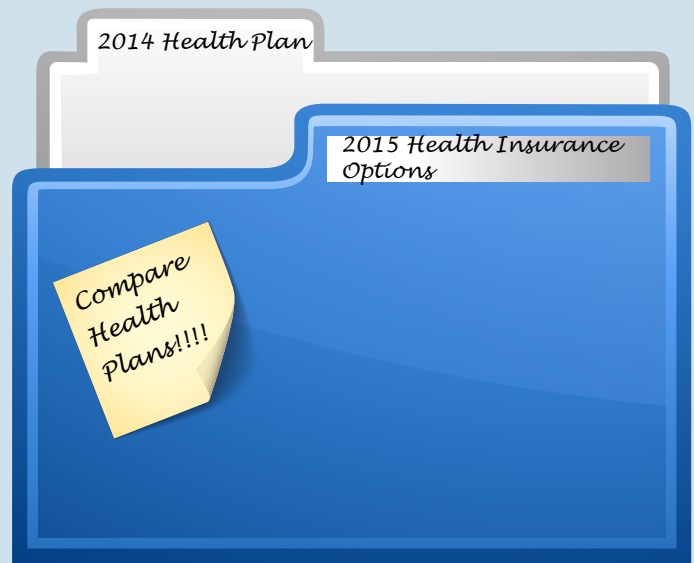
Reporting changes will help consumers avoid getting a smaller refund or owing money they didn't expect to owe on their federal tax return. If you're working with consumers who are claiming the premium tax credit for 2014, you may want to remind them that they must file a federal tax return in order to get it. If they are married, they generally must file taxes jointly with their spouse.

When consumers file their annual federal income taxes, the IRS will match up the information they report with the premium tax credit they received. The IRS may adjust the amounts consumers owe or are due if:

- The amount of advance payments of the premium tax credit that consumer got is less than the premium tax credit due. **Consumers will receive the difference as a refund.**

OR

- A consumer's advance payment of the premium tax credit for the year is more than the amount of the premium tax credit due. **Consumers will have to repay the excess with their tax return, subject to statutory repayment limits.**



Health plans will be different this year.

Let consumers know that every year health insurance plans may change benefits and how they cover certain services, prescription drugs, or include particular providers in their networks. Teach them how to review their coverage this year – and every year. Let them know they could find a more affordable plan, or one with better choices and value, if they go back to the Marketplace and look at their options during open enrollment.



RESOURCES

Helping consumers compare and select a plan (Partner)

<http://marketplace.cms.gov/technical-assistance-resources/plan-compare-walk-through.pdf>

Essential Health Benefits covered in the Marketplace (Consumer)

<https://www.healthcare.gov/blog/10-health-care-benefits-covered-in-the-health-insurance-marketplace/>

How to estimate your income for the Marketplace (Consumer)

<https://www.healthcare.gov/income-and-household-information/>

Videos with facts about the Premium Tax Credit (Consumer)

<http://www.irs.gov/uac/The-Premium-Tax-Credit>

Qualifying for Marketplace cost-sharing reductions (Consumer)

<https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/>

Find and compare plans in your area (Consumer)

<https://www.healthcare.gov/see-plans/>

HealthCare.gov employer-provided coverage tool (Consumer)

<https://www.healthcare.gov/downloads/employer-coverage-tool.pdf>

MEDICAID & CHIP

To find out information about specific State Medicaid programs (Partner)

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State>

Information on Medicaid programs (Partner/Consumer)

<http://www.medicaid.gov/>

Information on Children's Health Insurance Programs (Partner/Consumer)

<http://www.insurekidsnow.gov/>

3



WHAT CONSUMERS SHOULD KNOW BEFORE ENROLLING IN A PLAN

ARE THERE QUESTIONS ABOUT ...

PLAN
CATEGORIES?

GO TO
21

PROVIDER
NETWORKS?

GO TO
23

PRESCRIPTION
DRUGS &
FORMULARIES?

GO TO
26

DENTAL & VISION
COVERAGE?

GO TO
28

Once consumers have a basic understanding of health coverage and cost-sharing, they're ready to find the health plan that best meets their health care needs and budget. Explain that different plans and provider networks have different costs and benefits. For example: some plans may have very low premiums, but limited provider and hospital networks and high out-of-pocket costs. Other plans may have higher premiums but a bigger selection of providers and hospital facilities, and lower out-of-pocket costs like deductibles, copayments, and coinsurance.

This section has discussion-starters and diagrams to help you explain the benefits of different plans. If you haven't already, ask which things are most important to each individual you're helping so you can personalize your assistance.

1. Choosing your plan category generally means balancing monthly premium costs with costs when you get health care services (like copayments).

Plans sold in the Marketplace are divided into four different categories: Bronze, Silver, Gold, and Platinum. The main difference between metals, or plan categories, is the proportion of a consumer's health care costs that their plan will pay. Another difference will be how much cost-sharing the consumer will be responsible for. In general, there is a trade-off between premiums and costs at the time of care: **lower premiums usually come with higher out-of-pocket costs.** Make sure consumers understand this. Consumers should also be aware that no matter which category they choose, all plans cover the 10 Essential Health Benefits discussed in **Section 2**. Let consumers know that the plan categories only apply to certain health insurance plans, and not Medicaid, CHIP, or other coverage types.

