CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MARKETPLACE AGENT
AND BROKER TOOLKIT

Standard Operating Procedures Manual for Agents and Brokers in the Individual Marketplaces

Version 1.0, February 2017. This information is intended only for the use of entities and individuals that are certified to serve as agents and brokers, or web-brokers in a Federally-facilitated Marketplace (FFM). The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFMs where the state performs plan management functions and State Partnership Marketplaces. Some information contained in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and Federally-supported State-based Marketplaces.

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1. Introduction & Instructions for Use

1.1 Welcome

The Centers for Medicare & Medicaid Services (CMS) aims to ensure that all consumers have access to high- quality, affordable health coverage options through a Health Insurance Marketplace[SM][1]. Agents and brokers play a critical role in meeting this goal, and CMS appreciates your support in this effort.

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

1.2 Purpose of the Manual

The *Standard Operating Procedures Manual* (Manual) *for Agents and Brokers in the Individual Federally-facilitated Marketplaces* is an instructional guide intended for agents and brokers who are assisting consumers enroll in and make use of qualified health plans (QHPs) obtained through the Marketplaces.

In this Manual, the term "agents and brokers" refers to agents and brokers who have successfully completed registration for the Individual Marketplace, and who consequently can be compensated for helping consumers with eligibility and enrollment activities.[2] The Manual contains standard operating procedures (SOPs) that reflect requirements, policies contained within, and best practices under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the Affordable Care Act), as well as CMS regulations and implementing guidance.

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

NOTE: Agents and brokers can use two pathways to assist consumers with eligibility determinations and enrollment in QHPs. The two pathways are the:

- Marketplace Pathway (i.e., "Side-by-Side" Pathway)
- Direct Enrollment Pathway (i.e., issuer/web-broker-based enrollment)

This Manual focuses on the Marketplace Pathway as issuers and web-brokers may have different paths to access HealthCare.gov.

DISCLAIMER: This manual contains screenshots from http://www.healthcare.gov that are intended only as an example of what you and/or the consumer may see when the consumer is completing an application on HealthCare.gov. All names and contact information used in the screenshots are fictional; and the use of health insurer names and/or health plan names are for demonstration purposes only and should not be construed as an endorsement by CMS of any specific health insurer or health plan.

[1] Health Insurance MarketplaceSM and MarketplaceSM are service marks of the United States Department of Health & Human Services. When used in this document, the term "Health Insurance Marketplace" or "Marketplace" refers to Federally-facilitated Marketplaces (FFMs), including FFMs where states perform plan management functions and State-based Marketplaces on the Federal Platform (SBM-FPs).

[2] For more information on how agents and brokers can assist small employers and their employees in obtaining health plans through and/or Small Business Health Options Program (SHOP) Marketplace, refer to the Agents and Brokers Resources webpage and the SHOP Marketplace Resources webpage, which provides links to SHOP Marketplace-specific resources.

The instructions and information included in this Manual provide guidance to agents and brokers on how to help consumers in the Individual Marketplace with activities like:

- Preparing, completing, and updating Marketplace applications for health coverage
- Enrolling in health coverage through a Marketplace
- Understanding eligibility determinations for enrollment in health coverage through a Marketplace application
- Resolving data-matching issues (DMIs)
- Renewing eligibility and enrollment for health coverage through a Marketplace
- Learning how to complete requests for exemptions from the individual shared responsibility payment and the requirement to maintain minimum essential coverage (MEC)
- Understanding the process of filing Individual Marketplace eligibility appeals

1.3 Updates to the Manual

The Center for Consumer Information & Insurance Oversight (CCIIO) within CMS maintains this Manual in its entirety. CCIIO may alter, delete, suspend, or discontinue any part of the procedures in this Manual at any time. Procedural changes will be communicated to agents and brokers through the News for Agents and Brokers newsletter and through agent and broker webinars, as well as through federal regulations and guidance. CCIIO will also periodically update the Manual as relevant regulations, guidance, or policies are released, and disseminate updated versions of the Manual to agents and brokers. CMS plans to provide updated versions of the Manual via the Agents and Brokers Resources webpage.

1.4 Instructions for Use

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

1.4.1 Electronic Document Use

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

1.4.2 Paper Document Use

When using the paper version of the Manual, refer to the Table of Contents to navigate to the page containing the information you need. The Table of Contents provides an overview of the document by sections and subsections.

2. Consumer Protections

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

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

2.1 Privacy & Security Guidelines

When you help consumers apply for health coverage through a Marketplace, they may provide personal information to you. Consumers should be able to trust you to handle their personal information with care. Some of this information will be personally identifiable information (PII), which means information that can be used to distinguish or trace an individual's identity. Examples of PII include the consumer's:

- Name
- Social Security number (SSN)
- Date of birth
- Address
- Income
- Protected health information (PHI)
- Tax information

Another way to think about PII is that this information alone, or when combined with other personal information, can be linked to a specific individual.

In general, consumers should input their own information in an online or paper application, unless a consumer asks for help typing or using a computer to learn about, apply for, and enroll in Marketplace coverage online. An agent or broker may then use the keyboard or mouse, but must follow the consumer's specific directions, with the consumer physically present.

In summary, an agent or broker must not log in to the consumer's online Marketplace account, fill out the online or paper Marketplace application, or select a plan unless directed by the consumer. A consent form must be completed by that consumer or by his or her authorized representative.

2.1.1 Personally Identifiable Information

Review the guidelines in this section to understand your role in protecting consumers' PII and to be aware of situations in which you may come into contact with PII. Also review the "Protection Requirements and Appropriate Usage of Consumers' Personally Identifiable Information (PII)" webinar slides for more information on obtaining consumers' authorization prior to accessing their PII.

The guidance in this section summarizes and supplements privacy and security standards that are specifically listed or incorporated in the FFM Agreements you must execute as part of your Individual Marketplace registration (i.e., Appendix A, titled "Privacy and Security Standards and Implementation Specifications for Non-Exchange Entities," of the Individual Marketplace Privacy and Security Agreement), and referred to hereafter as the FFM Agreements.

Additionally, under 45 CFR 155.220(j) and CMS regulations, you must obtain a consumer's authorization (also referred to in this Manual as consent) prior to accessing a consumer's PII (see SOP 1. Receive Consent before Accessing Consumer PII). You are allowed to access, keep, and use consumer PII to carry out your agent or broker "authorized functions," which are listed in the Privacy and Security Agreement you signed as part of your Marketplace registration, as well as for any other purpose for which a consumer has provided specific consent, consistent with applicable law.

In the event that you encounter a consumer's PII, you must adhere to all applicable privacy and security standards. Your responsibilities include:

- Knowing, understanding, and complying with the privacy and security standards in the Marketplace Agreements, and in any contract or agreement between you and any corporate entity (i.e., an entity that has its own National Producer Number [NPN], such as a group of agents and brokers functioning as an agency, brokerage or web-broker) for which you are an authorized representative (referred to hereafter as "your organization")
- Recognizing and protecting consumers' PII
- Informing consumers how their private information will be secured
- Obtaining consumers' authorization (or consent) prior to gaining access to their PII
- Maintaining a record of a consumer's authorization for at least six years (unless a different and longer retention period has already been provided under other applicable federal law); and informing consumers that they can revoke this authorization at any time
- Providing consumers with a written privacy notice statement that has been developed by your organization (or ensuring that your organization has provided consumers with this privacy notice statement) prior to collecting PII or other information from them in connection with carrying out your agent or broker duties
  - Refer to the "Privacy Notice Statements" section of the "Protection Requirements and Appropriate Usage of Consumers' PII" webinar slides for more information on the content of these statements.
  - The privacy notice statement doesn't need to be provided to consumers prior to collecting their name, physical address, email address or telephone number if that information is being used solely for making future contact with the consumer to carry out an authorized function, such as setting up an appointment, or to send them educational information directly related to your authorized functions.
- Only sharing consumers' PII with other individuals or organizations as authorized by the terms and conditions of the privacy and security standards in the FFM Agreements, in any contract or agreement between you and your organization, and with a consumer's express consent
- Maintaining an accounting of any and all disclosures of PII if you maintain and/or store PII, except for those disclosures that are necessary when carrying out your authorized functions
  - Your accounting of uses of a consumer's PII should contain the date, nature, and purpose of such disclosures, and the name and address of the person or agency to whom the disclosure is made.
  - You should retain the accounting for at least six years after the disclosure, or the life of the record, whichever is longer. This accounting will need to be made available to CMS or the consumer who is the subject of the record, upon request.

You may come across consumers' PII when you:

- Obtain their authorization to provide assistance
- Assist them with creating an account through the FFM
- Assist them with the FFM eligibility application for health coverage
- Assist them with certain issues related to exemptions from the individual shared responsibility payment and the requirement to maintain minimum essential coverage, or with understanding how to file an FFM eligibility appeal

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

- Request or require an SSN, information regarding citizenship, status as a U.S. national, or immigration status for any individual who is not seeking coverage for himself or herself on an application
- Request information from or concerning any individual who is not seeking coverage for himself or herself, unless that information is necessary for the eligibility application of another person seeking coverage
  - Such necessary information may include information on individuals who are in an individual's tax household or who live with an individual applying for coverage, including contact information, addresses, tax filing status, income and deductions, access to employer-sponsored coverage, familial or legal relationships, American Indian or Alaska Native status, or

pregnancy status.

- Use consumers' PII to discriminate against them, such as by refusing to assist consumers who have significant or complex health care needs

Exhibit 1 is a resource you can use to answer common questions from consumers about agents' and brokers' use of PII in the Marketplace.

Exhibit 1. Common Consumer Questions about Agents' and Brokers' Use of PII

Why might you ask to see my PII?	What will happen with my PII?	What will NOT happen with my PII?
• To help a consumer apply for eligibility for health coverage through a Marketplace • To help a consumer apply for eligibility for programs to lower costs of health coverage • To help a consumer identify QHP options available through a Marketplace • To schedule appointments with consumers • To provide agent or broker services in a culturally and linguistically appropriate manner, and/or in a manner that is accessible to persons with disabilities	• Information will be used only for purposes related to the agent's or broker's authorized functions, or with the consumer's express consent • Consumers can limit or revoke their authorization for an agent or broker to have access to their information • Information will be retained by the agent or broker in a manner that complies with privacy and security standards • Information will be stored securely and used appropriately according to Marketplace guidelines (e.g., agents or brokers will retain a record of the consumer's authorization for at least six years)	• Information will not be used for purposes unrelated to the agent's or broker's authorized functions or for purposes to which a consumer hasn't consented

2.1.1.1 Tips for Protecting PII

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

2.1.1.1.1 Handling PII

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

- Remind consumers they should keep their PII in a secure place that they will remember.
- If consumers mistakenly or accidentally leave behind PII at a facility or enrollment event, return it to consumers as soon as possible and store the PII securely until that time.
- If it is not possible to return PII to a consumer and th9e PII is not in the form of an original document (such as an original Social Security card or government-issued identification card), you should consider destroying the PII and maintaining a record of its destruction. If the PII is in the form of an important original document like a Social Security card or government-issued identification card, we recommend that you return the document to the agency or entity that issued it and keep a record of its submission to that agency.
- Use email accounts, websites, and mobile devices in a manner consistent with your organization's implementation of the privacy and security standards when collecting, transmitting, or accessing PII.
- As a best practice, clear your web browser history after using your browser to access PII, so that another person using the same computer and web browser does not inadvertently access the PII.
- Use passwords to protect electronic accounts that may contain PII, as well as any additional safeguards to protect electronic accounts, consistent with your organization's implementation of the privacy and security standards. Remind consumers to do the same.

2.1.1.1.2 Reporting a Breach of PII

- Your organization must have its own breach[2] and incident[3] handling procedures that are consistent with CMS' *Risk Management Handbook,* Standard 7.1, Incident Handling and Breach Notification. These procedures must identify the designated Privacy Official for the organization (if applicable), and/or identify other personnel who are authorized or responsible for reporting and managing privacy and security incidents or breaches to CMS.
- You must also comply with your organization's breach and incident handling procedures.
- Your organization's breach and incident handling procedures must address how to identify an "incident." An "incident" is the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data, and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.
- If an incident occurs, your organization's policies and procedures should be followed to determine if PII is involved in the incident.
- If you discover that a potential incident or breach of PII has occurred, you should immediately report this to your organization's designated Privacy Official and/or any other person who has been identified as responsible for reporting or managing a breach of PII for your organization.
- Your organization must report any incident or breach of PII to the CMS IT Service Desk by telephone at (410) 786-2580 or 1-800-562-1963 or via email notification at cms_it_service-desk@cms.hhs.gov within one hour of discovery of the incident or breach.
- In addition, your organization must complete a CMS Security Incident Report.
- You and your organization must cooperate with CMS in resolving any incident or breach and provide details regarding identification, response, recovery, and follow-up of incidents and breaches. Your organization must also make its designated Privacy Official or other authorized personnel available to CMS upon request.

2.2 Fraud Prevention Guidelines

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

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

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

2.2.1 Preventing Fraud

To help prevent fraud from occurring, encourage consumers to:

- Accurately report all sources and amounts of income on eligibility applications
- Accurately report their age, tobacco usage, and address on eligibility applications
- Protect their SSNs
- Shred documents containing health information or other PII before throwing them away
- Never give out information over the telephone or Internet unless the requestor has proven they have authority to have this information (e.g., a health insurance company, the Marketplace)[3]
- Review charges, bills, and explanations of benefits to ensure all charges for services, equipment, and prescriptions are accurate
- End any suspicious calls or visits immediately
- Report suspicious calls or visits to the Marketplace Call Center

Read How Can I Protect Myself from Fraud in the Health Insurance Marketplace℠ for additional information on how consumers can protect themselves against Marketplace fraud.

Be aware that some consumers are being targeted by tax scams. If consumers owe a payment, remember that it should be made only with their tax return or in response to a letter from the IRS. The payment should never be made directly to an individual or return preparer. Additional information on how consumers can identify and protect themselves from tax scams is available at https://www.healthcare.gov/how-can-i- protect-myself-from-tax-scams/.

2.2.2 Recognizing Fraud

Potentially fraudulent situations can occur when consumers:

- Purposely underreport their income or fail to report all sources of income

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

- Purposely do not report an accurate level of tobacco use to attempt to change the cost of health coverage
- Use another person's information to get health coverage through a Marketplace

It might also constitute fraud when a person:

- Falsifies information to mislead a consumer into joining a health plan
- Makes an unsolicited request for consumers' personal information fraudulently claiming that they will enroll them in QHPs sold through a Marketplace
- Falsely claims to be an agent, broker, or agent or broker who sends a consumer an email that asks for personal information
- Tries to collect a tax payment directly from the consumer

2.2.3 Reporting Fraud

If you or a consumer thinks fraud may have occurred, use the resources in Exhibit 2 to report it.

Exhibit 2. Resources to Report Fraud

Resource	Contact Information	Description
HHS Office of the Inspector General (OIG)	• Online: HHS OIG Fraud Hotline[4] • 1-800-HHS-TIPS (1-800-447-8477) • TTY: 1-800-377-4950	To report that a consumer's information was used to enroll someone else in the Marketplace
The Federal Trade Commission (FTC)	• Online: Secure Complaint Form[5] • 1-877-ID-THEFT (1-877-438-4338); • TTY: 1-866-653-4261	To report identity theft
State Department of Insurance (DOI)	• Your local State Department of Insurance	To report agent/broker fraud
Marketplace Call Center	• 1-800-318-2596; • TTY: 1-855-889-4325 (all languages available)	To report that a consumer received suspicious calls or visits, or to report fraudulent conduct by an agent or broker
Internal Revenue Service (IRS)	• Complete and send Form 14157, Complaint: Tax Return Preparer with all supporting documentation to the IRS. • Mail: Internal Revenue Service Attn: Return Preparer Office 401 W. Peachtree Street NW Mail Stop 421-D Atlanta, GA 30308 • Fax: 855-889-7957	To report suspected misconduct or fraudulent activity related to a tax return preparer or tax preparation firm

2.3 Complaint & Grievance Process

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

[4] https://forms.oig.hhs.gov/hotlineoperations/

[5] https://www.ftccomplaintassistant.gov/

Additionally, if you have knowledge of agent or broker fraud, you should contact CMS at FFMProducer-AssisterHelpDesk@cms.hhs.gov.

3. Individual Marketplace SOPs

The SOPs contained in this section provide guidance to help you assist consumers who select and purchase their health coverage through the Individual Marketplace or who have questions about exemptions from the individual shared responsibility payment or requirement to maintain minimum essential coverage. Consumers might:

- Request assistance with the process to assess eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- Identify, compare, and select QHPs
- Complete a number of other eligibility and enrollment activities
- Request assistance related to exemptions from the individual shared responsibility payment or requirement to maintain minimum essential coverage

Each SOP adheres to the following general structure:

A. **Introduction**: Outlines general task(s) and describes the SOP topic

B. **Procedures**: Provides step-by-step instructions, tables, and graphics to guide agents and brokers as they help consumers complete Marketplace activities

C. **Next Steps**: Identifies next steps or associated SOPs that agents and brokers can reference to further assist consumers with Marketplace activities

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

SOP 1. Receive Consent before Accessing Consumer PII

A. Introduction

As an agent or broker, you must receive a consumer's consent (referred to in CMS regulations as an authorization) before accessing their PII to assist with enrollment through the Marketplace. This is an essential step to ensure that consumers are making an informed decision to share their PII with agents and brokers. As a best practice, to ensure that you receive informed consent from consumers, first have a conversation with consumers about your roles and responsibilities as an agent or broker.

Next, ask consumers to provide consent, which could be done by asking each consumer to complete a consumer consent form. Your organization might have a consumer consent form that you can use each time you assist a consumer. If you obtain consent verbally rather than through a form or other written document, you should keep a written record of the consent as described in the procedures below.

You must follow the privacy and security standards contained in the Marketplace Agreement(s) you signed during Marketplace registration, as well as the terms and conditions of the terms and conditions of the contract or agreement between you and your organization. You must also comply with these and other applicable standards or policies, including your organization's privacy and security policies, when collecting and storing consent forms.

Note that all agent or broker organizations are federally required to store written consumer consent forms and other records of consumer authorization for at least six years, unless a different and longer retention period has already been provided under other applicable federal law. For more information on obtaining a consumers' consent to access their PII, see the guidance available at https://marketplace.CMS.gov/technical-assistance-resources/obtain-consumer-authorization.pdf.

