Coverage to Care Assistance

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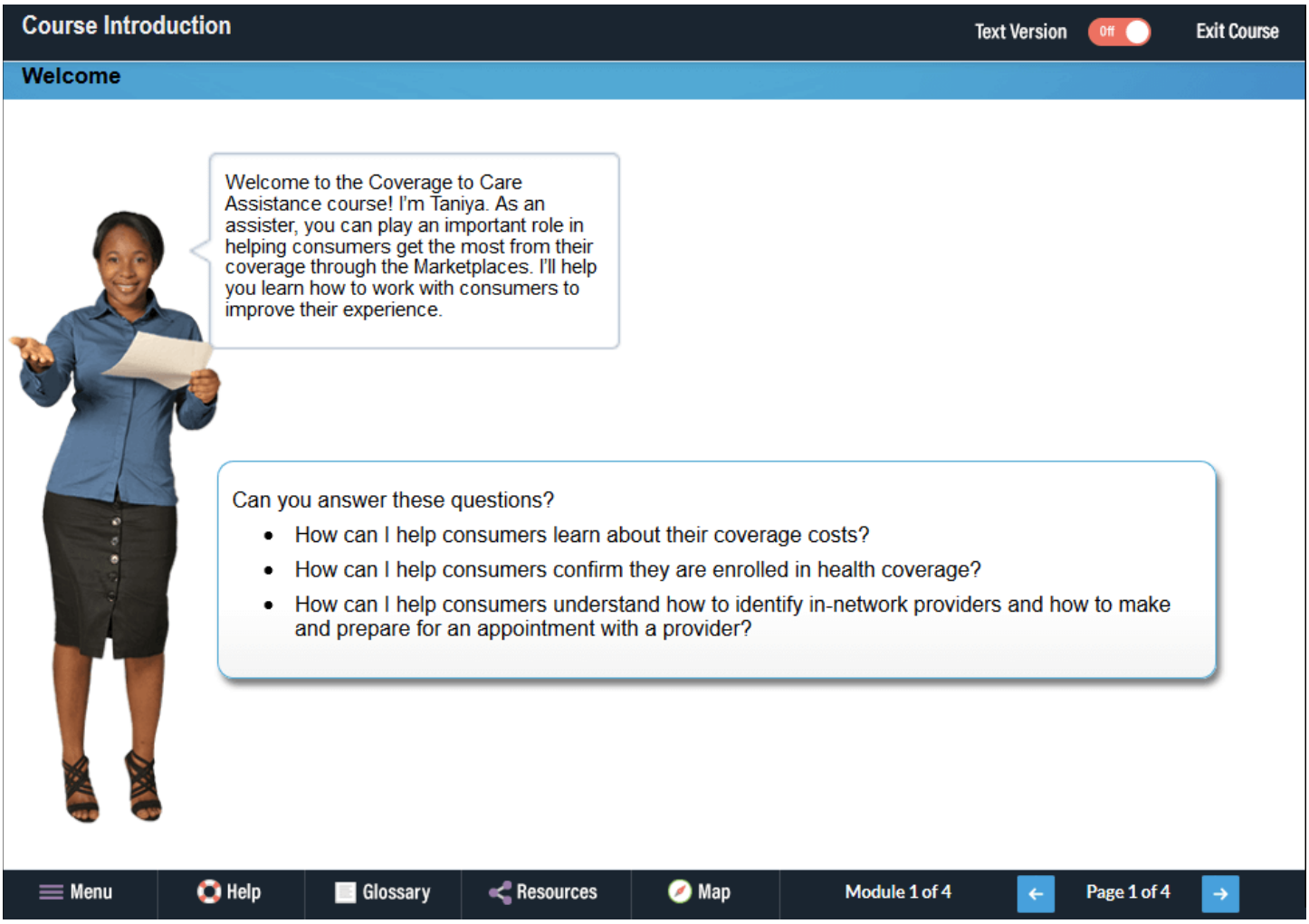
Course Introduction

Welcome

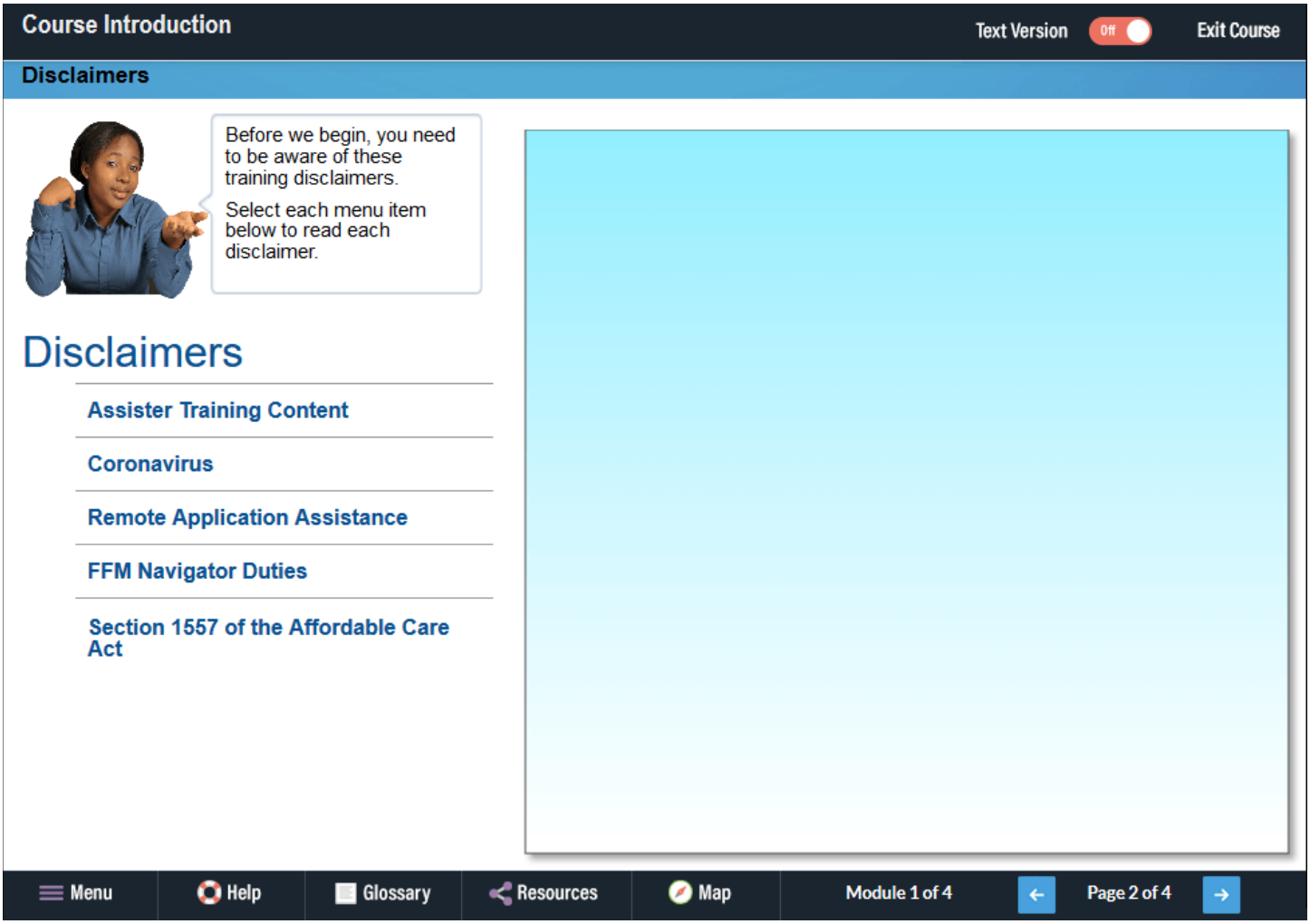


Welcome to the Coverage to Care Assistance course! I'm Taniya. As an assister, you can play an important role in helping consumers get the most from their coverage through the Marketplaces. I'll help you learn how to work with consumers to improve their experience.

Can you answer these questions?

- How can I help consumers learn about their coverage costs?
- How can I help consumers confirm they are enrolled in health coverage?
- How can I help consumers understand how to identify in-network providers and how to make and prepare for an appointment with a provider?

Disclaimers



Before we begin, you need to be aware of these training disclaimers.

Assister Training Content:
The information provided in this training course is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This course summarizes current policy and operations as of the date it was uploaded to the Marketplace Learning Management System. Links to certain source documents have been provided for your reference. We encourage persons taking the course to refer to the applicable statutes, regulations, CMS assister webinars, and other interpretive materials for complete and current information.

This course includes references and links to nongovernmental third-party websites. CMS offers these links for informational purposes only, and inclusion of these websites should not be construed as an endorsement of any third-party organization's programs or activities.

Coronavirus (COVID-19):
This training does not address COVID-19-related guidance or related requirements for assisters. CMS will communicate applicable information to assisters and assister organizations through separate channels.

- To learn more about how we're responding to coronavirus, visit HealthCare.gov/coronavirus/.
- For preventive practices and applicable state/local guidance, visit CDC.gov/coronavirus.

Remote Application Assistance:
Navigators in FFMs are not required to maintain a physical presence in their Marketplace service area. In some cases, Navigators may provide remote application assistance (e.g., online or by phone), provided that such assistance is permissible under their organization's contract, grant terms and conditions, or agreement with CMS and/or their organization.

Certified application counselors in FFMs may also provide remote application assistance if such assistance is permissible with their certified application counselor designated organization (CDO).

For guidance on obtaining consumers' consent remotely over the phone, visit: Marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf.

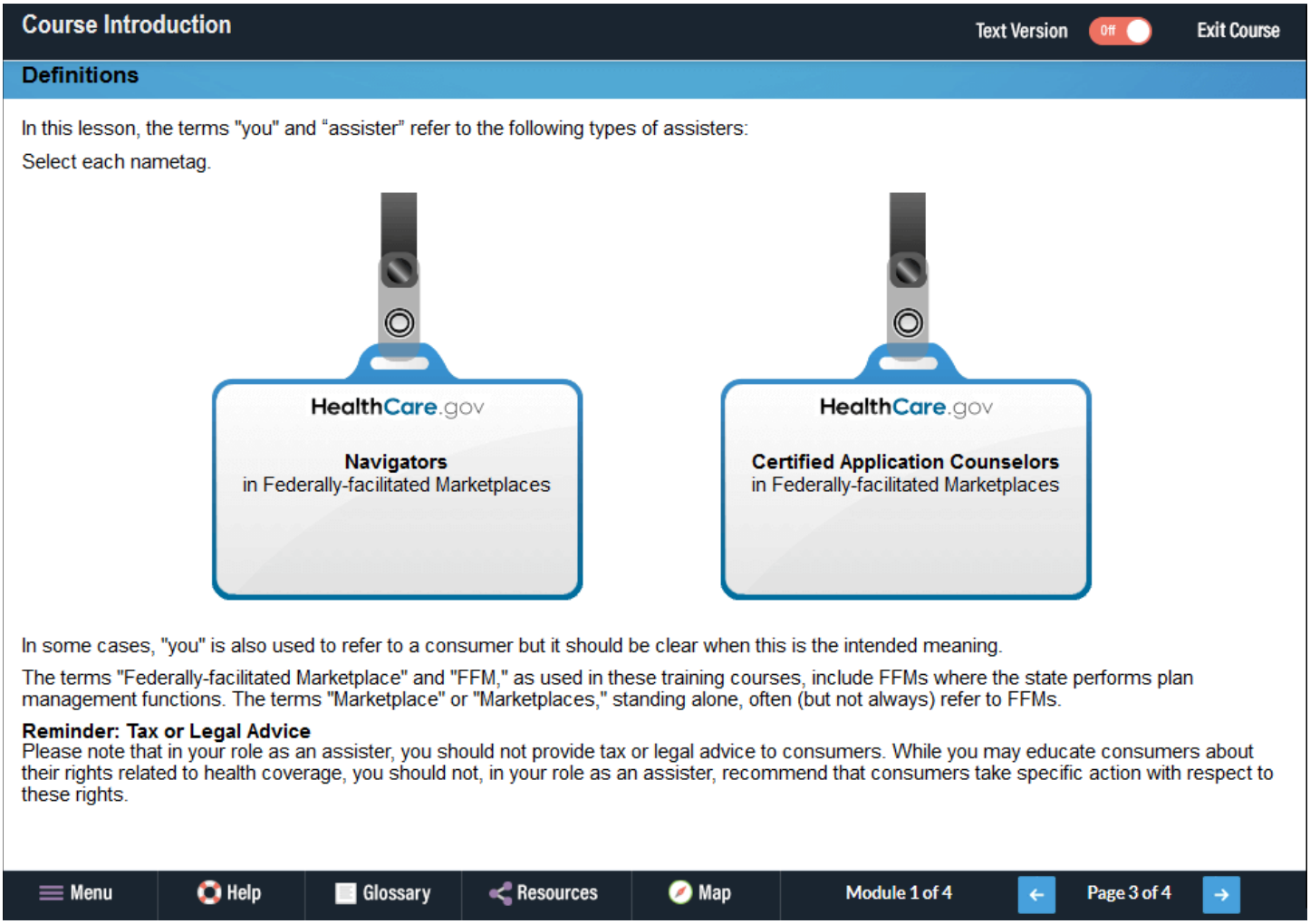
FFM Navigator Duties:
Beginning with Navigator grants awarded in 2019, FFM Navigators may but are no longer required to provide information on or assist consumers with the following topics:

1. Understanding the process of filing Marketplace eligibility appeals;
2. Understanding and applying for exemptions granted through the Marketplace and/or claimed through the tax filing process if over age 30 and seeking to enroll in a catastrophic plan;
3. Marketplace-related components of the premium tax credit reconciliation process;
4. Understanding basic concepts and rights related to health coverage and how to use it; and
5. Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process, exemptions from the requirement to maintain minimum essential coverage, and premium tax credit reconciliations.

CMS will continue to provide all assisters with additional information related to these assistance activities through webinars, job aids, and other technical assistance resources.

Section 1557 of the Affordable Care Act:
The Section 1557 Final Rule published on June 19, 2020 (85 FR 37160) is the subject of litigation and court orders. Some of Section 1557's requirements may change pending the outcome of lawsuits brought against HHS seeking declaratory and injunctive relief from the Final Rule, and are also affected by previous court orders dating back to December 2016 that continue to be litigated.

Definitions



In this lesson, the terms "you" and "assister" refer to the following types of assisters:

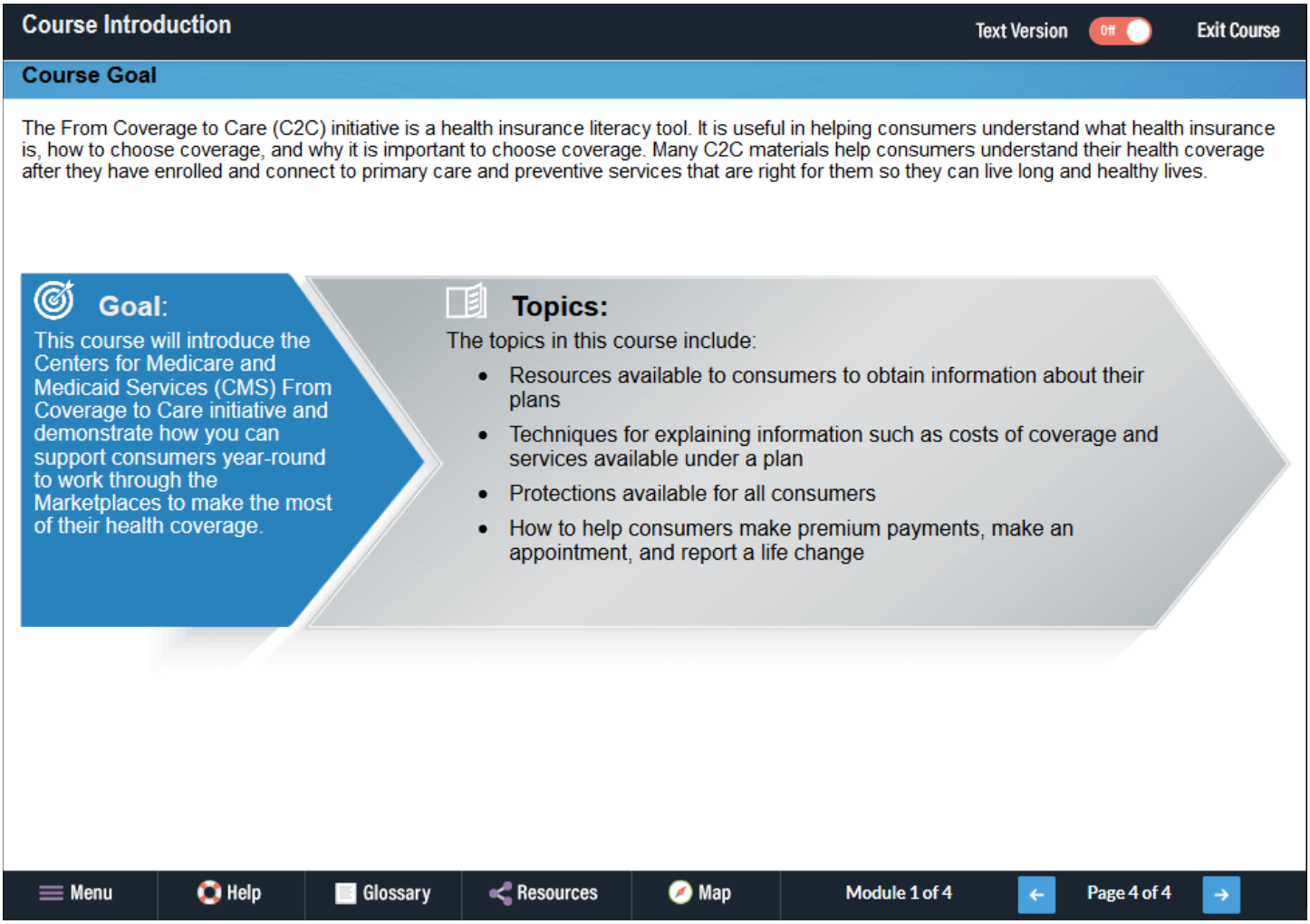
- **Navigators** in Federally-facilitated Marketplaces
- **Certified Application Counselors** in Federally-facilitated Marketplaces

In some cases, "you" is also used to refer to a consumer but it should be clear when this is the intended meaning.

The terms "Federally-facilitated Marketplace" and "FFM," as used in these training courses, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.

Reminder: Tax or Legal Advice
Please note that in your role as an assister, you should not provide tax or legal advice to consumers. While you may educate consumers about their rights related to health coverage, you should not, in your role as an assister, recommend that consumers take specific action with respect to these rights.

Course Goal



The From Coverage to Care (C2C) initiative is a health insurance literacy tool. It is useful in helping consumers understand what health insurance is, how to choose coverage, and why it is important to choose coverage. Many C2C materials help consumers understand their health coverage after they have enrolled and connect to primary care and preventive services that are right for them so they can live long and healthy lives.

Goal:
This course will introduce the Centers for Medicare and Medicaid Services (CMS) From Coverage to Care initiative and demonstrate how you can support consumers year-round to work through the Marketplaces to make the most of their health coverage.

Topics:
The topics in this course include:

- Resources available to consumers to obtain information about their plans
- Techniques for explaining information such as costs of coverage and services available under a plan
- Protections available for all consumers
- How to help consumers make premium payments, make an appointment, and report a life change

From Coverage to Care (C2C)

Introduction

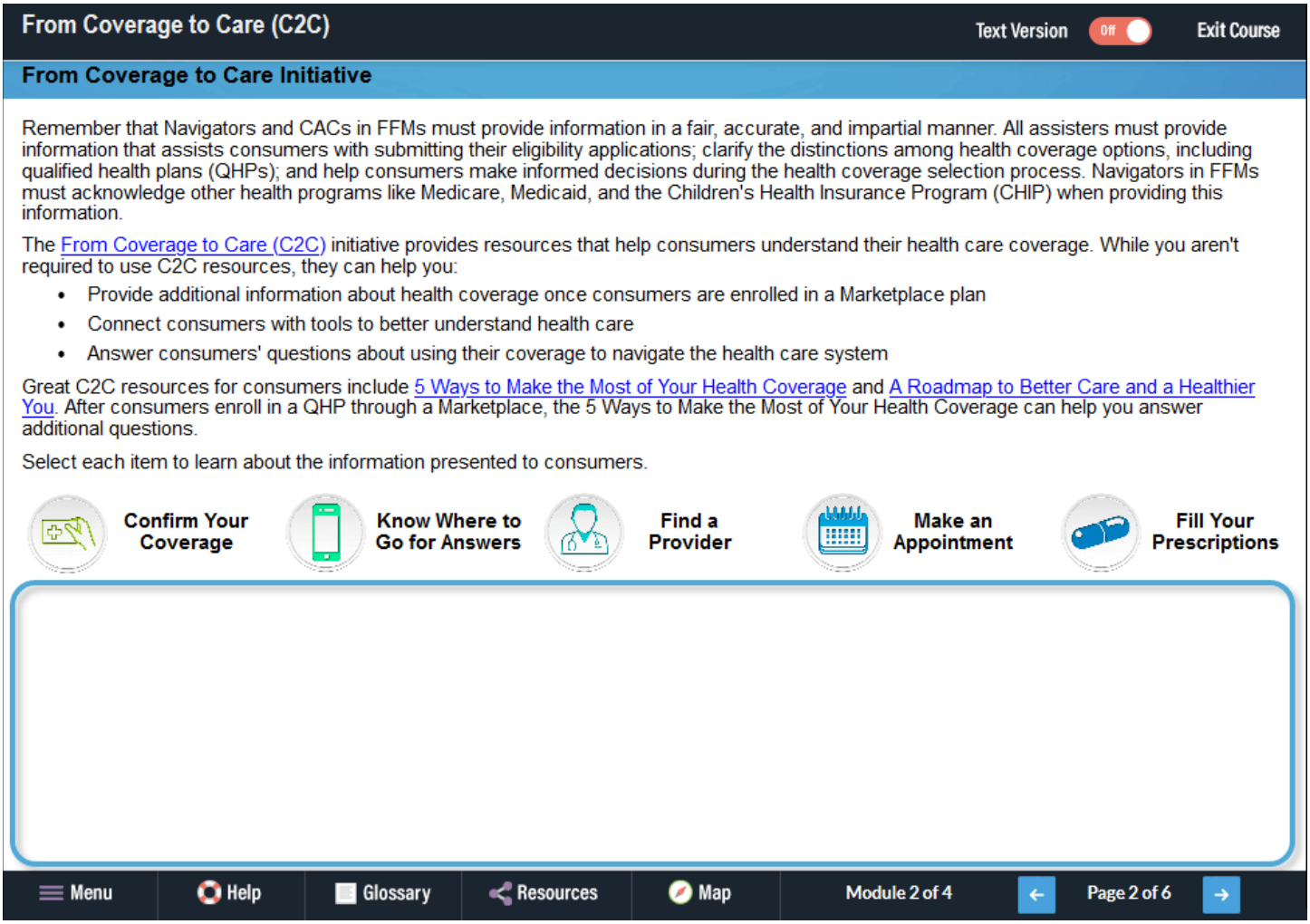
During your interaction with consumers, you can help them understand basic concepts and rights related to their health coverage at every stage of the application process.

Coverage to Care Purpose
State the purpose of the From Coverage to Care initiative

Plan Details
Identify the basic details every consumer should know about their plan to take advantage of health coverage

First Month's Premium
Describe options for making the first month's premium payment

From Coverage to Care Initiative



Remember that Navigators and CACs in FFMs must provide information in a fair, accurate, and impartial manner. All assisters must provide information that assists consumers with submitting their eligibility applications; clarify the distinctions among health coverage options, including qualified health plans (QHPs); and help consumers make informed decisions during the health coverage selection process. Navigators in FFMs must acknowledge other health programs like Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) when providing this information.

The From Coverage to Care (C2C) initiative provides resources that help consumers understand their health care coverage. While you aren't required to use C2C resources, they can help you:

- Provide additional information about health coverage once consumers are enrolled in a Marketplace plan
- Connect consumers with tools to better understand health care
- Answer consumers' questions about using their coverage to navigate the health care system

Great C2C resources for consumers include 5 Ways to Make the Most of Your Health Coverage and A Roadmap to Better Care and a Healthier You. After consumers enroll in a QHP through a Marketplace, the 5 Ways to Make the Most of Your Health Coverage can help you answer additional questions.

Confirm Your Coverage
It's always a good idea for consumers to contact their selected health plan and/or their state Medicaid office to confirm that their enrollment is complete. Consumers must also pay their premium, if they have one, to stay covered.