Consumers under 30 (and certain individuals who qualify for an exemption from the individual shared responsibility fee) may want to consider a Catastrophic plan. These plans have low premiums and require consumers to meet a high deductible before their coverage starts, except for coverage for certain preventive services and a

limited number of primary care visits (three visits, generally). Consumers who do not plan on using much health care during the year and who only want protection against very high costs in case of a serious accident or illness may want to consider this type of plan.

As with all Marketplace plans, the maximum amount consumers with a Catastrophic plan will pay during a policy year is \$6,600 for an individual plan and \$13,200 for a family plan in 2015. After that, the plan covers 100% of the cost of the covered Essential Health Benefits. Without any coverage, a serious accident or illness could cost a consumer thousands of dollars in health care bills. Let consumers know that premium tax credits can't be used to discount premiums on Catastrophic plans.

BRONZE

SILVER

GOLD

PLATINUM



1. Choosing your plan category generally means balancing monthly premium costs with costs when you get health care services (like copayments) - Continued.

Cost-sharing reductions are available for **Silver Plans** if you are eligible.

	BRONZE	SILVER	GOLD	PLATINUM
What You Pay Each Month (Premium*)	\$	\$\$	\$\$\$	\$\$\$\$
What You Pay When You Go For Care (Out of Pocket Costs, including Deductible, Copays & Coinsurance)	\$\$\$\$	\$\$\$	\$\$	\$
Percent of Total Average Costs of Care Your Plan Will Cover (Actuarial Value)	60% Your Plan 40% You	70% Your Plan 30% You	80% Your Plan 20% You	90% Your Plan 10% You
Might Be Good For You If You...	don't plan to need a lot of health care services for the year.	need to balance your monthly premium with your out of pocket costs.	want to keep your out of pocket costs low, but can afford a higher monthly premium.	plan to use a lot of health care services.

The **actuarial value** of your plan is the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actual value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total cost of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

* Note: These numbers are not real and give an idea of different premium costs. Check the plans in your area for exact costs. You may find a lower premium on a higher metal level plan.

2. Aside from choosing a plan category, you must decide what type of provider network helps you balance the pool of providers you can see with how much you'll pay for each visit.

A plan's provider network is the list of providers, facilities, and suppliers a health insurer or plan has contracted with to provide health care services. The **From Coverage to Care Roadmap, Step 2** introduces the provider network concept to consumers. Explain that plans negotiate lower rates for consumers with providers who are "in-network" for a plan. These providers can be called "preferred providers" or "participating providers." So, in-network providers will usually cost consumers less than out-of-network providers. With some plans, out-of-network care will not be covered, meaning the consumer will pay the full cost.

Each consumer has different priorities, so as you talk about provider network types, **discuss whether they would be willing to pay more to have a larger pool of providers.** Some plans keep premiums low by contracting with a smaller, "tighter" network of providers. Emphasize the key differences between networks, like:

- Costs of care inside and outside the network
- Size of the network
- Specialists in the network

Use **HealthCare.gov's** "window shopping" feature and the Summary of Benefits and Coverage to show differences between provider networks. Point out how plans vary in provider networks and how services are covered by out-of-network/non-participating providers versus in-network/participating providers. As you compare Marketplace plans



on **HealthCare.gov**, consumers can look at each plan's provider directory and search for a specific provider or hospital they want to continue using. **You may want to emphasize that for HMOs and EPOs, the plan may not pay anything for out of network services, but with PPOs and POS networks the plan will generally provide some coverage.**

Refer to the definitions below and talk about each type of network. Have consumers look at a specific plan's Summary of Benefits and Coverage to understand how that plan covers in-network versus out-of-network services.