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

B. Procedures

1. Inform Consumers of Your Agent and Broker Roles and Responsibilities

Inform consumers of the functions and responsibilities that apply to agents and brokers, including all the consumer protection standards that apply through CMS regulations to agents and brokers, such as:

a. The requirement to provide information in a fair, accurate, and impartial manner

b. Conflict of interest requirements

c. Rules about accepting payment and providing gifts

d. Rules about unsolicited direct contact with consumers, including "robo-calls"

e. Rules about nondiscrimination7 and providing culturally and linguistically appropriate services and services accessible to consumers with disabilities

f. That you are not acting as a tax adviser or attorney when providing assistance as an agent or broker, and cannot provide tax or legal advice within your capacity as an agent or broker

2. Review Methods of Protecting PII

Step 1. You are strongly encouraged to review with consumers the privacy and security standards required under the terms and conditions of the contract or agreement between you and your

agent or broker organization. Explain to the consumer:

a. PII is information that can be used to distinguish or trace an individual's identity, such as their name, SSN, or biometric records, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, or mother's maiden name.

b. Agents and brokers are required to follow privacy and security standards to protect consumers' PII.

c. Agents and brokers might access consumers' PII, such as their names, dates of birth, financial information, or SSNs, when carrying out their authorized functions.

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

a. CMS permits you to access, keep, and use consumer PII only to carry out your authorized functions or with a consumer's specific consent. In the event that you encounter a consumer's PII, you must adhere to all applicable privacy and security standards. If you are authorized to share consumers' PII with individuals or entities, you will share only the minimum necessary consumer information.

b. You will take precautions while handling consumers' PII to protect the confidentiality of their information.

c. When disposing of physical or electronic copies of consumers' PII, you will adhere to all privacy and security standards that apply to you.

Step 3. Answer consumers' questions about the privacy and security of the PII they share with you. If needed to answer consumers' questions, refer to the consumer consent form; your organization's Privacy Notice Statement; or the terms and conditions of the Privacy Agreement.

3. Discuss Consumers' Responsibilities

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

a. Consumers must provide complete and accurate information on the Marketplace eligibility application.

b. Consumers must accurately report all required sources and amounts of income.

c. Consumers should not ask agent or brokers to misrepresent consumers' information while applying for health coverage.

d. Consumers must notify the Marketplace of any inaccurate information included on their eligibility application.

4. Obtain Consumers' Consent

Step 1. You can obtain a consumer's consent orally[6] and/or in writing. At a minimum, the consent should include the following:

a. An acknowledgment that you informed the consumer of the functions and responsibilities that apply to your agent and broker role

b. Consent for you to access and use the consumer's PII to carry out your authorized functions

c. An acknowledgment that the consumer may revoke any part of the authorization at any time, as well as a description of any limitations that the consumer wants to place on your access or use of the consumer's PII.

We also recommend that the authorization include:

a. An explanation of what PII includes and examples of the kinds of PII you may request from the consumer

b. An acknowledgment that the consumer is not required to provide you with any PII

c. An explanation that the help you provide is based only on the information the consumer provides, and that if the information given is inaccurate or incomplete, you might not be able to offer all the help that is available for the consumer's situation

d. An acknowledgment that you will ask only for the minimum amount of PII necessary for you to carry out your functions and responsibilities

5. Check Consumers' Understanding and Complete Consent Form

Step 1. Ask consumers if they have any questions about the information and/or form you have shared with them, and answer their questions. It's a good idea to have the consumer verbally confirm that they understand what you have told them before they sign the form.

Step 2. Ask consumers to read and sign your organization's consumer consent form before assisting them.

When you obtain consent verbally (e.g., over the phone), explain to the consumer the consent components (as described above), obtain consent, and make a written record of the

[6] You may obtain consumers' consent verbally by reading them your organization's standard written consent form or a script that contains, at a minimum, the required elements of the authorization that are summarized above. You must record in writing that the consumer's consent was obtained. The record of the authorization must include at a minimum, the required components summarized in Item 5, Step 2. Agents or brokers are strongly encouraged to create a record of the authorization as it is being provided, and then read back the content of the record to the consumer once it is complete, so

a. The consumer's name (and, if applicable, the name of the consumer's authorized representative);
b. The date the consent was given;
c. Your name and/or the name of the agent or broker to whom the consent was given (and the names of any other agents or brokers that the consumer authorized to access the consumer's PII);
d. Notes regarding limitations, if any, the consumer makes on the scope of the consent provided; and e. Notes recording all acknowledgments and consents obtained from the consumer, including any applicable specific consents to access consumer PII for CMS-approved purposes that are not already captured in the list of purposes set forth in your agreement with CMS and/or your organization.

Store a signed copy of the consumer consent form or record of authorization (paper or electronic) for at least six years (unless a different and longer retention period has already been provided under other applicable federal law) in a secure manner in accordance with your agreement with CMS and/or your organization. If any changes are later made to the consent, including if and when a consumer revoked the consent or part of the consent, this should be included with the original record.

It is strongly recommended that you provide the consumer with a copy of the signed consumer consent form (or, if applicable, the record of a verbally given consent).

consent. The record of the consumer's consent should contain, at a minimum:

C. Next Steps

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

SOP 2. Assess Consumers' Knowledge & Needs

A. Introduction

This section will assist you in understanding the type of support consumers require so that you can assist them.

B. Procedures

1. Assess Consumers' Knowledge

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

Exhibit 3. Knowledge Assessment Guide

Knowledge Category	Knowledge Checks	Sample Questions
Health Coverage	Determine if consumers: • Understand the basics of health coverage. • Know that for individual market health insurance, consumers and insurance companies pay for health care. • Understand key terms, such as premiums, deductibles, coinsurance, and copayments. • Know that insurance companies contract with different networks of doctors, and that their health care provider may not be included in some insurance networks.	• What questions do you have about health coverage? • How have you managed your health care costs in the past? • Do you understand how premiums, deductibles, coinsurance, and copayments function? • Do you have a doctor you see regularly? How would you feel if you had to see a new or different doctor?
Affordable Care Act	Determine if consumers: • Are aware of the preventive services available to them without cost sharing when they have non-grandfathered coverage. • Understand that there are limits on the amount they will pay in cost sharing for essential health benefits each year (excluding grandfathered coverage). • Are aware that they can no longer be denied coverage or charged more for having a pre- existing medical condition. • Understand the individual shared responsibility payment. • Know the exemptions available from the individual shared responsibility payment and the requirement to maintain minimum essential coverage and how to apply for an exemption if they think they might be eligible.	• What questions do you have about how the Affordable Care Act can lower the cost of your coverage? • What questions do you have about the requirement to maintain minimum essential coverage? • Do you understand the consequences for consumers who do not meet this requirement? • Are you aware that some consumers may be exempt from the requirement to maintain minimum essential coverage?

Knowledge Category	Knowledge Checks	Sample Questions
Marketplace	Determine if consumers: • Understand the eligibility requirements for health coverage, tax credits, and cost savings available through a Marketplace. • Are aware of the key dates for the Marketplace annual Open Enrollment period, during which any consumer can apply for health coverage. • Are aware of the different health coverage options. • Are aware of the available programs to lower the costs of health coverage. • Understand the essential health benefits covered by all QHPs offered through a Marketplace (as well as most individual and small group coverage outside the Marketplace).	• What questions do you have about applying for and enrolling in health coverage through a Marketplace? • Are you aware of the start and end dates for the Marketplace annual Open Enrollment period? • How can I help you apply for health coverage through a Marketplace? • What questions do you have about the health coverage available through a Marketplace? • What are your concerns about paying for coverage? • Are you aware of the types of services covered by health coverage available through a Marketplace?

2. Assess Consumers' Needs

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

a. Whether consumers have existing health coverage and, if so, whether that coverage continues to meet their needs (e.g., if it is ending, benefits are changing, costs are changing)

b. Who is in need of health coverage (e.g., consumers and/or family members)

c. Whether consumers have started the Marketplace eligibility application process, and if they have, what stage in the application process they have reached (e.g., submitted the application, received an eligibility determination, ready to select a QHP)

d. How consumers intend to pay for the coverage (e.g., with advance payments of the premium tax credit [APTC], with personal income)

e. What additional information, if any, consumers need to know about the Affordable Care Act, health coverage, or the Marketplaces (e.g., how to apply for an exemption to the individual shared responsibility payment or requirement to maintain minimum essential coverage, how to make changes to their account profile)

C. Next Steps

1. If consumers require additional information about health coverage, the Affordable Care Act, or the Marketplace, a good place to start is to refer to the resources on Marketplace.cms.gov.
2. If consumers are ready to begin eligibility and enrollment activities or have questions about exemptions from the individual shared responsibility payment or requirement to maintain minimum essential coverage, proceed to the appropriate SOP(s) in this Manual.
3. For more help answering consumers' specific questions, see the Frequently Asked Questions (FAQs) related to SOP-2 Assess Consumers' Knowledge & Needs.

SOP 3. Create an Account

A. Introduction

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

Note: The consumer or a legally authorized representative must create his or her own Marketplace user name and password, and should not share this information with third parties, including agents and brokers.

B. Procedures

1. Create an Account

To assist consumers with creating an account, complete the following required steps shown in Exhibit 4:

Things You Should Know

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

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

a. Assist consumers with entering the following information on the screen:

i. First name (required to create an account); (Ensure consumers use their given first name and not a nickname to be consistent with their Marketplace applications.)

ii. Last name (required to create an account)

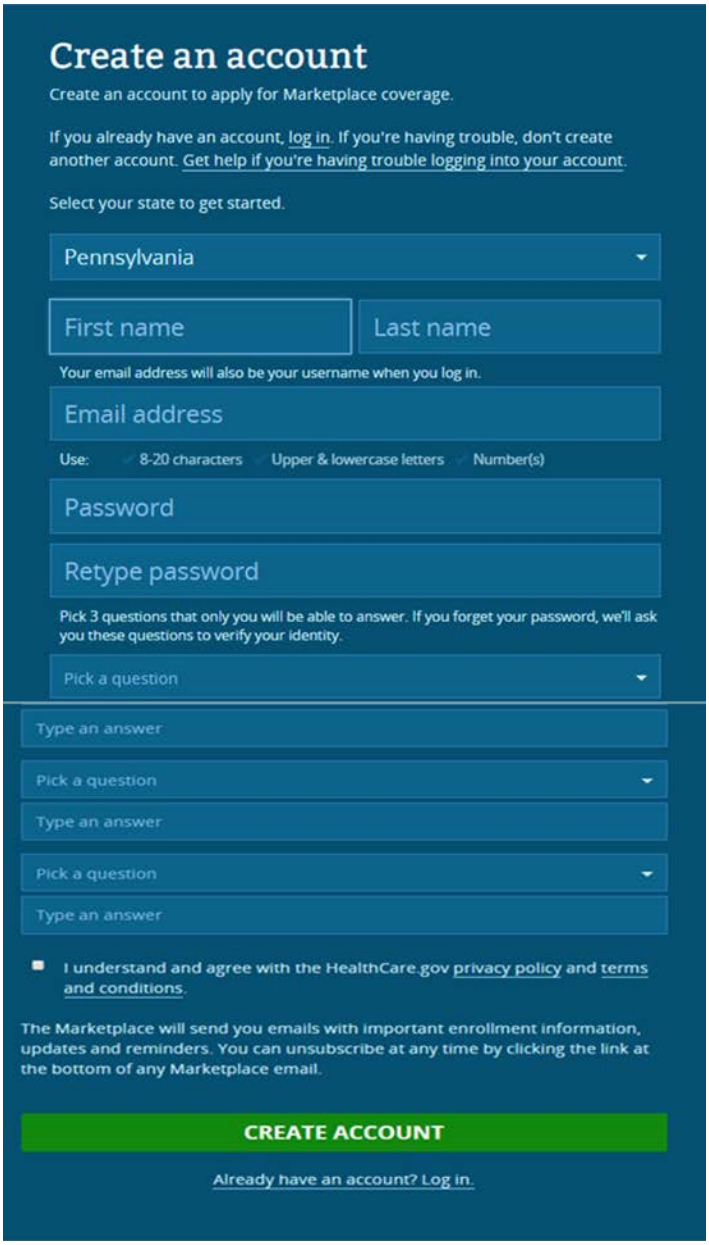
iii. Email address, which will also be the consumer's username (required to create an account)

iv. Password (required to create an account)

b. Explain to consumers that they must select and provide answers to three security questions to protect their accounts from unauthorized access. Guide consumers through selecting and answering these security questions to protect their account.

c. Advise the consumer that they must select the "I understand and agree with the HealthCare.gov privacy policy and terms and conditions" check box.

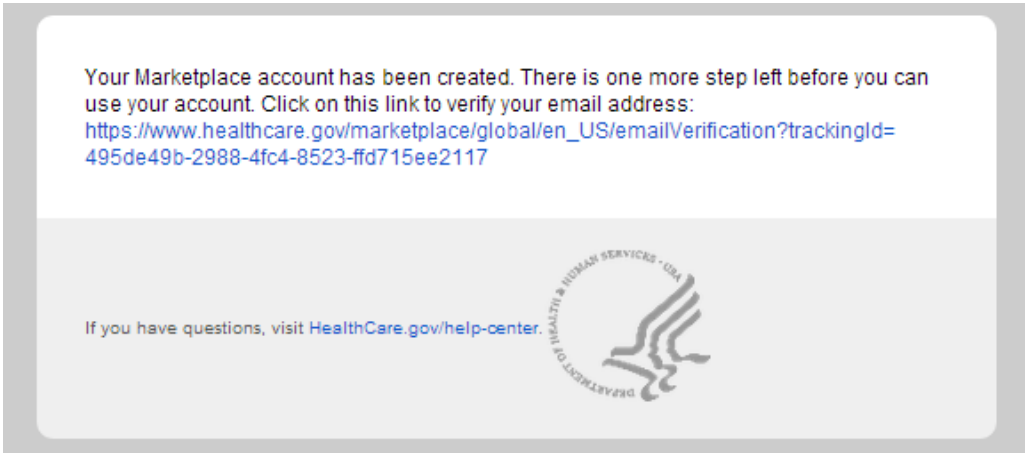
Exhibit 4. Marketplace Account Creation Screenshot



Step 2. Once consumers click the "Create Account" button, a "Check your email" message will display on the same page with a reminder to click the verification link found in the consumer's email inbox to continue his/her application (Exhibit 5). Consumers cannot proceed with applying for coverage through the Marketplace before verifying their email address and activating their account.

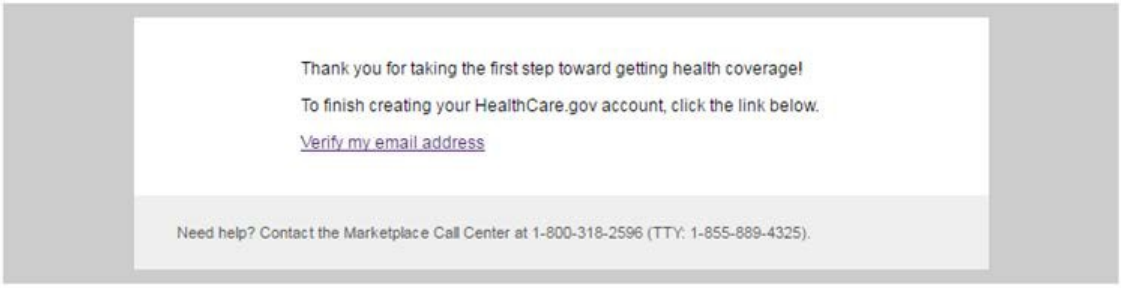
Once consumers check their email, they will see an email from the sender "Health Insurance Marketplace;" the subject line of the email will read "Marketplace account created."

Exhibit 5. Marketplace Account Verification Email



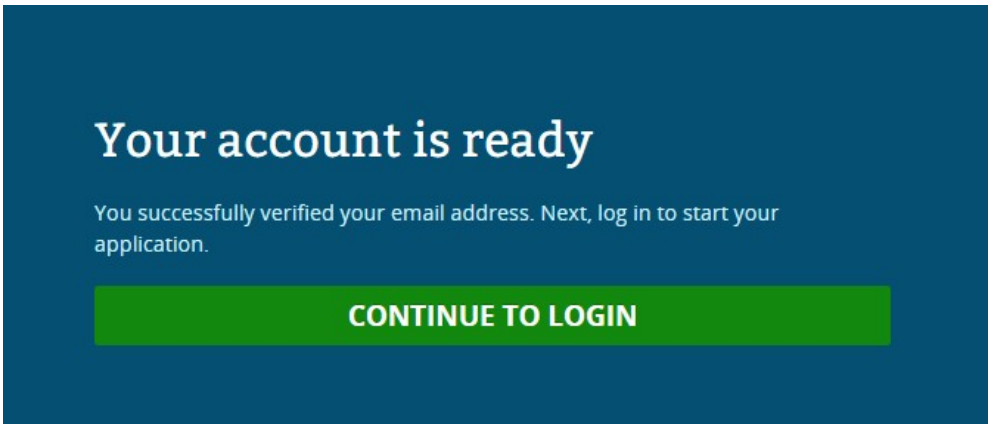
Instruct consumers to click the link in the email to verify their email address, as shown in Exhibit 6. When they click the link, they will see the "Please wait" screen while the Marketplace finishes creating the account, and then the account will be processed.

Exhibit 6. Marketplace Account Verification E-mail



c. Once consumers successfully verify their account, they will see the screen shown in Exhibit 7.

Exhibit 7. Marketplace Account Created Screenshot



2. Troubleshooting

Consumers may receive error messages during the account creation process. Exhibit 8 provides reasons for errors encountered and steps to assist consumers in resolving the errors.

Exhibit 8. Account Errors and Action Items

Error/Condition	Explanation & Discussion	Action Items
A profile already exists for that user	• Explain that if consumers have previously created an account, it is stored in the Marketplace and consumers can access the account with the correct login information. Consumers can only create one account. • Explain that consumers may have mistakenly entered information that belongs to another consumer's account.	• Assist consumers with ensuring that login information is correct and that they do not have an existing account. • Consumers should contact the Marketplace Call Center or use the system prompts on HealthCare.gov to retrieve login information if an account already exists.
An account cannot be created with the information entered	• Explain that the Marketplace requires consumers to enter information in a valid format. • Explain that the system identifies each piece of information that is missing or invalid so consumers can correct the information. • Explain that consumers have the option to cancel the account creation activity.	• Walk consumers through each piece of information that the system has identified as missing or invalid. • Help consumers correct the information or show them how to cancel the entire account creation activity.

C. Next Steps

1. If consumers would like to submit a Marketplace application or select a QHP, proceed to SOP-4 Verify Identity to complete the identity verification process required before beginning these eligibility and enrollment activities.
2. If consumers would like to perform account maintenance activities (e.g., reset password), proceed to SOP-12 Update Account Profile.
3. For more help answering consumers' specific questions, see the Frequently Asked Questions related to SOP-3 Create an Account.