Know Where to Go for Answers
Once consumers have enrolled in a health plan, they should receive a health insurance card with a member service number in the mail. Consumers can contact their health plan to see what services are covered and what their costs will be. Additionally, many health insurance companies' websites allow consumers to:

- Find additional contact and coverage information
- Create an account where they can access messages about coverage
- Print a copy of their health insurance card and more

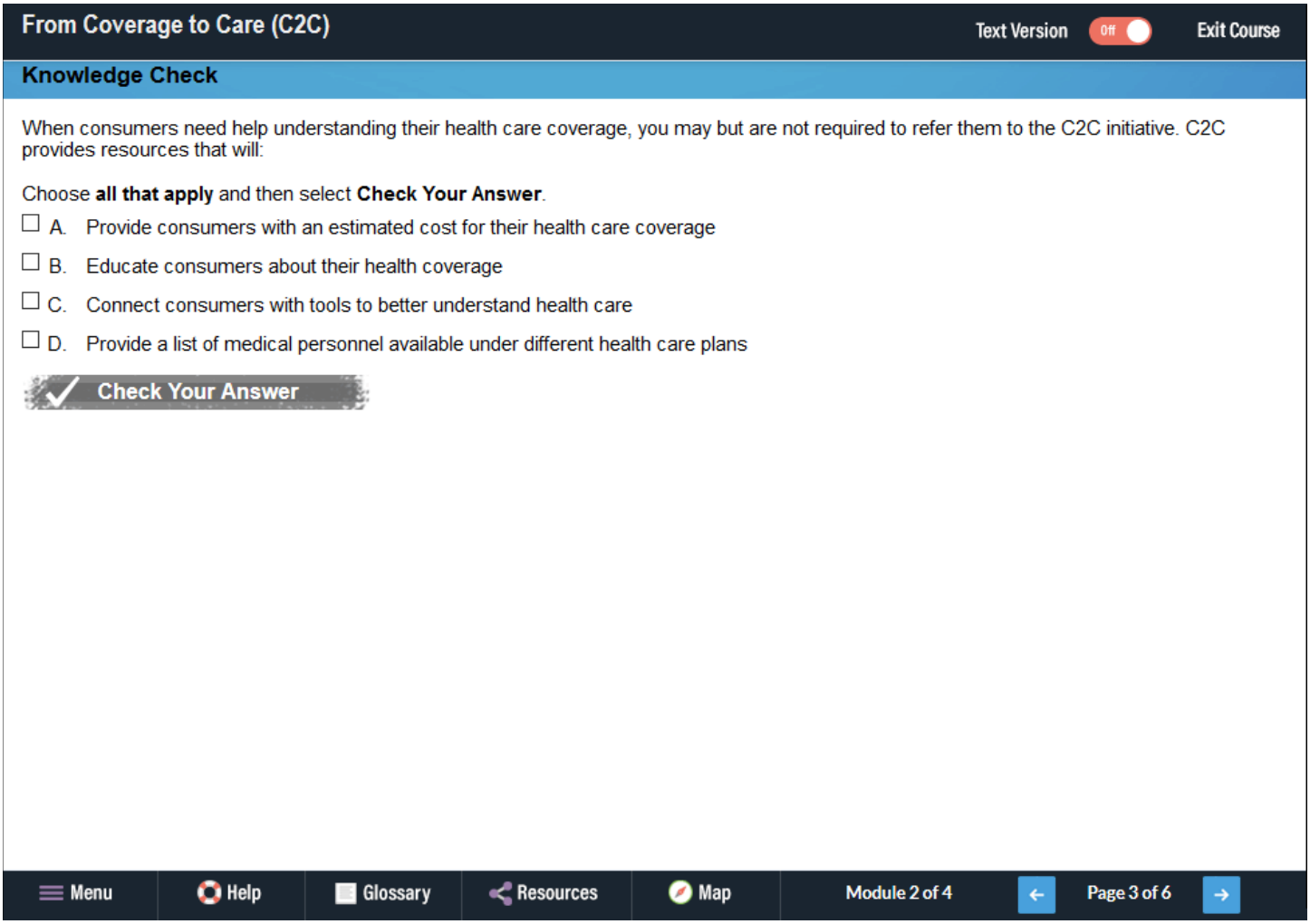
If consumers still have questions about key health insurance terms such as "coinsurance" or "deductible" after they meet with you, they can use A Roadmap to Better Care and a Healthier You to learn more.

Find a Provider
Consumers should select a health care provider in their plan's network who will work with them to get recommended health screenings. Consumers can find information about which providers are in network by visiting their health insurance company's website, calling the number on their health insurance card, or by calling a provider directly. Remember, consumers might pay more if they see a provider who is out of network.

Make an Appointment
After confirming that their provider accepts their coverage, it's a good idea for consumers to make an appointment and talk to them about preventive services; ask questions about any health concerns they have; and find out what they can do to stay healthy.

Fill Your Prescriptions
Consumers should also verify that their health plan covers their prescriptions and use it to fill any prescriptions they need. Since some drugs cost more than others, consumers should ask in advance how much a prescription costs and if a more affordable option is available.

Knowledge Check

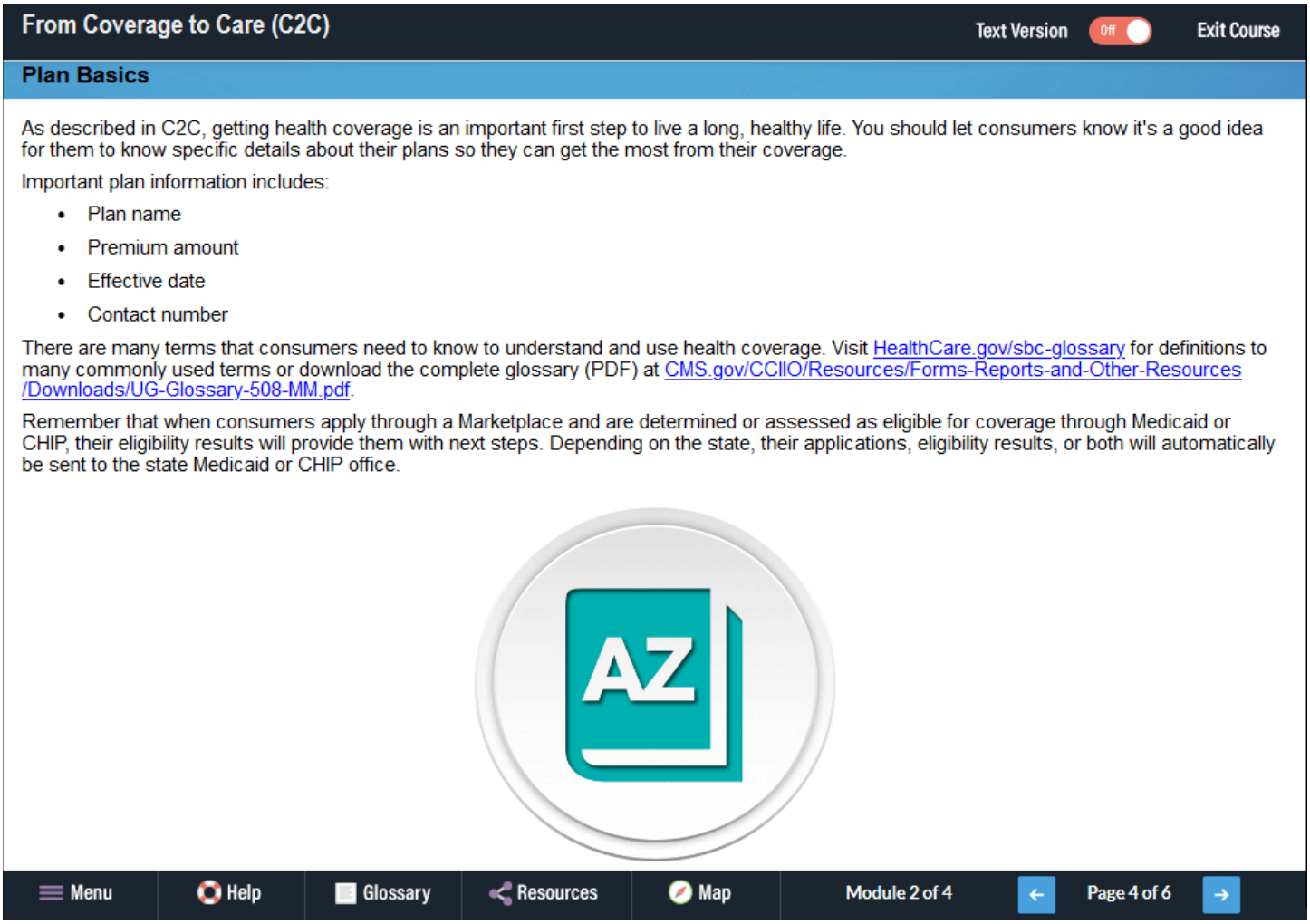


When consumers need help understanding their health care coverage, you may but are not required to refer them to the C2C initiative. C2C provides resources that will:

A. Provide consumers with an estimated cost for their health care coverage
B. Educate consumers about their health coverage
C. Connect consumers with tools to better understand health care
D. Provide a list of medical personnel available under different health care plans

The correct answers are B and C. C2C provides resources that will educate consumers about their health coverage and connect consumers with tools to better understand health care. C2C does not provide costs or lists of medical personnel for health care coverage.

Plan Basics



As described in C2C, getting health coverage is an important first step to live a long, healthy life. You should let consumers know it's a good idea for them to know specific details about their plans so they can get the most from their coverage.

Important plan information includes:

- Plan name
- Premium amount
- Effective date
- Contact number

There are many terms that consumers need to know to understand and use health coverage. Visit HealthCare.gov/sbc-glossary for definitions to many commonly used terms or download the complete glossary (PDF) at CMS.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf.

Remember that when consumers apply through a Marketplace and are determined or assessed as eligible for coverage through Medicaid or CHIP, their eligibility results will provide them with next steps. Depending on the state, their applications, eligibility results, or both will automatically be sent to the state Medicaid or CHIP office.

Paying Premiums

After consumers have enrolled, it's a good idea to tell them that they must:

- Pay their first month's premium by the health plan's due date to avoid losing coverage
- Continue to pay their premiums every month of the year to stay covered

Consumers need to pay careful attention to their due dates because each health insurance company is different. They can contact their health plan to learn what forms of premium payments are accepted. Here are the most common ways health insurance companies accept premium payments:

Online. Consumers should check for instructions on their premium bill to pay online or call their insurance company to find out if the plan takes online payments. Some plans mail online payment instructions separately.

Consumers who enroll online at HealthCare.gov can check if their “Enroll To-Do list” has a green **Pay for Health Plan** button. Selecting the green button directs the consumer to the plan’s payment portal to make a payment.

Mail. Consumers should review instructions received in the mail with the bill from the insurance company on how to pay.

Phone. Consumers should call the insurance company to find out if payment can be made over the phone by using a credit card, debit card, prepaid card number, or by providing bank account information.

In Person. Consumers should contact their insurance company to find out if it has walk-in centers and ask for locations and hours of operation.

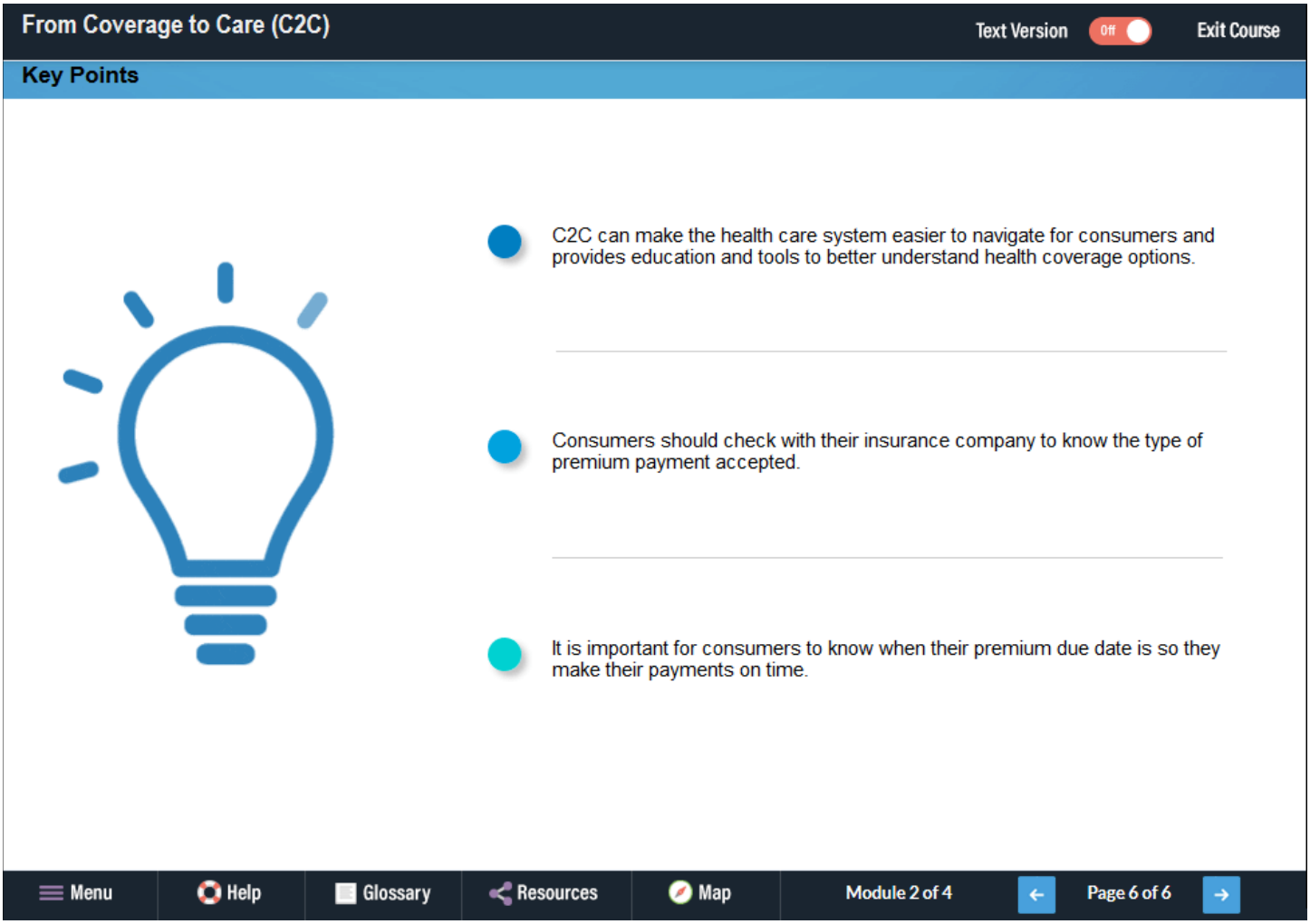
Cash. Consumers should contact their insurance company to find out if and where cash is accepted. Some insurance companies allow cash payments as a special service at local pharmacies, convenience stores, or other locations. If the insurance company doesn’t accept cash payments, other options may be available,

including second-chance bank accounts or prepaid cards.

If consumers have Medicaid, they will generally not have to pay a premium.

Policy Updates
Monthly premium payments may be made on behalf of a consumer or directly by the consumer from an individual health reimbursement account (HRA) or qualified small employer health reimbursement account (QSEHRA) as long as the payments are made using a method that the individual market QHP issuer is already required to accept.

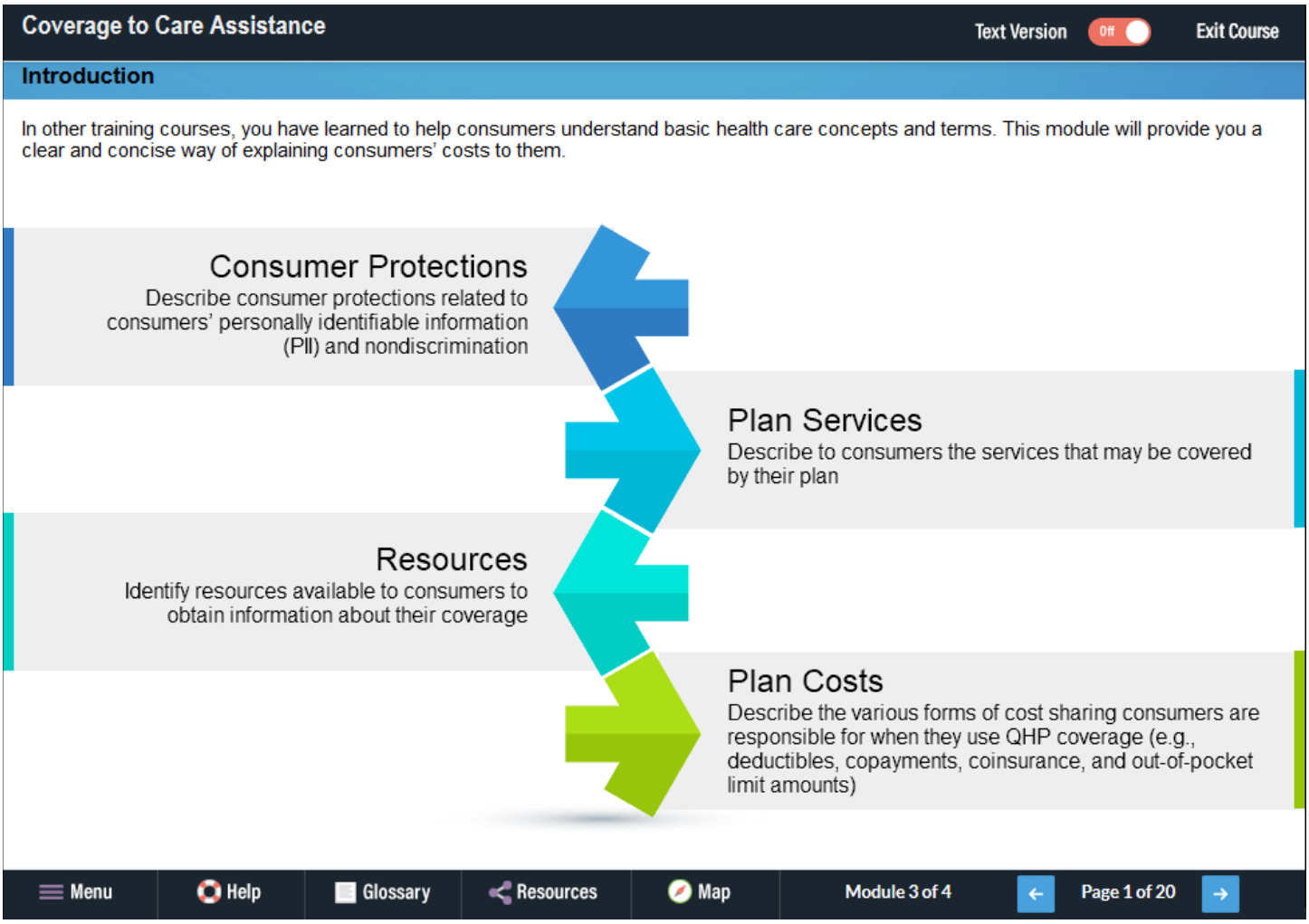
Key Points



- C2C can make the health care system easier to navigate for consumers and provides education and tools to better understand health coverage options.
- Consumers should check with their insurance company to know the type of premium payment accepted.
- It is important for consumers to know when their premium due date is so they make their payments on time.

Coverage to Care Assistance

Introduction



In other training courses, you have learned to help consumers understand basic health care concepts and terms. This module will provide you a clear and concise way of explaining consumers' costs to them.

Consumer Protections
Describe consumer protections related to consumers' personally identifiable information (PII) and nondiscrimination

Plan Services
Describe to consumers the services that may be covered by their plan

Resources
Identify resources available to consumers to obtain information about their coverage

Plan Costs
Describe the various forms of cost sharing consumers are responsible for when they use QHP coverage (e.g., deductibles, copayments, coinsurance, and out-of-pocket limit amounts)

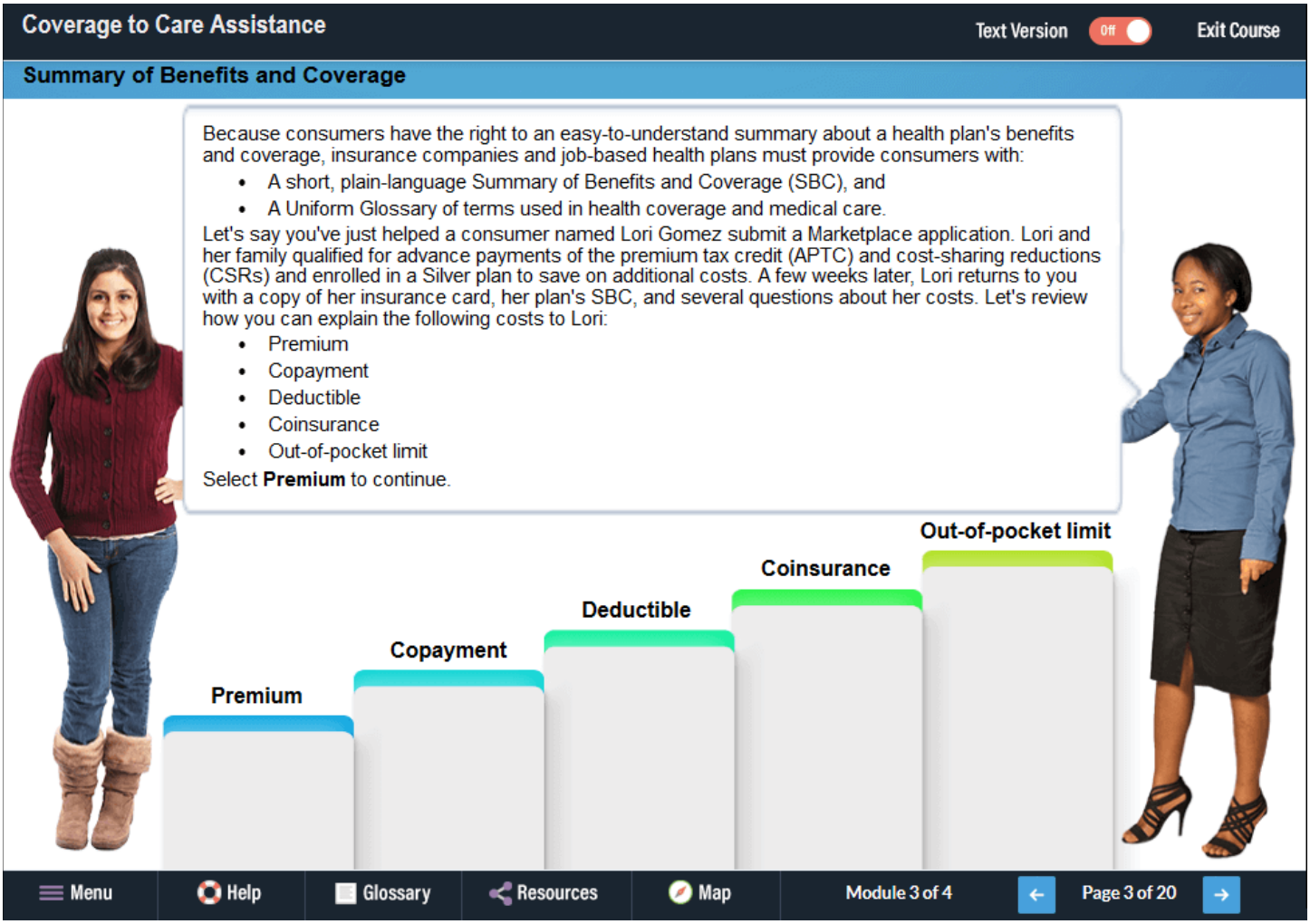
Know Where to Go for Answers

Millions of consumers have obtained health coverage through the Marketplaces, Medicaid, CHIP, or Medicare or from their employers. Some consumers you help are getting coverage for the very first time or the first time in a long time. Many of these consumers are unsure of what they signed up for, how to use their coverage to get the care they need, and where to go for answers.

To answer some of these questions, all forms of health coverage have to provide some kind of document to explain benefits and coverage to consumers. You can also provide consumers with A Roadmap to Better Care and a Healthier You. It describes key insurance terms and other information about consumers' coverage.

Note: You can order copies for free in seven languages other than English. Other resources, such as videos, are available at go.CMS.gov/c2c.

Summary of Benefits and Coverage



Because consumers have the right to an easy-to-understand summary about a health plan's benefits and coverage, insurance companies and job-based health plans must provide consumers with:

- A short, plain-language Summary of Benefits and Coverage (SBC), and
- A Uniform Glossary of terms used in health coverage and medical care.

Let's say you've just helped a consumer named Lori Gomez submit a Marketplace application. Lori and her family qualified for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) and enrolled in a Silver plan to save on additional costs. A few weeks later, Lori returns to you with a copy of her insurance card, her plan's SBC, and several questions about her costs. Let's review how you can explain the following costs to Lori:

- Premium
- Copayment
- Deductible
- Coinsurance
- Out-of-pocket limit

Coach
Hi Lori, I'm glad you came in today! Let's look at an example of how your premium, copayments, deductible, and coinsurance work together so you can understand how much your new plan will cost.

Even if you do not use any health care services, your family pays a **premium** each month to have health insurance. Since you receive APTC, your monthly premium for this plan is lower than other people who don't

get APTC.

You will pay a fixed, discounted amount called a **copayment** for certain covered services when you get them. Copayments can vary for different services within the same plan, like prescription drugs, lab tests, and visits to specialists. Your insurance company pays the difference between the actual cost of these services and your copayment amounts.

Thanks to the Affordable Care Act (ACA), you won't have to pay a copayment for certain preventive services like flu shots, cholesterol screenings, and depression screenings. If you didn't have insurance, all of these things would cost a lot more money.

Key Tip: Depending on the plan, consumers pay copayments either before or after they meet their yearly deductible.

Even though you receive these discounts for certain covered services when you stay in your plan's network, you may have to pay 100 percent of any other medical and/or pharmacy bills each year until you meet an amount called your **deductible**. Once you spend enough money out of pocket to meet your plan's annual deductible, it will start to cover the majority of your costs for the rest of the plan year. Monthly premium amounts don't count toward your deductible.