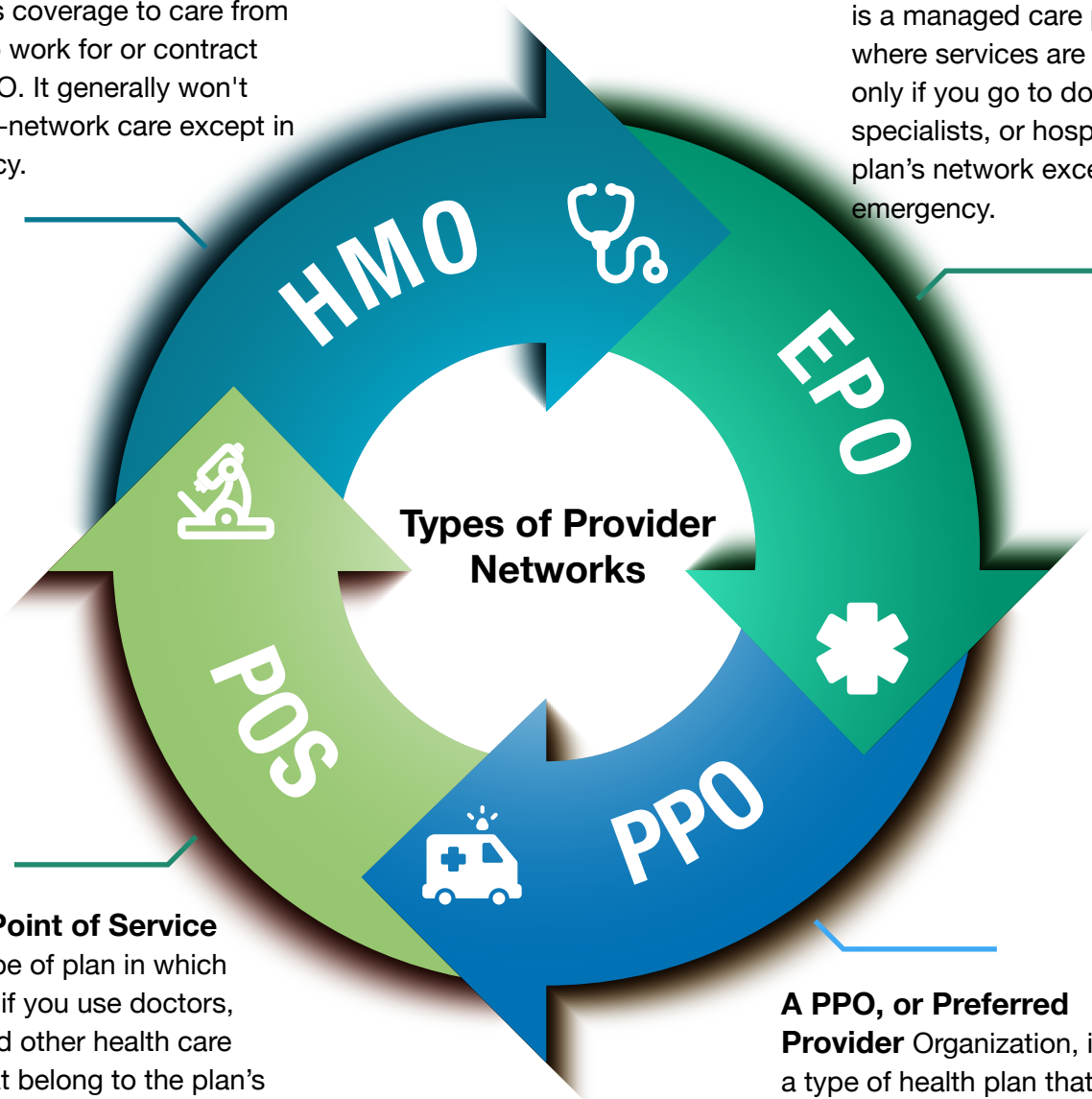
There are links at the end of this section on page 29 to a sample Summary of Benefits and Coverage and other resources to help you talk with consumers about provider network types.

An HMO, or Health

Maintenance Organization, is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

An EPO, or Exclusive

Provider Organization, is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network except in an emergency.



A POS, or Point of Service

Plan, is a type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

A PPO, or Preferred

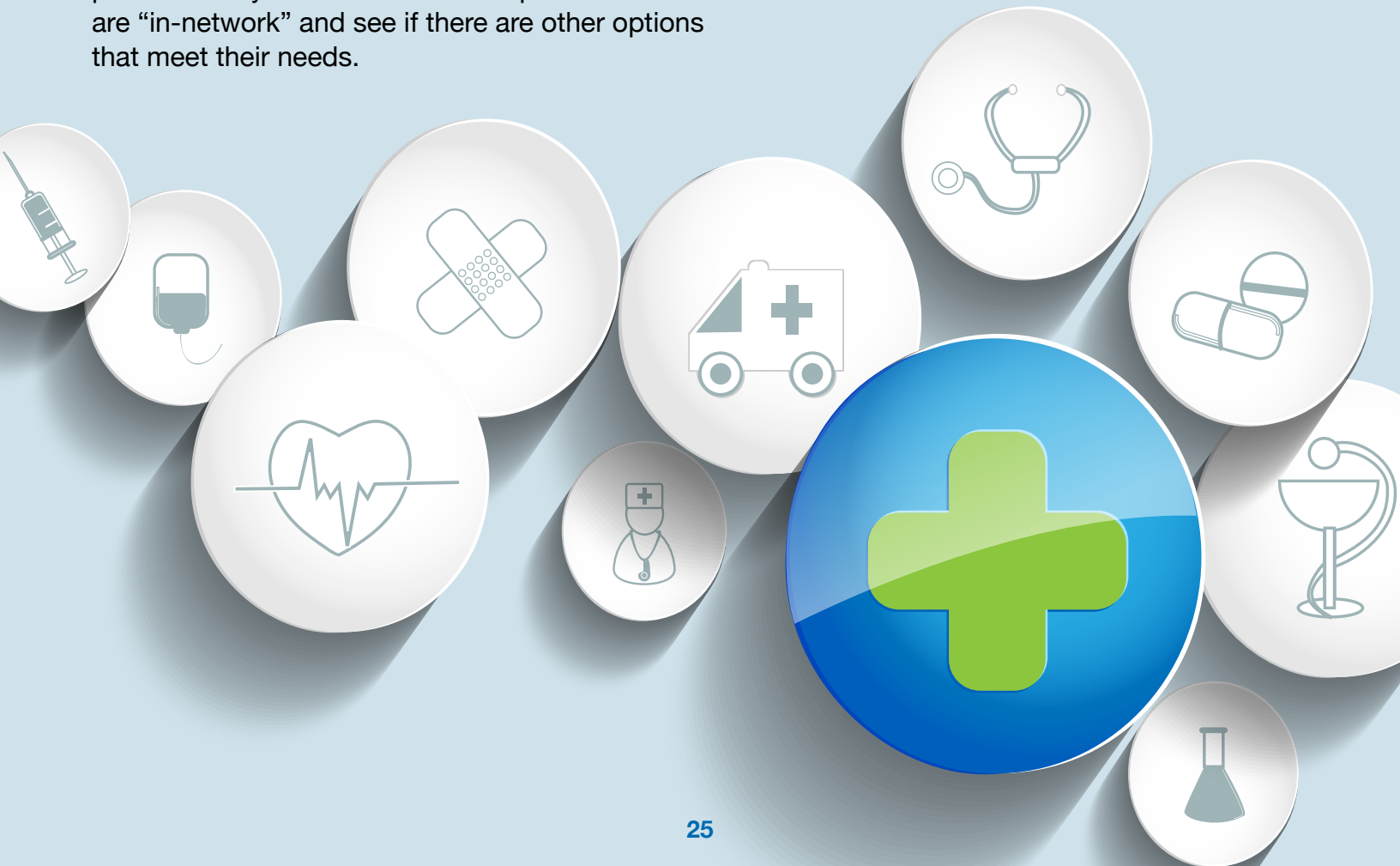
Provider Organization, is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