SOP 4. Verify Identity

A. Introduction

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

B. Procedures

1. Verify Identity

Step 1. If consumers would like to complete an application on the Marketplace, they will log in and select "Start a new application or update an existing one."

Note: The Marketplace now requires consumers to check for an existing Marketplace application before they initiate a new application to avoid dual enrollment. See the "Health Insurance Marketplace 2017 Open Enrollment: Operational Updates and Announcements for Agents and Brokers Participating in the Marketplace webinar," slides 45 and following for instructions on how to help a consumer check for an existing Marketplace application.

Consumers will then select their state and click "Start my application." To start the application, consumers will need to complete their identity verification, shown in Exhibit 8. The identity verification will be auto-populated with information consumers entered when they first created their Marketplace account.

Exhibit 8. Verify Your Identity Message Screenshot

Step 2. Assist consumers with entering the following additional information, as shown in Exhibit 9.

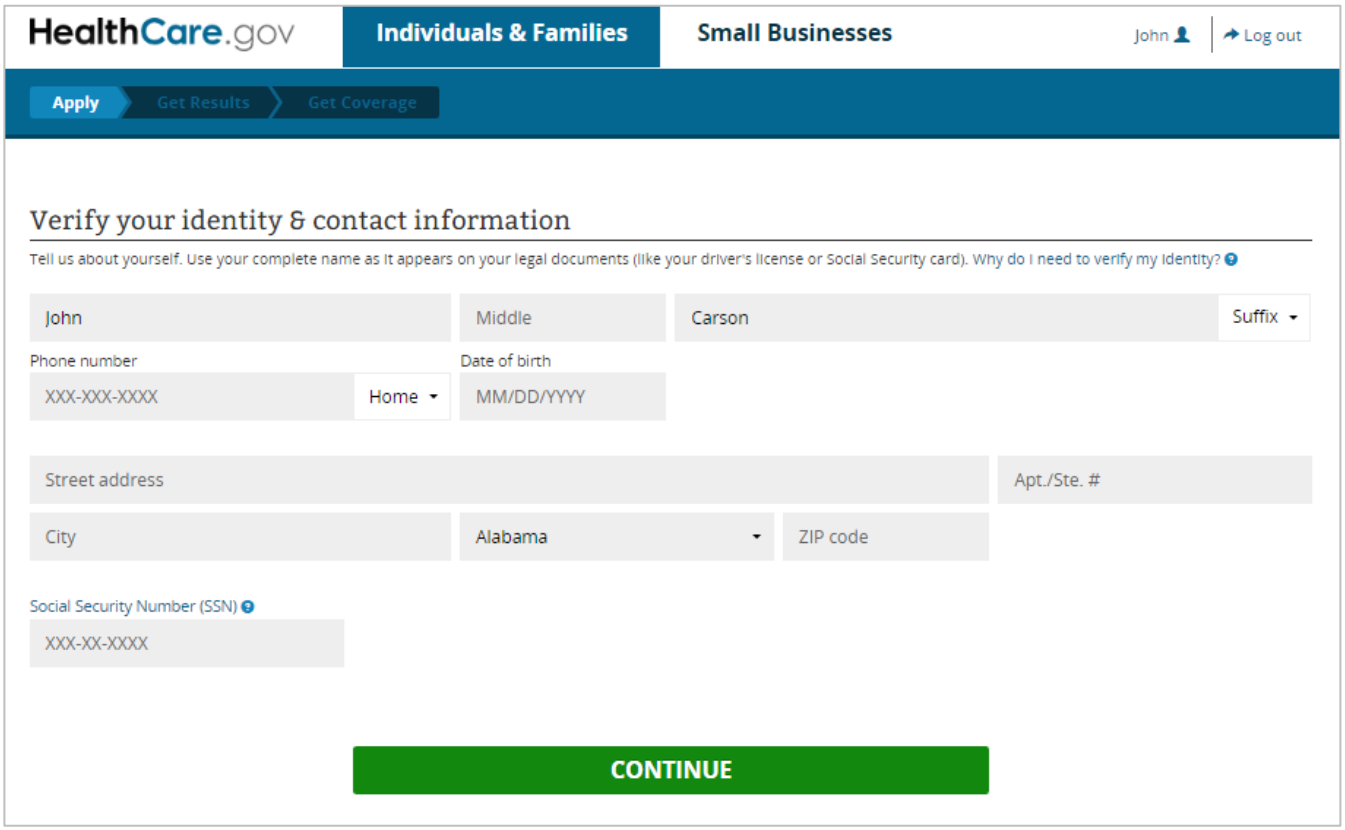
a. First name (no nicknames)
b. Middle name
c. Last name
d. Phone number
e. Date of birth (required to process an eligibility application)
f. Address (required to process an eligibility application)
    i. Street
    ii. Apartment number (if applicable)
    iii. City
    iv. State
    v. ZIP code
g. SSN

Note: Although providing an SSN for the application filer can help expedite the identity proofing process, not all application filers are required to provide one to the Marketplace. Examples of individuals who are not required to provide a SSN include:

a. Application filers who are not applying for coverage for themselves and who are not the tax filer for the household
b. Individuals who do not have an SSN, are not required to provide one to the Marketplace

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

Exhibit 9. Marketplace Verify Your Identity and Contact Information Screenshot

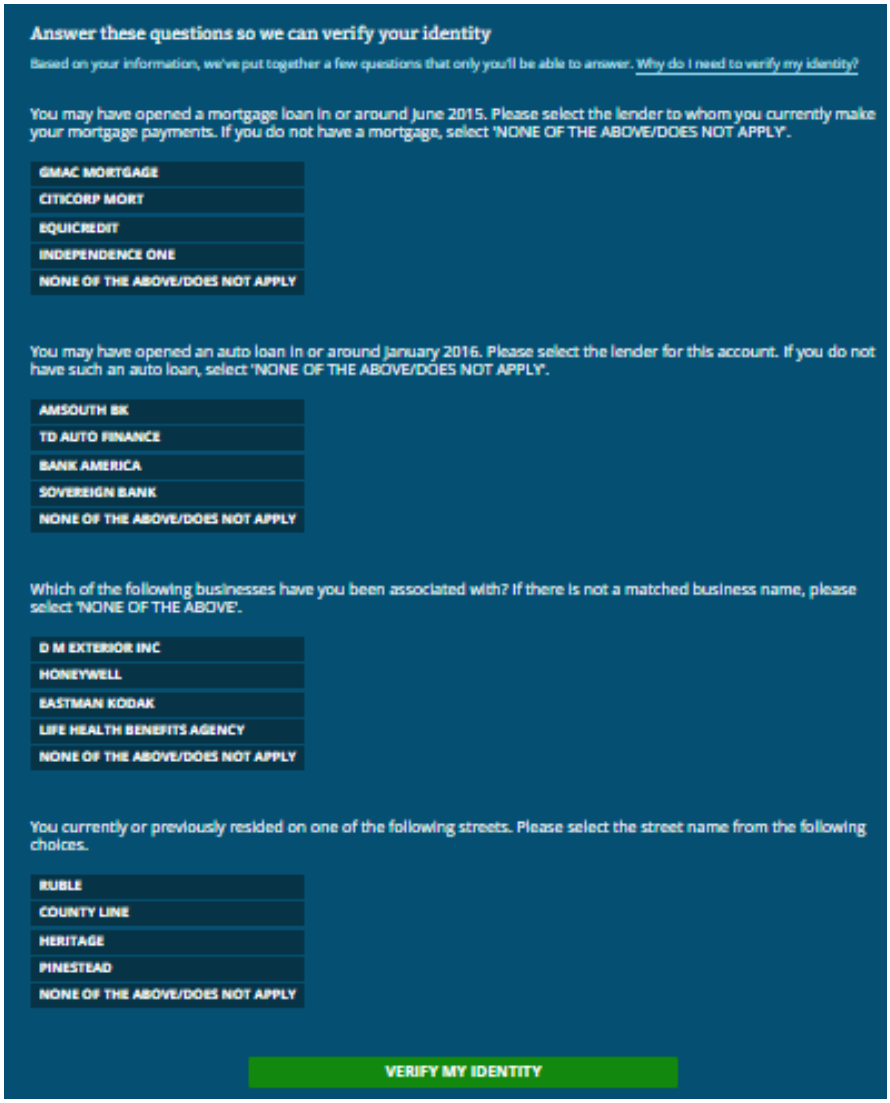


Note: Consumers will be asked questions about their identity based on information in their consumer report maintained by Experian, a consumer reporting agency. Some of these questions may be based on a consumer's personal and financial history, so it may be helpful to prepare consumers to expect questions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

Step 3. Assist consumers with answering identity questions. Examples of the question and answer formats are shown in Exhibit 10. Once consumers click "Continue" on the Verify Your Identity and Contact Information page, a set of four questions will display. Consumers must answer these questions to verify their identity and help protect their PII.

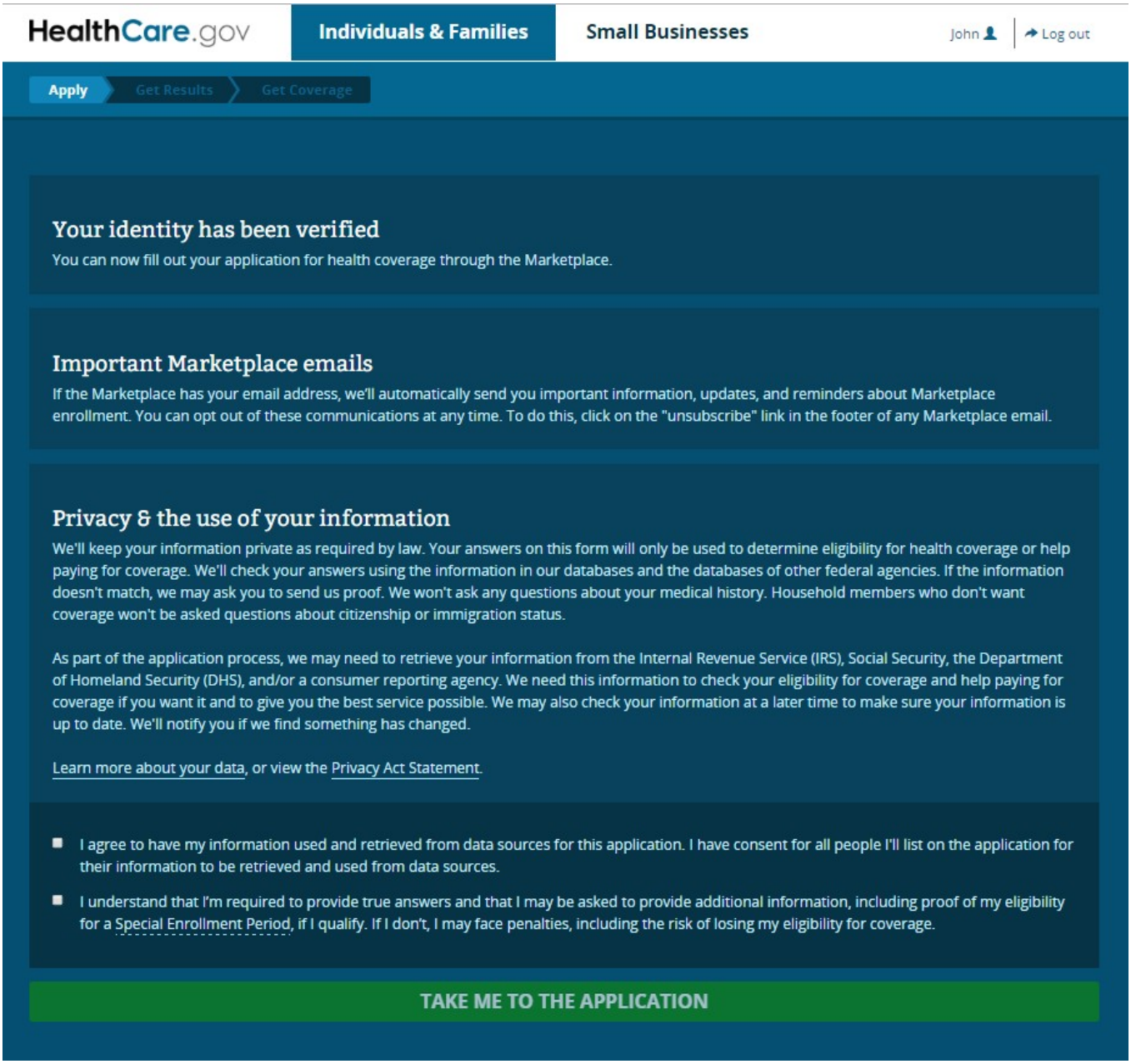
Note: Because identity proofing is based, in part, on a consumer's financial history, consumers may see an "inquiry" on their credit report. This inquiry will not affect their credit score.

Exhibit 10. Marketplace Verify Your Identity Questions Screenshot



Step 4. Once consumers are finished answering the questions, they need to click the "Verify My Identity" button. If they pass the identity proofing process, they will be taken to the "Your Identity has been Verified" page. You can see an example of what this page looks like in Exhibit 11.

Exhibit 11. Your Identity Has Been Verified Screenshot



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

Step 5. Consumers need to check the boxes to indicate they agree to have their information used and retrieved from the trusted data sources to verify the information provided on their applications. Then,

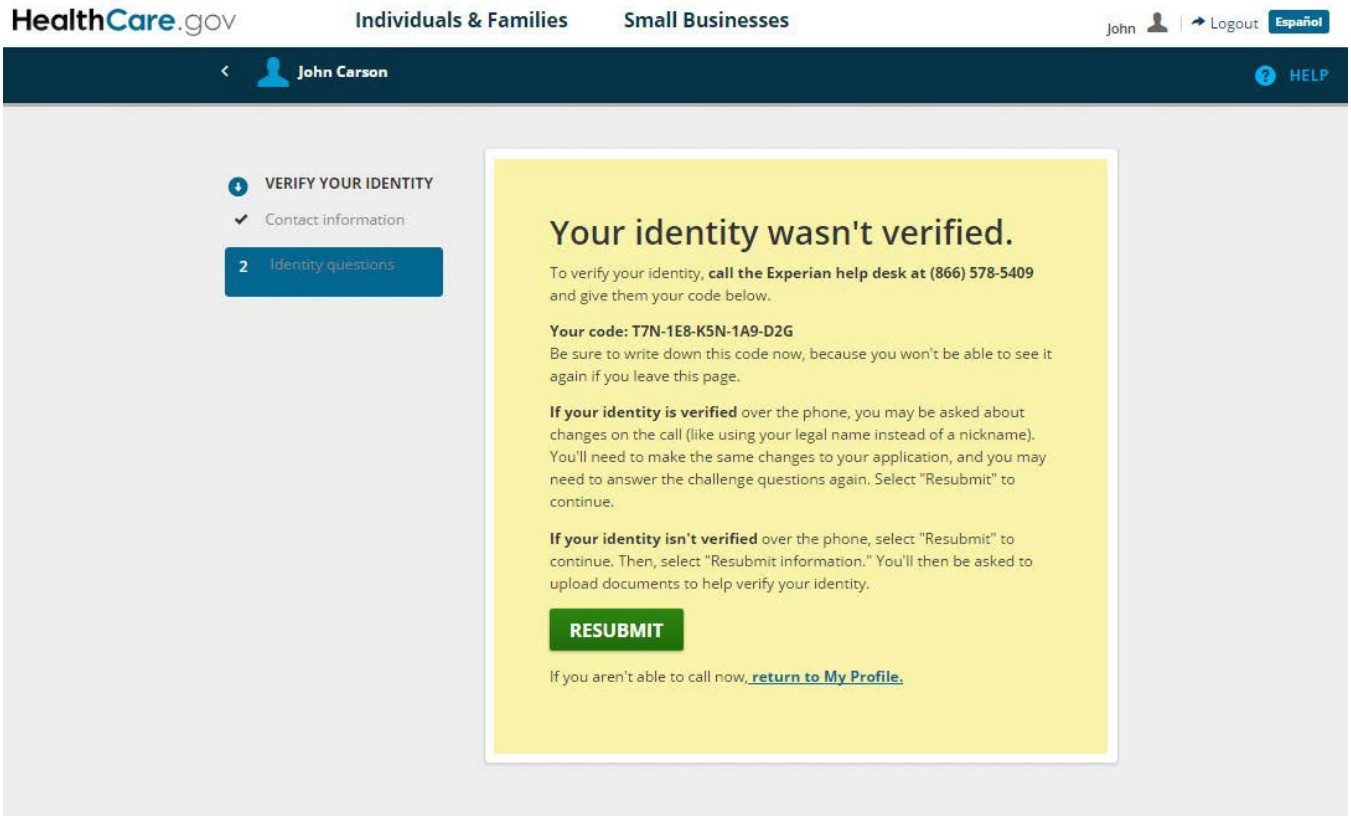
they need to click the "Take Me to the Application" button.

Step 6. If online identity verification is successful, proceed to SOP 5. Apply for Health Coverage to assist consumers with beginning the application process. If online identity verification is unsuccessful, continue with Step 7.

Step 7. Consumers will receive a code, or reference number, on the response screen from their online application indicating that their identity verification attempt was unsuccessful. Refer consumers to the Experian Help Desk for assistance with identity proofing. The consumer will need to write down the code on the screen and give it to Experian. If a consumer only makes one attempt to identity proof, he or she may not receive the code or reference number until the consumer makes a second attempt.

