

GETTING STARTED

Every year, consumers can enroll in health insurance coverage, or change their health insurance plan. Choosing the right health plan can be difficult and overwhelming. But it is essential for people to choose a plan they can afford—and that gives them access to the providers and services they need. This Toolkit is for community partners, assisters, and others who help consumers enroll in coverage or change their plan.

Before consumers choose a plan, they may wish to review:

- [Manage Your Health Care Costs](#): This resource is a series of tools to help consumers understand health insurance costs and terms, know their own specific health insurance costs, plan for health care costs, and know how to pay their premium.

After consumers choose a plan, encourage them to use:

- [My Health Coverage at a Glance](#): This tool is meant to be customized by consumers, to be specific to their health plan. It can help consumers understand their plan, what they pay for health care, and where to go—all on one page.
- [Roadmap to Better Care](#): This resource explains what health coverage is and how to use it to get primary care and preventive services.

For more consumer resources and partner tools, visit Coverage to Care (C2C) at go.cms.gov/c2c.

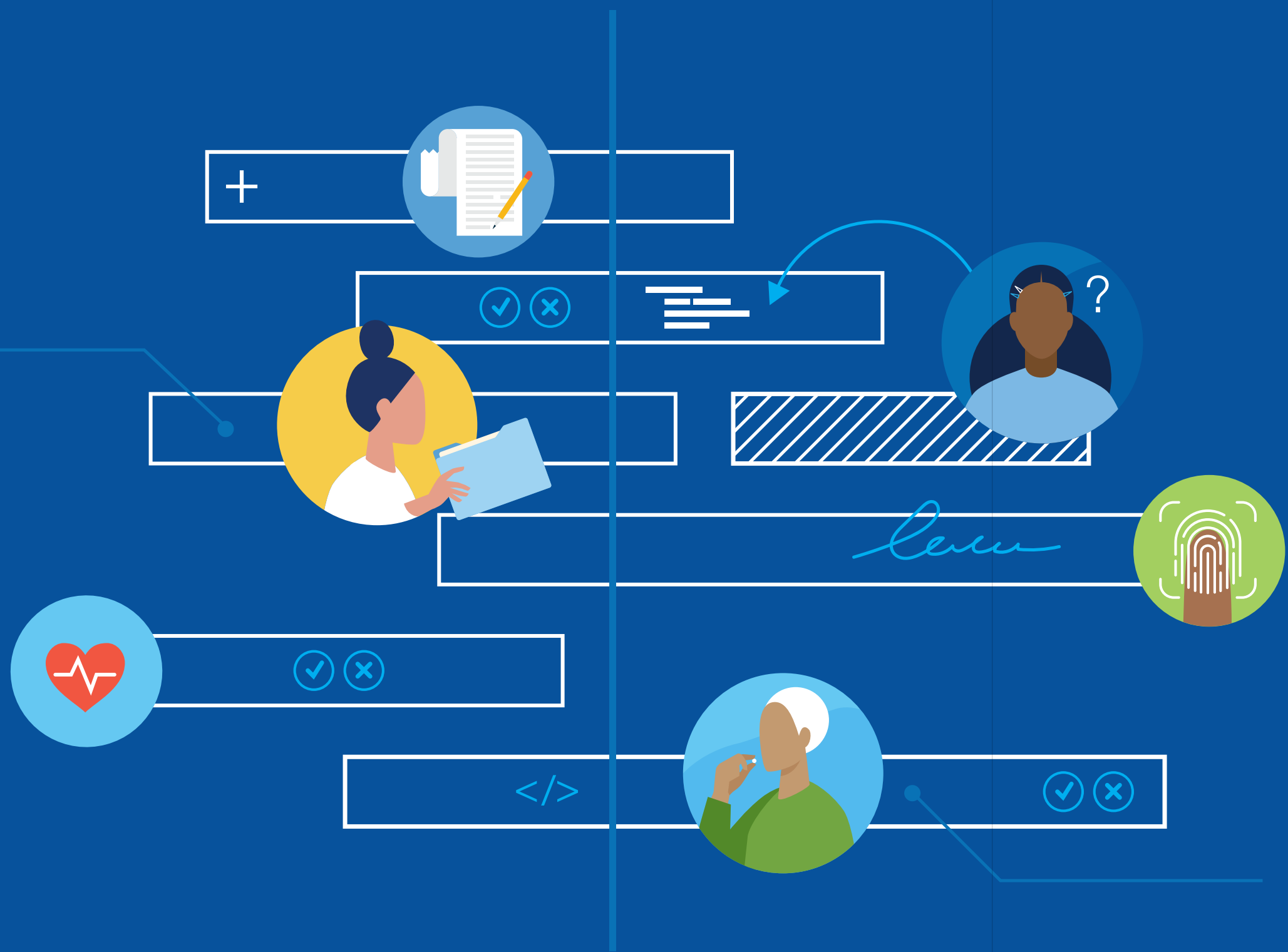


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1. COVERAGE IS IMPORTANT & AFFORDABLE



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 companies
- Group health plans offered in connection with employment
- Government programs like Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP)

Benefits of coverage

If the consumer you’re working with isn’t sure why they should get coverage, explain that coverage is security. Make it personal. Here are some examples:

- Explain that they need coverage so they can get the care they need to stay healthy for their loved ones.
- Tell them that together you can find a plan that meets their health care needs and budget.
- Ask questions like: Was there a time when they thought they should go to a doctor but didn’t? Was it because of the cost? Are they afraid of finding a problem and how much it would cost?
- Explain how finding out early is better for their health and budget. If you know about a particular chronic condition, personalize the conversation. For example, talk to a patient with diabetes about the cost of insulin and the need to monitor for related conditions.
- For young adults, remind them about the costs of treating illness or injury and finding affordable coverage after the age of 26, when they may not be able to stay on a parent’s plan.
- Highlight that having coverage relieves the stress of finding and affording health care services when they are sick.



Consumers need coverage so they can get the care they need to stay healthy.

Affordability

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

Minimum essential coverage