3. Check for your providers before enrolling.

Ask if the consumer has a provider they would like to continue seeing. If a consumer wants to keep his or her provider, show how to check to see if the provider is “in-network” for the plan under consideration. You can use the provider directories linked on **HealthCare.gov**, or show consumers how to look up their provider by name on a particular plan’s website. However, since providers can change the plans they contract with at any time, encourage consumers to call their provider’s office directly to confirm their participation in a plan’s network before enrolling and, if possible, before seeking care.

If the provider they’re looking for isn’t in one plan’s network, a consumer may want to select a different plan to continue seeing the same provider. They can also look at the providers who are “in-network” and see if there are other options that meet their needs.

————— //// —————
**ENCOURAGE CONSUMERS TO
CALL THEIR PROVIDER’S OFFICE
TO CONFIRM THEIR PLAN
PARTICIPATION.**
————— //// —————



CHECK PLAN'S FORMULARY FOR EXPENSIVE PRESCRIPTION DRUGS.

4. Know what prescription drugs are covered and what they'll cost.

A plan's formulary is a list of prescription drugs that are covered by a plan. Ask consumers if they're currently taking any prescription drugs. Consumers, especially those with a chronic condition, need to understand how much they'll pay. Help consumers see how much their drugs will cost by showing them how to find and read a plan's formulary. Consumers with Medicaid and CHIP generally have to pay some money for prescription drugs, but it's not a lot. Marketplace plans' formularies are posted on HealthCare.gov and consumers can see lists of covered drugs as they compare plans.

Some drugs cost more than others. Formularies are usually divided into categories, or tiers. They tell you how much drugs in each category cost for the health plan and for the consumer. The tiers are usually called:

- Generics (often the lowest cost for consumers)
- Preferred brands
- Non-preferred brands
- Specialty drugs (often the highest cost)





If a consumer takes an expensive prescription drug or fills several prescriptions, they should check the plan's formulary for these particular prescription drugs to see if they're covered. Some people may want to choose a Gold or Platinum plan because although the monthly premium may

cost more, if their prescription drugs or treatments are covered their care would cost less over the year.

For example, if a consumer is prescribed a drug to manage their cholesterol, the cost would depend on: 1) how the plan classifies that drug in its formulary, and 2) what level of coverage the plan provides for each type of drug. Also explain to the consumer that they can talk to their provider about switching from a particular brand to the generic brand for the same drug, which may cost less. Use the table below as an example of how a plan might cover different prescription drugs in its formulary.

SAMPLE CONSUMER COST TABLE

Bronze vs. Gold Plan for 30 day supply of their prescription drug

		BRONZE	GOLD
	Generic Drugs	\$20 copay	\$10 copay
	Preferred Brand Drugs	\$45 copay	\$35 copay
	Non-Preferred Brand or Generic Drugs	\$75 copay	\$70 copay
	Specialty Drugs	40% coinsurance	30% coinsurance

Some drugs have special rules. Most health plan formularies have rules, or restrictions, on certain prescription drugs. These rules can include:

- Requiring prior authorization
- Limiting the amount of a drug a person can get over a certain period of time
- Requiring a consumer to use a cheaper drug that has been proven effective before covering the more expensive drug if the first option doesn't work (also known as "step therapy")

Talk to consumers about any restrictions in the formularies for the plans they're considering since this could impact their care. Reassure consumers that they can work with their provider and their plan to get the care they need.



Re-enrolling? Remind consumers that health plans update their formularies regularly and can change which drugs are covered, add new generic drugs, or change their costs. If there are changes that could affect their care, consumers may want to consider switching plans or talking with their provider about changing to another covered prescription drug instead.

Prescription drugs still too expensive?

Even with coverage, consumers may still be concerned about the cost of their prescription drugs. National and local patient assistance groups such as the Partnership for Prescription Assistance may be able to help qualifying patients get their prescription drugs for very low or no cost.