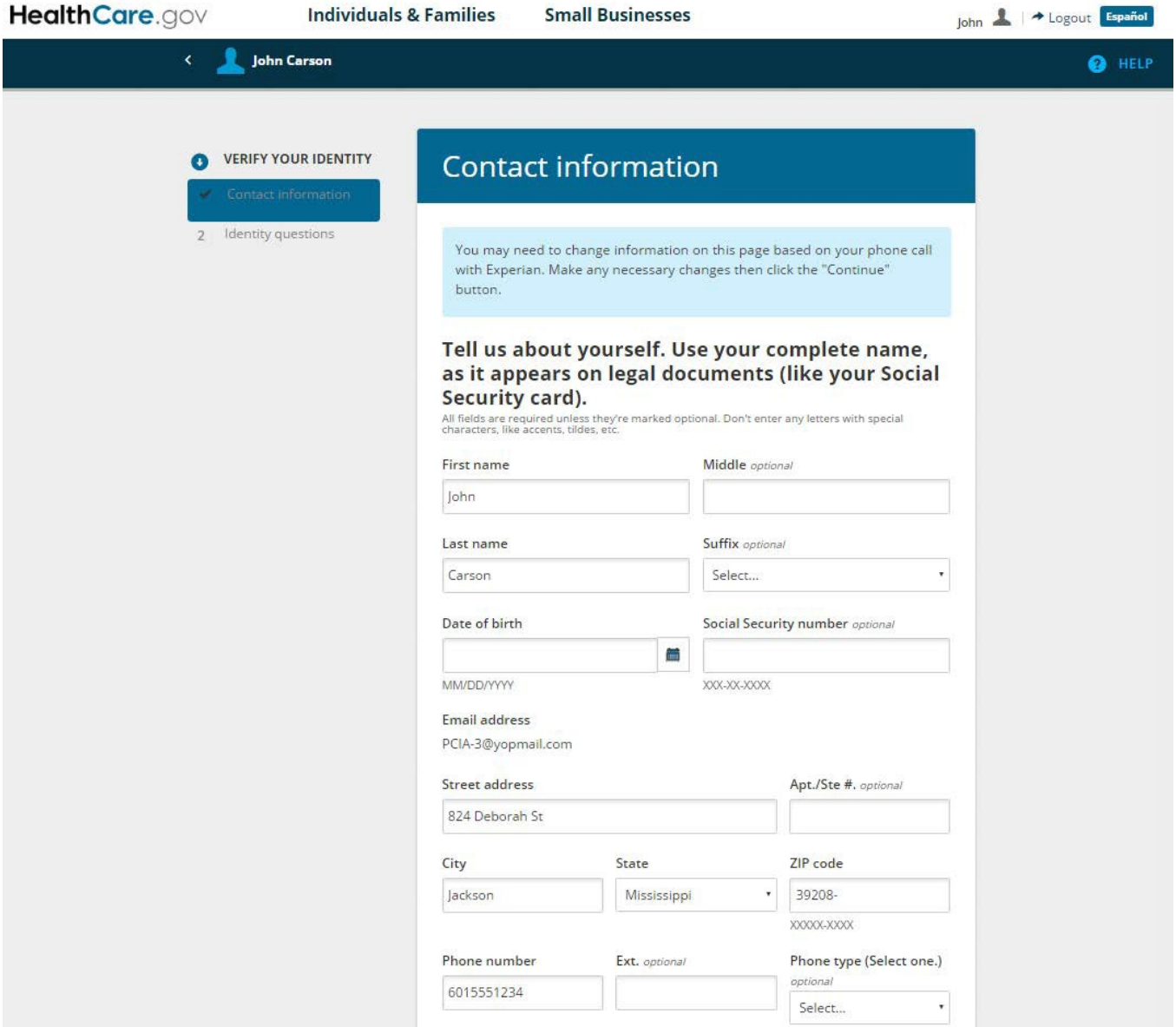
If the reference number was generated, but the consumer did not write it down and cannot remember it when calling the Experian Help Desk, he or she can log back into the account and pull up the code or reference number again. Inform consumers that they must verify their identity before they can submit an application online and receive a final eligibility determination. Direct consumers to contact the Experian Help Desk, as shown in Exhibit 12, if they are not able to verify their identity as described above in Steps 1 through 5.

Exhibit 12. Consumer Directed to Contact Experian to Verify Identity Screenshot



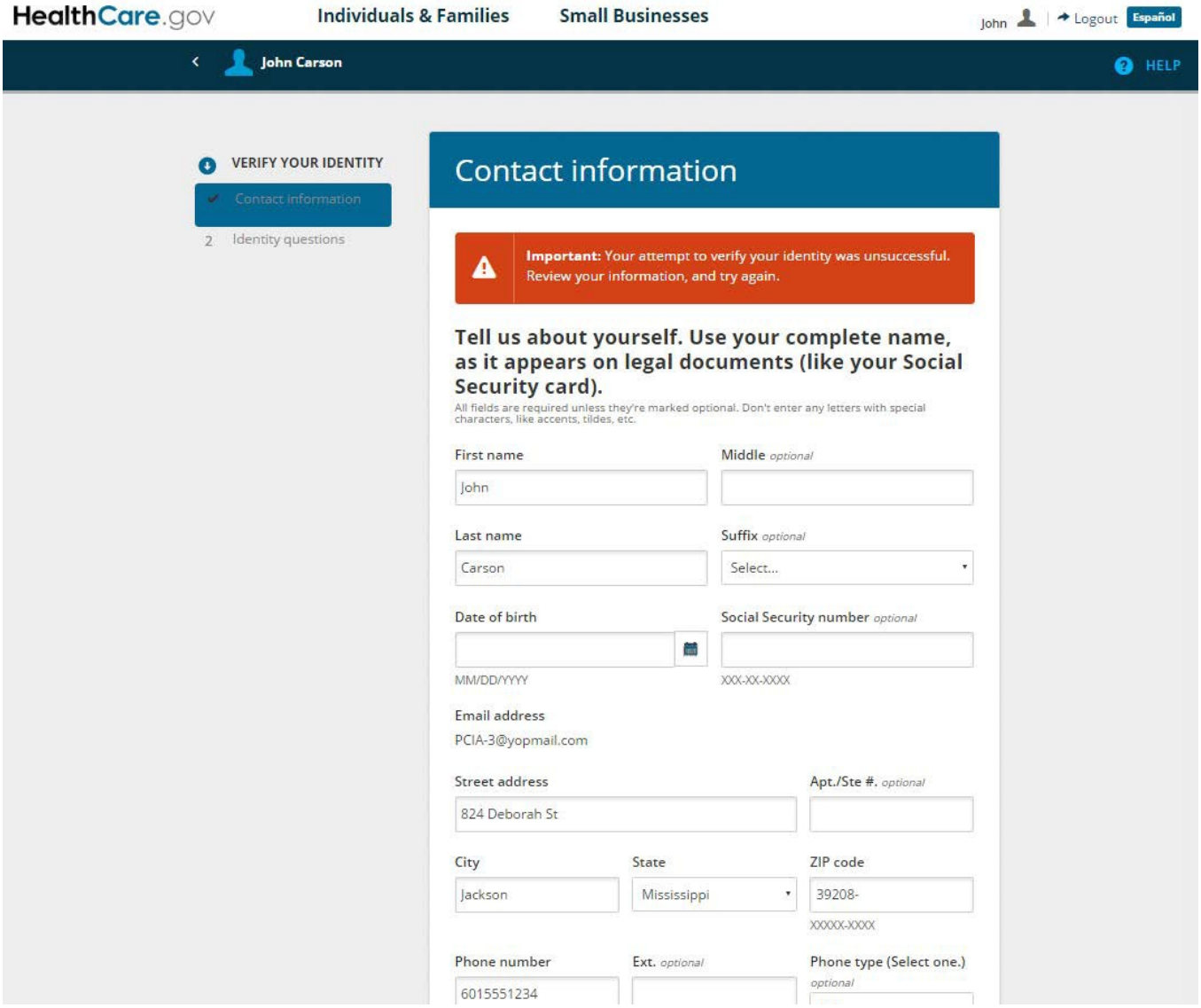
a. If identity verification with Experian over the phone is successful (see Exhibit 13), the consumer can click the "Resubmit" button, then submit updated contact information, and click "Continue." Proceed to SOP 5. Apply for Health Coverage to help consumers begin the application process.

Exhibit 13. Consumer Resubmission Contact Information for Verification Screenshot



b. If identity verification over the phone is unsuccessful, the consumers will also need to click the "Resubmit" button and then enter his or her contact information again (see Exhibit 14).

Exhibit 14. Consumer Resubmission of Contact Information Does Not Verify Identity Screenshot



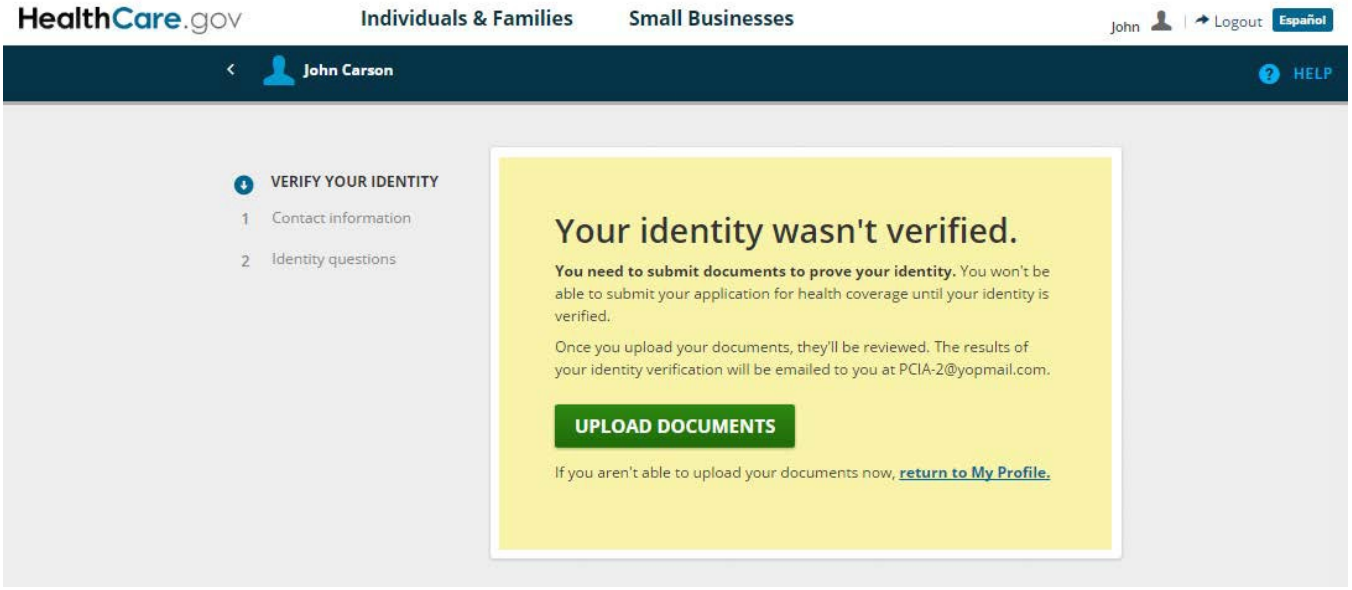
c. If the identity proofing process is unsuccessful after two additional attempts, HealthCare.gov will display a screen for consumers to upload documents for manual verification of their identity.

d. Please proceed to the Submit Supporting Documentation section in this Manual to learn more about submitting additional information to the Marketplace (see Exhibit 15).

While the vast majority of consumers who create an account on HealthCare.gov successfully complete identity proofing online, there is a small percentage who need to submit documents to complete identity proofing.

Consumers who are unable to complete identity proofing on HealthCare.gov can contact the Experian Call Center to complete the process, but if consumer responses indicate the Experian Call Center will not be able to help, new enhancements in the Marketplace software will route the consumer around the Marketplace Call Center and directly to the document upload step.

Exhibit 15. Consumer Directed to Upload Documents Manually to Verify Identity Screenshot



e. If for some reason the "Upload" button does not appear or is not working (see Exhibit 16), the consumer should mail the documentation and contact the Marketplace Call Center to report the issue. If consumers were unable to verify their identity over the phone, inform them they must upload supporting documentation to HealthCare.gov or mail copies of supporting documentation to complete the identity verification process.[7] Consumers will be asked to submit copy of a document with a picture ID from the list of documents shown on the HealthCare.gov "How do I resolve an inconsistency?" webpage and that are also listed below.

   Consumers can submit one of the following to verify their identity:

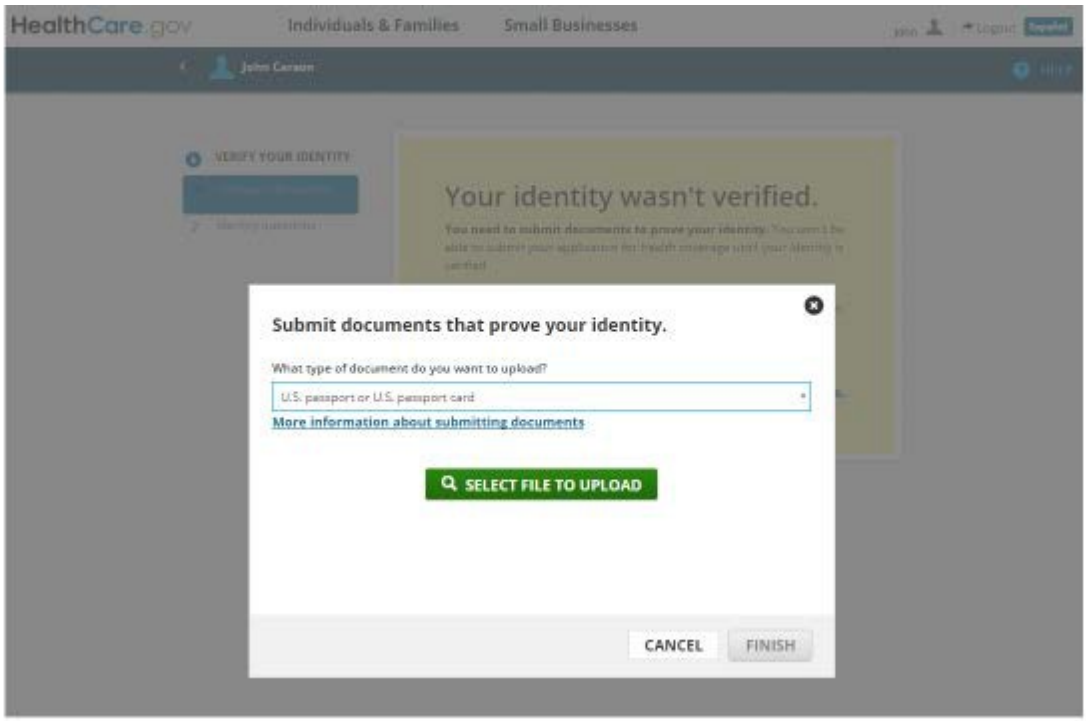
   i. Driver's license issued by a state or territory
   ii. School identification card
   iii. Voter registration card
   iv. U.S. military card or draft record
   v. Any identification card issued by the federal, state, or local government
   vi. U.S. passport or U.S. passport card
   vii. Certificate of Naturalization (Form N-550 or N-570) or Certificate of Citizenship (Form N-560 or N-561)
   viii. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
   ix. Employment Authorization Document that contains a photograph (Form I-766)
   x. Military dependent identification card
   xi. American Indian Tribal document
   xii. U.S. Coast Guard Merchant Mariner card
   xiii. Foreign passport, or identification card issued by a foreign embassy or consulate that contains a photograph.

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

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

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

Exhibit 16. Uploading Documents Screenshot

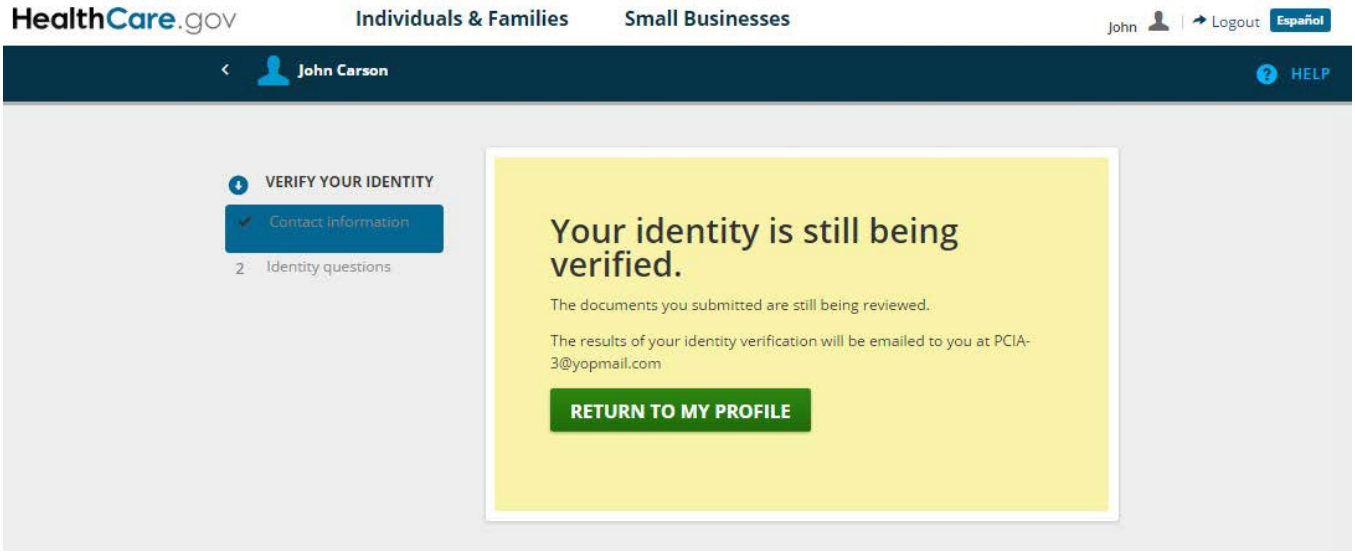


Consumers who have manually uploaded supporting documents required for identity proofing will be notified by the Marketplace via email or U.S. Postal Service about the results of their identity verification (see Exhibit 17).

Note: If a consumer is unable to successfully verify his or her identity, this does not prevent the consumer from completing an application and enrolling in coverage. Consumers who have gone through the steps above and continue to have issues verifying their identity should call the Marketplace Call Center and complete the online application with a Call Center Representative. Encourage the consumer to notify the Call Center Representative that you have been offering assistance and to enter your National Producer Number (NPN) in the application so you can receive credit with the issuer for the enrollment.

- If using the Classic Application, the consumer should enter your NPN when prompted to indicate that an agent or broker provided assistance.
- If the consumer is using the Marketplace 2.0 (Streamlined) Application, the consumer should select the "Another person is helping me" check box to enter your NPN.

Exhibit 17. Identity Still Being Verified Screenshot



For more information about submitting documents, see the presentation on "Tips for Submitting Supporting Documents to the Health Insurance Marketplace℠."

C. Next Steps

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

SOP 5. Apply for Health Coverage

A. Introduction

As an agent or broker, you can help consumers apply for health coverage through the Marketplace. When consumers apply, the Marketplace will consider the application for eligibility for a number of things. If consumers apply for help paying for coverage, the Marketplace will check for their eligibility for advance payments of the premium tax credit (APTC), cost-sharing reductions (CSR), and Medicaid or CHIP. Consumers can apply for enrollment in QHPs with or without APTC and CSR. This SOP provides guidance on how to assist consumers in completing their applications.