Applicable individuals must maintain minimum essential coverage each month. In prior tax years, consumers without coverage had to pay the Individual Shared Responsibility Payment—a fee for going without coverage for part or all of the year. Beginning January 1, 2019, the fee was reduced to \$0, but individuals must still maintain coverage.

What counts as minimum essential coverage?

Qualified health plans in the Marketplace meet this standard. So do TRICARE, the Veterans health care program, Medicare Part A, Medicaid, coverage for Peace Corps Volunteers, and job-based coverage. Minimum essential coverage doesn't include plans that provide only limited benefits. For example, coverage for just vision or dental care, Medicaid just for certain benefits like family planning, and workers' compensation or disability don't meet this standard. To find out what coverage qualifies, visit: [HealthCare.gov/fees/plans-that-count-as-coverage](https://www.healthcare.gov/fees/plans-that-count-as-coverage).

Some consumers are exempt from this requirement if any of these apply to 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 Service 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 believe they are exempt. Once they see that they can get affordable coverage, they may decide they want the peace of mind and access to affordable health care that they get when they're covered. More resources at the end of this section below explain 1) what qualifies for an exemption, and 2) how consumers can apply.

Need more information?

- Coverage to Care resources: [go.cms.gov/c2c](https://www.cms.gov/c2c)
- Manage Your Health Care Costs: [CMS.gov/About-CMS/Agency-Information/OMH/Downloads/C2C-Manage-Your-Healthcare-Costs-508.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/C2C-Manage-Your-Healthcare-Costs-508.pdf)
- Incomes that qualify for lower costs: [HealthCare.gov/lower-costs/qualifying-for-lower-costs](https://www.healthcare.gov/lower-costs/qualifying-for-lower-costs)
- How to estimate income for the Marketplace: [HealthCare.gov/income-and-household-information/how-to-report](https://www.healthcare.gov/income-and-household-information/how-to-report)
- How health coverage affects your taxes: [HealthCare.gov/taxes](https://www.healthcare.gov/taxes)
- Where and how to get an exemption: [IRS.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions](https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions)
- Qualifying for a hardship exemption: [HealthCare.gov/health-coverage-exemptions/hardship-exemptions](https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions)
- Health coverage for young adults: [HealthCare.gov/young-adults/coverage](https://www.healthcare.gov/young-adults/coverage)
- MyHealthfinder web app for personalized preventive care recommendations: [Health.gov/myhealthfinder](https://www.health.gov/myhealthfinder)
- Mental health and substance use disorder services treatment locator and resources: [MentalHealth.gov](https://www.mentalhealth.gov)

Consumers need to understand how to budget for health care costs, including premiums and deductibles, in their regular household budget.