Go to sites like this one for help:

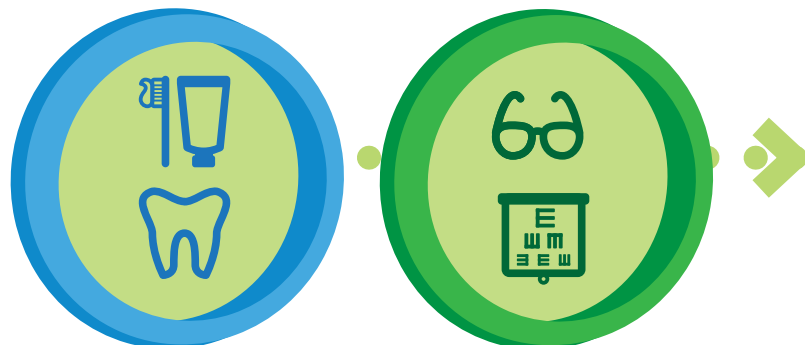
<https://www.pparx.org/>

5. Not all plans cover dental and vision care.

Individuals and families who are new to coverage may assume that enrolling in a Marketplace plan will give them coverage for dental or vision care automatically. Ask consumers if they want dental or vision coverage. **All Marketplace plans are required to cover pediatric dental care for consumers who are 18 and under, and pediatric vision care.** This is not true for adults. Insurers do not have to offer adult dental coverage. If adult dental or vision coverage is important to them, check the Summary of Benefits and Coverage for a particular plan to see if it's included. If it is, let consumers know they'll pay one monthly premium for everything – the premium shown for the plan on **HealthCare.gov** includes both health and dental coverage.

If the plan they're considering doesn't cover adult dental or if they want different dental coverage, consumers can compare the stand-alone dental plans that may be available using the "window shopping" feature of **HealthCare.gov**. If they choose a separate dental plan, consumers will pay a separate, additional premium. If dental plans aren't available, or if consumers would like to enroll in other coverage like a stand-alone vision plan that is not offered in the Marketplace, talk about how to find a stand-alone plan in your state, including contacting your state's Department of Insurance or a local agent or broker.

—————
**INSURERS ARE NOT REQUIRED TO OFFER
ADULTS DENTAL AND VISION BENEFITS. BE
SURE TO SHOP AROUND IF YOU WANT
THIS TYPE OF COVERAGE.**
—————



RESOURCES

Marketplace background guide for Federally Facilitated Marketplace and Partnership states (Partner)

<https://marketplace.cms.gov/technical-assistance-resources/marketplace-background-guide.pdf>

Explaining a Summary of Benefits and Coverage (Partner)

<http://marketplace.cms.gov/technical-assistance-resources/summary-of-benefits-and-coverage.pdf>

FAQs on coverage for young invincibles (Consumer)

<https://www.healthcare.gov/young-adults>

Marketplace coverage and metal levels (Consumer)

<https://www.healthcare.gov/choose-a-plan/plans-categories/>

How to find information on health care providers (Consumer)

<https://www.healthcare.gov/choose-a-plan/find-provider-information/>

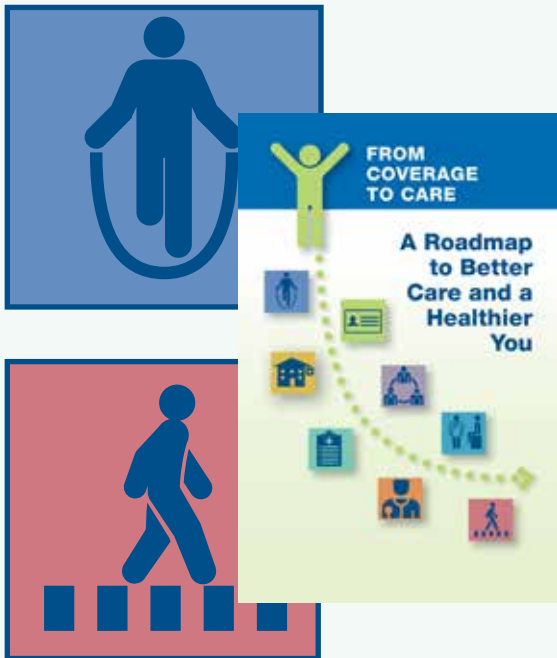


4



WHAT CONSUMERS SHOULD DO AFTER THEY GET COVERAGE

After enrolling, many consumers may be unsure what they should do next. Let consumers know that getting coverage is the first step in their journey to better health. Use the **From Coverage to Care Roadmap** and the messages in this section to help consumers understand how to use their coverage to live a long and healthy life.



ARE THERE QUESTIONS ABOUT ...

COMPLETING
ENROLLMENT?

GO TO
31

HOW TO
KNOW WHAT'S
COVERED?

GO TO
32

PICKING OR
CHANGING
PROVIDERS?

GO TO
32

ONGOING
TREATMENT OR
PRESCRIPTION
DRUGS?

GO TO
33

1. Confirm you're covered.

After consumers complete the enrollment process, they should receive information from their plan about benefits and paying their premiums. Let consumers know there are ways to confirm they're covered if they don't hear from their plan or they aren't sure they've finished the enrollment process. They can:

- **Log in to their account on HealthCare.gov** and click on their application. Consumers will see a summary on the “My Applications & Coverage” page where they can find more details about their enrollment and plan benefits.
- **Call the Customer Service Center of their new plan**, using the listing and instructions on **HealthCare.gov**. Consumers can confirm whether they're enrolled and whether they've paid their first month's premium. Go to: <https://marketplace.cms.gov/outreach-and-education/contact-health-plan.pdf>.
- If they are still having trouble, **call the Marketplace Call Center** at 1-800-318-2596 (TTY: 1-855-889-4325).

2. Pay your monthly premium to keep your coverage.

Consumers who are new to health coverage may not realize they have to pay their premiums every month. Tell them they need to do this even if they don't use any services in the month. Let people know that once they are enrolled, they must pay their first premium directly to the insurance company – not to the Marketplace. They should follow any instructions from their insurer about how and when to make their premium payment. **Consumers who don't pay their premiums risk losing their coverage and having to pay for 100 percent of the cost of their health care.** It may also mean they have to pay the fee for not having coverage. Remind consumers that staying covered is as important as getting covered.