Things You Should Know

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

B. Procedures

1. Complete Online Application: Marketplace (or Side-by-Side) Pathway

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

Step 1. If consumers do not yet have a HealthCare.gov account, proceed to SOP-3 Create an Account to assist consumers with account creation. Check to be sure consumers have completed their identity verification, explained in SOP-4 Verify Identity. If consumers have a HealthCare.gov account and have verified their identity, proceed to Step 2.

Step 2. Help consumers go to their account to determine if they have previously started their Marketplace application online.

a. If consumers have previously started and saved their Marketplace application, they should proceed to the section of the application where assistance is required. Ensure that consumers complete all required fields accurately.

b. If consumers do not have an existing Marketplace application, assist them with starting the application process.

Step 3. Guide consumers through the application process by following the application prompts to gather consumers' responses for each section of the application.

a. Refer to Exhibit 18 to educate consumers on the information collected in each section of the eligibility application.

Exhibit 18. Information Collected on the Eligibility Application (if Applying for Financial Assistance)

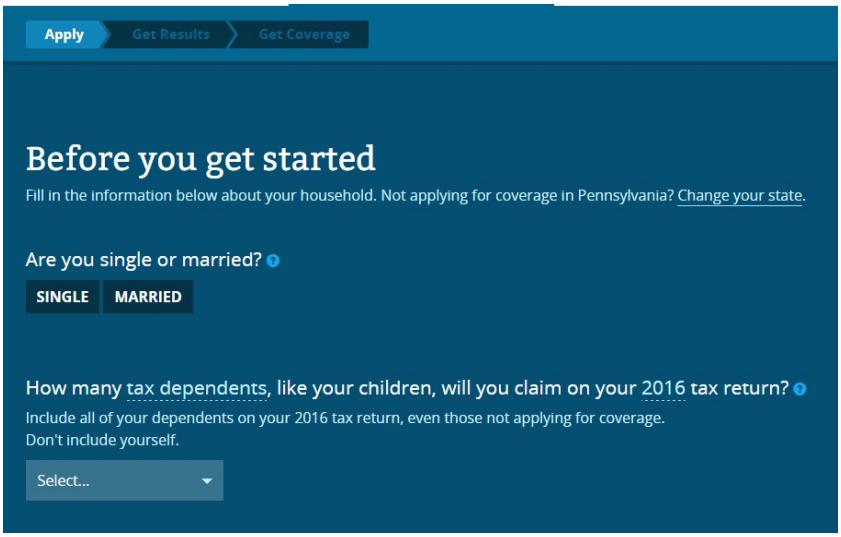
Section	Information Collected
Get Started	• **Marital Status:** Applicants must disclose if they are legally married, whether to a spouse of the opposite sex or the same sex. Generally, married couples must file taxes jointly to qualify for the PTC and CSR. If a couple receiving APTC is expecting to divorce during the calendar year, the couple should plan to indicate that they will file their taxes jointly while still married, if they otherwise would. The couple should update their eligibility application after they are divorced to be reassessed for APTC eligibility.[8] • **Number of Dependent:** Applicants must disclose the number of dependents they will claim on their next tax return. • **Income Range:** Applicants may disclose their household income range, which will help determine whether they are eligible for help paying for coverage. • **Help Paying for Coverage:** Applicants must indicate whether they are interested in help paying for coverage through the Marketplace. If they are not interested in getting help paying for coverage, they will not be asked any additional income information during the application process. • **Screening Questions:** How applicants respond to these screening questions determines whether they complete the shorter, streamlined application, or go through the more detailed, traditional application. • Contact Information – Name – Home address – Mailing address – Email address – Phone number – Preferred spoken language – Preferred written language – Preferred method of communication (e.g., electronic or paper notices) – Race and ethnicity (optional) • **Help Applying for Coverage:** Applicants should indicate whether they are receiving help from an agent or broker by inserting the agent's or broker's National Producer Number (NPN). For more information on where to enter the NPN, see Plan Year 2017 Open Enrollment: A Primer for Agents and Brokers Participating in the Marketplace, slide 74.
Family & Household Information	Many of the following questions serve to verify information the applicant may have provided earlier in the process, including: • Sex • Social Security Number (SSN) • Citizenship/Immigration status • Plans to file taxes for 2017 • Marital status • Dependents • Race/Ethnicity (optional)
Income Information*	**Income:** When applying for help paying for coverage, applicants must enter information about the monthly and annual income (e.g., job-based income, Social Security benefits, unemployment, and investments income) for everyone in the tax household, even if other household members are not applying for coverage.

[8] According to IRS Notice 2014-23, married couples who are living apart at the time of filing their tax return, and who are unable to file joint return because the taxpayer is a victim of domestic abuse and indicates on their income tax return that they fall within the two criteria are not mandated to file a joint tax return. https://www.irs.gov/pub/irs-drop/n-14-23.pdf.

Section	Information Collected
	• Make sure that consumers are very explicit about their expected household income and how it should be reflected in the application. There are multiple ways to enter household income into the application (weekly, monthly, etc.), and you need to ensure that it is entered correctly. • Applicants are only required to complete the Income section if they would like to see their options to lower health plan costs via APTC and CSR or be evaluated for Medicaid or CHIP eligibility.
Additional Information	• **Additional Questions:** The series of additional questions helps applicants determine whether they may have special circumstances that may qualify them for Medicaid. Specifically, they can indicate whether they have a physical disability or mental health condition that limits their ability to function on a daily basis; and whether they need help with daily activities or live in a medical facility or nursing home. The system also asks whether they needed help paying medical bills in the last three months. • **Current Health Coverage Information:** When applying for help paying for coverage, applicants must enter information on whether they are enrolled in or eligible for certain other coverage, and if so, information about the existing coverage. • **Special Enrollment Period Eligibility:** Additional questions are included to see whether applicants may be eligible for a special enrollment period to enroll in a Marketplace plan outside of Open Enrollment.

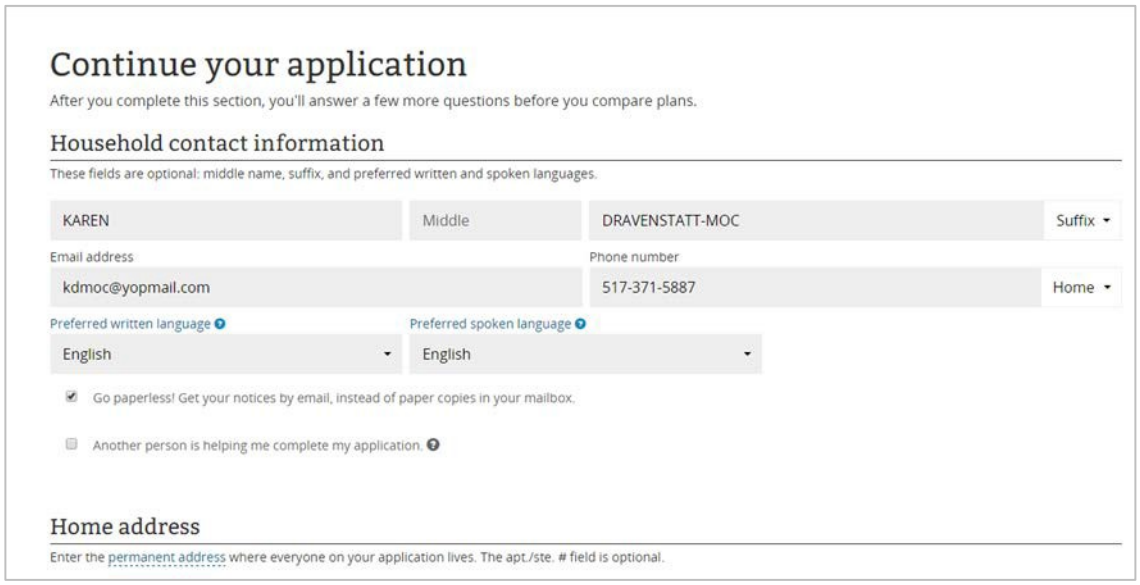
b. Assist consumers with entering the information collected on the "Before You Get Started" section of the application, shown in Exhibit 19.

Exhibit 19. HealthCare.gov Application: Before You Get Started Screenshot



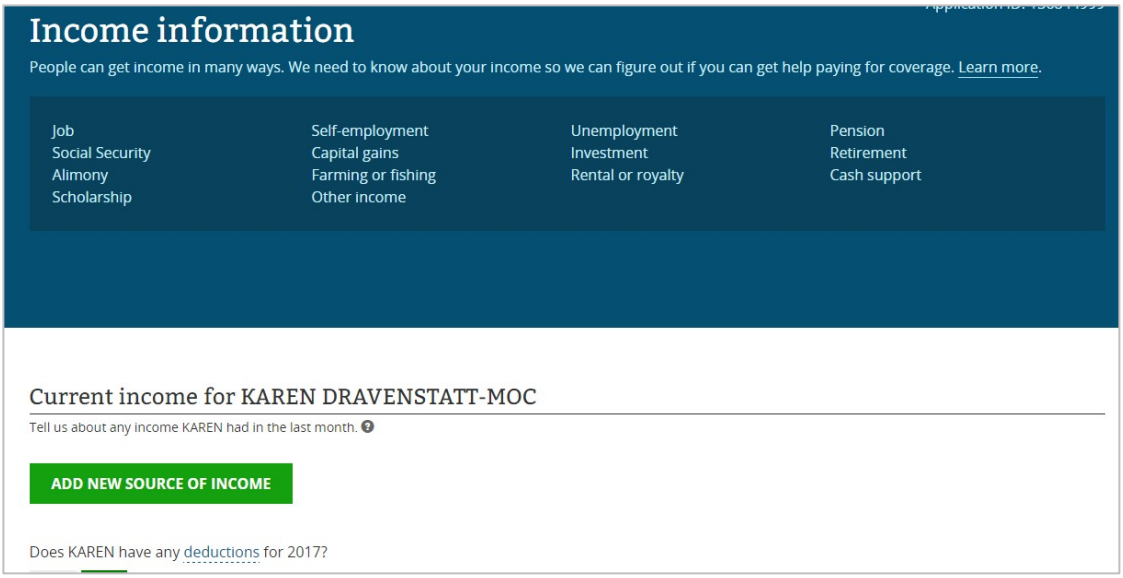
b. Assist consumers with entering the information collected on the "Family & household" section of the application, shown in Exhibit 20. (The "Family & household" section of the application must be completed in one sitting.)

Exhibit 20. HealthCare.gov Application: Family & Household Screenshot



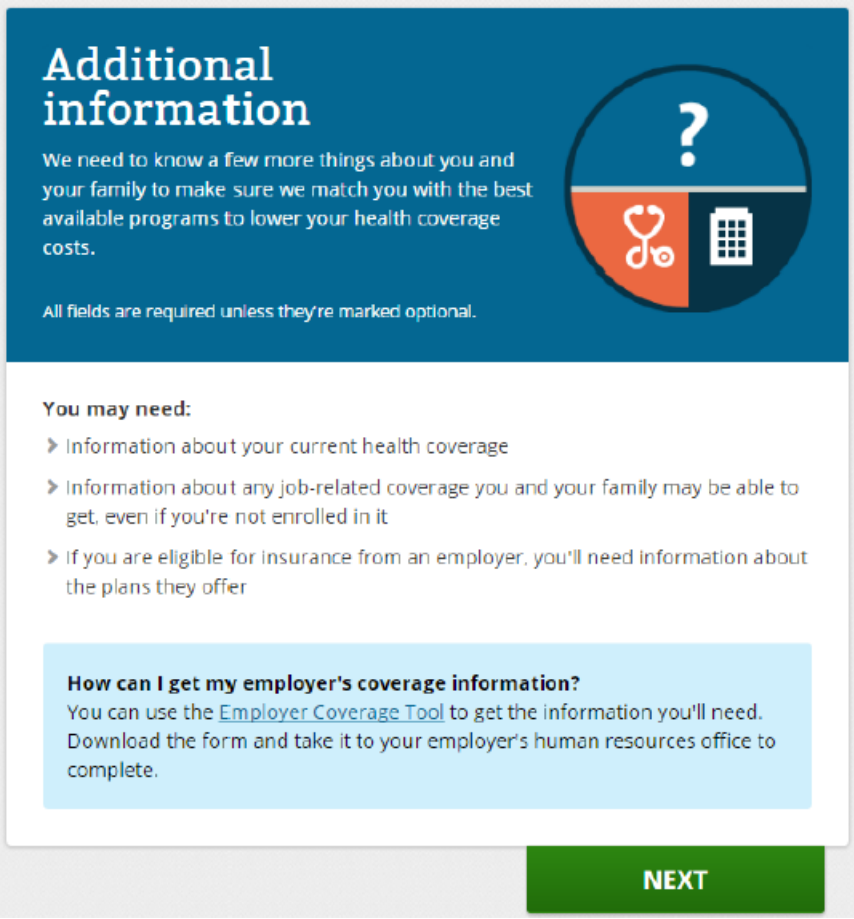
d. Assist consumers with entering the information collected on the "Income" section of the application, shown in Exhibit 21.

Exhibit 21. HealthCare.gov Application: Income Screenshot



e. Assist consumers with entering the information collected on the "Additional information" section of the application, shown in Exhibit 22.

Exhibit 22. HealthCare.gov Application: Additional Information Screenshot



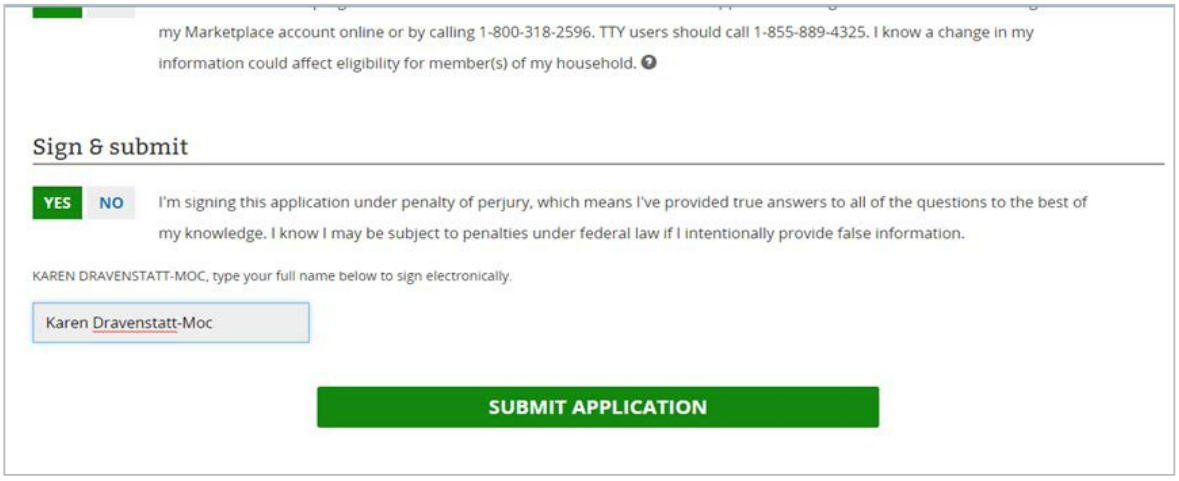
f. Inform consumers that they can save and resume their eligibility application at a later date during the enrollment period by logging into their account again prior to submission. If consumers would like to submit their eligibility application, proceed to Step 4.

Step 5. Consumers should review their application answers, verify accuracy of information provided, electronically sign, and submit the application. Before submitting their applications, consumers can review and edit any information provided on the application using the "Review Application" page.

a. Consumers must attest to the accuracy of the information provided in their applications before submission. On the "Sign & submit" page, consumers will read a series of statements and confirm that they have read and understood each statement.

b. On the "Sign & Submit" page, consumers must input their electronic signatures before clicking the "Submit Application" button to submit their eligibility application. Exhibit 23 provides an example of the screen consumers may see when it is time to electronically sign and submit their applications.

Exhibit 23. Marketplace Electronic Signature Screenshot



Step 6. If consumers receive an immediate eligibility determination, proceed to SOP-6 Review Eligibility Results to help consumers review their eligibility notice.

a. Assist consumers with reviewing their eligibility notice in their online accounts (see Exhibit 24). The eligibility notice will notify consumers if they need to submit supporting documentation or perform additional activities to complete the application process.

b. If consumers are asked to submit supporting documentation and have the necessary supporting documentation with them, assist them with scanning and uploading the documents. Be sure to return all original documents to consumers and to delete or erase all electronic copies of consumers' documents from all of your electronic devices (e.g., printers, scanners).