2. BEFORE CHOOSING A PLAN



People enrolling in health coverage for the first time may not understand common health insurance coverage terms. They also need to understand how to budget for health care costs, including premiums and deductibles, in their regular household budget. To help with those pieces, encourage them to review the [Roadmap to Better Care](#) and [Manage Your Health Care Costs](#).

Reassure consumers that although each plan is different, Marketplace plans must meet certain minimum standards.

Essential Health Benefits

- Plans must include coverage for 10 Essential Health Benefits.
- Plans also cover many preventive services like screenings and vaccines without out-of-pocket costs to the consumer—meaning no copays, coinsurance, or deductibles.
- Talk to consumers about what else they may need (like prescriptions) and consider this when you begin comparing plans.

What are Essential Health Benefits?

Essential Health Benefits are types of health care that must be covered by Marketplace plans. They are:

1. Outpatient care, which 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 a person if they're injured or have a disability or chronic condition, or to help them 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 tailored to the needs of children to ensure they grow up and develop properly, including dental and vision care for kids

Key health terms

Consumers may not understand common health care terms, such as premium, copay, and deductible. Below are some key terms to explain:

Premiums

Premiums are the amount a consumer pays for health insurance every month. 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

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

Go to [Section 3](#) to learn more about talking with consumers about the costs of prescription drug coverage.

Coinsurance

Coinsurance is the consumer's percentage of costs of a covered health care service, after the consumer paid the deductible. It's different from a copay. 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, they would pay \$36.

Deductible

Deductible is the dollar amount consumers have to pay for covered health care services before their insurance plan will start paying for their care. The deductible may not apply to all services. For example, in all Marketplace plans, the deductible doesn't apply to preventive services. 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 plan will keep track of how much they've paid toward their deductible, but they should keep track as well.

Out-of-pocket limit

The out-of-pocket limit is the maximum amount consumers will have to pay for covered health care services in a plan year. After a consumer spends this amount on deductibles, copayments, and coinsurance for in-network care and services, the health plan pays 100% of the costs of covered benefits. 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.



Only **1** in **3** consumers understand key health insurance terms.

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

Talk about the types of costs to get a sense of the consumer's preferences. Some people may prefer to pay a smaller amount each month, even if their copays 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 talk with trusted family and friends about which plan meets their health care needs and budget.

Understand and plan for health costs

Many people don't think they can afford coverage and don't realize that financial assistance may be available. Always encourage consumers to apply for financial assistance, even if they think they aren't eligible, to be sure.

Talk about tax credits, cost-sharing reductions, Medicaid, CHIP, and protections for American Indians and Alaska Natives and members of federally recognized tribes and ANCSA shareholders. Let them know help is available for eligible people and families with lower household incomes.

Consumers often have questions about how to manage health care costs. Some consumers may be scared to use their coverage because they're unsure of the cost of care and if they can afford the care they need. C2C's [Manage Your Health Care Costs](#) can help you provide resources to help consumers understand the costs related to health coverage. Though these tools are mainly for consumers who are unsure if they can afford to use their current health coverage, those without coverage can benefit as well. Helping consumers choose the plan they can afford and know what costs to expect will help them use their coverage to stay healthy.

Financial assistance

Different types of financial assistance are available to consumers based on their income. Always encourage consumers to apply for financial assistance. That way they'll be sure if they qualify, and if so, how much assistance they can receive. The eligibility requirements are based on the federal poverty level (FPL), which changes each year and is different in Alaska and Hawaii. To find the latest FPL, visit [ASPE.hhs.gov/poverty-guidelines](https://aspe.hhs.gov/poverty-guidelines).

Use the [calculator](#) on HealthCare.gov to find out if a consumer qualifies for financial assistance and if so, how much they'll save.