YOU'RE COVERED. NOW GET THE CARE YOU NEED.

3. Review plan materials and learn about your benefits.

Suggest to consumers that they review their plan materials and coverage documents and store them in a safe place right after they enroll. They'll get the most out of their coverage if they know what's covered and what their costs will be. If they have questions, encourage them to call their health plan (or state Medicaid or CHIP office, if they are eligible for those programs) for answers.



4. Talk with a provider about how to improve your health and well-being.

While the consumer was enrolling in coverage, you probably talked about whether he or she already has a provider. If they don't, explain that having a regular provider is an important first step to getting the primary care and preventive services they need. Some consumers may have been assigned to a provider by their plan. If they want to change, show them how to contact their plan to do so.

You've picked a provider, now schedule an appointment. As soon as coverage begins, consumers can see a provider to learn about their health needs, and start working with them toward better health.

The **Roadmap, Steps 4, 5, and 6** help you talk with consumers about finding a provider, and how to scheduling and preparing for their first appointment.

The **Roadmap, Step 7** helps you guide the consumer to find the provider that's right for them.

Know where to go for care. Consumers who are new to coverage may have used the emergency department for care in the past. Remind them that they should only use the emergency department when they have a life-threatening illness or injury. Encourage them to use their primary care provider for other situations.

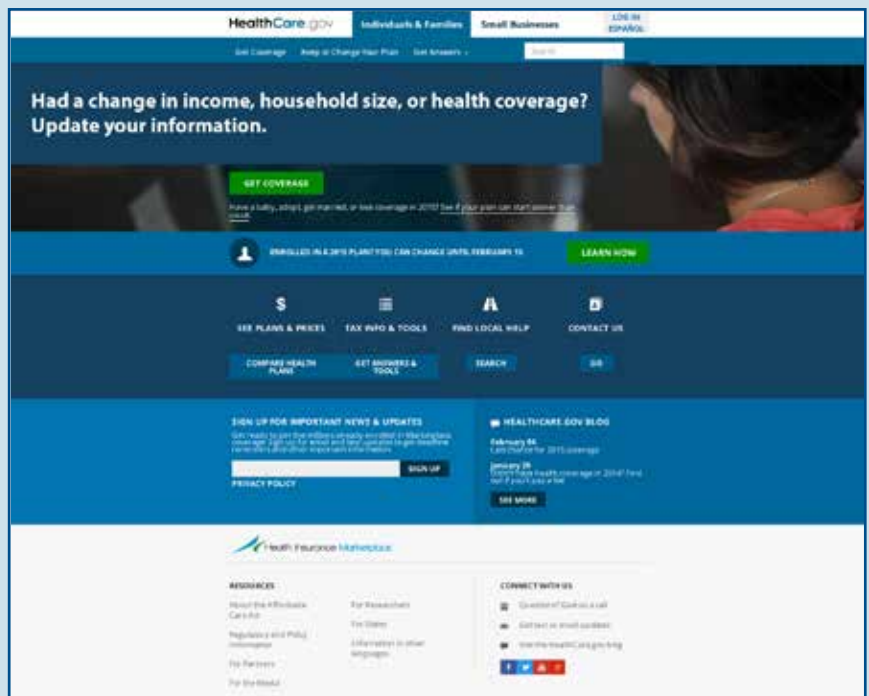
The **Roadmap, Step 3** helps you talk about where to go for care and the differences between primary care and the emergency department.

5. Keep getting the prescription drugs and treatment you need.

You probably talked about consumers' ongoing treatment or prescription drugs earlier in the enrollment process. Remind individuals that they'll need to take action to keep getting care while their coverage changes. If a consumer needs ongoing treatment for a chronic condition or needs to fill a prescription regularly, urge them to talk with their provider immediately to see what needs to be done under their new plan. Let the consumer know that if their new plan has restrictions on certain prescription drugs or services, sometimes these can be waived if their provider and plan work together. If their treatment is denied they always have the right to appeal that decision. Talk about where to look for their plan's appeals process, and remind them that their provider can help them appeal a decision. There are links to more information about the appeals process at the end of this section on page 34.

6. Keep your information current on HealthCare.gov.

The information consumers enter into their Marketplace application on **HealthCare.gov** (for example, family size and household income level) is used to calculate their premium tax credit. **Remind consumers about the importance of keeping their information current so they receive the right amount of financial assistance and don't end up owing money when they file their taxes.** Encourage them to update their information on **HealthCare.gov** when there is a change within 30 days of the change. In addition to keeping their records accurate, consumers may become eligible for a Special Enrollment Period if they have a major life event like a birth, adoption, marriage, or job loss, and they may want to choose a new plan that meets their changing health care needs.



RESOURCES

Confirming enrollment in coverage

(Partner/Consumer)

<https://www.healthcare.gov/apply-and-enroll/complete-your-enrollment/>

Contact your Marketplace health plan

(Partner/Consumer)

<https://marketplace.cms.gov/outreach-and-education/contact-health-plan.pdf>

From Coverage to Care resources

(Partner/Consumer)

<https://marketplace.cms.gov/c2c>

Helping a consumer with appealing a plan's decision not to cover

(Partner)

<http://marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf>

Options for coverage outside of Open Enrollment

(Partner/Consumer)

<https://www.healthcare.gov/coverage-outside-open-enrollment/>

Qualifying for a Special Enrollment Period

(Consumer)

<https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>



5



WHAT CONSUMERS WITH SPECIAL CIRCUMSTANCES SHOULD KNOW ABOUT THEIR COVERAGE OPTIONS

Some consumers have special circumstances that affect their coverage options and enrollment. Three of these groups are discussed in this section, and there are resources on page 41 to help you work with these and other special populations. You may want to partner with others in your community to share resources, best-practices and tips to meet your consumers' needs.