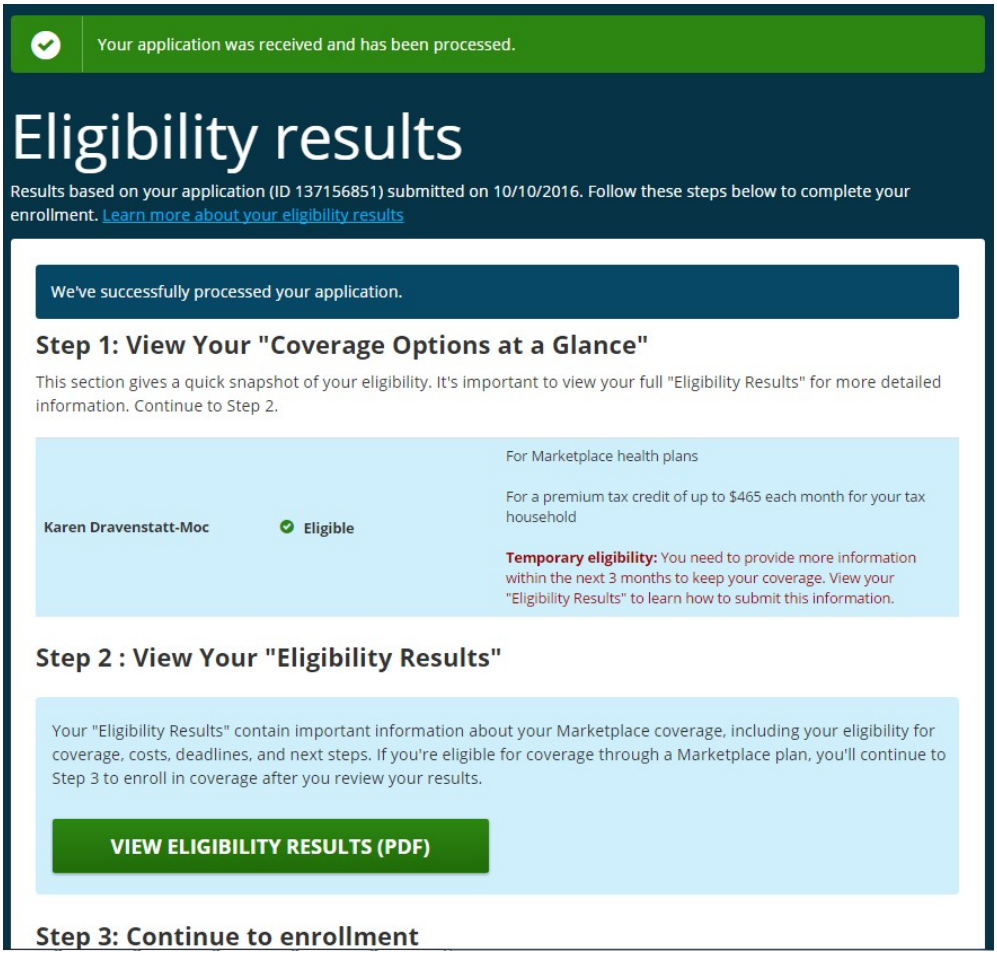
c. If consumers do not have the supporting documentation with them, but they need to submit supporting documents, explain their options to provide the documentation within the specified timeframe, which include:

   i. Scanning and uploading documents from home;

   ii. Returning to the agent's or broker's office with the supporting documents to scan and upload them with the agent's or broker's help; or

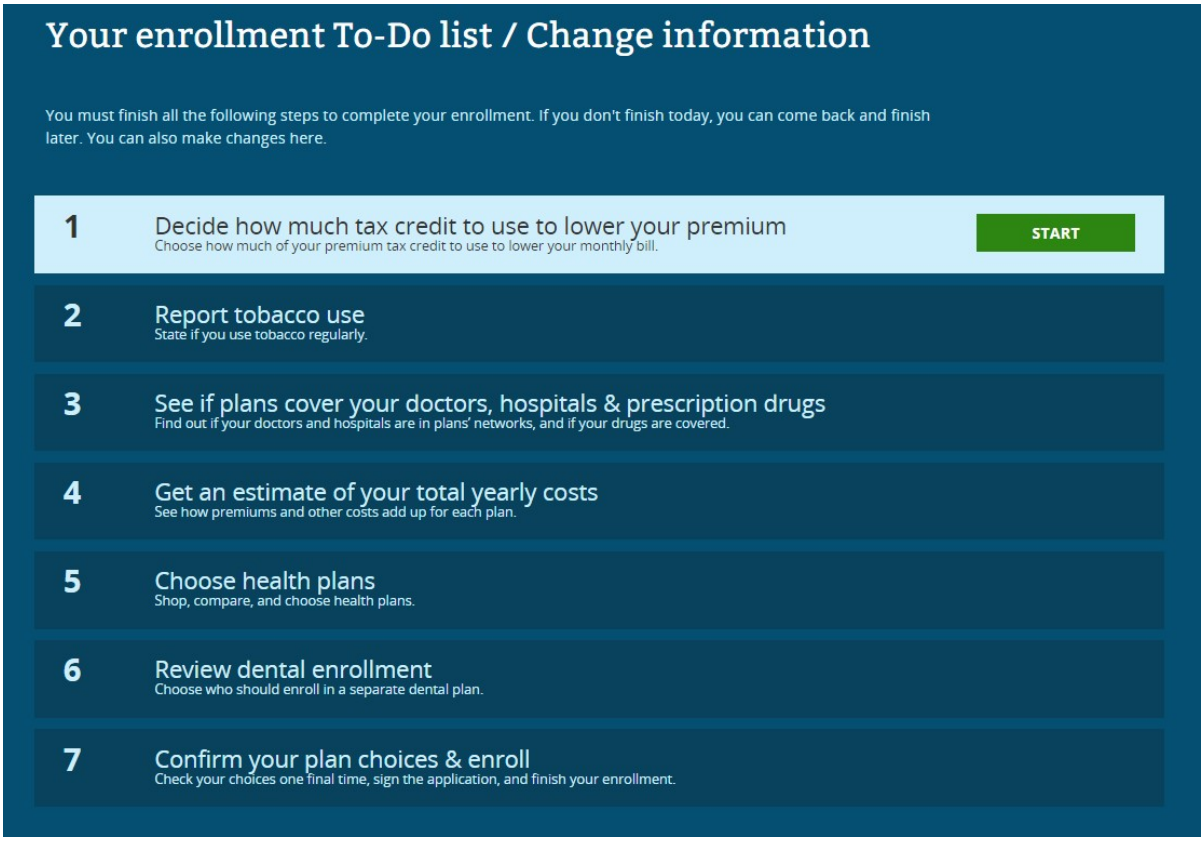
   iii. Mailing copies of the documents to the Marketplace.

Exhibit 24. Eligibility Results Screenshot



Step 7. After consumers review their eligibility results and select "Continue to Enrollment," the Enroll To-Do list will display as shown in Exhibit 25.

Exhibit 25. HealthCare.gov Enroll To-Do List Screenshot



2. Complete Marketplace Application: Paper Application

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

Things You Should Know

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

Step 1. Determine if consumers have previously started their Marketplace application.

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

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

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

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

3. Submit Supporting Documentation

The Marketplace reviews consumers' application information and verifies it using a service called the Federal Data Services Hub (the Hub) to verify that the information entered in an application is correct. The Hub connects the Marketplace with federal agencies, such as SSA, IRS, DHS, and certain other trusted data sources. The Marketplace compares consumers' application information against their information through the Hub to verify its accuracy.

Inconsistencies, also called data-matching issues (DMIs), may occur when the Hub's trusted data sources do not have a consumer's most up-to-date information. For example, a consumer's information may be flagged as potentially inaccurate if the consumer had a recent name change due to marriage. In this case, the consumer could receive a notice from the Marketplace asking for documents to prove the recent name change.

If consumers' application information cannot be confirmed through the Hub, they will receive a notice from the Marketplace notifying them that they need to verify their eligibility with their application. This is known as a data-matching issue, or inconsistency. The notice will specify the timeframe to provide the documentation. The supporting documentation will help the Marketplace verify the application information and make a final eligibility determination.

If consumers appear to be eligible for Medicaid or CHIP and experience a data- matching issue due to citizenship, immigration status, income or residency, they will receive a notice telling them they may be eligible for Medicaid or CHIP and that their case has been sent to the state Medicaid agency. The state Medicaid agency will then contact these consumers if the agencies need further information to complete the application.

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

Step 1. If consumers receive a notice instructing them to send the Marketplace more information, explain to consumers why they may have received this notice and the process that the Marketplace uses to verify consumers' application information.

Step 2. If consumers wish to scan and upload the requested documentation to HealthCare.gov, help them complete the following steps. If consumers wish to mail copies of the requested documentation, proceed to Step 3.

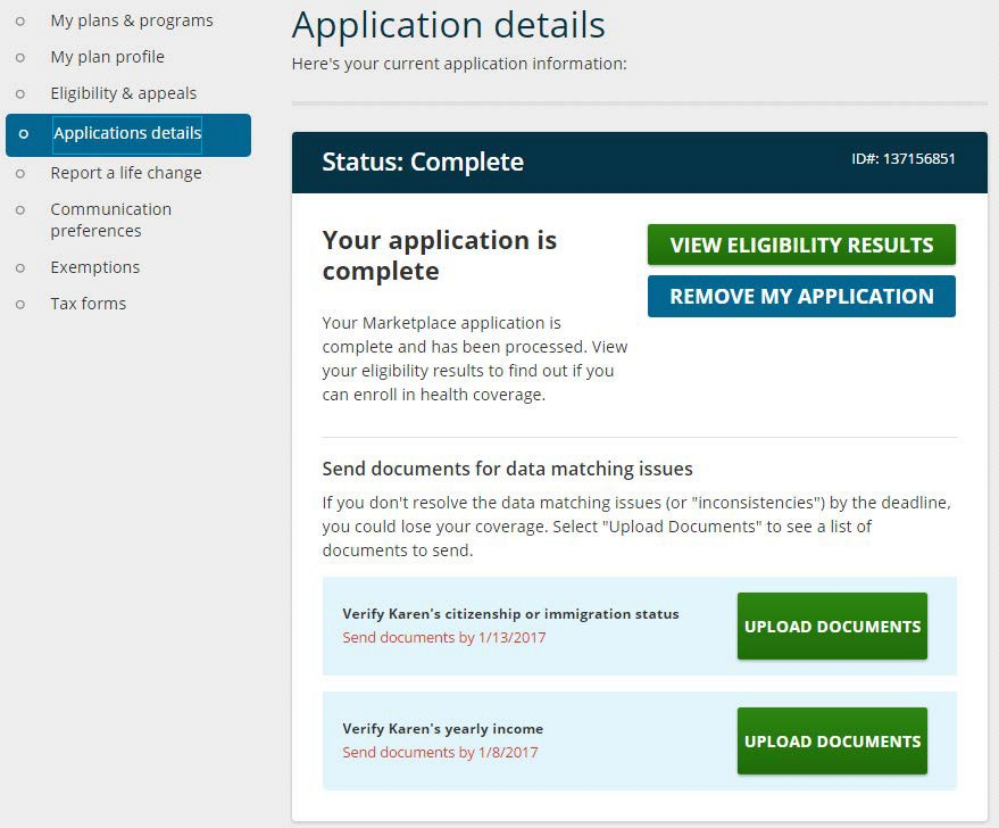
a. Help consumers review their eligibility notice to determine what type(s) of supporting documentation they need.

b. Assist consumers with logging in to their account on HealthCare.gov.

c. Instruct consumers to navigate to" My Applications & Coverage," and then select the relevant application.

d. Help consumers navigate to the "Applications Details" page where they should select the "Upload Documents" button for each application data matching issue, as shown in Exhibit 26.

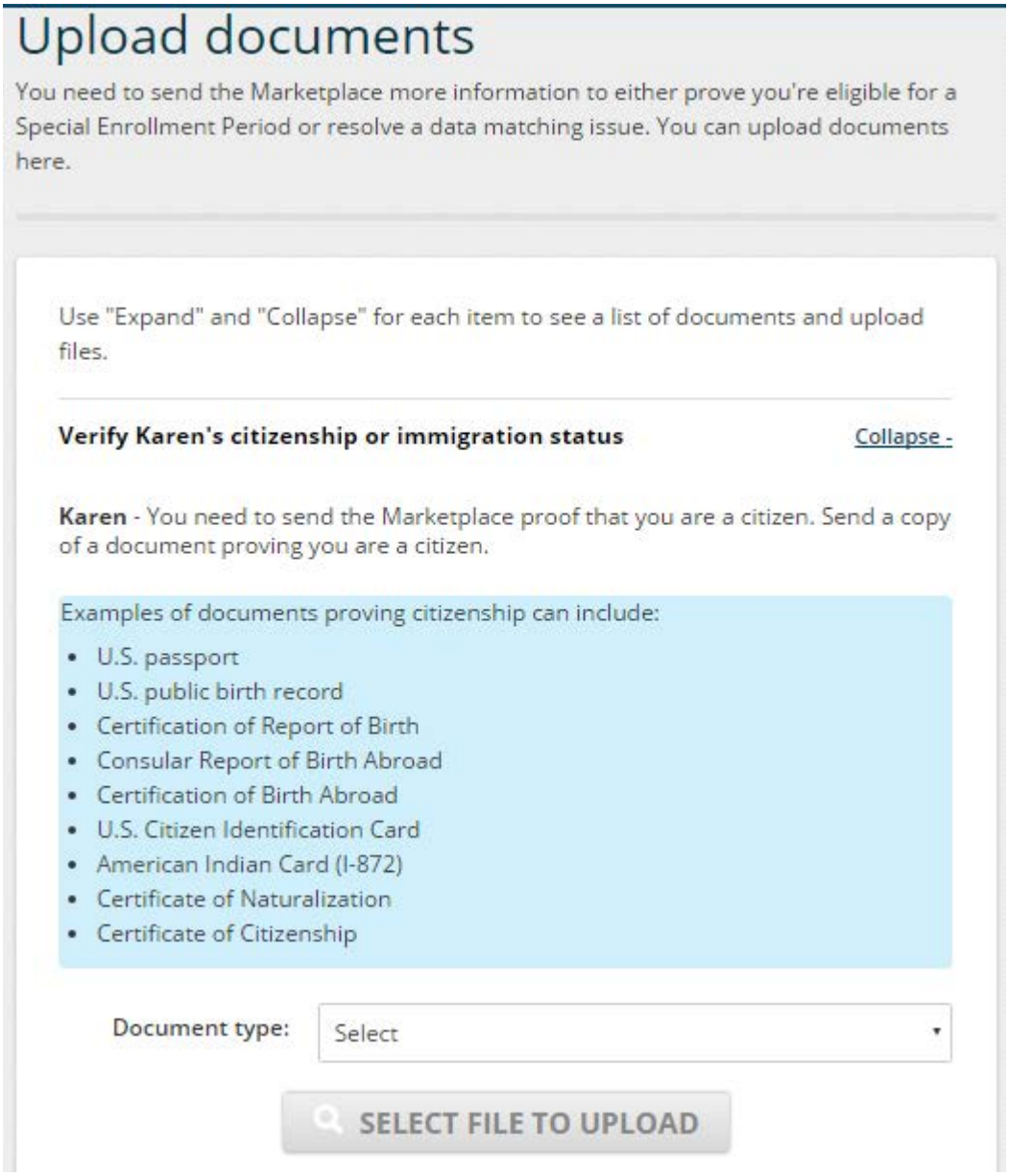
Exhibit 26: Application Details Page on HealthCare.gov Screenshot



e. Assist consumers with selecting the appropriate document type and uploading a scanned image of the document to HealthCare.gov, as shown in Exhibit 27. The document must be a .pdf, .jpeg, .jpg, .gif, .xml, .png, .tiff, or .bmp., and cannot be bigger than 10 MB.

f. If a red box error message appears, make sure the consumer uploaded the right type of document (e.g., PDF, not Excel file).

Exhibit 27. Document Type Screenshot



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

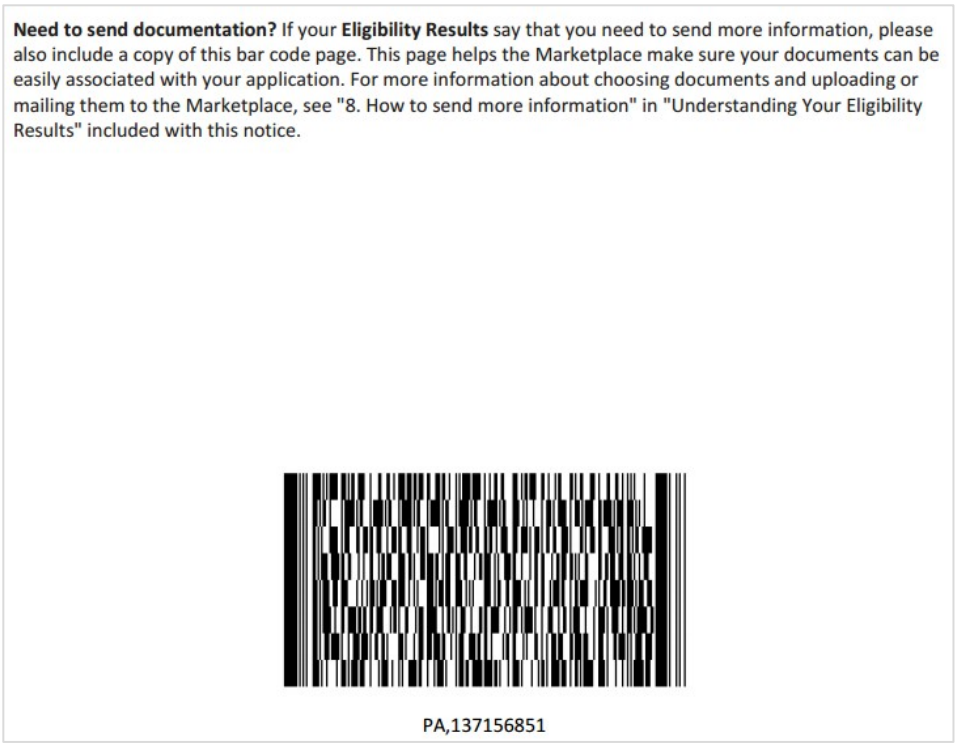
a. Help consumers review their eligibility notice to determine what type(s) of supporting documentation is needed. Help consumers review their eligibility notice to determine what type(s) of supporting documentation is needed. Consumers may need to submit more than one document for each data matching issue.

b. Assist consumers with making copies of all supporting documentation. Consumers should retain originals of any documents sent to the Marketplace.

c. Advise consumers to include the barcode page from their eligibility notice (shown in Exhibit 28) in the envelope when they mail their supporting documentation to the

Marketplace. If consumers do not have the page with the barcode, write the application ID number of the consumer who has the data matching issue, as well as the consumer's date of birth and SSN (if applicable) on the copies of supporting documents.

Exhibit 28. Barcode Page from Eligibility Notice Screenshot



d. Instruct consumers to mail copies of their supporting documentation to: Health Insurance Marketplace[SM]
Attn: Coverage Processing
465 Industrial
Blvd. London, KY
40750-0001

C. Next Steps

1. If consumers are not ready to submit their eligibility application, explain that they may save their online application to their account and resume the application at a later point in time.
2. If consumers receive an immediate eligibility determination and are eligible to enroll in QHPs through the Marketplace, proceed to SOP-6 Review Eligibility Results and SOP-8 Compare, Save, & Select Health Plans. If consumers need more information about a special enrollment period (SEP), proceed to SOP-13 Report Life Changes.
3. For more help answering consumers' specific questions, see Appendix A for Frequently Asked Questions (FAQs) Related to SOP-5 Apply for Health Coverage.

SOP 6. Review Eligibility Results

A. Introduction

As an agent or broker, you can help consumers review their Marketplace eligibility determination. This SOP provides guidance on how to assist consumers in understanding their eligibility determination.

B. Procedures

1. Review Eligibility Results

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

Step 1. Confirm with consumers that they have received an eligibility notice.

Step 2. Review the notices with consumers.

Step 3. Explain the eligibility results to consumers. Use Exhibit 29 to help consumers navigate the different sections of an eligibility notice.