Key Tips:

- All Marketplace plans must cover certain preventive services without charging a copayment or coinsurance, even if consumers haven't yet met their yearly deductible.
- Some plans have separate deductibles for certain services like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

After $2,900 deductible is paid. You pay 30 percent of covered in-network services. Once you meet your plan's deductible, you are responsible for paying a small percentage of your health care costs called coinsurance. Lori, since you qualify for extra savings on additional costs and picked a Silver plan, you'll get extra savings on copayments, annual deductibles, and coinsurance amounts. You'll find these extra savings reflected in your plan's costs on your SBC and at HealthCare.gov.

There is also an **out-of-pocket limit** for each person on the plan and for the whole family. This is the most that you or your family **could** pay during a coverage period (usually one year) for your share of the costs of covered services. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100 percent of the costs of covered benefits for the rest of the plan year—as long as you stay in the plan's network.

Here's a key tip about out-of-pocket limit.

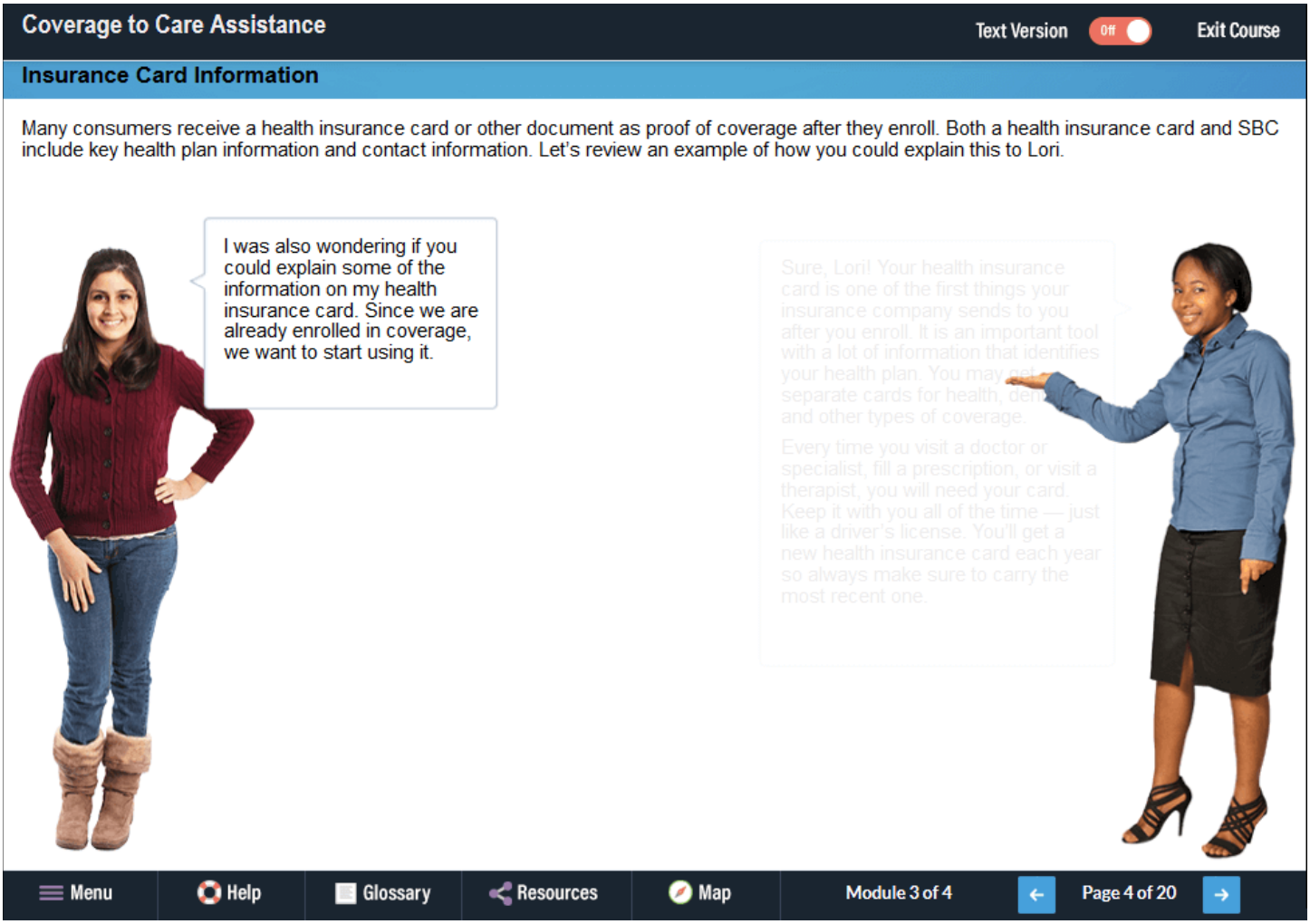
Key Tip
The out-of-pocket limit doesn't include monthly premiums. It also doesn't include any amount consumers may spend for services that their health plan doesn't cover or services outside of the network.

Out-of-pocket limit
The maximum out-of-pocket limit for any 2022 Marketplace plan is $8,700 for an individual and $17,400 for a family. Keep in mind that this does not include monthly premium amounts. To find out if a consumer may qualify for savings on additional costs, use the Savings Estimator Tool.

Key Tip: Remember, consumers qualify for CSRs if their household income is between 100 percent and 250 percent of the federal poverty level (FPL). Since the Gomez family earns $40,000 for a household of two, they are near the upper limit for CSR eligibility. Consumers with a lower household income would receive greater savings on additional costs than the example for the Gomez family that is used in this course.

For Plan Year 2021 only, under the American Rescue Plan Act of 2021, consumers who have received or are eligible to receive unemployment compensation during any week in 2021 may be eligible to receive enhanced subsidies to help pay for 2021 Marketplace coverage.

Insurance Card Information



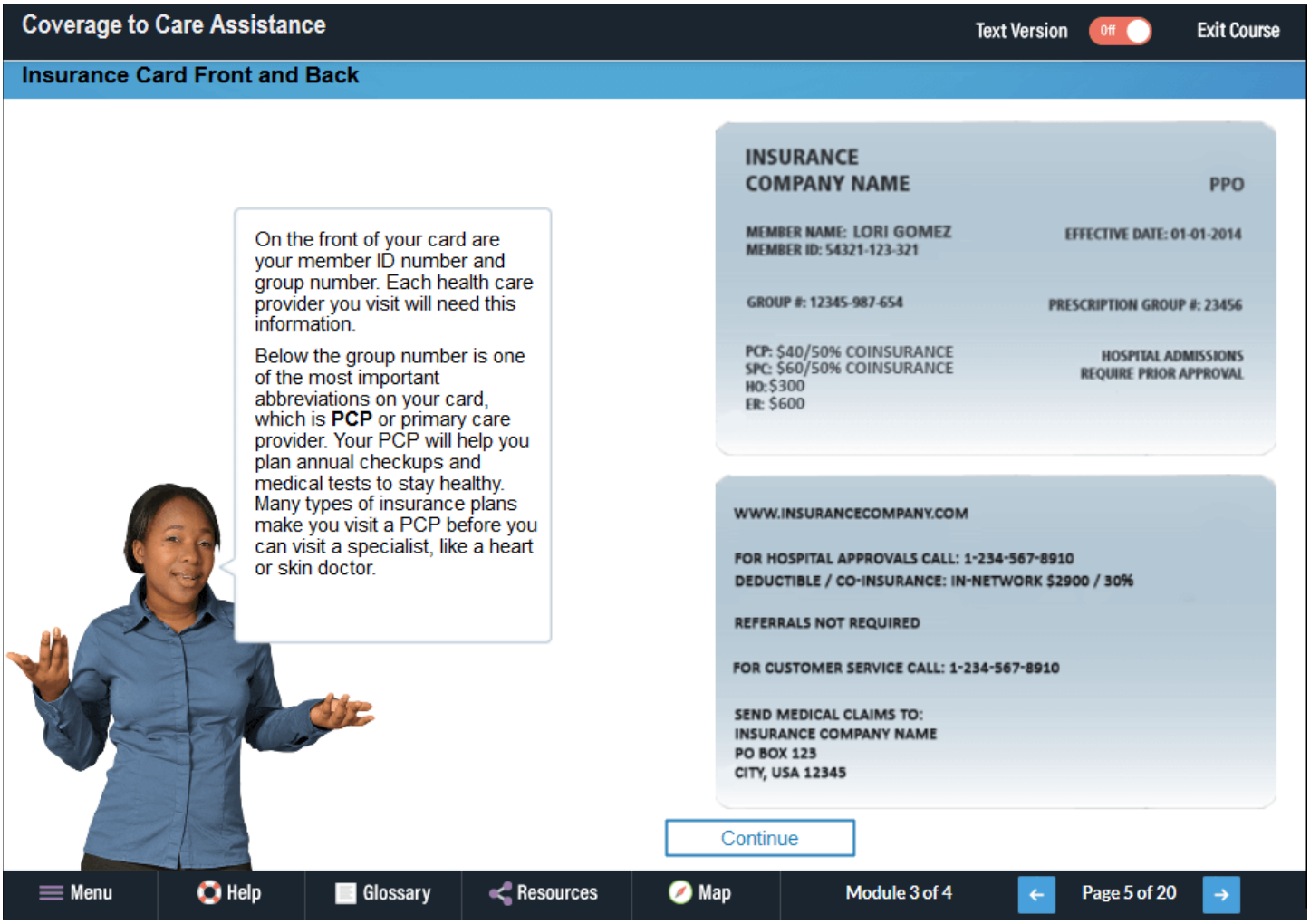
Many consumers receive a health insurance card or other document as proof of coverage after they enroll. Both a health insurance card and SBC include key health plan information and contact information. Let's review at an example of how you could explain this to Lori.

Lori
I was also wondering if you could explain some of the information on my health insurance card. Since we are already enrolled in coverage, we want to start using it.

Coach
Sure, Lori! Your health insurance card is one of the first things your insurance company sends to you after you enroll. It is an important tool with a lot of information that identifies your health plan. You may get separate cards for health, dental, and other types of coverage.

Every time you visit a doctor or specialist, fill a prescription, or visit a therapist, you will need your card. Keep it with you all of the time — just like a driver's license. You'll get a new health insurance card each year so always make sure to carry the most recent one.

Insurance Card Front and Back



Coach
On the front of your card are your member ID number and group number. Each health care provider you visit will need this information.

Below the group number is one of the most important abbreviations on your card, which is **PCP** or primary care provider. Your PCP will help you plan annual checkups and medical tests to stay healthy. Many types of insurance plans make you visit a PCP before you can visit a specialist, like a heart or skin doctor.

PCP: $40 is your copayment amount. This means that you have to pay $40 for services you receive from an in-network PCP. If the provider is out of network, you'll have to pay 50 percent coinsurance.

SPC is a specialist. The copayment amount you pay for an in-network specialist is $60, and the amount you pay out of network is 50 percent coinsurance.

Lori, a network is a list of doctors and hospitals that you have to use to get the best price. It's important to use doctors *in your plan's network* or you will pay more. If you already have a specific provider that is not in your plan's network, you may want to consider switching plans or providers.

Your plan keeps a directory of providers who are in network. You can generally find it on your plan's website or you can request a copy. Here are some tips for how to find a doctor in your plan's network.

HO: $300. For hospital stays and some other services, you'll have to pay a $300 copay. You may have to pay other costs for additional care or services you receive while you're in the hospital.

ER stands for "emergency room." Under your plan, you'll have a $600 copayment for an emergency room visit. Keep in mind that you'll still have to pay for any other services during an emergency room visit – things like MRIs and CT scans – until you meet your plan's deductible.

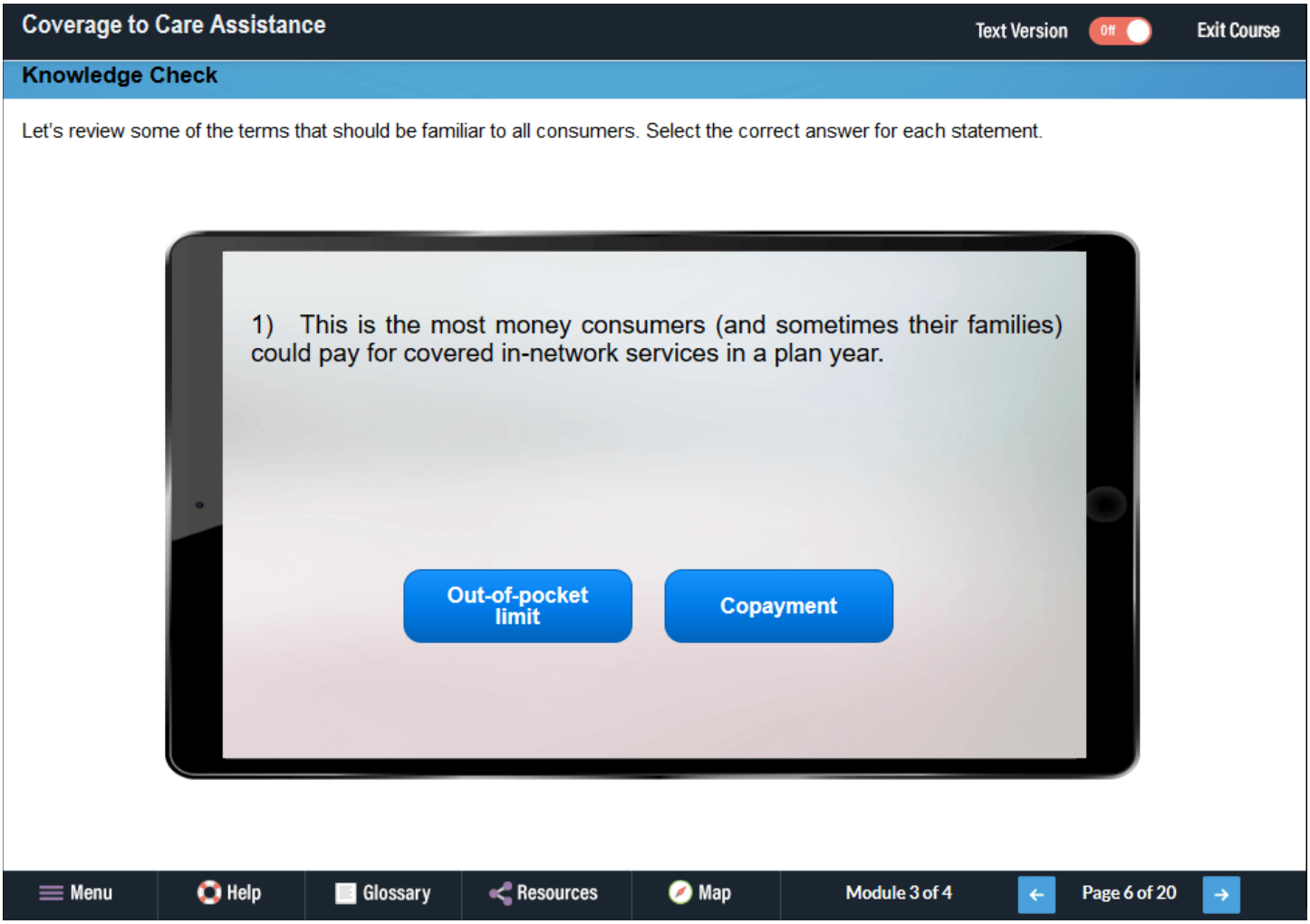
Lori, notice that your card says **Hospital Admissions Require Prior Approval**. If you have to be admitted to the hospital, you or someone with you should contact your insurance company as soon as possible to let them know an emergency happened.

The back of your card has other information like your plan's deductible and coinsurance amounts. Lori, your particular plan has a deductible of $2,900 and then requires you to pay about 30 percent coinsurance for covered in-network services. You'll pay more for out-of-network services. This means you must generally pay for the first $2,900 of your medical bills every year before your insurance company starts covering the majority of your health care costs. But remember, certain preventive services are covered in full by your insurance company with no coinsurance, even before you meet your deductible.

If you have questions, there is a customer service number you can call and a mailing address where you can send any medical claims.

Key Tip:
All health insurance cards are different depending on the provider and plan a consumer chooses. Please keep in mind that this is just an example and that most health insurance cards generally contain similar information.

Knowledge Check



Let's review some of the terms that should be familiar to all consumers. Determine the answer for each statement.

1. This is the most money consumers (and sometimes their families) could pay for covered in-network services in a plan year. Out-of-pocket limit or copayment?

   The most money that consumers and their families could have to pay for covered services in a plan year is their **out-of-pocket limit**.

2. This is the amount of health care costs consumers must pay themselves each plan year before their insurance company starts to pay for most covered services. Premium or deductible?

   The amount consumers must pay for health care costs each plan year before their plan starts helping to pay for covered services is a **deductible**

3. This is the amount a consumer generally pays each month to have health insurance. Copayment or premium?

   The amount consumers generally pay each month to have health insurance is their **premium**.

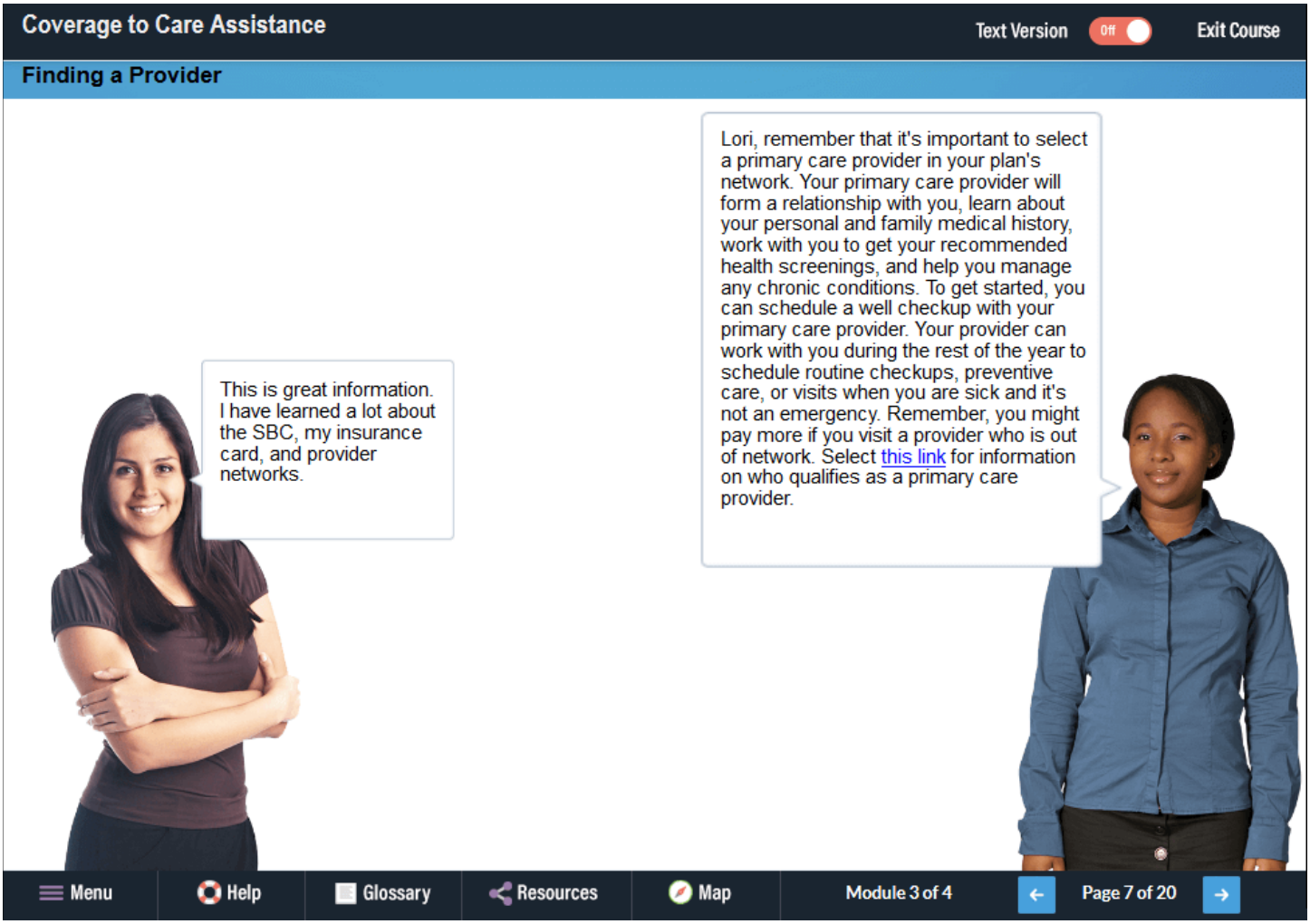
4. This is the percentage consumers generally owe for covered services once they meet their annual deductible. Coinsurance or out-of-pocket limit?

   The percentage that consumers are generally responsible for paying once they meet their deductible is called **coinsurance**.

5. This a fixed amount that consumers pay for some services, usually when they receive them. Copayment or deductible?

   A fixed amount that consumers pay for services like doctor visits or drugs is called a **copayment**.

Finding a Provider



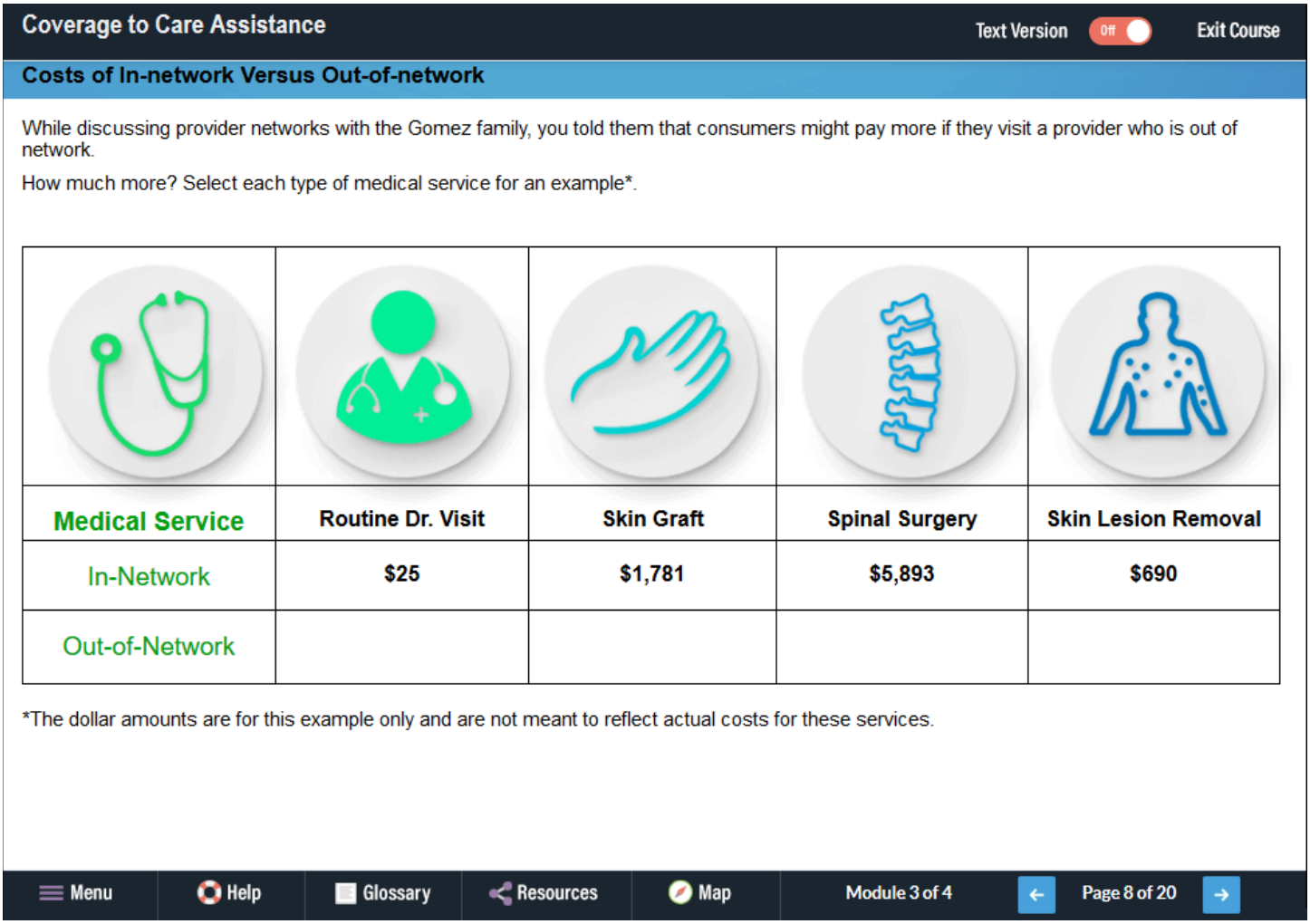
Coach
Lori, remember that it's important to select a primary care provider in your plan's network. Your primary care provider will form a relationship with you, learn about your personal and family medical history, work with you to get your recommended health screenings, and help you manage any chronic conditions. To get started, you can schedule a well checkup with your primary care provider*. Your provider can work with you during the rest of the year to schedule routine checkups, preventive care, or visits when you are sick and it's not an emergency. Remember, you might pay more if you visit a provider who is out of network.

Lori

This is great information. I have learned a lot about the SBC, my insurance card, and provider networks.

***Primary Care Provider**
A primary care provider doesn't have to be a doctor. The provider could be a doctor, nurse, physician's assistant, or other type of health professional. Primary care providers can be found in many places such as private offices, federally qualified health centers, or hospitals, just to name a few.