ARE THERE QUESTIONS ABOUT ...

Question	Go To
AMERICAN INDIANS & ALASKA NATIVES?	36
LIMITED ENGLISH PROFICIENCY?	38
IMMIGRANTS?	39

1. American Indians and Alaska Natives (AI/AN) may have new coverage benefits and protections.

Some benefits are available to members of federally recognized tribes or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders. Others are available to people of Indian descent or who are otherwise eligible for services from the Indian Health Service, a tribal program, or an urban Indian health program.

Based on their eligibility, talk to American Indian and Alaska Native consumers about limited and zero cost-sharing plans and Medicaid. Help them compare plans by window shopping at “See Plans & Prices” on **HealthCare.gov** to find one that works for them. Remind consumers they will have to pay their premiums if they enroll in a Marketplace plan. You should also help them check to see if they're eligible for premium tax credits (discussed in **Section 2**).

Financial Assistance for American Indians and Alaska Natives

Members of federally recognized Indian tribes and ANCSA Corporation shareholders (regional or village) may qualify for zero or limited cost-sharing plans or cost-sharing reductions based on their income. Let consumers know that they can enroll in a Marketplace plan any time during the year, not just during the yearly Open Enrollment period.

- **Household income is below \$70,650 for a family of 4 (\$88,320 in Alaska):** can enroll in a zero cost-sharing plan. Let them know they have no out-of-pocket costs like copayments, deductibles, or coinsurance.
- **Household income is above \$70,650 for a family of 4 (\$88,320 in Alaska):** Can enroll in a limited cost-sharing plan. Let people know they won't have to pay out-of-pocket costs when they get services from an Indian health care provider – or from another provider, if they have a referral from an Indian health care provider.

American Indians or Alaska Natives, and others eligible for services from the Indian Health Service, tribal program, or urban Indian Health program have additional opportunities for coverage:

- **May qualify for Medicaid or CHIP:** Let consumers know they have special cost and eligibility rules for Medicaid and CHIP that make it easier to qualify for these programs.
- **Don't pay out-of-pocket costs for Indian health programs:** regardless of their income, consumers won't have any out of pocket costs for items or services provided by the Indian Health Service, tribal programs, or urban Indian programs, including Contract Health Services.
- **Don't pay the penalty:** Consumers who do not enroll in coverage won't have to pay the fee that most other people without health insurance must pay, but do have to apply for an exemption.

For more information about coverage for American Indian and Alaska Natives, go to:
<https://www.healthcare.gov/american-indians-alaska-natives/>

Where do you go for care? Consumers who've been using tribal health care services may not know which other providers will take their new coverage. American Indian and Alaska Natives can use an Indian health care provider as a primary care provider or choose to use a provider in their new plan's network. If they get health care from an Indian health provider already, let them know that they can continue to see that Indian health provider and many others after they enroll in Marketplace coverage. They may also qualify for coverage with low or zero cost-sharing. If they don't have a provider, show them how to find one using the plan's provider directory posted on **HealthCare.gov** or the health plan's website, if they have one. Let consumers know that getting covered will give them more options when they need health care.

Enroll in coverage or apply for an exemption. Many American Indians and Alaska Natives get health care at various types of Indian health care providers, including Indian Health Services, tribal programs, and urban Indian programs (called ITUs). Although they have access to health care services, explain that this health care is not considered insurance for purposes of the individual shared responsibility requirement. Let them know that they still need to enroll in minimum essential coverage or apply for an exemption to avoid having to pay the individual shared responsibility fee.

You can use the **Tribal version of the Roadmap** and resources at the end of this section on page 41 to help you work with tribal populations. You'll find more information about help with costs, how American Indian and Alaska Native consumers can get an exemption, what documents are required, and how to access care.

HEALTH CARE SERVICES YOU GET AT IHS, URBAN INDIAN PROGRAMS, OR TRIBAL PROGRAMS DOESN'T COUNT AS MINIMUM ESSENTIAL COVERAGE.





2. Help is available if you speak a language other than English.

If you're helping someone who speaks a language other than English, there are resources in the box below for help that may be available in his or her preferred language. Some of these resources include interpreters, call center support, and print and web resources like a Uniform Glossary and Marketplace application guides. You can also use the “local help” feature on **HealthCare.gov** to find in-person support in your community.

Get In-Language Assistance

You can use these resources together, or consumers can access these services on their own.

The Marketplace Call Center has representatives available in English and Spanish-speaking representatives, and interpretation and translation services in 150 languages. These services are free.

For help in a language other than English, call **1-800-318-2596**.

Some In-person “assisters,” like navigators, Certified Application Counselors, and others partner offer services in languages other than English. Consumers can get a list of local organizations with contact information, office hours, and types of help offered including non-English language support. Visit <https://localhelp.healthcare.gov/> and type enter a city and state or ZIP Code.

Online resources are available in many languages, with more being developed. You can find Marketplace application guides in 27 languages. For more information visit: <https://www.healthcare.gov/language-resource/>.