Premium Tax Credit Applicable Percentages Under Prior Law and the American Rescue Plan (ARP)

Income Range (% of FPL)	Range of Applicable Percentages for 2021 under Prior Law	Range of Applicable Percentages for 2021 and 2022 under the ARP
100% – 133%	2.07%	0%
133% – 150%	3.10% – 4.14%	0%
150% – 200%	4.14% – 6.52%	0% – 2%
200% – 250%	6.53% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6% – 8.5%
400% and higher	NA	8.5%

The applicable percentage is the share of a consumer's income they must generally pay towards a benchmark (second-lowest-cost Silver) plan with the premium tax credit. Within the ranges shown the applicable percentage increases linearly.

Consumers who received unemployment compensation in 2021 may be eligible for a premium tax credit that covers the entire premium cost for the benchmark Marketplace plan for the whole household and cost savings reduction, regardless of the taxpayer's actual household income amount and even if they are under 100% FPL.

Premium tax credits

Premium tax credits help people with particular household incomes afford health coverage through the Marketplace. Lower incomes are eligible for a larger credit. The credit reduces monthly premium payments. Consumers can apply the credit either 1) before they pay their premium so they pay less per month, or 2) when they file taxes to get money back at the end of the year.

Talk to consumers about how coverage will affect their income taxes when they file their federal tax returns. People may not realize they can get a premium tax credit. 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. Remember, they can 1) apply the credit when their coverage starts and pay less per month, or 2) claim the credit when they file their taxes.

Let consumers know they must file their federal taxes to get this credit, whether they apply it up front as an advance payment of the premium tax credit or when they file their taxes. The person's actual household income from their annual federal income tax return determines the exact amount of premium tax credit they're eligible for. If the consumer received advance payments that totaled more than the premium tax credit they are eligible for, they may have to repay the excess amount.

Cost-sharing reductions

Cost-sharing reductions provide additional financial assistance for eligible consumers with particular incomes who also qualify for premium tax credits (but don't qualify for Medicaid). Make sure consumers know this is only in the Silver category of plans (see [Section 3](#) for more on the plan categories).

Let consumers know that this reduction lowers the amount they will have to pay out-of-pocket for deductibles, coinsurance, and copays. This subsidy is different from the premium tax credit in 3 ways: 1) it is only for Silver plans, 2) it reduces the consumer's out-of-pocket costs, and 3) it applies to their deductibles, copays, and coinsurance.

A plan can change how it combines its charges for copays, coinsurance, and deductibles, but consumers will never pay more than the out-of-pocket maximum amount 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.

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 if possible, connect them to any local or state resources that might help cover the costs of their care. Additionally, tell these consumers that they may qualify for a hardship exemption. Go to [Section 1](#) for more information on exemptions and use resources on [page 17](#) to help eligible consumers apply.

Encourage consumers to log in to [HealthCare.gov](#) to review and update their income, and to report life changes, including 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, 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.

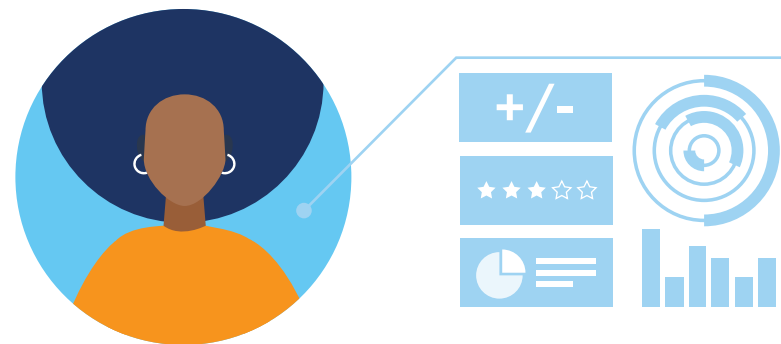
When consumers file their annual federal income taxes, the IRS will match up the information they report with the premium tax credit they received. The IRS may adjust the amounts consumers owe or are due if:

The amount of advance payment of the premium tax credit that a 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 may make changes each year. Let consumers know that every year, health plans may change their benefits, the way they cover certain services or prescription drugs, or which particular providers are included 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.