Costs of In-network Versus Out-of-network



While discussing provider networks with the Gomez family, you told them that consumers might pay more if they visit a provider who is out of network.

How much more? Here is an example of the differences between in-network and out-of-network costs.*

*The dollar amounts are for this example only and are not meant to reflect actual costs for these services.

Routine Dr. Visit

- In-network – $25
- Out-of-network – $30

Skin Graft

- In-network – $1,781
- Out-of-network – $105,500

Spinal Surgery

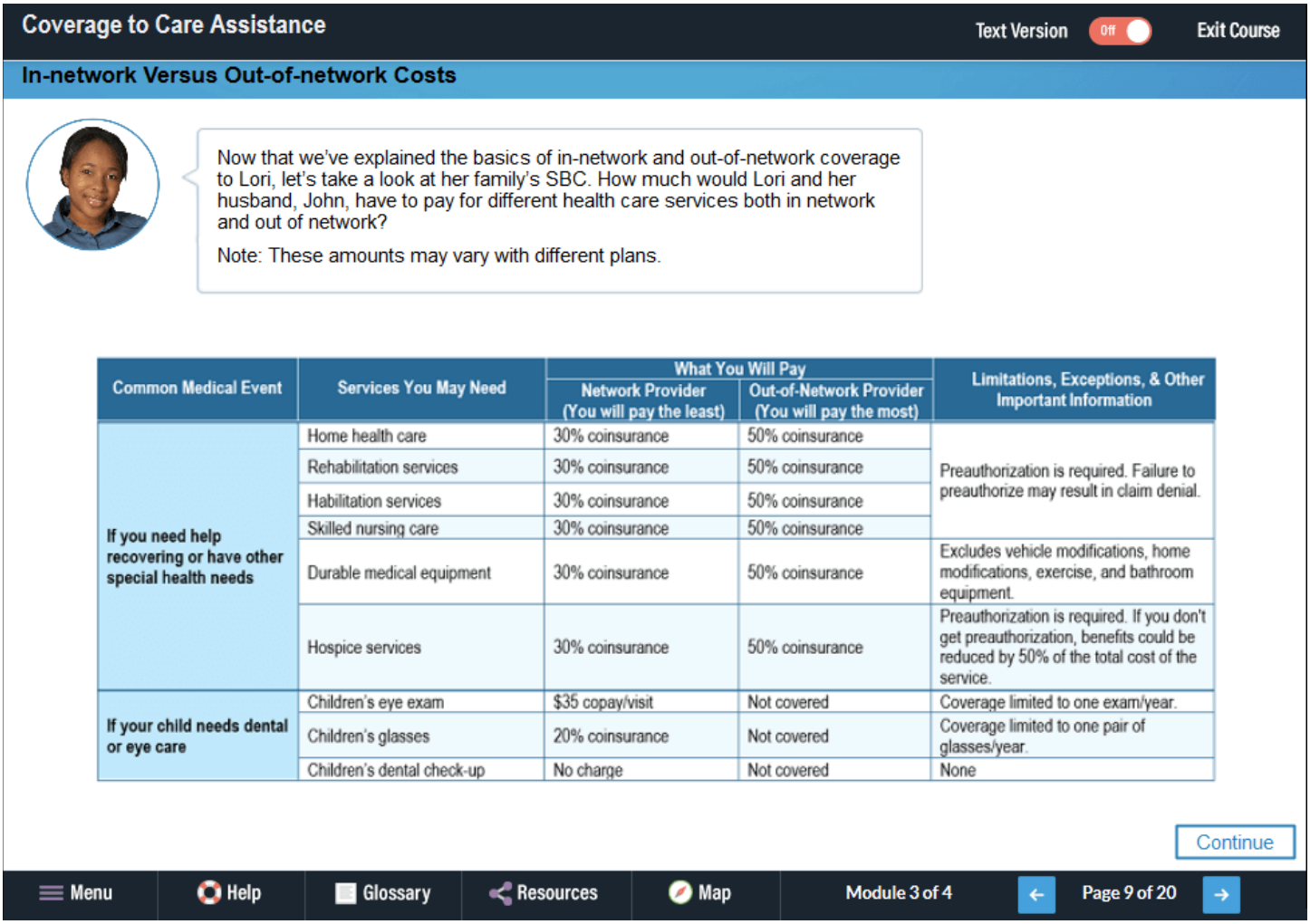
- In-network – $5,893
- Out-of-network – $115,625

Skin Lesion Removal

- In-network – $690
- Out-of-network – $18,275

Remember, it's important for consumers to use providers that are in network.

Costs of In-network Versus Out-of-network: SBC



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization is required. Failure to preauthorize may result in claim denial.
	Rehabilitation services	30% coinsurance	50% coinsurance	
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	
	Durable medical equipment	30% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	Not covered	Coverage limited to one exam/year.
	Children's glasses	20% coinsurance	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	Not covered	None

Now that we've explained the basics of in-network and out-of-network coverage to Lori, let's take a look at her family's SBC. How much would Lori and her husband, John, have to pay for different health care services both in network and out of network?

Note: These amounts may vary with different plans.

If the Gomez family needed home health care from a participating (in-network) provider, their cost would be 30 percent coinsurance. If they used a non-participating (out-of-network) provider, their cost would be 50 percent coinsurance.

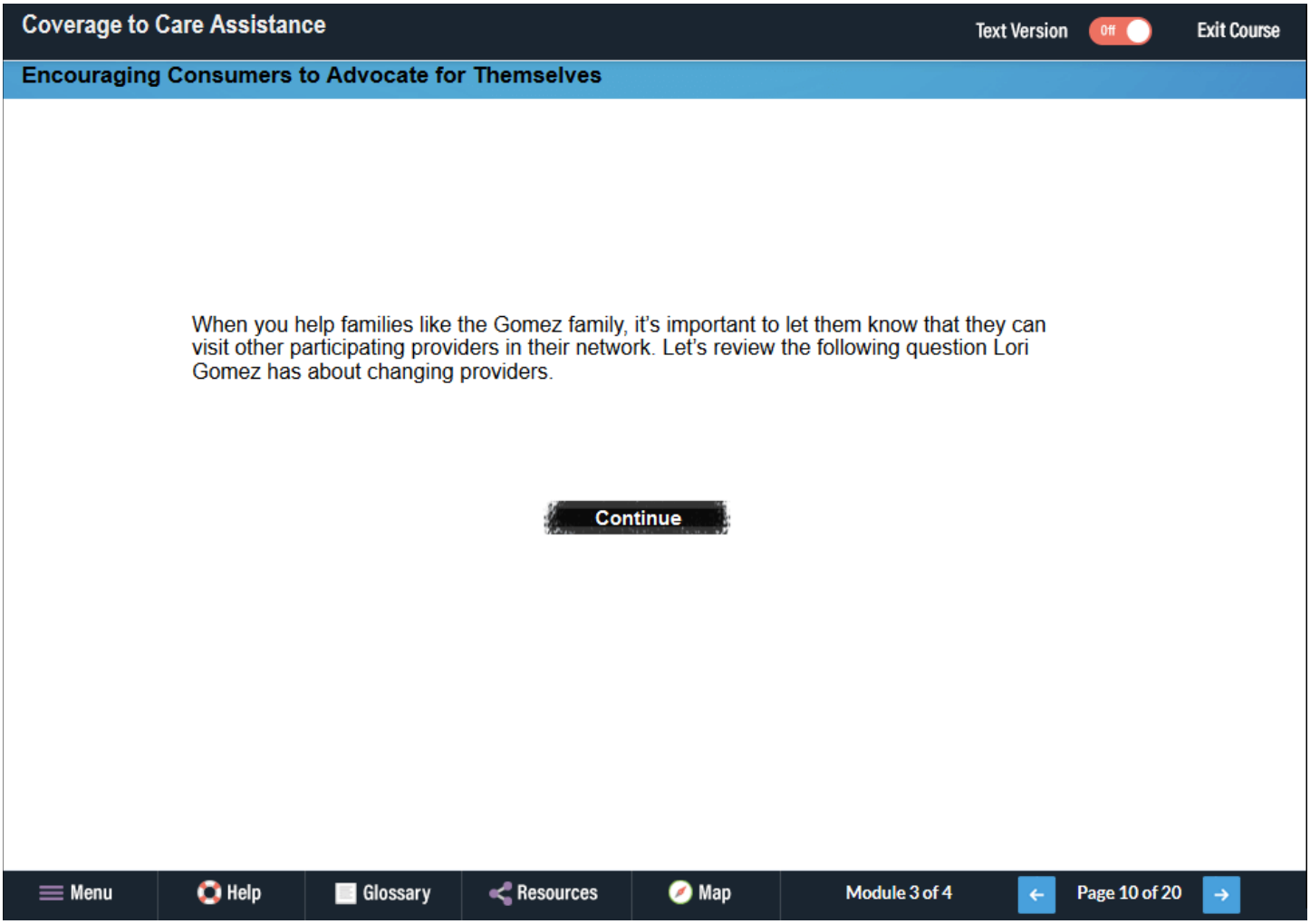
Note: This may change if they haven't met their deductible.

In the "Limitations & Exceptions" column, it states that preauthorization is required. Failure to preauthorize may result in claim denial. This means that Lori or John would have to pay all of their costs for home health care if a doctor or other health professional did not send prior authorization to their insurance company stating that it is medically necessary.

If Lori or John needed skilled nursing care from a participating (in-network) provider, their cost would be 30 percent coinsurance. If they used a non-participating (out-of-network) provider, their cost would be 50 percent coinsurance.

The "Limitations & Exceptions" column states that preauthorization is required. Failure to preauthorize may result in claim denial.

Encouraging Consumers to Advocate for Themselves



When you help families like the Gomez family, it's important to let them know that they can visit other participating providers in their network. Let's review the following question Lori Gomez has about changing providers.

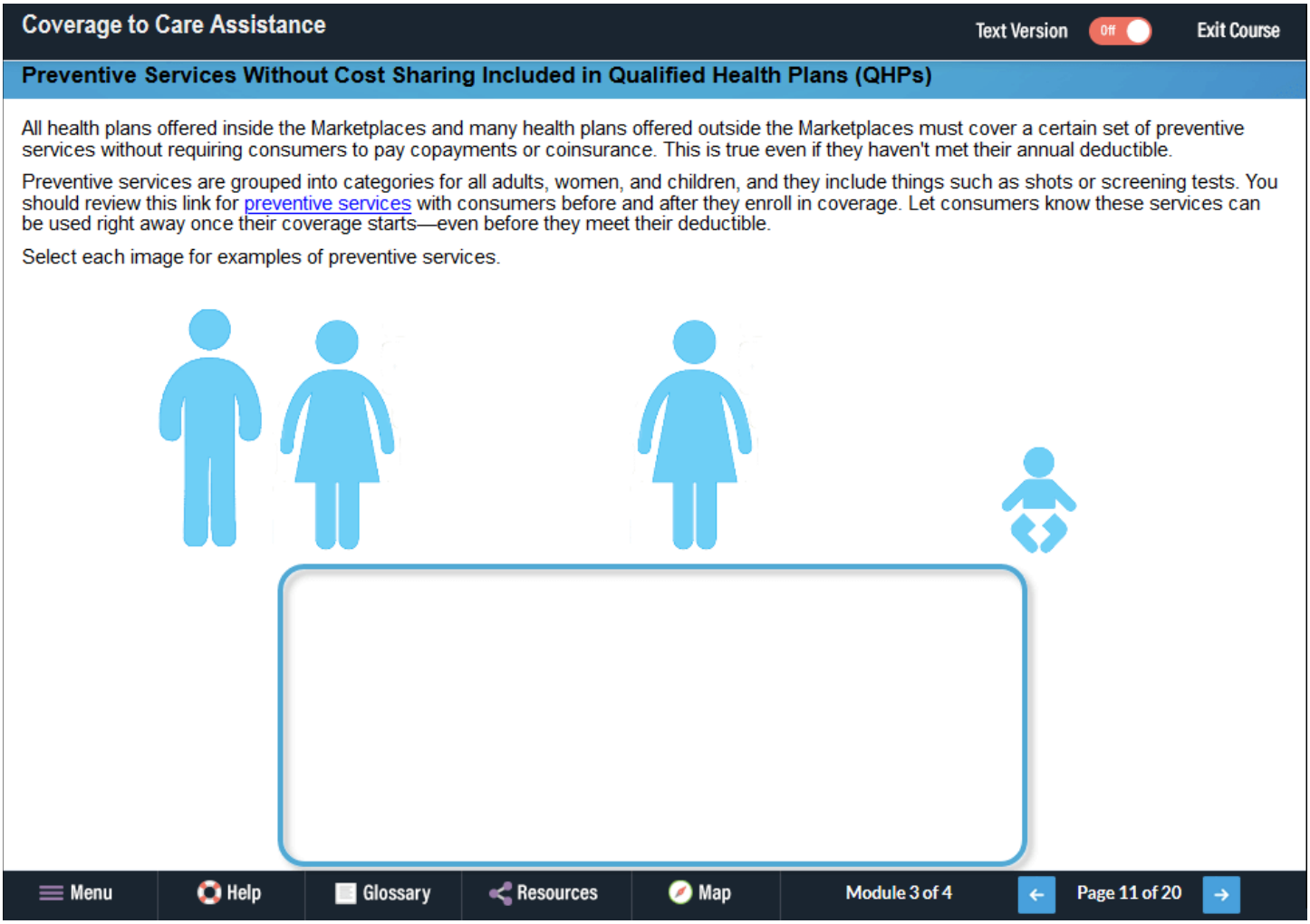
Lori
I went to a doctor and I really don't think he was a good fit for me. Can I change providers?

Coach
Yes, you have the right to request a change in provider. If you want to try someone else, call your health plan or visit your plan's website to make the change. Make sure you choose a provider in your network or you will pay more for your care.

It is OK to ask for changes or to find another provider.

Visit the C2C Roadmap resource provided earlier in this module to get more information about finding the right provider.

Preventive Services Without Cost Sharing Included in Qualified Health Plans (QHPs)



All health plans offered inside the Marketplaces and many health plans offered outside the Marketplaces must cover a certain set of preventive services without requiring consumers to pay copayments or coinsurance. This is true even if they haven't met their annual deductible.

Preventive services are grouped into categories for all adults, women, and children, and they include things such as shots or screening tests. You should review this link for preventive services with consumers before and after they enroll in coverage. Let consumers know these services can be used right away once their coverage starts—even before they meet their deductible.

Preventive services for adults include:

- Flu shot and other immunizations and vaccines
- Blood pressure screening
- Cholesterol screening
- Tobacco use screening
- Depression screening
- Obesity screening and counseling
- Alcohol misuse screening and counseling

For a complete list, visit HealthCare.gov/preventive-care-adults/.

Preventive services for women include:

- Prenatal screening
- Cervical cancer screening
- Urinary tract or other infection screening
- Well-woman visits

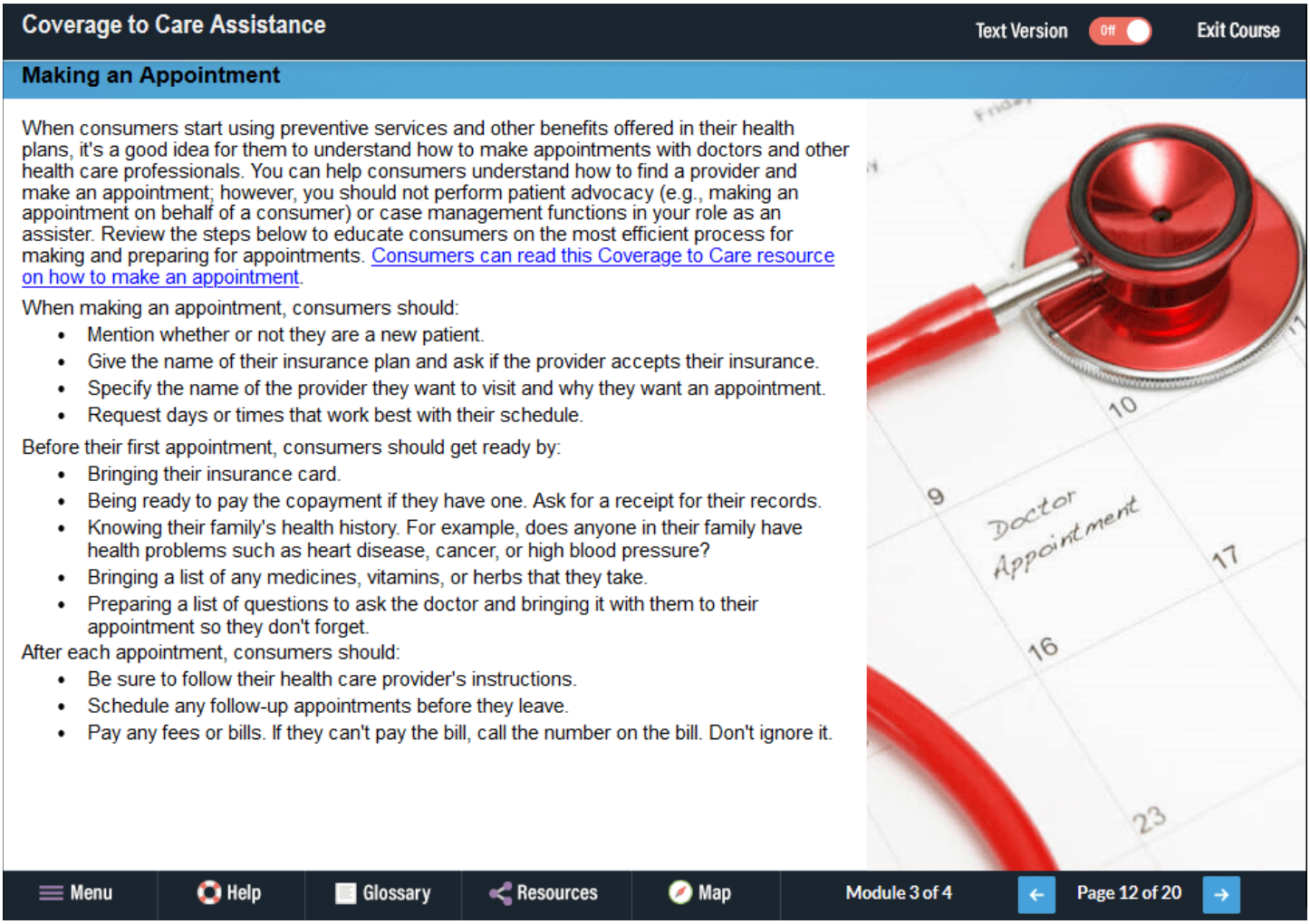
For a complete list, visit HealthCare.gov/preventive-care-women/.

Preventive services for children include:

- Flu shot and other immunizations and vaccines
- Behavioral assessments
- Height, weight, and body mass index (BMI) measurements
- Obesity screening and counseling
- Vision screening

For a complete list, visit HealthCare.gov/preventive-care-children/.

Making an Appointment



When consumers start using preventive services and other benefits offered in their health plans, it's a good idea for them to understand how to make appointments with doctors and other health care professionals. You can help consumers understand how to find a provider and make an appointment; however, you should not perform patient advocacy (e.g., making an appointment on behalf of a consumer) or case management functions in your role as an assister. Review the steps below to educate consumers on the most efficient process for making and preparing for appointments. Consumers can read this Coverage to Care resource on how to make an appointment.

When making an appointment, consumers should:

- Mention whether or not they are a new patient.
- Give the name of their insurance plan and ask if the provider accepts their insurance.
- Specify the name of the provider they want to visit and why they want an appointment.
- Request days or times that work best with their schedule.

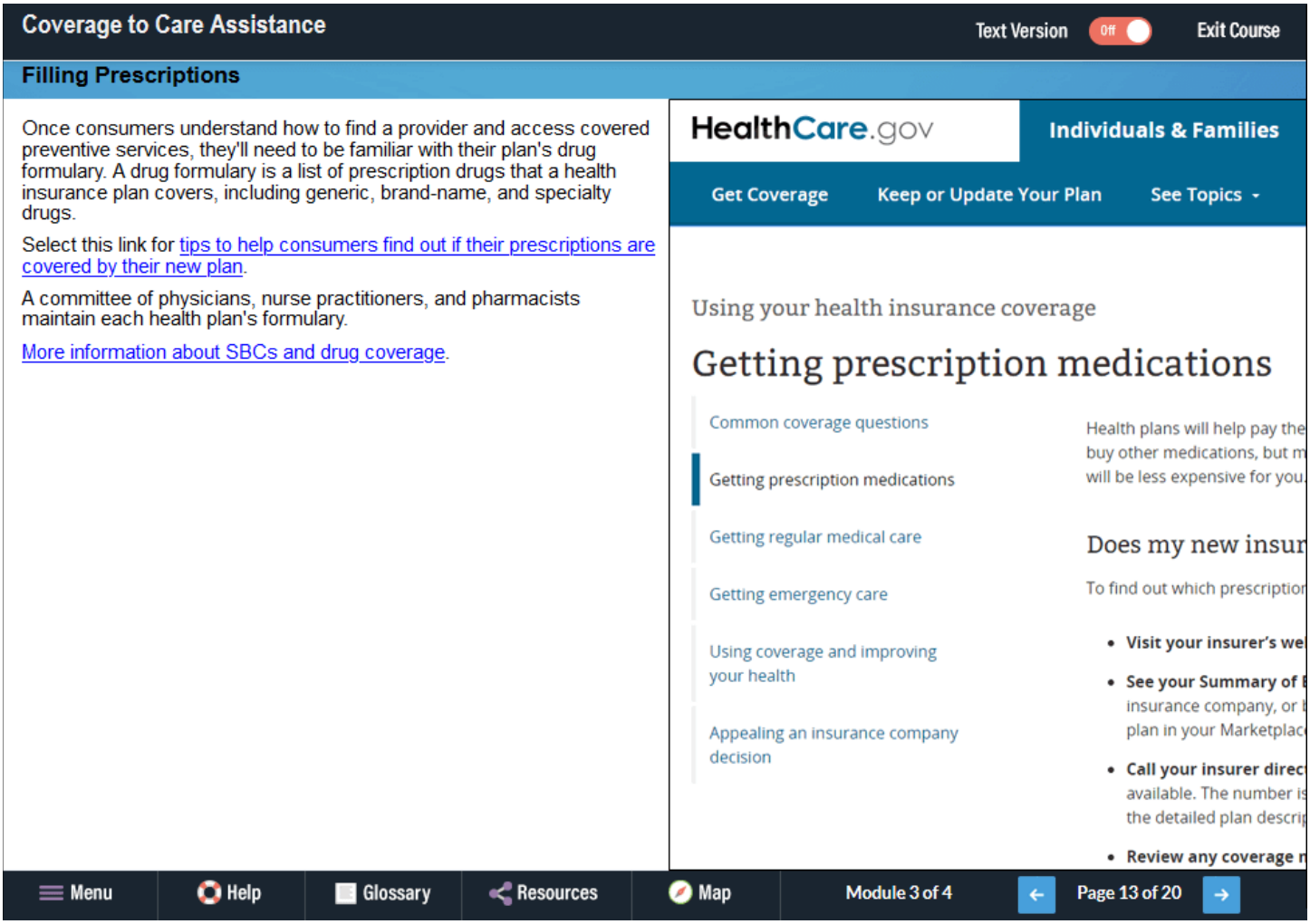
Before their first appointment, consumers should get ready by:

- Bringing their insurance card.
- Being ready to pay the copayment if they have one. Ask for a receipt for their records.
- Knowing their family's health history. For example, does anyone in their family have health problems such as heart disease, cancer, or high blood pressure?
- Bringing a list of any medicines, vitamins, or herbs that they take.
- Preparing a list of questions to ask the doctor and bringing it with them to their appointment so they don't forget.

After each appointment, consumers should:

- Be sure to follow their health care provider's instructions.
- Schedule any follow-up appointments before they leave.
- Pay any fees or bills. If they can't pay the bill, call the number on the bill. Don't ignore it.

Filling Prescriptions



Once consumers understand how to find a provider and access covered preventive services, they'll need to be familiar with their plan's drug formulary. A drug formulary is a list of prescription drugs that a health insurance plan covers, including generic, brand-name, and specialty drugs.