En Español: <https://www.cuidadodesalud.gov/es/>

3. Many immigrants can enroll in Marketplace plans, Medicaid, or CHIP, and may be eligible for financial assistance.

Non-U.S. citizens or members of their family may have questions about whether they can enroll in coverage and get help with costs. They may also wonder what documentation they need.

People with the following immigration status qualify for Marketplace coverage:

- Lawful Permanent Resident (LPR or Green Card Holder)
- Asylees
- Refugees
- Cuban and Haitian entrants
- Paroled to the U.S. for at least 1 year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children or parents
- Victims of trafficking or and their spouses, children, siblings or parents
- Granted withholding of deportation
- American Indian born in Canada
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
- Valid non-immigrant visas
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals)

See a full list of eligible immigration statuses eligible to use the Marketplace here:
<https://www.healthcare.gov/immigrants/immigration-status/>

In general, Medicaid and CHIP require lawfully present immigrants to become lawful permanent residents, and to wait five years before they can enroll in coverage. During this five-year waiting period eligible individuals may be able to get coverage to treat an emergency medical condition. Lawful permanent residents who haven't completed the five-year waiting period can enroll in a Marketplace plan and may be eligible for premium tax credits and cost-sharing reductions during that time. Some states don't have the five-year waiting period for children and pregnant women. Use the resource below to see if your state is one of them.

DO THEY HAVE TO WAIT 5 YEARS?

Check whether your state allows children and/or pregnant women to enroll in Medicaid and CHIP with no five-year waiting period. Go to:

http://insurekidsnow.gov/professionals/eligibility/lawfully_residing.html

FOR A COMPLETE LIST OF DOCUMENTATION IMMIGRANTS
CAN USE WHEN ENROLLING IN COVERAGE:

<https://www.healthcare.gov/help/immigration-document-types/>

Immigrants who aren't lawfully present aren't eligible to enroll for coverage through the Marketplace, get premium tax credits or cost-sharing reductions, or enroll in non-emergency Medicaid or CHIP. They can file a Marketplace application for their lawfully present children or family members. Family members who aren't applying for coverage for themselves will not have to give information about their immigration status, so they can help anyone in their family apply.

You may need documentation when you apply and enroll. The documents individuals need to enroll in Marketplace coverage will depend on their immigration status. Here are some of the documents immigrants may need:

- Permanent Resident Card, "Green Card" (I-551)
- Reentry Permit (I-327)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Temporary I-551 Stamp (on passport or I-94/I-94A)
- Arrival/Departure Record (I-94/I-94A)
- Arrival/Departure Record in foreign passport (I-94)
- Foreign Passport
- Certificate of Eligibility for Nonimmigrant Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor Status (DS2019)
- Notice of Action (I-797)
- Document indicating membership in a federally recognized Indian tribe or American Indian born in Canada
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Alien number (also called alien registration number or USCIS number) or 1-94 number



RESOURCES

AMERICAN INDIANS AND ALASKA NATIVES

From Coverage to Care Roadmap – Tribal Version (Partner/Consumer)

<https://marketplace.cms.gov/c2c>

Tip sheet for Assisters working with AI/ANs (Partner)

<https://marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf>

Details on special Marketplace protections and benefits for AI/ANs
(Consumer)

<https://www.healthcare.gov/tribal>

How to apply for an exemption (Consumer)

<https://www.healthcare.gov/fees-exemptions/apply-for-exemption/>

Information for tribal leaders and tribal health programs, National Indian Health Outreach and Education (NIHOE) (Partner/Consumer)

<http://tribalhealthcare.org/>

LIMITED ENGLISH PROFICIENCY

Glossary of health care terms for consumers with limited English proficiency (Partner/Consumer)

<https://marketplace.cms.gov/technical-assistance-resources/plan-compare-and-plan-selection-help.html>

Translated resources from Marketplace (Partner)

<https://marketplace.cms.gov/outreach-and-education/other-languages.html>

Uniform Glossaries in other languages (Partner/Consumer)

<https://marketplace.cms.gov/outreach-and-education/tools-and-toolkits.html>

Marketplace Call Center instructions in other languages (Consumer)

<https://marketplace.cms.gov/outreach-and-education/getting-help-in-a-language-other-than-english.pdf>

RESOURCES (Continued)

Find local enrollment help in other languages (Consumer)

<https://localhelp.healthcare.gov/>

HealthCare.gov resources in other languages (Consumer)

<https://www.healthcare.gov/language-resource/>

Spanish version of HealthCare.gov (Consumer)

<https://www.cuidadodesalud.gov/es/>

Help filing a complain in other languages (Consumer)

<http://www.hhs.gov/ocr/office/file/languageaccess.html>

IMMIGRANTS

Overview of immigrant eligibility for affordable health coverage (Partner)

<http://www.healthreformbeyondthebasics.org/wp-content/uploads/2014/09/CMS-Assister-Webinar-09.19.14-Immigrant-Eligibility.pdf>

Information on immigration status and the Marketplace (Consumer)

<https://www.healthcare.gov/immigrants/immigration-status>

OTHER VULNERABLE POPULATIONS

Helping special populations enroll (Partner)

<https://marketplace.cms.gov/outreach-and-education/special-populations.html>

Health care toolkit for faith and community-based organizations (Partner)

http://www.hhs.gov/partnerships/aca_act_and_community/index.html

Tools for working with consumers with HIV/AIDS (Partner/Consumer)

<https://careacttarget.org/category/audience/consumers-and-community>



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