Need more information?

- Quick guide to the Health Insurance Marketplace: [HealthCare.gov/quick-guide/getting-marketplace-health-insurance/](https://www.healthcare.gov/quick-guide/getting-marketplace-health-insurance/)
- Helping consumers compare and select a plan (Partner): [Marketplace.cms.gov/technical-assistance-resources/plan-compare-and-plan-selection-help](https://www.Marketplace.cms.gov/technical-assistance-resources/plan-compare-and-plan-selection-help)
- Essential Health Benefits covered in the Marketplace: [HealthCare.gov/coverage/what-marketplace-plans-cover](https://www.HealthCare.gov/coverage/what-marketplace-plans-cover)
- How to estimate your income for the Marketplace: [HealthCare.gov/income-and-household-information](https://www.HealthCare.gov/income-and-household-information)
- Basics about the premium tax credit: [IRS.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics](https://www.IRS.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics)
- Health insurance savings calculator: [HealthCare.gov/lower-costs](https://www.HealthCare.gov/lower-costs)
- Qualifying for Marketplace cost-sharing reductions: [HealthCare.gov/lower-costs/save-on-out-of-pocket-costs](https://www.HealthCare.gov/lower-costs/save-on-out-of-pocket-costs)
- Find and compare plans in your area: [HealthCare.gov/see-plans](https://www.HealthCare.gov/see-plans)
- HealthCare.gov employer-provided coverage tool: [HealthCare.gov/downloads/employer-coverage-tool.pdf](https://www.HealthCare.gov/downloads/employer-coverage-tool.pdf)

MEDICAID & CHIP

- To find out information about specific State Medicaid programs: [Medicaid.gov/state-overviews/index.html](https://www.Medicaid.gov/state-overviews/index.html)
- Information on Medicaid programs: [Medicaid.gov](https://www.Medicaid.gov)
- Information on CHIP: [InsureKidsNow.gov](https://www.InsureKidsNow.gov)

3. KNOW BEFORE YOU ENROLL



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.

Help consumers think through how 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 larger selection of providers and hospitals and lower out-of-pocket costs like deductibles, copays, 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 consumer you're helping so you can personalize your assistance.

Types of plans

Plans sold in the Marketplace are divided into 4 different categories: Bronze, Silver, Gold, and Platinum. The main difference between 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 may need to pay.

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 plans, and not Medicaid, CHIP, or other coverage types.



Consumers need to think through how different plans and provider networks have different costs and benefits.

Consumers under age 30 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 (3 visits, generally). Consumers who do not plan on using much health care during the year and who want protection only 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 varies but can't go over a set amount each year. 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.

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 actuarial 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.

A plan's network is the list of providers, facilities, and suppliers that the health plan has contracted with for health care services. Explain that plans negotiate lower rates 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 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](https://www.healthcare.gov) "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 in how services are covered for out-of-network/non-participating providers versus in-network/participating providers. As you compare Marketplace plans on [HealthCare.gov](https://www.healthcare.gov), consumers can look at each plan's network directory and search for a specific provider or hospital they want to continue using.

There are links at the end of this section on [page 27](#) to a sample Summary of Benefits and Coverage and other resources to help you talk with consumers about provider network types.

Types of provider networks

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. Consumers pay less if they use providers that belong to the plan's network. They can use doctors, hospitals, and providers outside of the network for an additional cost.

An HMO, or Health Maintenance Organization, is a type of health 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.

A POS, or Point of Service plan, is a type of health plan in which consumers pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require a referral from a primary care doctor in order to see a specialist.

An EPO, or Exclusive Provider Organization, is a managed care plan where services are covered only for doctors, specialists, or hospitals in the plan's network except in an emergency.

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 above 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.

Ask if the consumer has a provider they would like to continue seeing. If a consumer wants to keep their provider, show them how to check if the provider is "in-network" for the plan under consideration. You can use the provider directories linked on [HealthCare.gov](https://www.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



Encourage consumers to call their provider's office to confirm their plan participation.

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. If possible, they should also confirm with their provider's office 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 other options meet their needs.