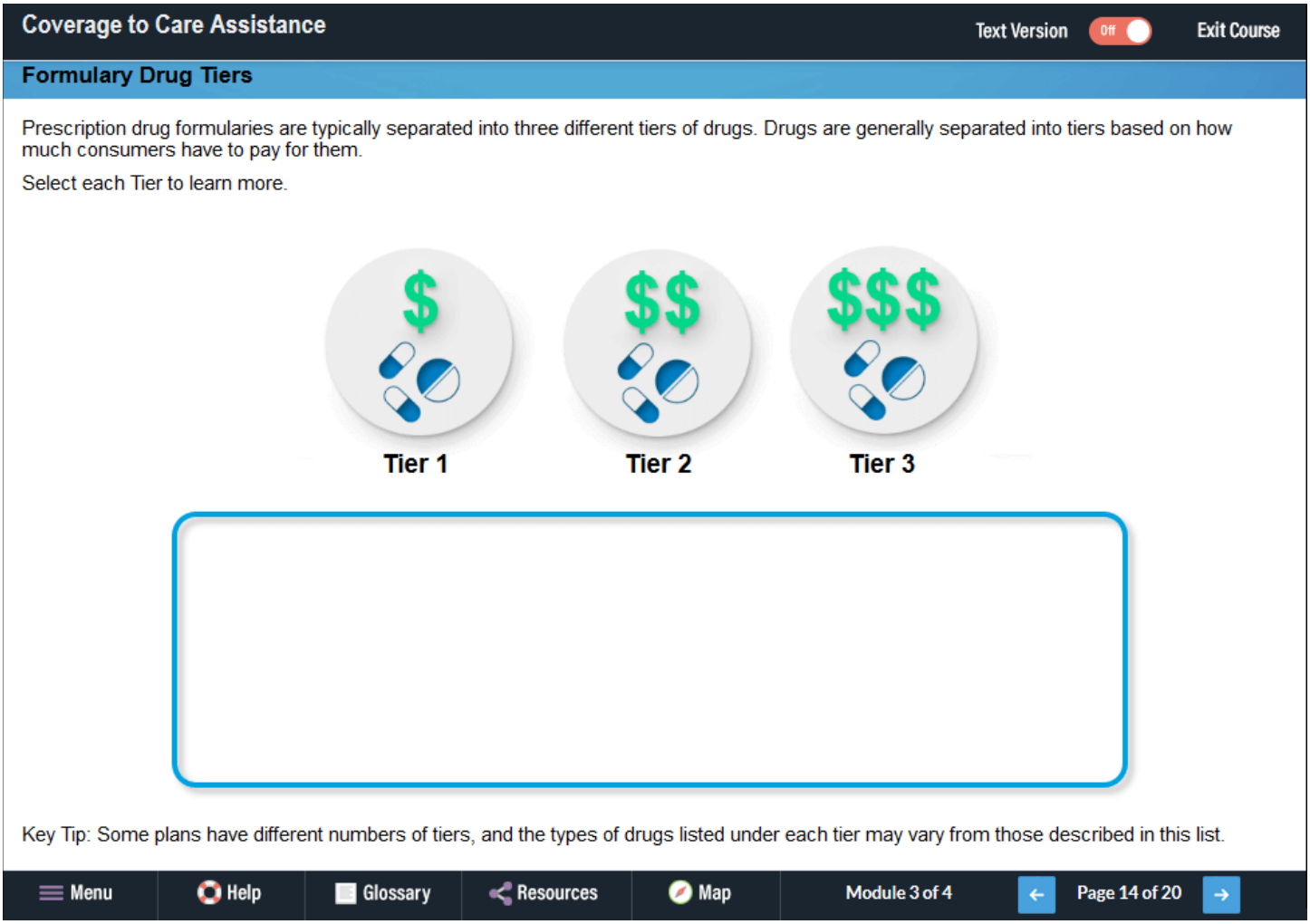
Select this link for tips to help consumers find out if their prescriptions are covered by their new plan.

A committee of physicians, nurse practitioners, and pharmacists maintain each health plan's formulary.

Here are a few things to keep in mind when reviewing drug formularies with consumers.

- Formularies change regularly.
- They differ by the type of insurance and also by how many categories and classes of medicines are covered. For example, a category of drugs may be blood glucose regulators. "Insulins" are the class for this drug.
- There are several different ways you can find drug coverage information, including:
  - The plan's SBC.
  - The "My plans & programs" page at HealthCare.gov.
- Insurance companies often use an outside pharmacy benefits manager to provide prescription drugs. In this case, consumers receive a separate insurance card for prescription drugs. Consumers need to have this card with them when they pick up prescription drugs at a doctor's office or pharmacy.

Formulary Drug Tiers



Prescription drug formularies are typically separated into three different tiers of drugs. Drugs are generally separated into tiers based on how much consumers have to pay for them.

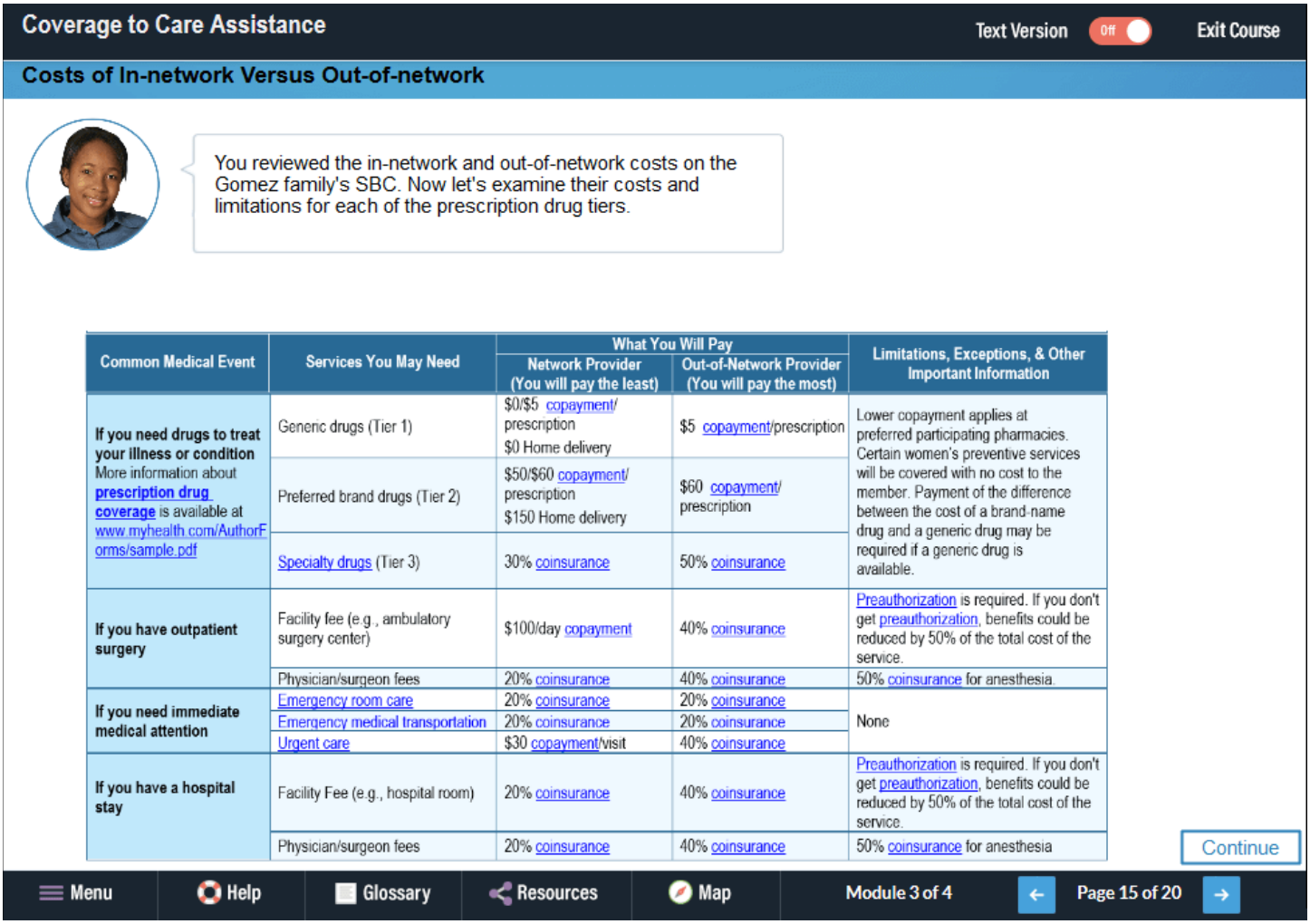
Tier 1:
Includes mostly generic drugs or the lowest-cost drugs. Sometimes other regularly lower-price branded drugs will fall into this tier too.

Tier 2:
Typically includes formulary brand-name drugs. If a brand-name drug is required, an insurance company will have a list of branded drugs it prefers because they cost less.

Tier 3:
Tier 3 generally includes non-formulary brand-name drugs or specialty drugs. Chemotherapies (cancer medications) fall into this category. Many plans group certain drugs into third, fourth, or even fifth drug tiers because 1) they are new and not yet proven to be safe or effective or 2) a similar drug is available in a lower tier of the formulary that may provide the same benefit at a lower cost.

Key Tip: Some plans have different numbers of tiers, and the types of drugs listed under each tier may vary from those described in this list.

Costs of In-network Versus Out-of-network



You reviewed the in-network and out-of-network costs on the Gomez family's SBC. Now let's examine their costs and limitations for each of the prescription drug tiers.

Tier 1: If the Gomez family uses a generic drug from a participating provider, they would have to pay a $0 to $5 copayment. The drug would be covered if they used a non-participating provider with a $5 copayment.

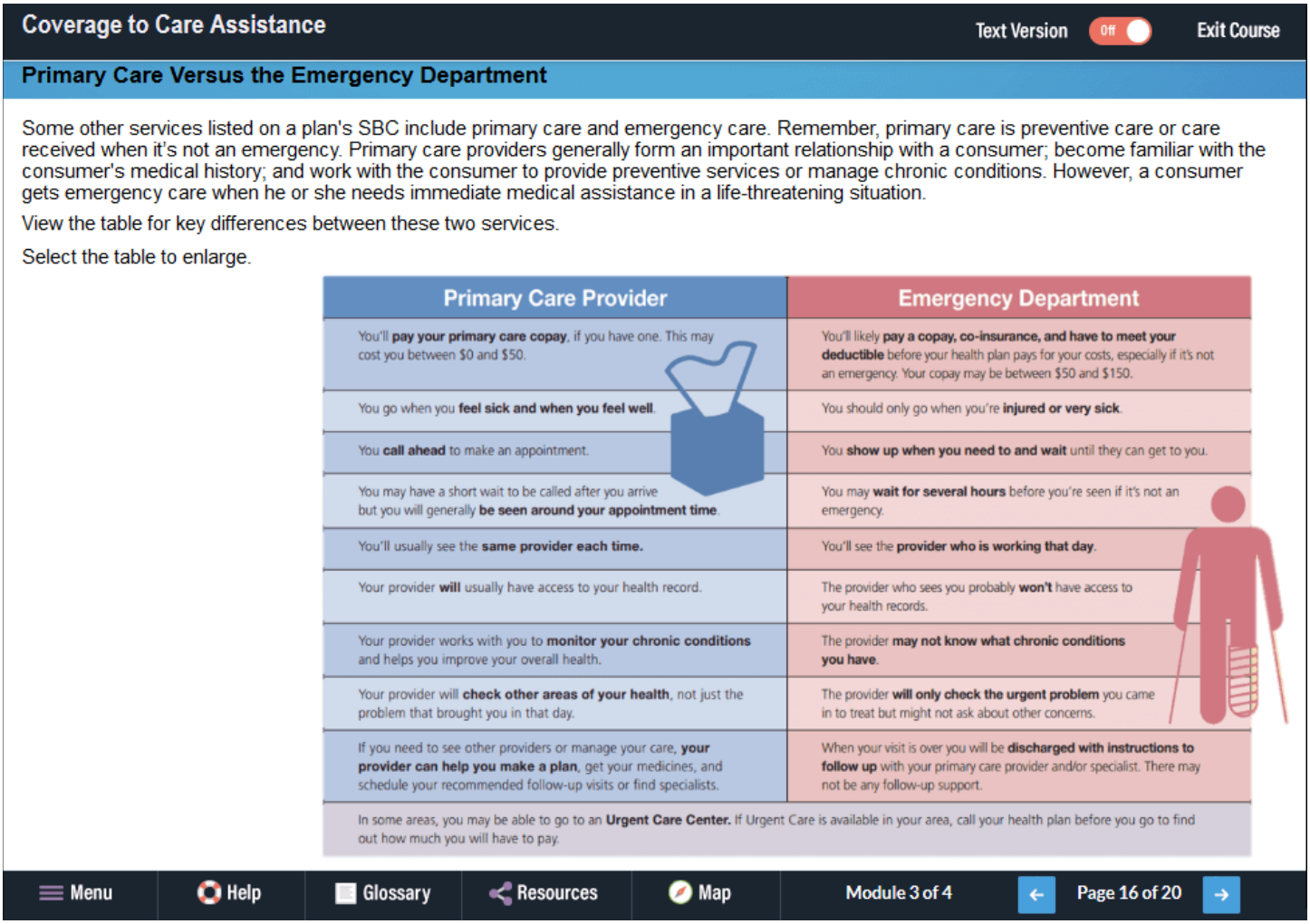
The "Limitations & Exceptions" column states that the lower copayment applies at preferred participating pharmacies.

Tier 2: If the Gomez family uses a formulary brand-name drug from a participating provider, they would have to pay a $50 to $60 copayment. If they used a non-participating provider they would have to pay a $60 copayment.

The "Limitations & Exceptions" column states that if a brand-name drug is dispensed when a generic drug is available, the Gomez family will be responsible for paying the difference between the brand-name drug cost and the generic drug cost.

Tier 3: If the Gomez family uses a specialty drug from a participating provider, they would have to pay 30 percent coinsurance. They would have to pay 50 percent coinsurance for drugs from a non-participating provider.

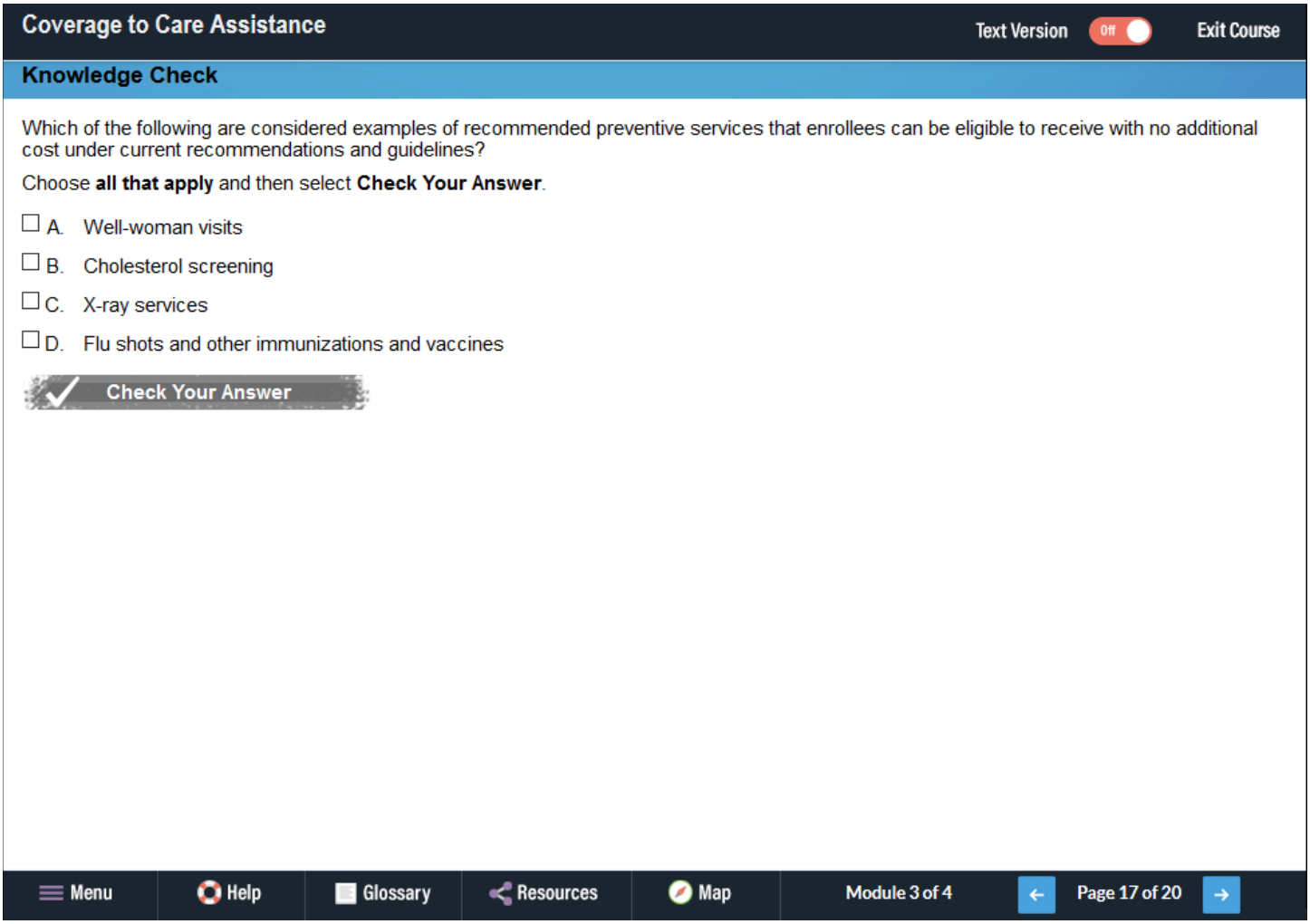
Primary Care Versus the Emergency Department



Some other services listed on a plan's SBC include primary care and emergency care. Remember, primary care is preventive care or care received when it's not an emergency. Primary care providers generally form an important relationship with a consumer; become familiar with the consumer's medical history; and work with the consumer to provide preventive services or manage chronic conditions. However, a consumer gets emergency care when he or she needs immediate medical assistance in a life-threatening situation.

Select this link to access the table for key differences between these two services.

Knowledge Check

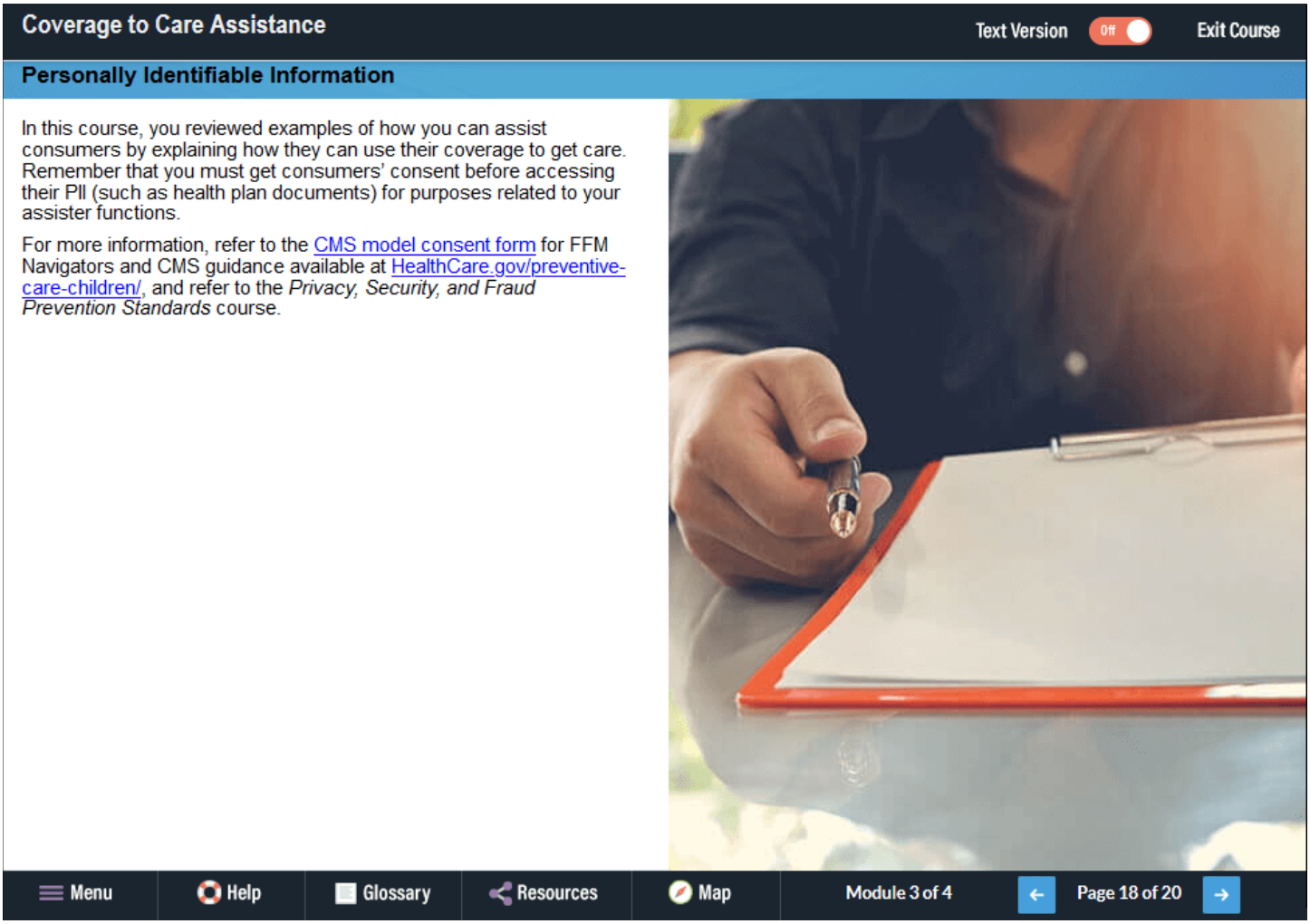


Which of the following are considered examples of recommended preventive services that enrollees can be eligible to receive with no additional cost under current recommendations and guidelines?

A. Well-woman visits
B. Cholesterol screening
C. X-ray services
D. Flu shots and other immunizations and vaccines

The correct answers are A, B, and D. Well-woman visits, cholesterol screening, and flu shots and other immunizations and vaccines are all considered preventive services. X-ray services are not included in this group.

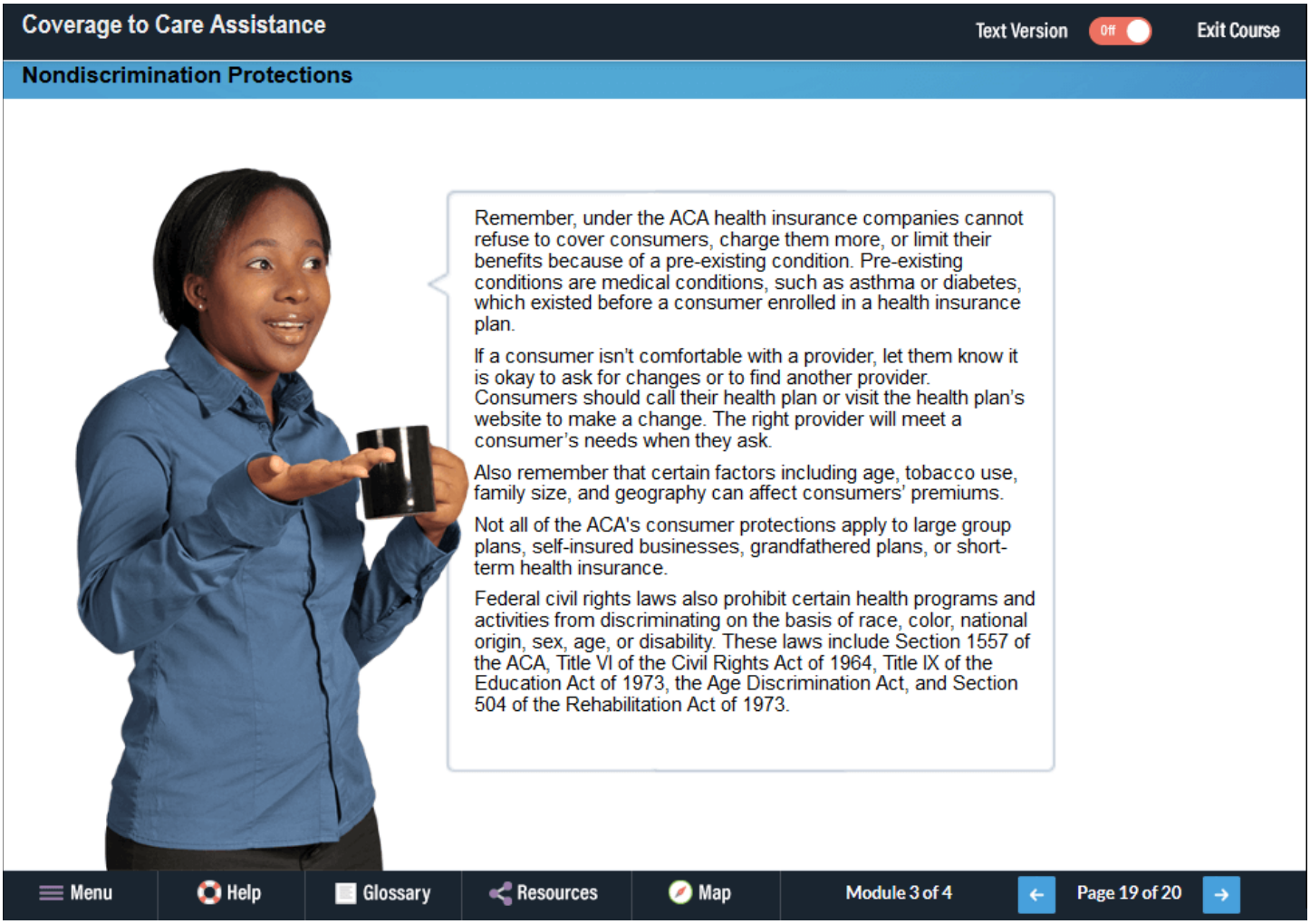
Personally Identifiable Information



In this course, you reviewed examples of how you can assist consumers by explaining how they can use their coverage to get care. Remember that you must get consumers' consent before accessing their PII (such as health plan documents) for purposes related to your assister functions.

For more information, refer to the CMS model consent form for FFM Navigators and CMS guidance available at HealthCare.gov/preventive-care-children/, and refer to the *Privacy, Security and Fraud Prevention Standards* course.