Exhibit 29. Eligibility Results

Section of Eligibility Notice	Information Displayed
Eligibility Results	List of whether applicant(s) are eligible for purchasing coverage through the Marketplace (including, if applicable, a catastrophic plan), APTC and CSR, an SEP, and are or may be eligible for Medicaid/CHIP. Explain the eligibility results, including information about each program, to the individual. This information will be unique for each household applicant.
Why don't I qualify for other programs?	Information about why the applicant(s) did not qualify for other programs (e.g., Medicaid). This information will not be the same for all consumers. Explain to consumers their bases of ineligibility and direct them to their appeal rights in the following sections.
What should I do next?	Instructions and key deadlines for submitting any necessary supporting documentation. This information will be unique for each household applicant.
When will coverage begin?	Information about coverage effective dates. This information will be unique for each household applicant. If determined eligible for Medicaid or CHIP, the FFM notices may not provide information on when coverage will begin. In this case, explain to the individual that their state Medicaid/CHIP agency will be sending a separate notice detailing the effective date for the coverage.
What if information from my application changes during the year?	Information about the process and effect of reporting changes. Explain to those consumers that reporting changes is important as it will affect their coverage
What should I do if I think my eligibility results are wrong?	Instructions and important information to know about requesting an appeal of an eligibility determination. This information will be the same for all consumers.
More about getting Medicaid or CHIP	Information about applying for Medicaid/CHIP if the Marketplace application found the applicant(s) ineligible for Medicaid/CHIP based on their income, but the applicant(s) thinks they have a family income close to the Medicaid income limit , or that they may qualify for other
For more help	Contact information for the Marketplace and, if applicable, state Medicaid/CHIP agencies. This information will be the same for all consumers.
Additional information	Information on tax credits, lowering out-of-pocket costs, Medicaid, and getting help in a language other than English. This information will be the same for all consumers.

Section of Eligibility Notice	Information Displayed
Bar code page	Bar code should be included with copies of documentation if a consumer decides to mail supporting documents to the Marketplace. This bar code page will not be needed if the consumer (1) does not need to submit supporting documentation, or (2) decides to upload supporting documentation through HealthCare.gov.

Eligibility notices from the Marketplace will provide appeals information in case consumers believe their eligibility results are wrong. Consumers are able to request an appeal through the Marketplace Appeals Center within 90 days of receiving their eligibility results. The appeals information can be found on the eligibility notice and is summarized in Exhibit 30.

Exhibit 30. Appeals Information

Important Information About Appeals	Information on What and How a Consumer Can Appeal
Important information about appeals	Information about when, where, and how to appeal an eligibility decision
More information about the PTC	Information about what the PTC is and how it works
More information about lower out-of-pocket costs	Information about cost-sharing, CSR, and how they work
More information about Medicaid and CHIP	Information about Medicaid and CHIP benefits
Getting help with the cost of special health care needs	Information about how applicant(s) may be eligible for Medicaid coverage for special health care needs in addition to their other coverage. This information will be the same for all consumers.
Coverage for immigrant families	Information on coverage options for immigrant families
Reporting changes	Information about types of changes consumers must report and where they can report the change
How to send more information	Information about how consumers can submit additional documents to support an appeal of their eligibility determination

Applicants who have a data-matching issue in their information will have a note in their eligibility notice and may receive an additional notice that: (1) additional supporting documentation is necessary, (2) that the indicated applicant(s) has to submit documentation to verify their eligibility, or (3) that this eligibility notice is not a final eligibility determination. You should help these applicant(s) with their data matching issue by helping them complete the steps listed on the eligibility notice, including providing additional supporting documentation.

Until the data matching issue is resolved, this eligibility notice is not final and cannot be appealed. Consumers may enroll in coverage while they are resolving the data matching issue, but they typically have a period of time, between 90 and 95 days, to submit documentation before their coverage or help paying for coverage ends.

Proceed with Sections 1.1 through 1.4 below to explain eligibility results.

1.1 Options to Lower Health Plan Costs

If consumers are eligible for APTC and CSR, discuss the differences in the how these two programs work. Refer to SOP 7. Lower Costs of Coverage for more information on these financial assistance options.

1.2 Medicaid/CHIP Eligibility

Depending on the state in which consumers reside, the Marketplace may either determine consumers' eligibility for Medicaid or CHIP, or make an initial assessment of eligibility for those programs and have the state make the final determination. In a state in which the Marketplace determines Medicaid/CHIP eligibility, the Marketplace's determination is considered final.

- In a state in which the Marketplace's finding regarding Medicaid/CHIP eligibility is an assessment, the Marketplace simply makes an initial assessment, but the state Medicaid or CHIP agency will make the final determination if the individual is eligible for Medicaid or CHIP.

- When the Marketplace assesses (as opposed to determines) consumers as eligible for Medicaid or CHIP, consumers' eligibility notices will indicate that the consumer "may be eligible" for Medicaid or CHIP and that the state agency will make the final determination on their eligibility.

The eligibility results do not indicate whether the consumer lives in an assessment state or a determination state. A list of assessment and determination states is available at Medicaid and CHIP Marketplace Interactions.

On a Marketplace application, any applicant who meets their state's income, residency, immigration, and other requirements will be transferred to the state Medicaid or CHIP agency. In any state, if it appears a consumer may be eligible for Medicaid on another basis or if the consumer requests a full Medicaid eligibility determination, the Marketplace will transfer the consumer's application to the state agency for a final determination.

Note: If consumers have been determined eligible for or are enrolled in minimum essential coverage (MEC) Medicaid or CHIP, they are NOT eligible to receive APTC or income-based CSR to help pay for a Marketplace plan.

Transferring Consumer Information to the State Medicaid and CHIP Agency

There are several reasons the Marketplace may transfer a consumer's information to the state Medicaid or CHIP agency. For example, on a Marketplace application, any applicant who meets their state's income, residency, immigration status, and other requirements for Medicaid or CHIP will have their account and information transferred to the state Medicaid or CHIP agency. Also, if it appears a consumer may be eligible for Medicaid on another basis (e.g., through special health care needs or a disability), the Marketplace will transfer the consumer's application to the state agency for a determination on those bases.

Consumers who live in a state where the Marketplace provides an eligibility determination can also request to send their application to the state agency; if they do so, the Marketplace will transfer their information to the state agency. In this scenario, the Marketplace may have told the consumer that they were not eligible for Medicaid and CHIP in the Eligibility Determination Notice. However, consumers can request a full determination from their state agency.

- **Assessed as Potentially Eligible:** If the consumer resides in a state in which the Marketplace provides an initial eligibility assessment for Medicaid or CHIP, and the Marketplace assesses a consumer potentially eligible for Medicaid or CHIP, the consumer's application is transferred to the state Medicaid or CHIP agency for a final eligibility determination. Individuals are not eligible for PTC and CSR when they are assessed as potentially eligible for Medicaid/CHIP and transferred to the state Medicaid/CHIP agency, unless the state determines the consumer ineligible for Medicaid/CHIP.

  If this happens, the state Medicaid agency will transfer the account back to the Marketplace and the consumer may then be eligible for premium tax credits and cost sharing reductions. It is important to remember that after the Marketplace's initial assessment, the consumer's determination of eligibility for coverage is not yet done. The state agency will provide a final decision on eligibility for Medicaid/CHIP in assessment states.

- **Determined Eligible:** If the consumer resides in a state in which the Marketplace provides a final eligibility determination for Medicaid or CHIP and the Marketplace determines that the consumer is eligible, the consumer's determination of eligibility for Medicaid/CHIP is complete. The consumer's application will be transferred to the state Medicaid or CHIP agency and the consumer will be enrolled in Medicaid or CHIP coverage. Consumers' state Medicaid/CHIP agency will notify them about next steps, including benefit and potential cost-sharing information. If an applicant appears to be eligible for Medicaid or CHIP but the Marketplace is unable to verify all information necessary to determine eligibility, the Marketplace transfers the consumer's application to the state Medicaid or CHIP agency to collect additional information and complete the final determination.

Things You Should Know

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

Exhibit 31 highlights the differences between an assessment and a determination of eligibility. You can use it to help explain to consumers whether they are ***assessed potentially eligible*** or ***determined to be eligible*** for Medicaid or CHIP.

Exhibit 31. Eligibility Assessment vs. Determination

Consumers Who Are Assessed by the Marketplace as Potentially Eligible for Medicaid/CHIP	Consumers Who Are Determined by the Marketplace to be Eligible for Medicaid/CHIP
• If the Marketplace assesses a consumer as potentially eligible for Medicaid/CHIP, it will transfer the account to the state Medicaid/CHIP agency for a final determination • The state Medicaid or CHIP agency will make a final Medicaid/CHIP eligibility determination. • Consumers' state Medicaid/CHIP agency may follow up with them to collect additional information. • Consumers' state Medicaid/CHIP agency will notify them about the results of the final determination and next steps. • If the state Medicaid or CHIP agency determines the consumer not eligible, the consumer's account will be transferred back to the Marketplace for a determination of APTC/CSR eligibility. • In most states, Medicaid coverage will be effective back to the date of application; Medicaid coverage may be effective up to three months prior to the month of application in certain states if the consumer would have been eligible during that time and has unpaid bills for Medicaid-covered services. • Some states have different start dates for different types of Medicaid coverage and for CHIP. – Check with your state Medicaid or CHIP agency to understand what the start dates are for different types of Medicaid and for CHIP.	• If the Marketplace determines a consumer as eligible for Medicaid/CHIP, it will transfer the account to the Medicaid/CHIP agency for enrollment. • Consumers are enrolled directly in Medicaid or CHIP coverage in most cases. • Consumers' state Medicaid/CHIP agency will notify them about next steps, including benefit and potential cost-sharing information. • In most states, Medicaid coverage will be effective back to the date of application; Medicaid coverage may be effective up to three months prior to the month of application in certain states if the consumer would have been eligible during that time. • States have different start dates for CHIP. The state will notify the consumer about when CHIP coverage will begin.

If consumers who are determined eligible for Medicaid or CHIP indicate that they would rather enroll in a QHP, explain that they may do so; however, they will not be eligible for APTC and/or CSR for enrollment in a QHP through the Marketplace.

An individual cannot be enrolled in Medicaid/CHIP and remain eligible to receive APTC for Marketplace coverage.[9] Ensure that these consumers are aware of the cost associated with maintaining coverage through the Marketplace, when a consumer is eligible for Medicaid or CHIP. Use the following guidance when assisting consumers eligible for Medicaid or CHIP who want to enroll in a QHP through the Marketplace and pay the full cost:

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

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

[9] See https://marketplace.cms.gov/applications-and-forms/pdm-round-2-notice.pdf.

financial assistance to enroll in a QHP through the Marketplace.

1.3 Ineligibility for Coverage

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

1.4 Eligible for Coverage through the Marketplace without Financial Assistance

Consumers who are ineligible for APTC, CSR, or Medicaid or CHIP may still enroll in QHPs through the Marketplace if they are qualified. These consumers will receive an eligibility determination stating the reason they are not eligible and/or the reason they were denied eligibility for APTC.

C. Next Steps

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

SOP 7. Lower Costs of Coverage

A. Introduction

When consumers who apply for help lowering the costs of coverage receive their eligibility results, the Marketplace will inform them of their eligibility for options to lower their health plan costs through APTC and CSR. If eligible, consumers can choose whether to apply APTC to the cost of their health plans.

When comparing plans, consumers select the amount of APTC for which they are eligible that they want paid on their behalf to their chosen insurance provider. The amount of APTC for which a consumer is eligible is based on the consumer's projected household income for the coming year and other factors. Consumers can also select health plans that apply CSR if they are eligible.

While assisting consumers with selecting the amount of APTC or viewing a plan's CSR, remind consumers that they must accurately represent their household income information. Consumers generally are required to report all forms of household income, although Supplemental Security Income (SSI) and certain other items are not included in household income.[10] This SOP provides guidance on how to assist consumers with understanding APTC and CSR.

B. Procedures

1. Select APTC

If consumers are eligible for APTC, they have the option of using all, some, or none of the amount for which they are eligible to reduce their monthly premium cost. Before helping them make changes to their Marketplace accounts, make sure that consumers understand APTC. APTC is reconciled on tax returns, so using too much or too little of their credit can result in balances owed or refunds at tax time. Exhibit 32 provides information to help answer questions about APTC available through the Marketplace.

Exhibit 32. Common PTC Questions and Answers

Question	Answer
What is the premium tax credit (PTC)?	A tax credit that helps low- and moderate-income individuals afford health insurance.
What are advance payments of the premium tax credit (APTC)?	Individuals who meet certain criteria at the time of enrollment in a QHP may choose to have APTC paid to their insurance provider to lower the cost of their monthly premiums. Consumers may choose to have some, none, or all of the APTC for which they are eligible paid on their behalf.
How do APTC affect individuals' tax returns?	When consumers file their tax returns for the year, the actual amount of the PTC they were eligible for is calculated. Consumers whose APTC exceed their actual premium tax credit eligibility may be required to pay back all or a portion of the difference (see the Repayment Limitation Table). Consumers whose APTC is less than the amount they were eligible for will owe less in taxes or get a refund for the difference.
Who is eligible for PTC?	To be eligible for a PTC: • Consumers or family members, such as their spouse or dependent, must be enrolled in a QHP through the Marketplace for one or more months in which they were not eligible for other minimum essential coverage (MEC) such as Medicaid, CHIP, TRICARE, or affordable employer-sponsored coverage that meets the minimum value standard;

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

Question	Answer
	• Consumers must file a joint tax return if married, unless the consumer is a victim of domestic abuse or spousal abandonment, and will not be claimed as a dependent on another taxpayer's tax return;† • In general, consumers must have household income between 100% and 400% of the federal poverty level (FPL) (see Appendix C: Federal Poverty Guidelines);* and • Note that a PTC is only allowed for months in which consumers pay their share of the premium by the due date of the consumers' tax return

†*Consumers who are married but living apart from their spouse and are unable to file a joint income tax return because of a case of spousal abandonment or domestic abuse can obtain APTC and CSR as long as they are otherwise eligible. For more information, see the guidance available at: https://www.CMS.gov/CCIIO/Resources/Regulations-and- Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf.*

**Adult consumers generally must have a household income between 138% and 400% of the FPL if they live in a state that has expanded Medicaid. Consumers living in a Medicaid expansion state whose household income is less than 100% of the FPL and who are not eligible for Medicaid due to immigration status may also be eligible for financial assistance through the Marketplace. See the Agent and Broker Guide to the Immigration Section of the Online Marketplace Application for more information on helping non-citizens through the Marketplace application process.*

2. Select the Amount of APTC

If consumers are eligible for APTC, the Marketplace will notify them of the maximum dollar amount available to them. Consumers can choose to apply the entire amount to their monthly health plan premiums or a lesser amount of their choice, including zero. Be sure to point out the differences between their eligibility for a certain amount of PTC and receiving APTC.

APTC is based on estimates of the premium tax credit consumers may be allowed to claim when filing their tax return. Eligibility for the PTC and the amount of the credit they are allowed is not determined until the consumer files a tax return.

Also point out that when filing their tax return for the year, consumers must reconcile or compare their APTC with the PTC they are allowed. Consumers whose APTC exceed their actual PTC will owe all or a portion of the difference to the IRS when filing their taxes. Consumers whose actual premium tax credit is more than their APTC may get a credit on their taxes or get a refund for the difference.

You can help consumers select the amount of APTC to apply to their monthly premiums during plan selection after the initial application or when reporting a life change to the Marketplace. For example, if a consumer will have an uncertain variable income, you may want to discuss the idea of claiming only part of the tax credit for which they are eligible as an advance payment. This may reduce the amount of money the consumer may owe at tax filing time in the event the consumer's actual income is higher than anticipated. However, it's important to remind consumers that you cannot provide tax advice within your capacity as an agent or broker.

To help consumers select the amount of APTC they would like to have paid on their behalf, complete the following steps:

Step 1. Help consumers review the amount of APTC for which they are eligible. The amount of APTC for which consumers are eligible can be found in the *Eligibility Results* table on their eligibility notice, as shown in Exhibit 33.

Explain that the amount shown on the table represents the amount of the APTC for the entire family, not just the individual, on that particular row of the chart. For example, if a married couple is eligible for $300 of APTC, the eligibility results table will show $300 after the husband's name and $300 after the wife's name. Even though the amount of $300 appears twice, the couple is not eligible for $600.

Exhibit 33. What Are the Results of my Application?

Family Members	Results	Next Steps
Andre Hall	• Eligible to purchase health coverage through the	Send the Marketplace more

Family Members	Results	Next Steps
	• Marketplace, but more information is needed • Eligible for APTC ($300 each month, which is $3,600 for the year), but more information is needed	information
Bridget Hill	• Eligible to purchase health coverage through the • Marketplace, but more information is needed • Eligible for APTC ($300 each month, which is $3,600 for the year), but more information is needed	Send the Marketplace more information

Explain to consumers that they have the option to use less than the total amount of APTC for which they are found eligible. The amount they use will lower the cost they will pay for QHP monthly premiums.

Step 2. Describe the potential effects of adjusting APTC amount, including:

a. Premium amount paid by consumers
b. Tax consequences (see Section 2.1 Potential Tax Consequences).

Step 3. Explain when the APTC take effect.

During Open Enrollment:

a. If consumers adjust their APTC between the 1st and 15th of the month, the change in premium takes effect on the first of the next month (e.g., if the change is made on December 8, the change in premium takes effect on January 1).

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

Outside of Open Enrollment:

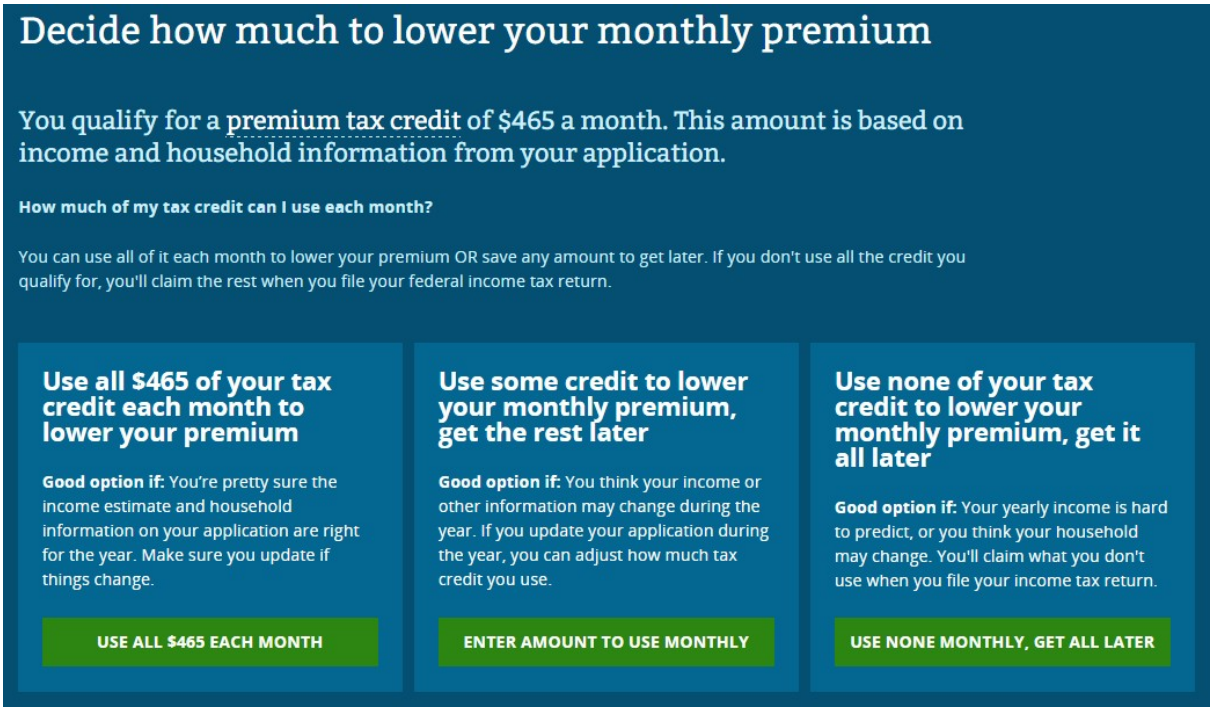
a. If consumers adjust the amount of APTC, the change generally takes effect the day the adjustment is made, unless the family simultaneously receives a special enrollment period (SEP) determination, in which case the APTC change follows the SEP effective date.