Behavioral and substance use disorder coverage

Consumers may not be familiar with behavioral health parity. Or they may want to know if behavioral health services are covered in a particular plan. Explain that there's a law that generally prevents health plans from limiting access to behavioral health and substance use disorder services more than they restrict access to medical and surgical services. If consumers want to locate a treatment provider, suggest they use the provider locator on [MentalHealth.gov](https://www.mentalhealth.gov). As with their primary care provider, remind consumers to check whether the provider they're thinking about is in their network before they get care.

Prescriptions

A plan's formulary is a list of prescription drugs covered by the 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](https://www.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 prescriptions to see if they're covered. Some people may want to choose a Gold or Platinum plan. The monthly premium may cost more, but if their prescriptions are covered, their care could cost less over the year.



Check a plan’s formulary for expensive prescription drugs.

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 name brand to the generic brand for the same drug, which may cost less. Use the table below as an example of how a plan might cover different prescription drugs in its formulary.

Sample consumer cost table

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

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

Some drugs have special rules. Most 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 prescription drug.



Prescription drugs still too expensive?

Even with coverage, consumers may still be concerned about the cost of their prescriptions. National and local patient assistance groups may be able to help patients get their prescription drugs for very low or no cost. Go to sites like the Medicine Assistance Tool for help: [medicineassistancetool.org](https://www.medicineassistancetool.org).

Additional coverage: dental and vision

People 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 and vision care for children age 18 and under. This is not true for adults. Insurers do not have to offer adult dental and vision coverage and only some plans include dental or vision. 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.

If the plan they're considering doesn't cover adult dental or vision, or if they want different coverage, consumers can compare the stand-alone plans that may be available using the "window shopping" feature of [HealthCare.gov](https://www.healthcare.gov). Stand-alone vision plans are not offered in the Marketplace. If they choose a separate plan, consumers will pay a separate, additional premium. Consumers may find a stand-alone plan in their state and could contact their state's Department of Insurance or a local agent or broker.



Insurers are not required to offer adults dental and vision benefits. Be sure consumers shop around if they want this type of coverage.

Need more information?

- Get ready to apply for or renew your Health Insurance Marketplace coverage: [Marketplace.cms.gov/outreach-and-education/apply-for-or-renew-coverage.pdf](https://www.Marketplace.cms.gov/outreach-and-education/apply-for-or-renew-coverage.pdf)
- Explaining a Summary of Benefits and Coverage: [Marketplace.cms.gov/technical-assistance-resources/summary-of-benefits-fast-facts.pdf](https://www.Marketplace.cms.gov/technical-assistance-resources/summary-of-benefits-fast-facts.pdf)
- FAQs on coverage for young adults (under 30): [HealthCare.gov/young-adults](https://www.HealthCare.gov/young-adults)
- Marketplace coverage and metal levels: [HealthCare.gov/choose-a-plan/plans-categories](https://www.HealthCare.gov/choose-a-plan/plans-categories)
- How to find information on health care providers: [HealthCare.gov/using-marketplace-coverage/getting-medical-care](https://www.HealthCare.gov/using-marketplace-coverage/getting-medical-care)
- Health insurance coverage of mental health and substance use disorder services: [MentalHealth.gov/get-help/health-insurance](https://www.MentalHealth.gov/get-help/health-insurance)

Consumers need to know that getting coverage is only the first step in their journey to better health.



4. NEXT STEPS AFTER ENROLLING



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 [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.

Confirm coverage

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 if 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 for 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: [HealthCare.gov/apply-and-enroll/complete-your-enrollment](#).
- If they are still having trouble, they can call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Pay your premium

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 enroll, 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 coverage and having to pay for 100% of the cost of their health care. Remind consumers that staying covered is as important as getting covered.

Make an appointment and fill any prescriptions

While the consumer was enrolling in coverage, you probably talked about whether they already have 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 a provider by their plan. If they want to change, show them how to contact their plan to do so.

As soon as coverage begins, consumers can see a provider to learn about their health needs and start working with them toward better health.

Use the [Roadmap to Better Care](#) to help consumers know the differences between primary care and the emergency department, and to talk about finding a provider, making an appointment, and more.