Nondiscrimination Protections



Remember, under the ACA health insurance companies cannot refuse to cover consumers, charge them more, or limit their benefits because of a pre-existing condition. Pre-existing conditions are medical conditions, such as asthma or diabetes, which existed before a consumer enrolled in a health insurance plan.

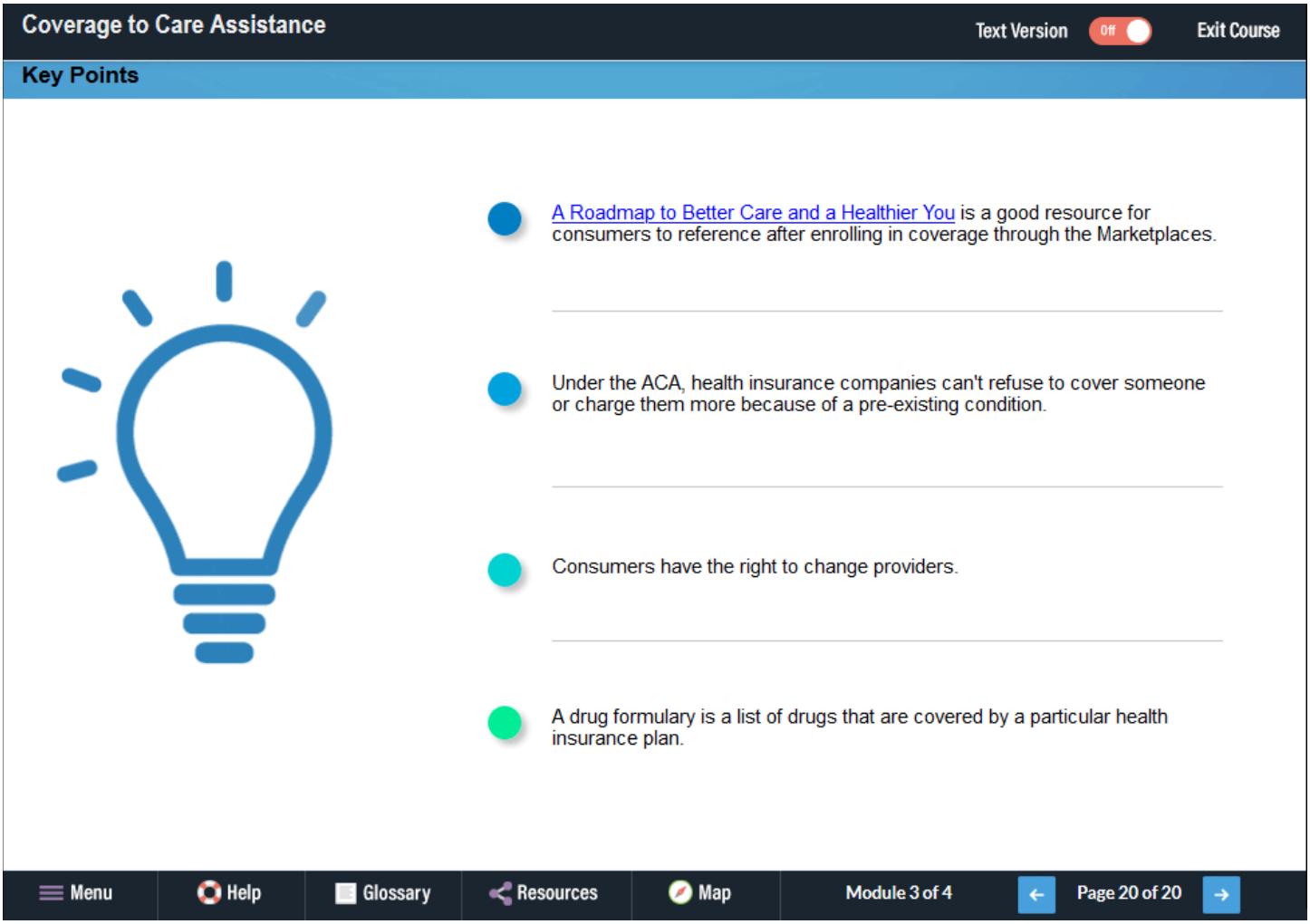
If a consumer isn't comfortable with a provider, let them know it is okay to ask for changes or to find another provider. Consumers should call their health plan or visit the health plan's website to make a change. The right provider will meet a consumer's needs when they ask.

Also remember that certain factors including age, tobacco use, family size, and geography can affect consumers' premiums.

Not all of the ACA's consumer protections apply to large group plans, self-insured businesses, grandfathered plans, or short-term health insurance.

Federal civil rights laws also prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, sex, age, or disability. These laws include Section 1557 of the ACA, Title VI of the Civil Rights Act of 1964, Title IX of the Education Act of 1973, the Age Discrimination Act, and Section 504 of the Rehabilitation Act of 1973.

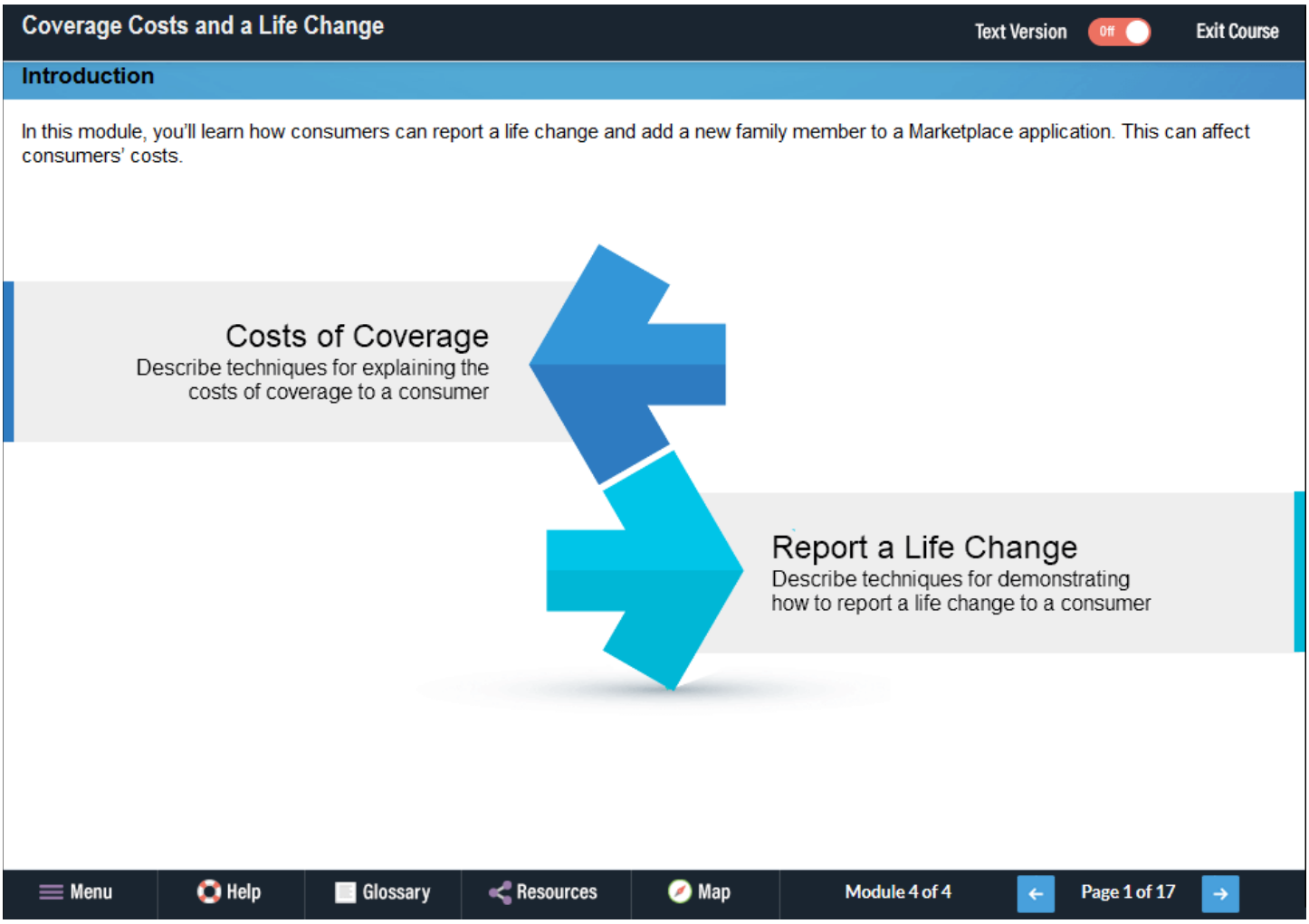
Key Points



- A Roadmap to Better Care and a Healthier You is a good resource for consumers to reference after enrolling in coverage through the Marketplaces.
- Under the ACA, health insurance companies can't refuse to cover someone or charge them more because of a pre-existing condition.
- Consumers have the right to change providers.
- A drug formulary is a list of drugs that are covered by a particular health insurance plan.

Coverage Costs and a Life Change

Introduction

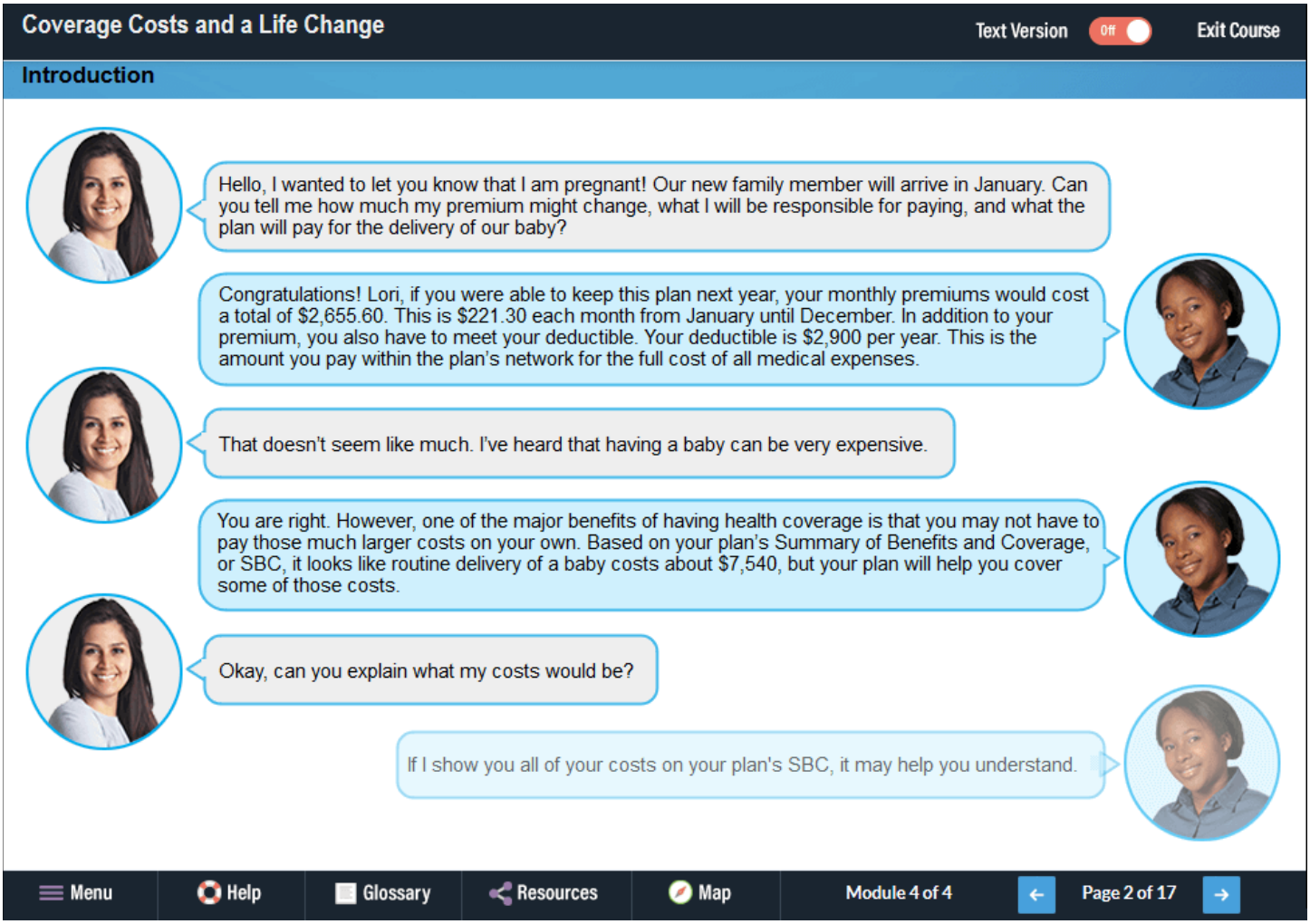


In this module, you'll learn how consumers can report a life change and add a new family member to a Marketplace application. This can affect consumers' costs.

Costs of Coverage
Describe techniques for explaining the costs of coverage to a consumer

Report a Life Change
Describe techniques for demonstrating how to report a life change to a consumer

Introduction



Lori
Hello, I wanted to let you know that I am pregnant! Our new family member will arrive in January. Can you tell me how much my premium might change, what I will be responsible for paying, and what the plan will pay for the delivery of our baby?

Coach
Congratulations! Lori, if you were able to keep this plan next year, your monthly premiums would cost a total of $2,655.60. This is $221.30 each month from January until December. In addition to your premium, you also have to meet your deductible. Your deductible is $2,900 per year. This is the amount you pay within the plan's network for the full cost of all medical expenses.

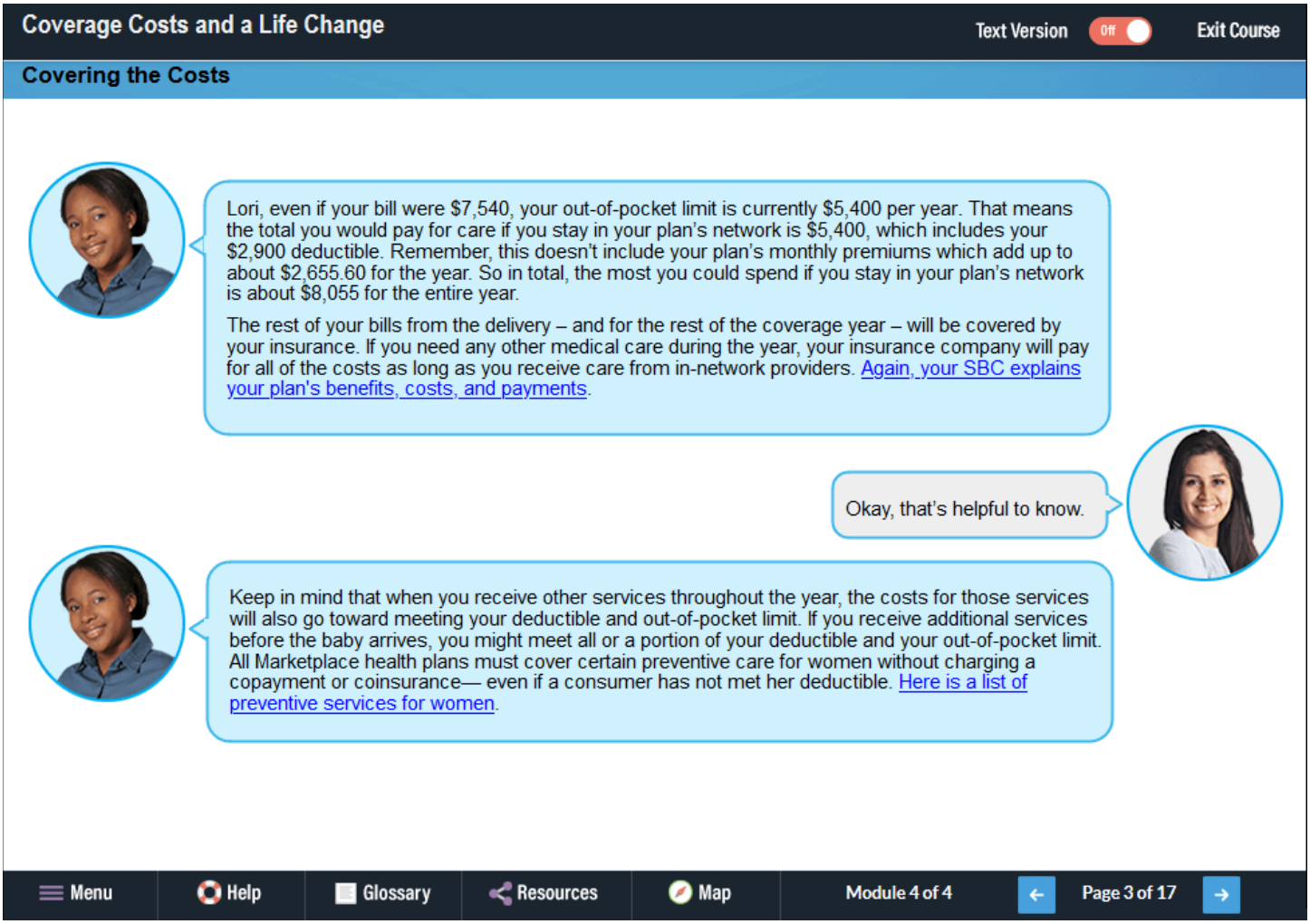
Lori
That doesn't seem like much. I've heard that having a baby can be very expensive.

Coach
You are right. However, one of the major benefits of having health coverage is that you may not have to pay those much larger costs on your own. Based on your plan's Summary of Benefits and Coverage, or SBC, it looks like routine delivery of a baby costs about $7,540, but your plan will help you cover some of those costs.

Lori
Okay, can you explain what my costs would be?

Coach
If I show you all of your costs on your plan's SBC, it may help you understand.

Covering the Costs



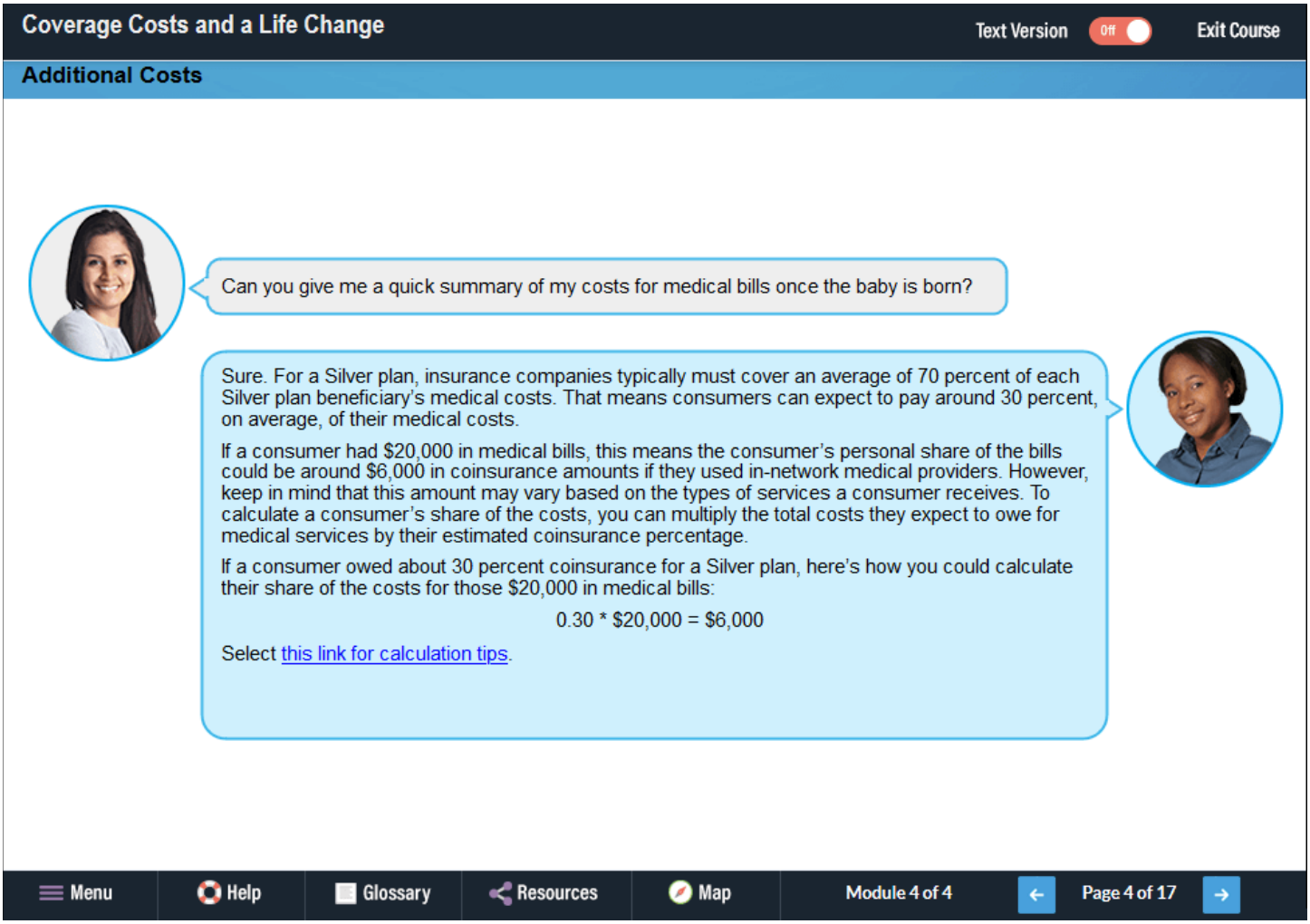
Coach
Lori, even if your bill were $7,540, your out-of-pocket limit is currently $5,400 per year. That means the total you would pay for care if you stay in your plan's network is $5,400, which includes your $2,900 deductible. Remember, this doesn't include your plan's monthly premiums which add up to about $2,655.60 for the year. So in total, the most you could spend if you stay in your plan's network is about $8,055 for the entire year.

The rest of your bills from the delivery – and for the rest of the coverage year – will be covered by your insurance. If you need any other medical care during the year, your insurance company will pay for all of the costs as long as you receive care from in-network providers. Again, your SBC explains your plan's benefits, costs, and payments.

Lori
Okay, that's helpful to know.

Coach
Keep in mind that when you receive other services throughout the year, the costs for those services will also go toward meeting your deductible and out-of-pocket maximum. If you receive additional services before the baby arrives, you might meet all or a portion of your deductible and your out-of-pocket maximum. All Marketplace health plans must cover certain preventive care for women without charging a copay or coinsurance— even if a consumer has not met her deductible. Here is a list of preventive services for women.

Additional Costs



Lori:
Can you give me a quick summary of my costs for medical bills once the baby is born?

Coach:
Sure. For a Silver plan, insurance companies typically must cover an average of 70 percent of each Silver plan beneficiary's medical costs. That means consumers can expect to pay around 30 percent, on average, of their medical costs.

If a consumer had $20,000 in medical bills, this means the consumer's personal share of the bills could be around $6,000 in coinsurance amounts if they used in-network medical providers. However, keep in mind that this amount may vary based on the types of services a consumer receives. To calculate a consumer's share of the costs, you can multiply the total costs they expect to owe for medical services by their estimated coinsurance percentage.

If a consumer owed about 30 percent coinsurance for a Silver plan, here's how you could calculate their share of the costs for those $20,000 in medical bills:

0.30 times $20,000 = $6,000

To make calculations easy, turn the coinsurance percentage into a decimal by adding a period in front of the number.

Calculation Tips

50 percent = 0.50

30 percent = 0.30

15 percent = 0.15

5 percent = 0.05*

*For numbers lower than 10 percent, be sure to add a 0 in between the period and the percentage number.

Maximum Cost With Insurance

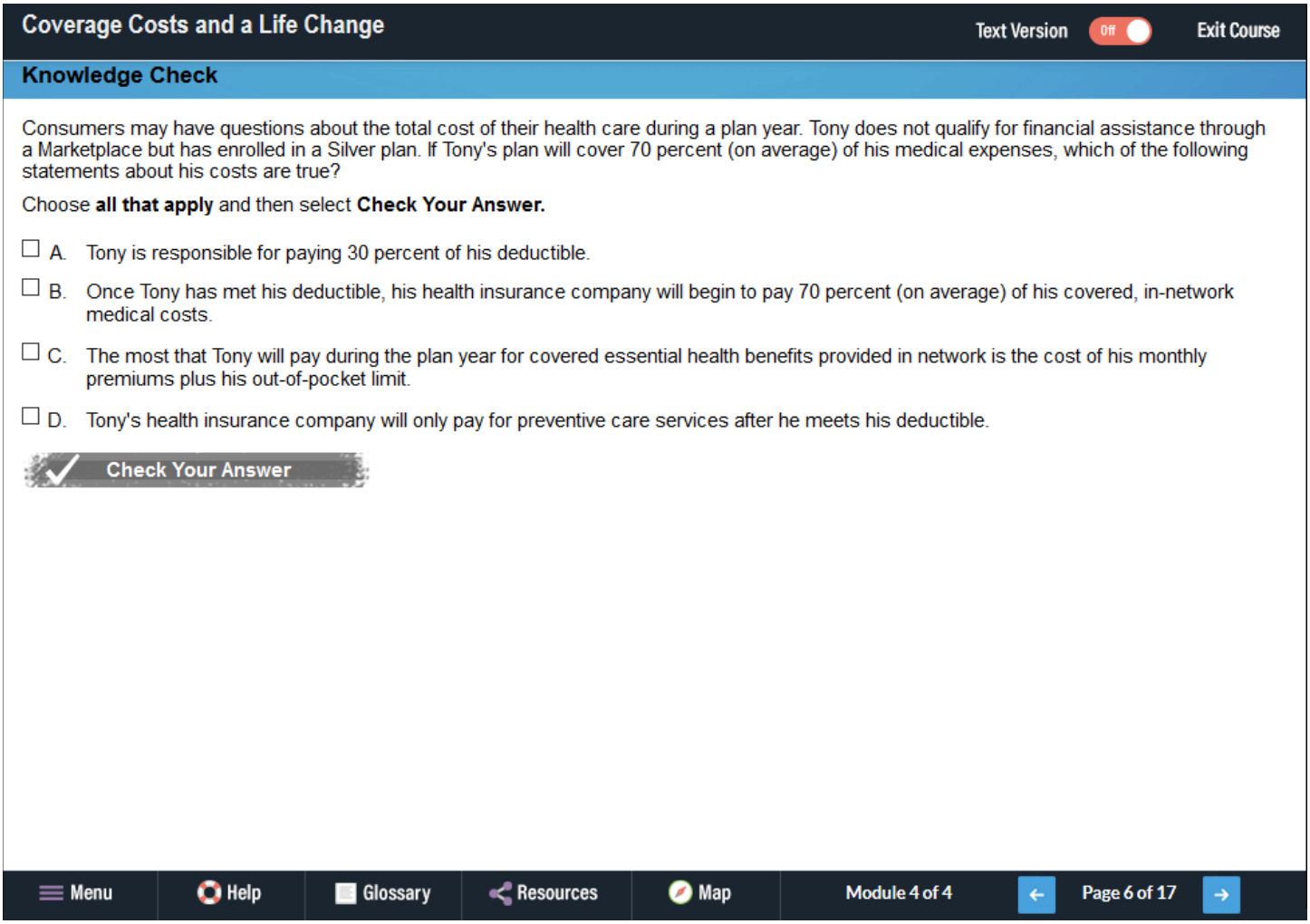
Lori, even though a consumer would typically owe $6,000 for covered in-network medical services to have a baby in our previous example, keep in mind that your family qualifies for extra savings on additional costs, and you also have an annual out-of-pocket limit. Since you enrolled in a Silver plan with CSRs, your out-of-pocket limit for your family's Silver plan is $5,400. This means your total costs for the year would actually be $5,400 plus the monthly premiums to your insurance company. As long as you get in-network care and services, your insurance company will cover the rest of your costs for EHB during the plan year.

Lori, your total health care costs for the year are $2,655.60 for all of your monthly premiums (that is, $221.30/month for 12 months) and $5,400 for all of your essential health benefit costs after that (your annual out-of-pocket limit). With your insurance, the most you could possibly pay in a year for covered, in-network essential health benefits is $8,055.60.

Key Tip:

Remember, many plans don't start paying for the majority of consumers' medical expenses until they meet their annual deductible. However, all plans must cover certain preventive services at 100 percent (without cost sharing to the consumer) and many plans let consumers pay a fixed, discounted amount (copayment) for certain covered services and prescriptions.

Knowledge Check



Consumers may have questions about the total cost of their health care during a plan year.

Tony does not qualify for financial assistance through a Marketplace but has enrolled in a Silver plan. If Tony's plan will cover 70 percent (on average) of his medical expenses, which of the following statements about his costs are true?

A. Tony is responsible for paying 30 percent of his deductible.

B. Once Tony has met his deductible, his health insurance company will begin to pay 70 percent (on average) of his covered, in-network medical costs.

C. The most that Tony will pay during the plan year for covered essential health benefits provided in network is the cost of his monthly premiums plus his out-of-pocket limit.

D. Tony's health insurance company will only pay for preventive care services after he meets his deductible.

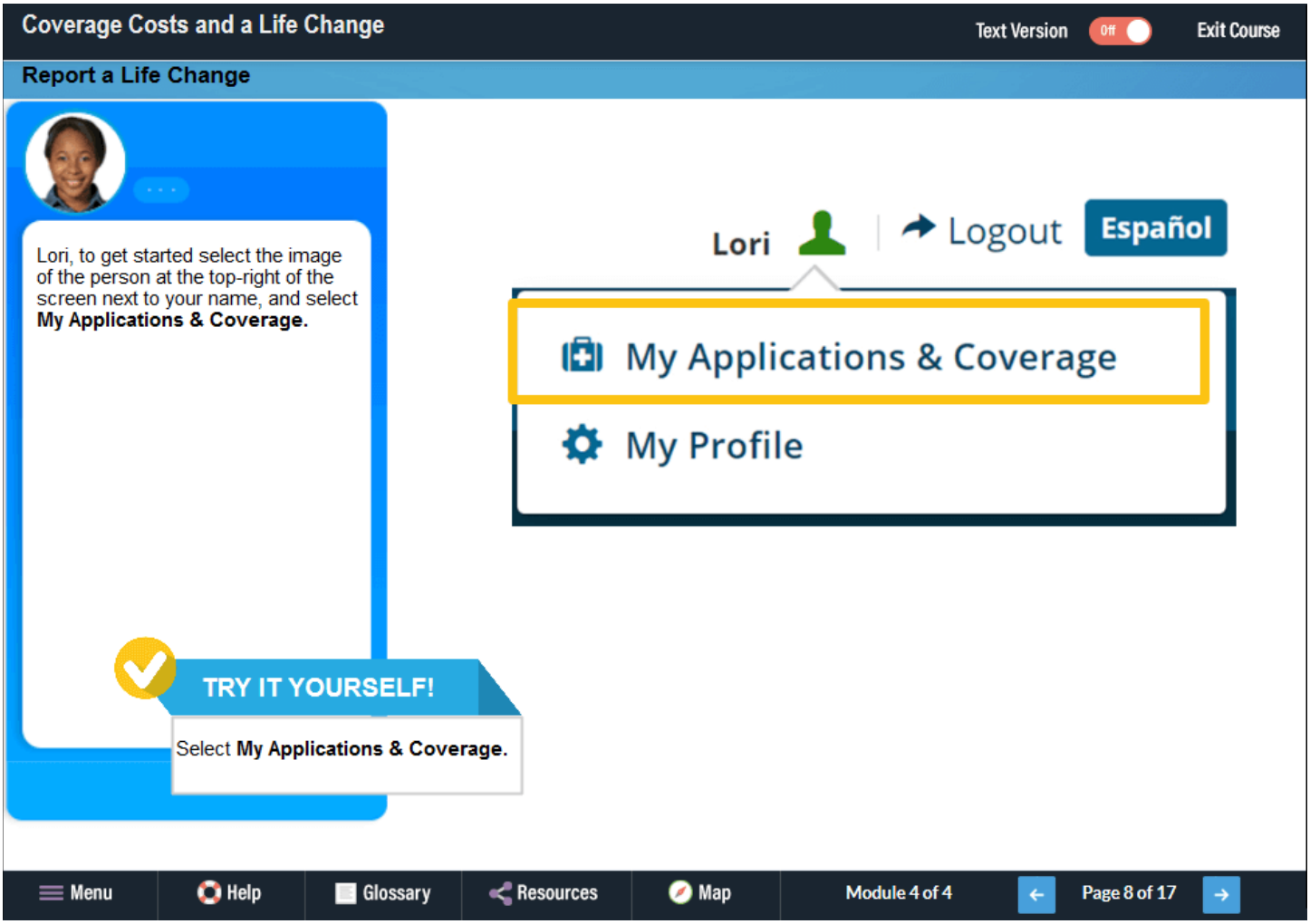
The correct answers are B and C. Once Tony meets his deductible, his health insurance company will begin to pay for about 70 percent of the costs of in-network essential health benefits. The most that Tony will pay during the coverage year is the cost of his monthly premiums plus his out-of-pocket limit. Tony is responsible for 30 percent of the cost of covered health care services after he meets his deductible, but his insurance company must cover many preventive care services at 100 percent—even before he meets his deductible.

The Gomez Family Addition

Lori Gomez has returned to your office with a newborn baby and would like to add this new family member to her Marketplace plan. Let's review how you can help.

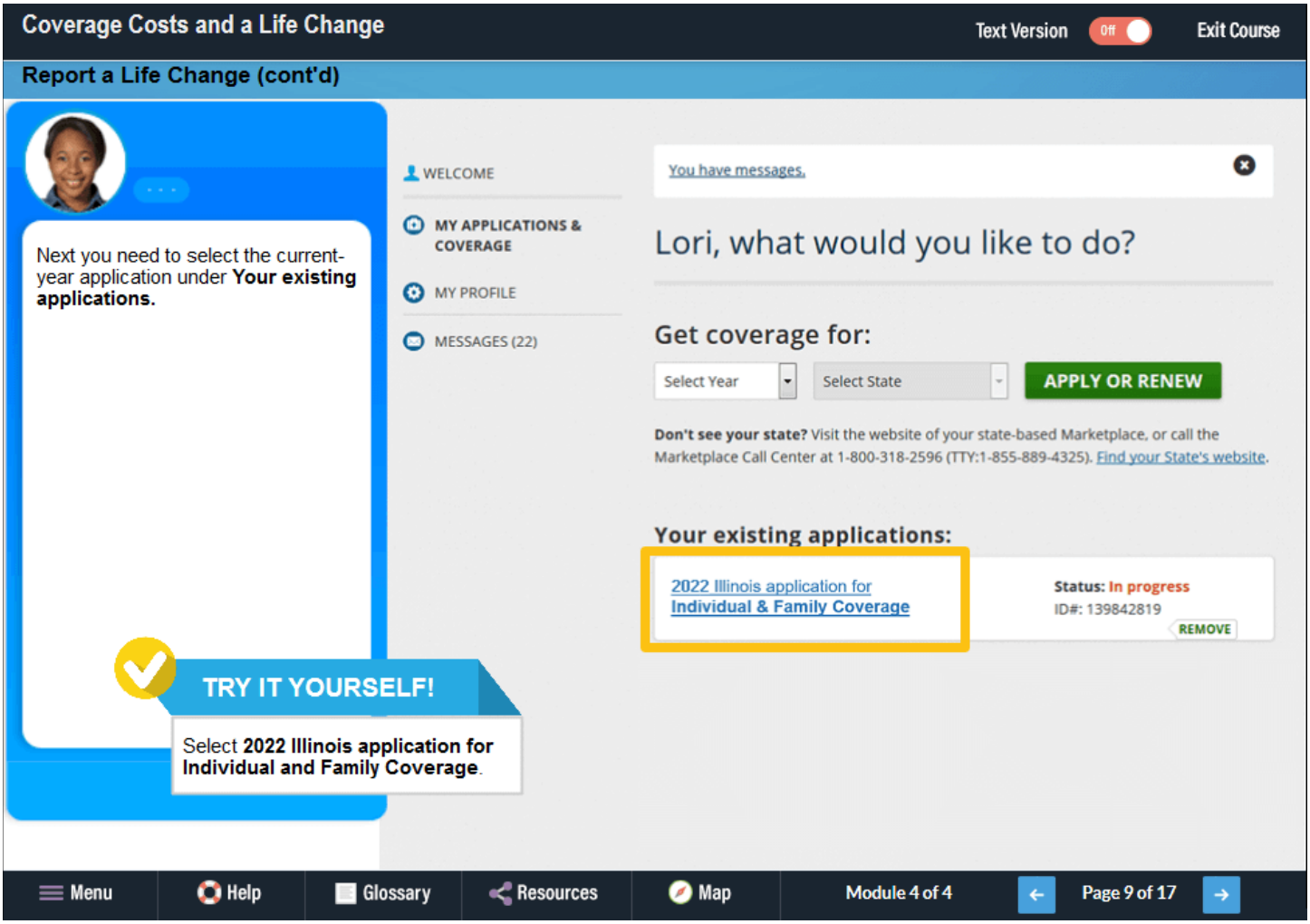
Remember, consumers can report a life change by calling the FFM Call Center or by logging into HealthCare.gov and updating their Marketplace account. Let's review the online process.

Report a Life Change



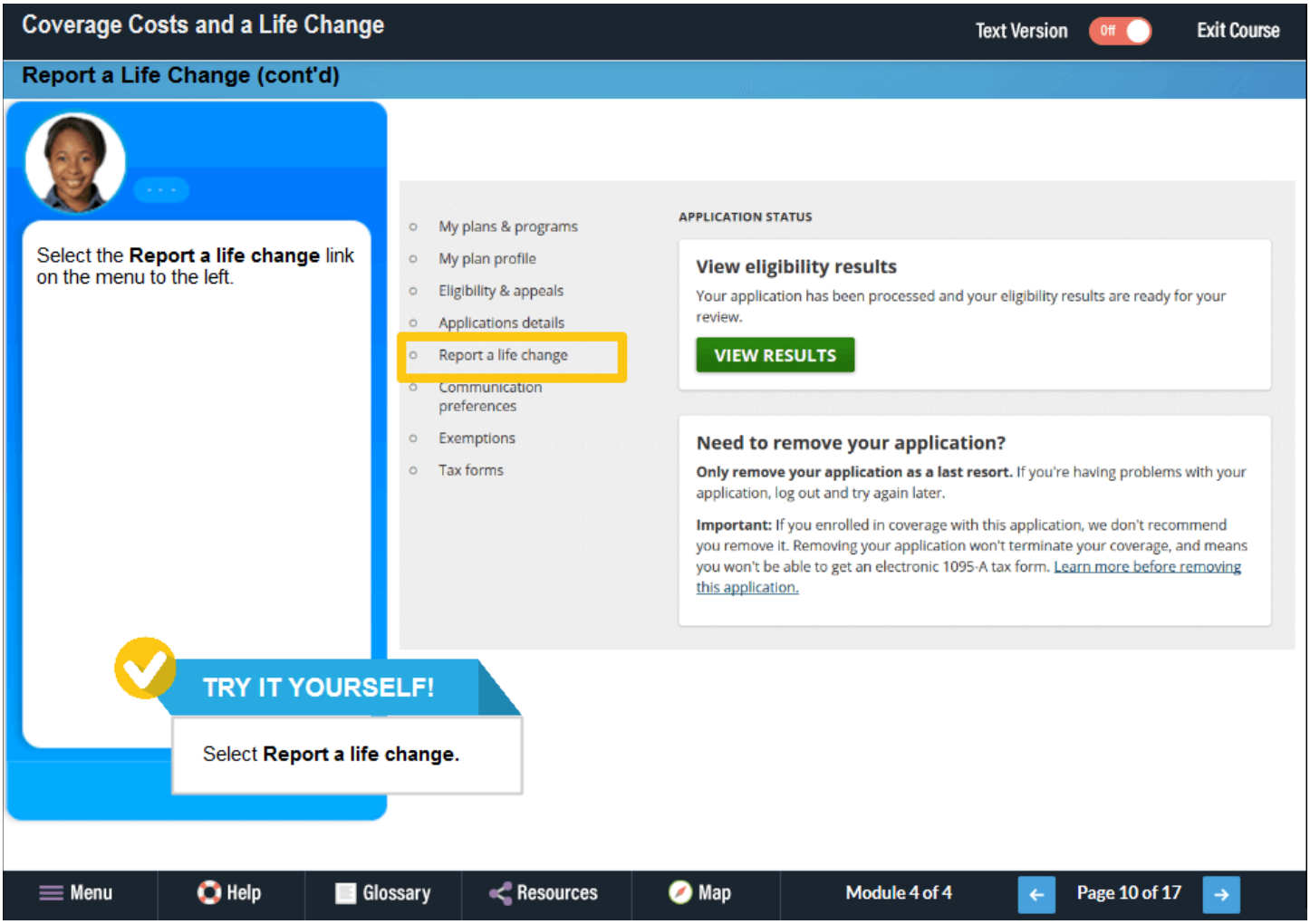
Lori, to get started select the image of the person at the top-right of the screen next to your name, and select **My Applications & Coverage.**

Report a Life Change (cont'd)



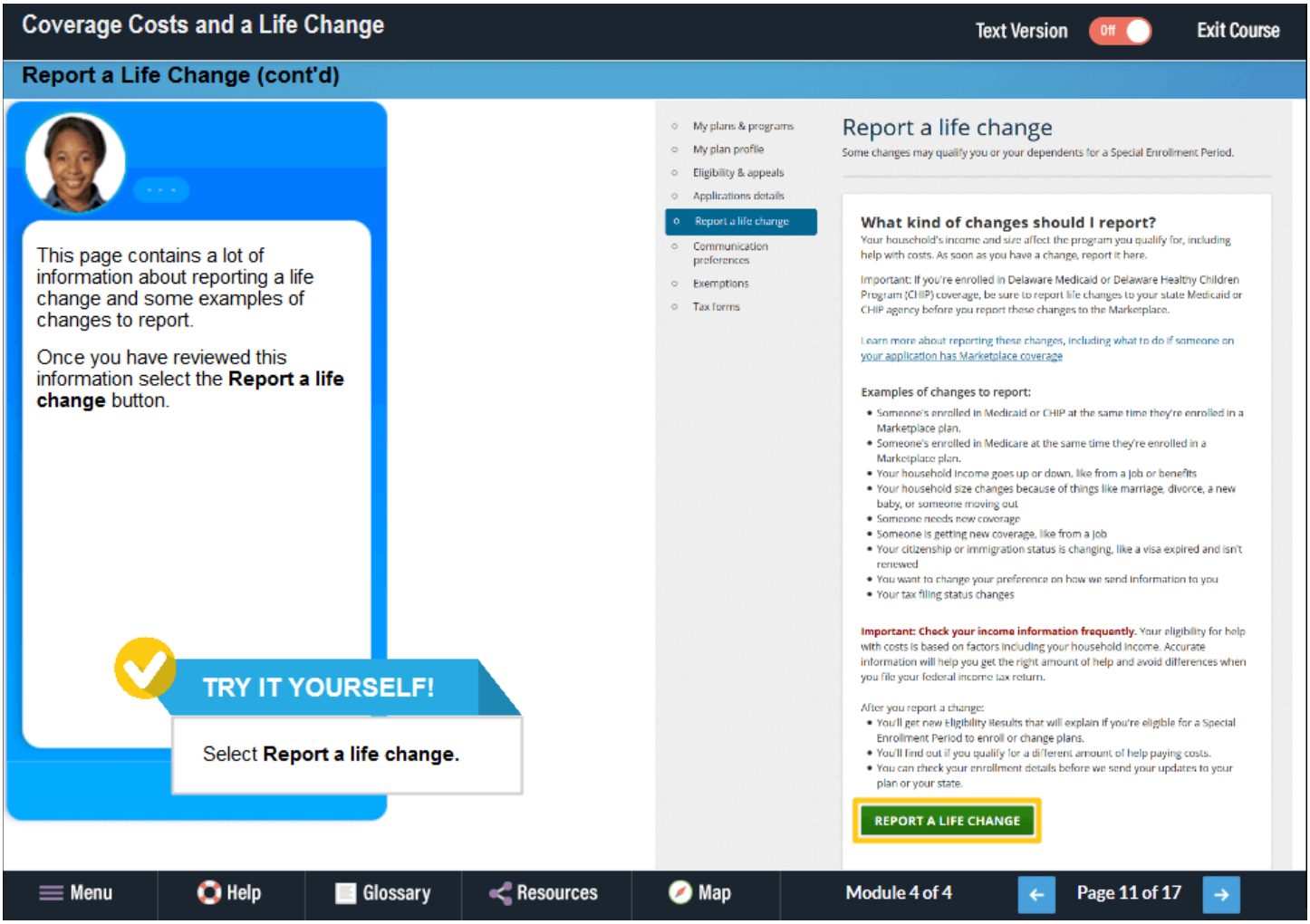
Next you need to select the current-year application under **Your existing applications.**

Report a Life Change (cont'd)



Select the **Report a life change** link on the menu to the left.

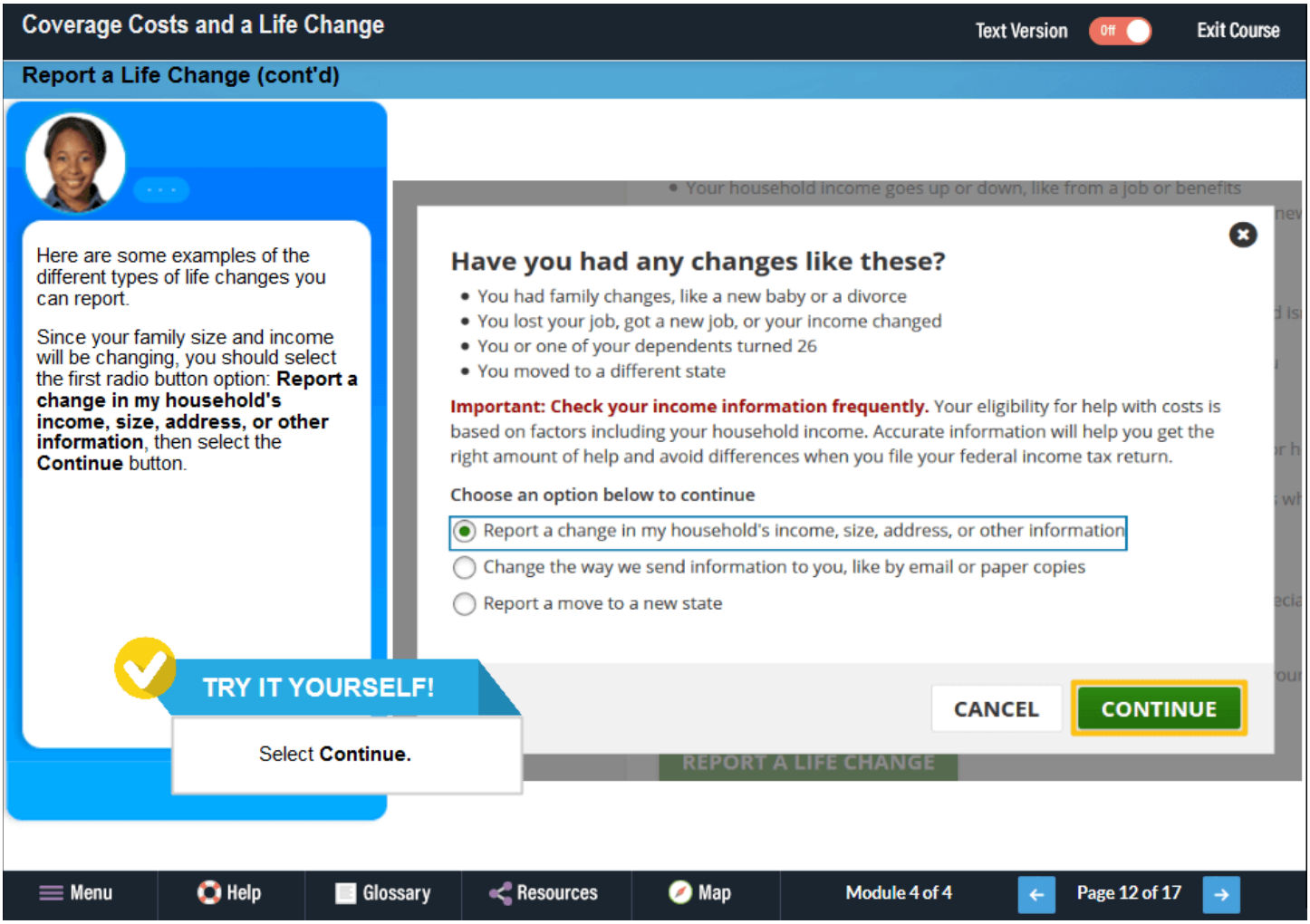
Report a Life Change (cont'd)



This page contains a lot of information about reporting a life change and some examples of changes to report.

Once you have reviewed this information select the **Report a life change** button.