You probably talked about consumers' ongoing treatments or prescription drugs earlier in the enrollment process. Remind them 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 their new plan may have restrictions on certain prescription drugs or services. Sometimes these can be waived if their provider and plan work together.

If their treatment is denied, consumers 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 31](#).

Stay updated

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](#) within 30 days of any major life event like a birth, adoption, marriage, or job loss. Consumers may become eligible for a Special Enrollment Period if they have a major life event. Then they can choose a new plan that meets their changing health care needs.

Need more information?

- Confirming enrollment in coverage: [HealthCare.gov/apply-and-enroll/complete-your-enrollment](#)
- Contact the Marketplace: [Healthcare.gov/contact-us](#)
- Coverage to Care resources: [go.cms.gov/c2c](#)
- Helping a consumer with appealing a plan's decision not to cover: [Marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf](#)
- Options for coverage outside of Open Enrollment: [HealthCare.gov/coverage-outside-open-enrollment/your-options](#)
- Qualifying for a Special Enrollment Period: [HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period](#)

5. INFORMATION FOR CONSUMERS WITH SPECIAL CIRCUMSTANCES



Some consumers have circumstances that affect their coverage options and enrollment. This section discusses 3 of those groups: American Indians and Alaska Natives, non-English speaking populations, and immigrants. The resources on [page 39](#) can 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.

American Indians and Alaska Natives

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 American 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 if they're eligible for premium tax credits (discussed in [Section 2](#)).

Partner with others in your community to share resources, best practices, and tips to meet your consumers' needs.



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.

- Household income is between 100% and 300% of the federal poverty level: Can enroll in a zero cost-sharing plan. Let them know they have no out-of-pocket costs like copays, deductibles, or coinsurance.
- Regardless of income: Can enroll in a limited cost-sharing plan. Let them 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.

Let these consumers know that they can enroll in a Marketplace plan any time during the year, not just during the yearly Open Enrollment period.

American Indians or Alaska Natives, and others eligible for services from the Indian Health Service, tribal programs, or urban Indian health programs 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 health programs, including Contract Health Services.

For more information about coverage for American Indians and Alaska Natives, go to: [HealthCare.gov/american-indians-alaska-natives](https://www.healthcare.gov/american-indians-alaska-natives).

Find care

Consumers who've been using tribal health care services may not know which other providers will take their new coverage. American Indians 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](https://www.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 use various types of Indian health care providers, including Indian Health Services, tribal programs, and urban Indian health programs (called ITUs).

You can use the [Tribal version of the Roadmap](#) and resources at the end of this section on [page 39](#) 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 from IHS, urban Indian health programs, or tribal programs don't count as minimum essential coverage.

Non-English-speaking populations

If you're helping someone who speaks a language other than English, there are resources below that may be available in their 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](https://www.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 who speak English and Spanish, 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 other partners—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 [LocalHelp.HealthCare.gov](https://www.localhelp.healthcare.gov) and type in a city and state or ZIP code.
- Online resources are available in many languages. You can find Marketplace application guides in 27 languages. For more information visit: [HealthCare.gov/language-resource](https://www.healthcare.gov/language-resource). En Español: [CuidadoDeSalud.gov/es](https://www.cuidadodesalud.gov/es)

Immigrants

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
- Granted withholding of deportation
- Victims of trafficking and their spouses, children, siblings, or parents
- 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 immigration statuses eligible to use the Marketplace here: [HealthCare.gov/immigrants/immigration-status](https://www.healthcare.gov/immigrants/immigration-status)

In general, Medicaid and CHIP require immigrants to become lawful permanent residents and to wait 5 years before they can enroll in coverage. During this 5-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 5-year waiting period can enroll in a Marketplace plan and may be eligible for premium tax credits and cost-sharing reductions.

Some states don't have the 5-year waiting period for children and pregnant women. Use the tool on the next page 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 5-year waiting period.

Go to: [InsureKidsNow.gov/coverage/index.html](https://insurekidsnow.gov/coverage/index.html)

Immigrants who aren't lawfully present aren't eligible to enroll for coverage through the Marketplace, to get premium tax credits or cost-sharing reductions, or to 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)
- Notice of Action (I-797)
- Certificate of Eligibility for Exchange Visitor Status (DS2019)
- 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 I-94 number



Need more information?