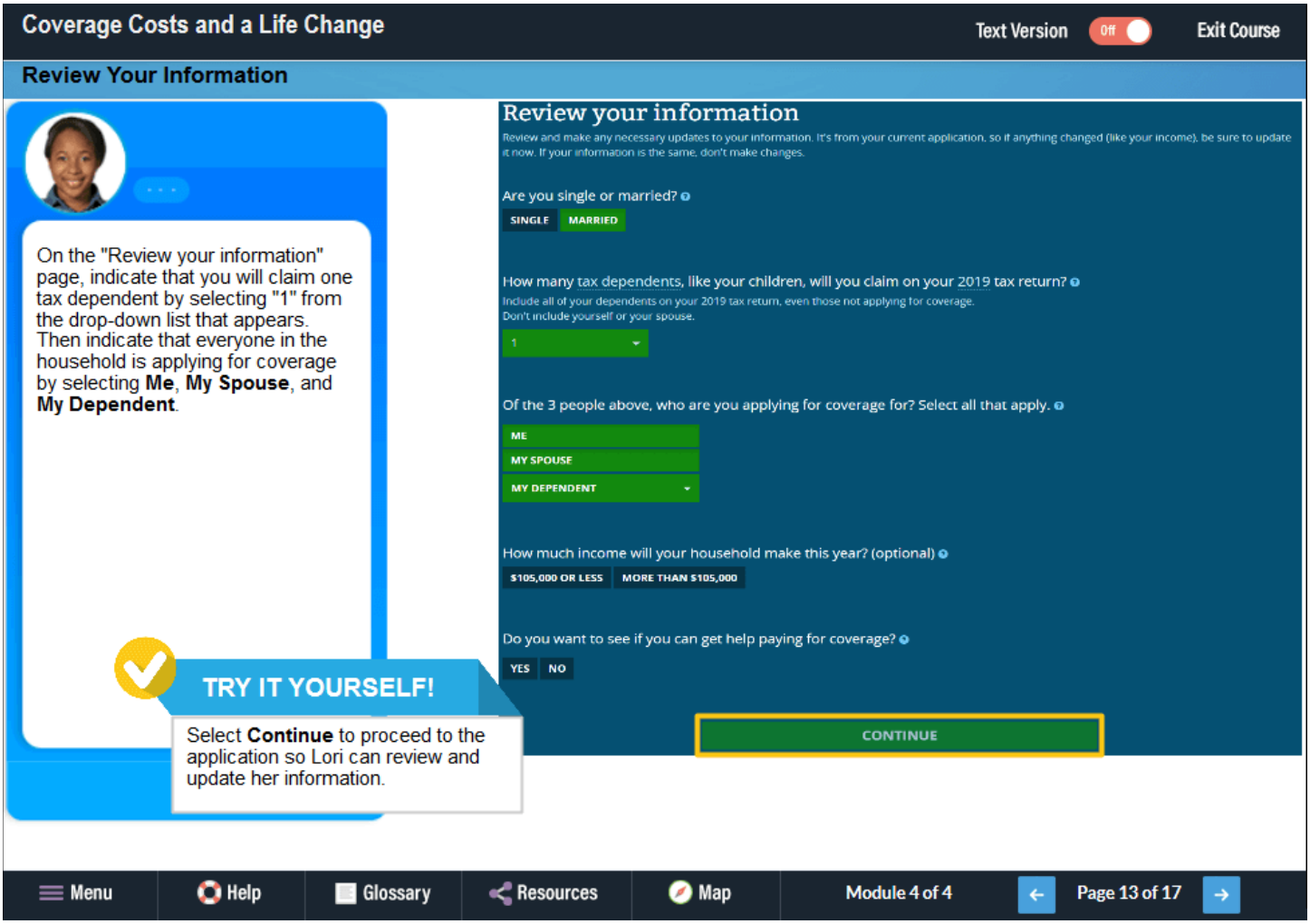
Report a Life Change (cont'd)



Here are some examples of the different types of life changes you can report.

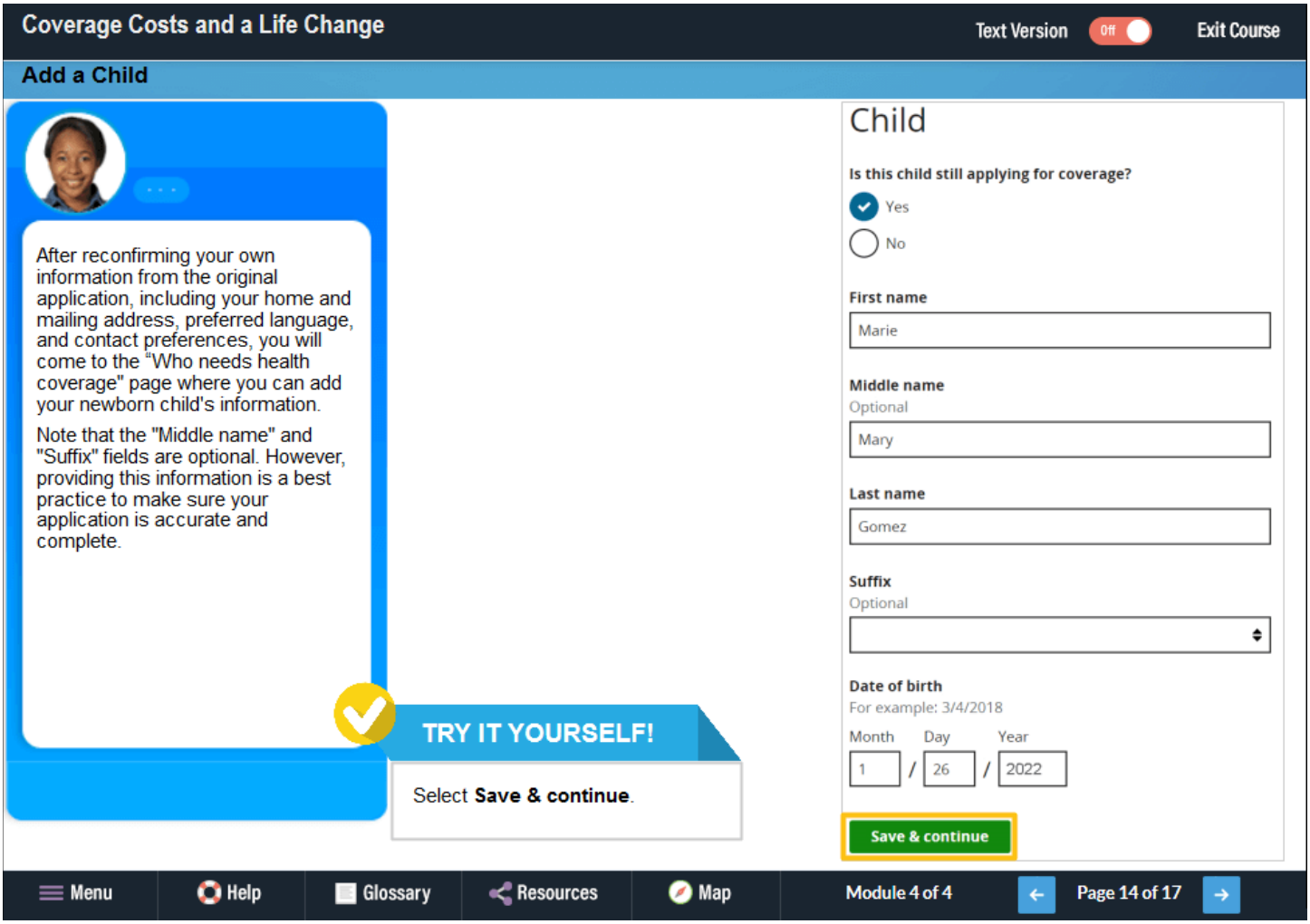
Since your family size and income will be changing, you should select the first radio button option: **Report a change in my household's income, size, address, or other information**, then select the **Continue** button.

Review Your Information



On the "Review your information" page, indicate that you will claim one tax dependent by selecting "1" from the drop-down list that appears. Then indicate that everyone in the household is applying for coverage by selecting **Me**, **My Spouse**, and **My Dependent**.

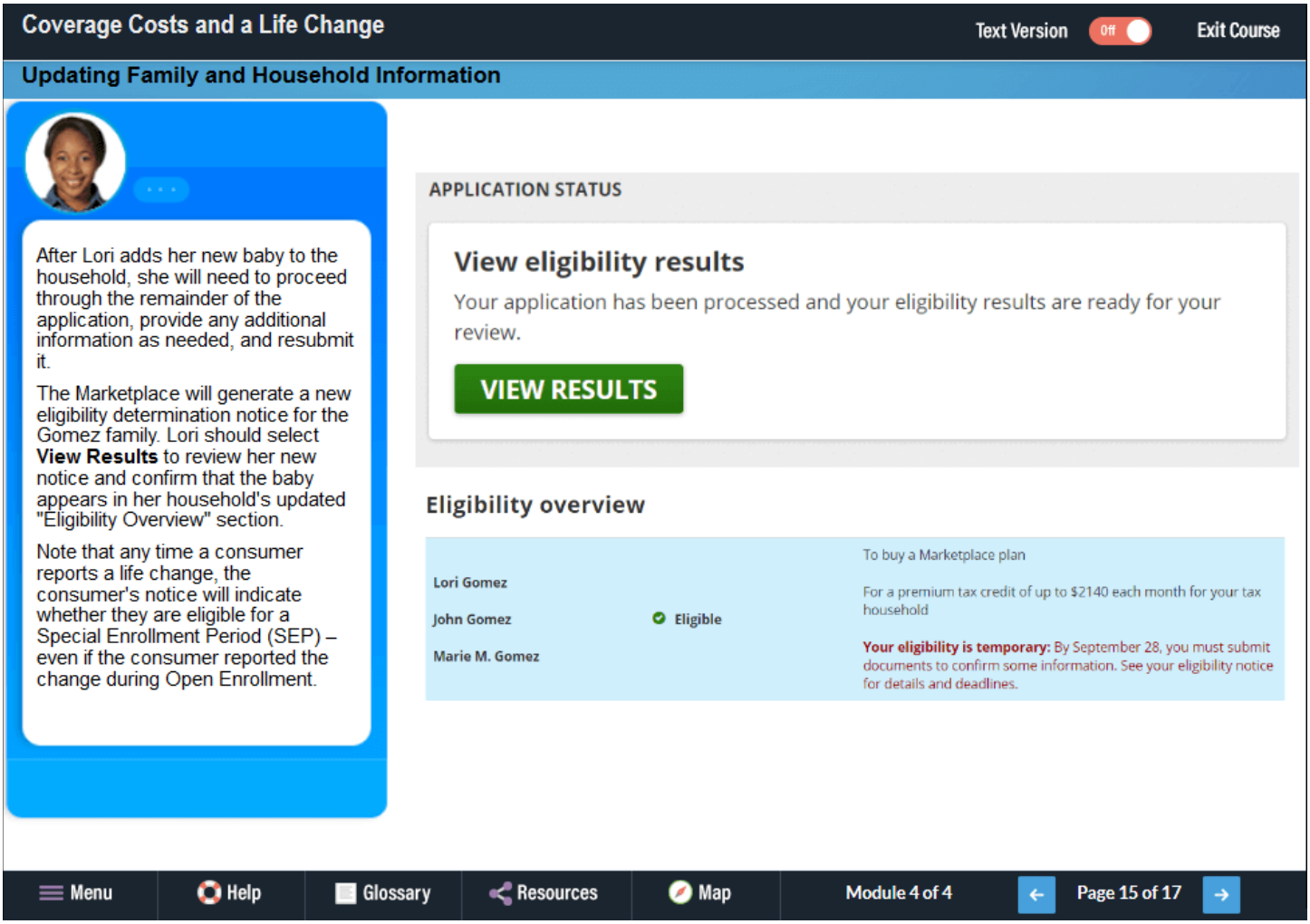
Add a Child



After reconfirming your own information from the original application, including your home and mailing address, preferred language, and contact preferences, you will come to the “Who needs health coverage" page where you can add your newborn child's information.

Note that the "Middle name" and "Suffix" fields are optional. However, providing this information is a best practice to make sure your application is accurate and complete.

Updating Family and Household Information

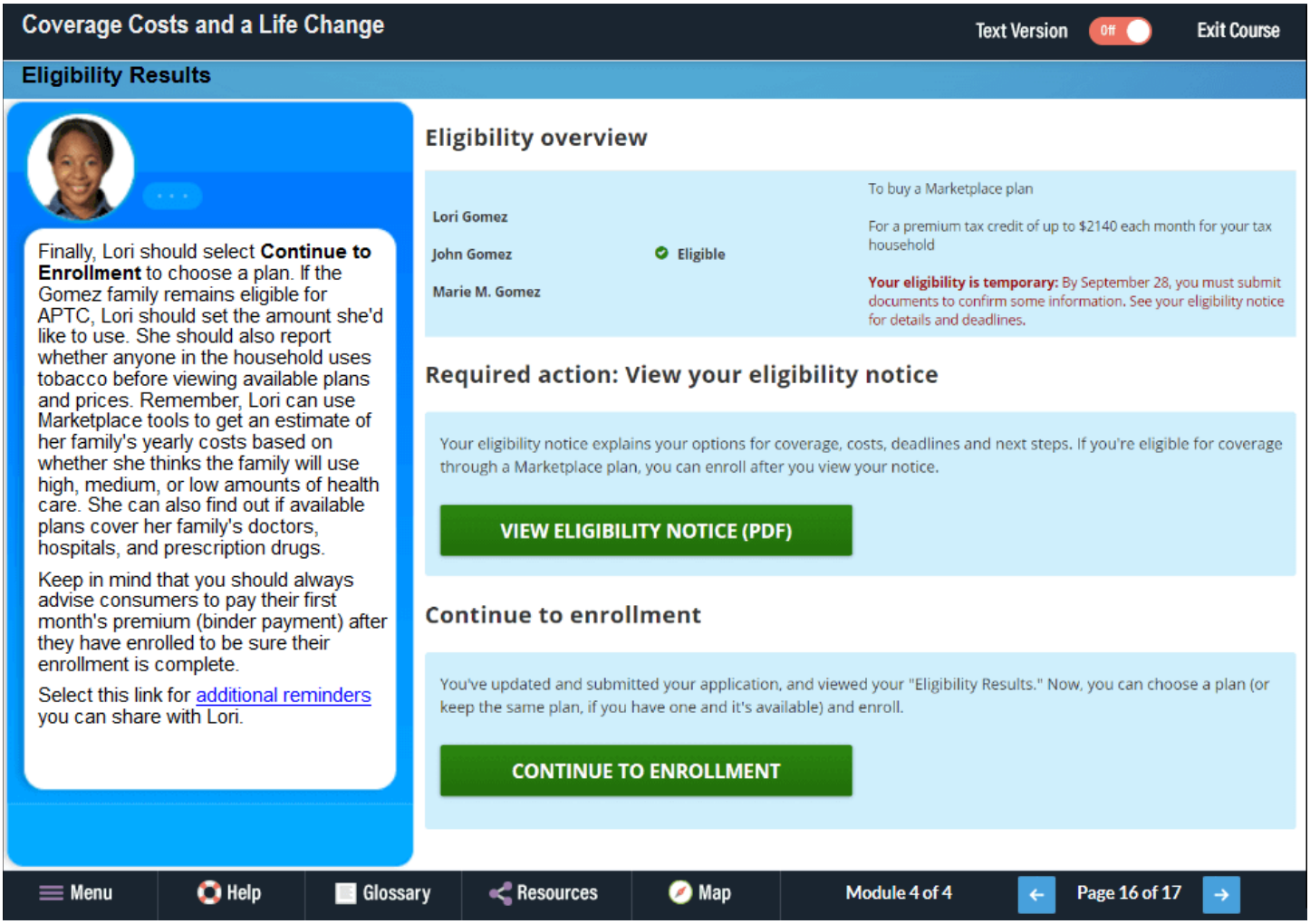


After Lori adds her new baby to the household, she will need to proceed through the remainder of the application, provide any additional information as needed, and resubmit it.

The Marketplace will generate a new eligibility determination notice for the Gomez family. Lori should select **View Results** to review her new notice and confirm that the baby appears in her household's updated "Eligibility Overview" section.

Note that any time a consumer reports a life change, the consumer's notice will indicate whether they are eligible for a Special Enrollment Period (SEP) – even if the consumer reported the change during Open Enrollment.

Eligibility Results



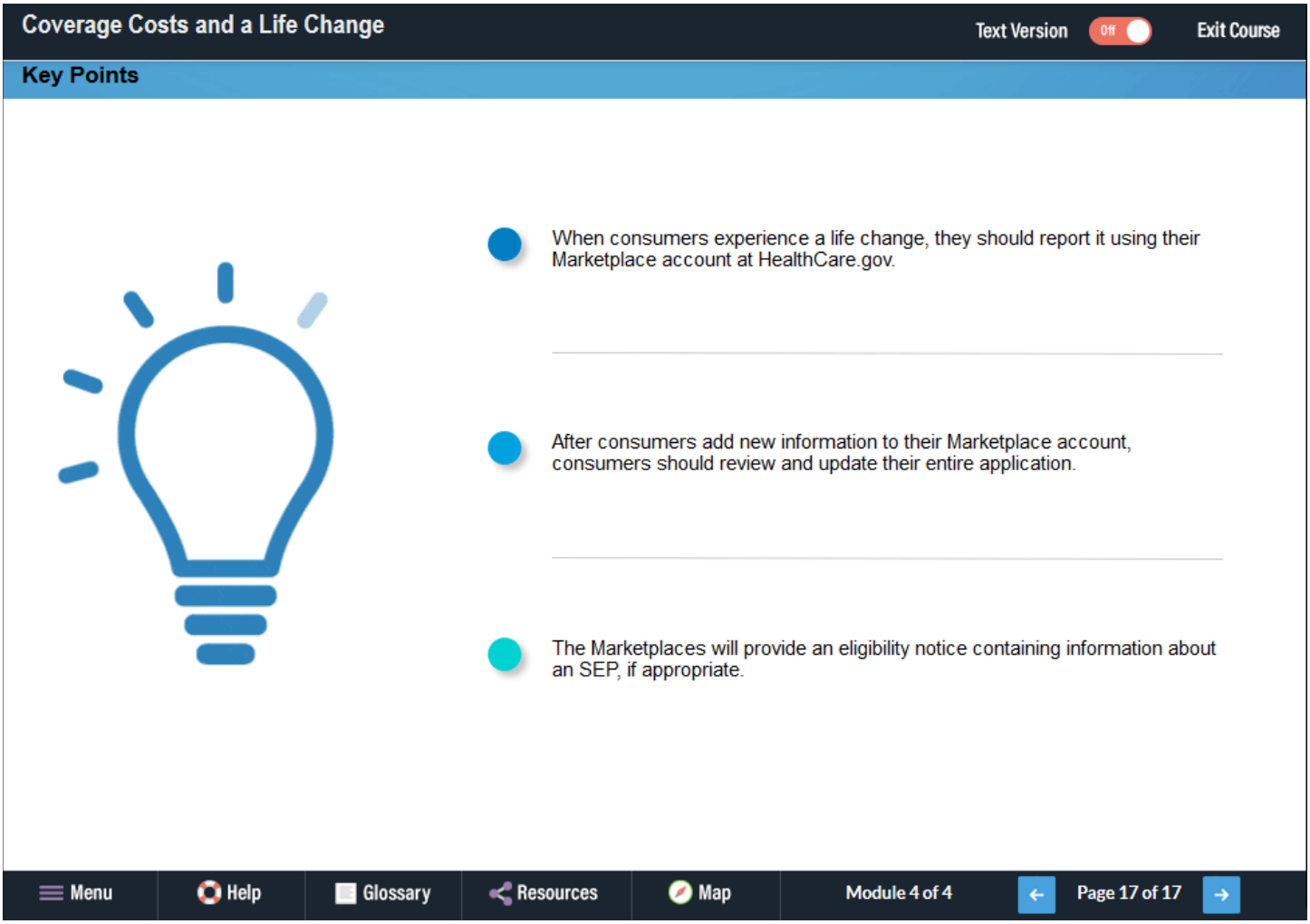
Finally, Lori should select **Continue to Enrollment** to choose a plan. If the Gomez family remains eligible for APTC, Lori should set the amount she'd like to use. She should also report whether anyone in the household uses tobacco before viewing available plans and prices. Remember, Lori can use Marketplace tools to get an estimate of her family's yearly costs based on whether she thinks the family will use high, medium, or low amounts of health care. She can also find out if available plans cover her family's doctors, hospitals, and prescription drugs.

Keep in mind that you should always advise consumers to pay their first month's premium (binder payment) after they have enrolled to be sure their enrollment is complete.

Additional Information for Lori
Remind Lori to complete all items on the "To-Do List," including selecting and confirming a plan.

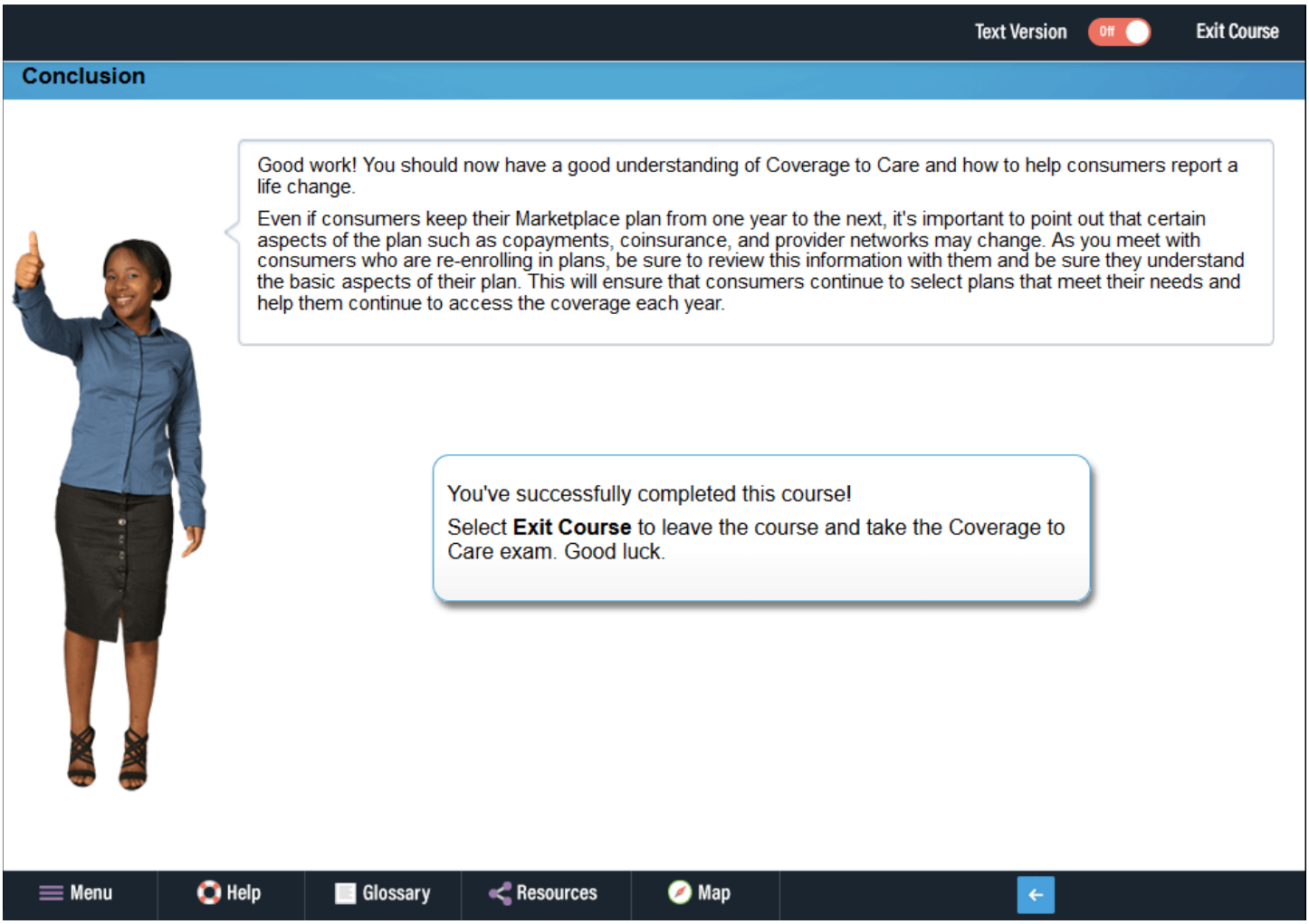
The plan selection will show only people who applied and were found eligible to enroll in a Marketplace plan. Anyone who is or may be eligible for Medicaid or CHIP or who is no longer applying for Marketplace coverage won't appear in the plan selection. Anyone continuing Marketplace coverage must select and confirm enrollment in a Marketplace plan for the coverage changes to take effect. Anyone eligible for an SEP can select a new plan if they desire, if applicable.

Key Points



- When consumers experience a life change, they should report it using their Marketplace account at HealthCare.gov.
- After consumers add new information to their Marketplace account, consumers should review and update their entire application.
- The Marketplaces will provide an eligibility notice containing information about an SEP, if appropriate.

Conclusion



Good work! You should now have a good understanding of Coverage to Care and how to help consumers report a life change.

Even if consumers keep their Marketplace plan from one year to the next, it's important to point out that certain aspects of the plan such as copayments, coinsurance, and provider networks may change. As you meet with consumers who are re-enrolling in plans, be sure to review this information with them and be sure they understand the basic aspects of their plan. This will ensure that consumers continue to select plans that meet their needs and help them continue to access the coverage each year.

You've successfully completed this course!

Select **Exit Course** to leave the course and take the Coverage to Care exam. Good luck.

Resources

Note: There are some references and links to nongovernmental third-party websites in this section. CMS offers these links for informational purposes only, and inclusion of these websites should not be construed as an endorsement of any third-party organization's programs or activities.

From Coverage to Care: Main Page
go.cms.gov/c2c

From Coverage to Care: Resources and Tools
https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumer-resources

From Coverage to Care: Enrollment Toolkit: The Enrollment Toolkit is for community partners, assisters, and other people who help consumers enroll in coverage or change plans.
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/C2C-Enrollment-Toolkit-2016-small-508.pdf

Getting Coverage: How to get coverage through a Health Insurance Marketplace®.
https://www.healthcare.gov/apply-and-enroll/how-to-apply/
Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

How much will health insurance cost? Health Insurance Marketplace Calculator.
http://kff.org/interactive/subsidy-calculator/

What plans are available in my area?
https://www.healthcare.gov/see-plans/

Value of Prevention: How can we help you?
https://www.healthcare.gov/get-answers/

See which preventive services you may need:
https://health.gov/myhealthfinder

Finding a Provider
Reviews and ratings of local providers
http://www.healthgrades.com/

Office for Civil Rights (OCR) website: Official website of HHS OCR, which contains information about federal regulations on discrimination and privacy. http://www.hhs.gov/ocr/. Consumers who believe they have been discriminated against on the basis of race, color, national origin, sex, age, disability, or religion may file a complaint with OCR at http://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.