American Indians and Alaska Natives

- Coverage to Care Roadmap— Tribal Version: [CMS.gov/files/document/c2c-roadmap-booklet-tribal.pdf](https://www.cms.gov/files/document/c2c-roadmap-booklet-tribal.pdf)
- Tip sheet for assisters working with AI/ANs: [Marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf)
- Details on special Marketplace protections and benefits for AI/ANs: [HealthCare.gov/american-indians-alaska-natives](https://www.healthcare.gov/american-indians-alaska-natives)
- How to apply for an exemption: [HealthCare.gov/health-coverage-exemptions/forms-how-to-apply](https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply)
- Information for tribal leaders and tribal health programs, Indian Health Service: [ihs.gov](https://www.ihs.gov)

Limited English proficiency

- Glossary of health care terms for consumers with limited English proficiency: [Marketplace.cms.gov/technical-assistance-resources/plan-compare-and-plan-selection-help](https://www.marketplace.cms.gov/technical-assistance-resources/plan-compare-and-plan-selection-help)
- Translated resources from Marketplace: [Marketplace.cms.gov/outreach-and-education/other-languages](https://www.marketplace.cms.gov/outreach-and-education/other-languages)
- Videos in English and other languages for outreach and enrollment to diverse populations: [youtube.com/playlist?list=PLBXgZMI_zqfRXt44Uk6YeMW0Npmbemc2h](https://www.youtube.com/playlist?list=PLBXgZMI_zqfRXt44Uk6YeMW0Npmbemc2h)
- Uniform glossaries in other languages: [Marketplace.cms.gov/outreach-and-education/tools-and-toolkits](https://www.marketplace.cms.gov/outreach-and-education/tools-and-toolkits)
- Marketplace Call Center instructions in other languages: [Marketplace.cms.gov/outreach-and-education/getting-help-in-a-language-other-than-english.pdf](https://www.marketplace.cms.gov/outreach-and-education/getting-help-in-a-language-other-than-english.pdf)
- Find local enrollment help in other languages: [LocalHelp.HealthCare.gov](https://www.localhelp.healthcare.gov)
- HealthCare.gov resources in other languages: [HealthCare.gov/language-resource](https://www.healthcare.gov/language-resource)
- Spanish version of HealthCare.gov: [CuidadoDeSalud.gov](https://www.cuidadoDesalud.gov)
- Help filing a complaint in other languages: [HHS.gov/ocr/office/file/languageaccess.html](https://www.hhs.gov/ocr/office/file/languageaccess.html)

Immigrants

- Overview of immigrant eligibility for affordable health coverage: [Marketplace.cms.gov/technical-assistance-resources/immigrants-refugees-need-to-know.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/immigrants-refugees-need-to-know.pdf)
- Information on immigration status and the Marketplace: [HealthCare.gov/immigrants/immigration-status](https://www.healthcare.gov/immigrants/immigration-status)

Other populations

- Helping special populations enroll: [Marketplace.cms.gov/outreach-and-education/special-populations](https://www.marketplace.cms.gov/outreach-and-education/special-populations)
- Understanding health coverage needs of people with disabilities: [nationaldisabilitynavigator.org/wp-content/uploads/presentations/NDNRC_CMS_Nov-21-14.pdf](https://www.nationaldisabilitynavigator.org/wp-content/uploads/presentations/NDNRC_CMS_Nov-21-14.pdf)
- Coverage options for people with disabilities: [HealthCare.gov/people-with-disabilities](https://www.healthcare.gov/people-with-disabilities)
- Overview of assisting people with disabilities in the Marketplace: [Marketplace.cms.gov/technical-assistance-resources/consumers-with-disabilities.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/consumers-with-disabilities.pdf)
- Tools for working with consumers with HIV/AIDS: targethiv.org/category/audience/plwh-community
- Enrollment assistance for lesbian, gay, bisexual, and transgender communities: store.samhsa.gov/product/PEP14-LGBTACAENROLL





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