Step 4. Help consumers select the amount of APTC they would like to apply towards their monthly premium payments. Consumers' maximum amount of the APTC cannot be more than the cost of their monthly premiums. The tool consumers can use to select the amount of APTC they would like to apply towards their monthly premium payments is shown in Exhibit 34.

Things You Should Know

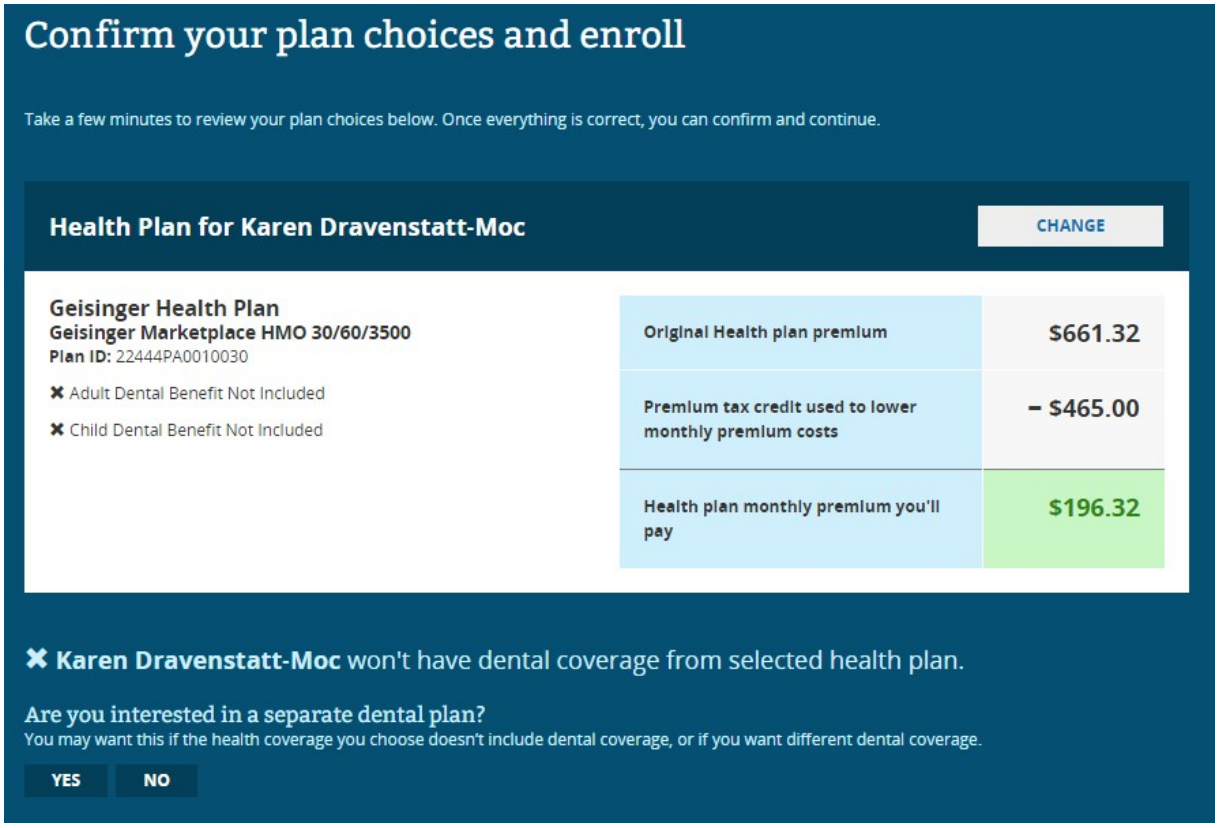
- Remind consumers that they must file a federal income tax return for any year during which APTC has been paid on their behalf. Also inform consumers they will be ineligible for APTC in future years if they do not file and reconcile for any previous year during which APTC was paid on their behalf.

Exhibit 34. Selecting the Amount of Advance Payments of the Premium Tax Credit Screenshot



IMPORTANT: If the consumer is shopping for a plan, monthly premium costs will reflect the amount of APTC the consumer selected. Some consumers may wish to change the amount of APTC they are using for an existing plan. These consumers should log in to their Marketplace accounts; select the plan they are currently enrolled in from the Plan Compare menu; and proceed to the Review and Confirm Plan Selection page to make the change. See Exhibit 35 for an example of what plan costs will look like once APTC has been applied.

Exhibit 35. Review and Confirm Plan Selection Screenshot



3. Potential Tax Consequences

Explain to consumers that the amount of the APTC paid on their behalf will affect the amount they owe or the amount of their refund when they file their federal income tax return. Consumers for whom APTC payments are made must file a tax return, even if they are not otherwise required to file taxes. On their tax return, the APTC they received will be compared to the actual PTC they are allowed to claim on that return.

A consumer's maximum APTC depends on the consumer's projected household income and family size. However, the consumer must use his or her actual household income and family size in calculating the PTC when filing his or her tax return to calculate the premium tax credit. If a consumer's actual household income differs from the projected household income amount, this may affect the amount the consumer will pay or receive as a credit or refund when filing the consumer's federal income tax return.

Consumer repayments of the excess APTC is limited to amounts based on their income and household size, as shown in Exhibit 36.

Exhibit 36. Consumer APTC Repayment Limits

Household Income Percentage of Federal Poverty Level	Limitation Amount for Single, Married Filing Separately, and HOH Taxpayers	Limitation Amount for All Other Filing Statuses
Less than 200%	$300	$600
At least 200%, but less than 300%	$750	$1,500
At least 300%, but less than 400%	$1,250	$2,500
400% or more	No limit	No limit

If consumers' actual household incomes are less than they projected when they submitted their Marketplace application, or if consumers chose to have less than all of the APTC for which they were eligible paid to the insurance provider, it is likely that the consumers' PTC will be more than their APTC. In that case, consumers will get a credit or a refund for the difference when they file a tax return for the year.

If a consumer's income is below 100% FPL, he or she may still be able to claim PTC at tax time if he or she has been enrolled in a Marketplace plan with APTC and had expected a household income between 100 and 400% FPL when he or she initially enrolled in the plan. However, for the next plan year, the consumer may be eligible for Medicaid and generally will not be eligible for APTC if household income for the next plan year is expected to remain below 100% FPL.

You should encourage consumers to go back to the Marketplace to update their income information. If a consumer does appear to qualify for Medicaid, his or her application information will be sent directly to the consumer's State Medicaid office. The consumer will receive a notice of Medicaid eligibility later.

Note that as an agent or broker, you may educate consumers on the Marketplace-related components of the PTC reconciliation process, and help them understand the availability of IRS resources on this process. However, you must inform consumers that you are not acting as a tax adviser or attorney when providing assistance as an agent or broker and cannot provide tax or legal advice within your capacity as an agent or broker.

Exhibit 37 provides a reference on when consumers should contact the Marketplace Call Center or the IRS if they have questions about how their coverage status and/or Marketplace financial assistance will affect the tax filing process. Use this resource in your work with consumers to help them route their questions accordingly.

Exhibit 37. Where Consumers Can Direct Questions About the Tax Consequences of APTC and Marketplace Coverage

The Marketplace Call Center will handle questions regarding:	The IRS will handle questions regarding:
• Form 1095-A (Advance Premium Tax Credit) • Form 8962 (Premium Tax Credit) and how it works with Form 1095-A • Advance Premium Tax Credit versus • Premium Tax Credit • Eligibility for Advance Premium Tax Credit • Exemptions (including who qualifies for exemptions, what to do if your exemption is pending, and how to get an Exemption Certificate Number (ECN) • Handling problems with Form 1095-A (including missing or incorrect information and duplicate copies) • How the Tax Credit may Impact Consumers' Tax Refunds • Fees for Not Having Coverage (what it is, how much it will cost, and what it will be in future years) • Tax Assistance (including free file, which forms to fill out, where to get assistance with tax filing, and what the tax deadline is)	• Help Filing Taxes • Help Paying Taxes Owed to the IRS • Questions Related to Tax Filing, such as: – How long can I delay filing? – What happens if I don't file? – I filed my taxes prior to getting Form 1095-A. How do I amend my tax return? • Questions on how to complete Form • Form 8962,"Premium Tax Credit" • Questions on how to complete Form 8965, "Exemptions" • Questions about other tax forms

4. Select Plans with Cost-Sharing Reductions

In addition to PTC, consumers may be eligible for financial assistance through the Marketplace in the form of income-based cost-sharing reductions or CSR. If consumers have household income between 100% and 250% of FPL or are members of a federally recognized Indian tribe, they may be eligible for plans with CSR. Plans with income-based CSR reduce the amount that consumers have to pay out of pocket for health care (e.g., deductibles, copayments, and coinsurance), provided that the consumer chooses a Silver-level QHP.[11] Eligible members of federally recognized Indian Tribes may receive their special cost sharing benefit in any Bronze, Silver, Gold or Platinum plan. The Marketplace will determine if consumers are eligible

[11] Members of federally recognized tribes may take advantage of CSR at any health plan metal level.

for CSR based on projected household income and family size; or membership in a federally recognized tribe. Exhibit 38 provides information to help answer questions about CSR.

Exhibit 38. Common Cost-Sharing Reductions Questions and Answers

Question	Answer
What is a cost-sharing reduction (CSR)?	A discount that lowers the amount a consumer has to pay for deductibles, coinsurance, and copayments.
Who is eligible for CSR?	To be eligible for and utilize CSR, a consumer must: • Have a projected household income between 100% and 250% of FPL (see Appendix C: Federal Poverty Guidelines) †; or an American Indian with household income under 300% of the FPL. • Enroll in a Silver category QHP* through the Marketplace; and • Be eligible for the PTC.

†Members of federally recognized tribes who have a household income below 300% of the FPL are exempt from cost-sharing and do nothave to pay out-of-pocket costs for health coverage.
**Members of federally recognized tribes may take advantage of CSR at any health plan metal level.*

Consumers will find out if they are eligible for CSR by reviewing their onscreen eligibility results. It is important for those eligible for the most generous CSR provided, at the 94%/06 and 87%/05 level, to understand that if they use medical services, they may potentially save thousands of dollars but only by selecting a Silver-level plan. See Exhibit 39 for the key notice content and next steps:

Exhibit 39. Key Notice Content and Next Steps

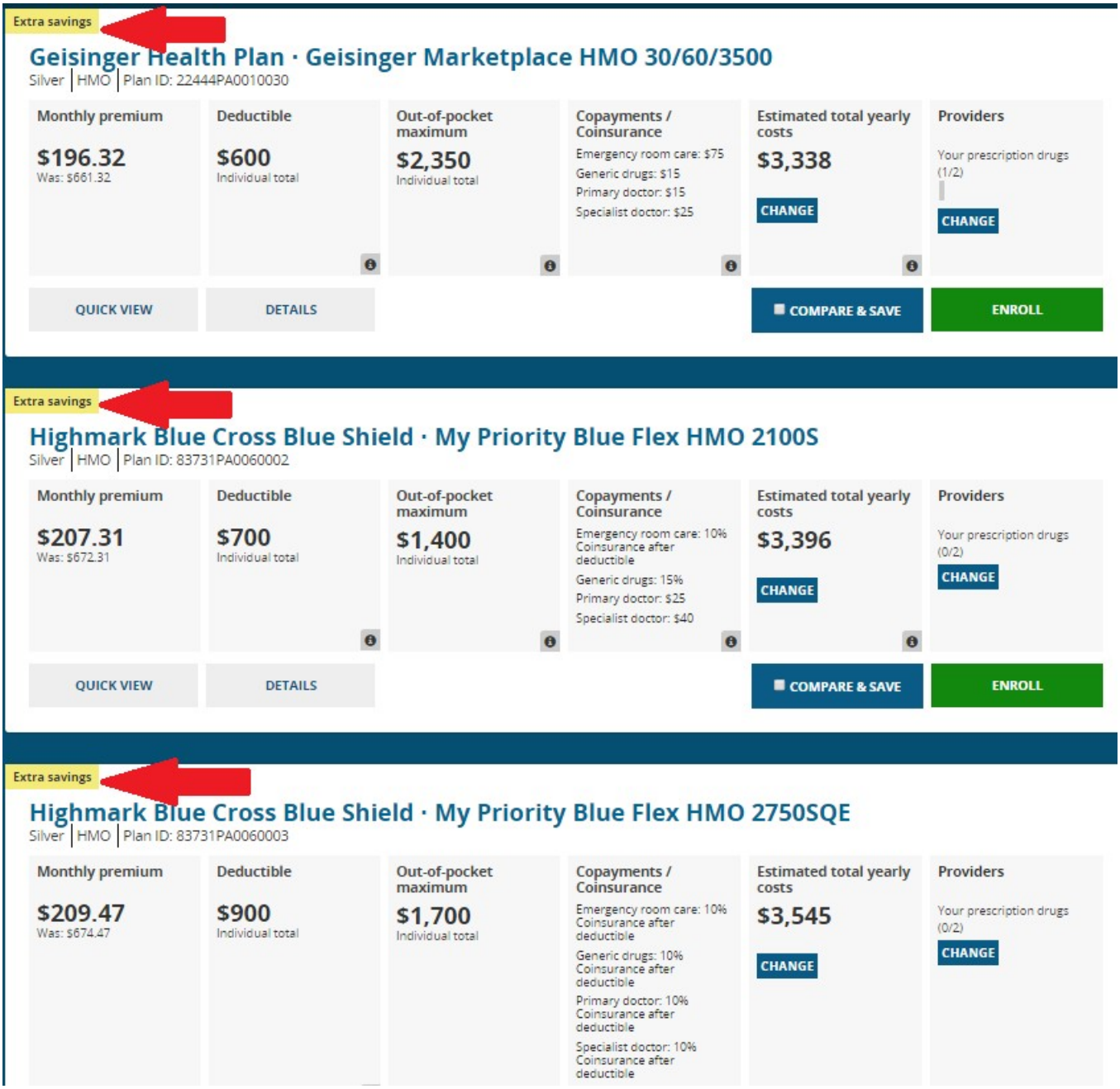
CSR Eligibility Type	Eligibility Notice Content English & Spanish	Next steps English & Spanish
94% Cost Sharing Reduction CSR Code = 06	• Can choose a health plan with lower copayments, coinsurance, and deductibles (i.e., CSR) (06)	• Choose a health plan and make first month's payment. Consumers must choose a Silver-level plan to get these extra savings on out-of-pocket costs. Choosing a Silver-level plan instead of a Bronze-level plan may save consumers thousands of dollars if they use a lot of medical services.
	• Puede elegir un plan médico con copagos, coseguro, y deducibles reducidos (reducciones en costos compartidos) (06)	• Elija un plan médico y haga el pago del primer mes. Debe elegir un plan Plata para obtener estos ahorros adicionales en los gastos directos de su bolsillo. La elección de un plan Plata en lugar de un plan Bronce puede ahorrarle miles de dólares si utiliza una gran cantidad de servicios médicos.
87% Cost Sharing Reduction CSR Code = 05	• Can choose a health plan with lower copayments, coinsurance, and deductibles (cost-sharing reductions) (05)	• Choose a health plan and make first month's payment. Consumers must choose a Silver-level plan to get these extra savings on out-of-pocket costs. • Choosing a Silver-level plan instead of a Bronze-level plan may save consumers thousands of dollars if they use a lot of medical services.
	• Puede elegir un plan médico con copagos, coseguro, y deducibles reducidos (reducciones en costos compartidos) (05)	• Elija un plan médico y haga el pago del primer mes. Debe elegir un plan Plata para obtener estos ahorros adicionales en los gastos directos de su bolsillo. La elección de un plan. • Plata en lugar de un plan Bronce puede ahorrarle miles de dólares si utiliza una gran cantidad de servicios médicos.
73% Cost Sharing Reduction CSR Code = 04	• Can choose a health plan with lower copayments, coinsurance, and deductibles (i.e., CSR) (04)	• Choose a health plan and make first month's payment. Consumers must choose a Silver-level plan to get these extra savings on out-of-pocket costs.
	• Puede elegir un plan médico con copagos, coseguro, y deducibles	• Elija un plan médico y haga el pago del primer mes. Debe elegir un plan Plata para obtener estos ahorros adicionales en los gastos directos de su bolsillo.

CSR Eligibility Type	Eligibility Notice Content English & Spanish	Next steps English & Spanish
	reducidos (reducciones en costos compartidos) (04)	
Limited Cost Sharing (for members of federally recognized tribes at 300% FPL and above) CSR Code = 03	• Can choose a health plan with lower copayments, coinsurance, and deductibles (i.e., CSR) under certain conditions (03). You won't pay any cost-sharing for covered services from the Indian Health Service, but we need more information from you.	• Choose a health plan and make first month's payment. Also, send the Marketplace more information, as required in the eligibility notice. • This notice explains what consumers need to send. Consumers won't pay copayments, coinsurance, or deductibles when they get care from an Indian Health Service provider, or from a Marketplace plan provider when referred by an Indian Health Service provider.
	• Puede elegir un plan médico con copagos, coseguro, y deducibles reducidos (reducciones en costos compartidos) (04)	• Elija un plan médico y haga el pago del primer mes. Debe elegir un plan Plata para obtener estos ahorros adicionales en los gastos directos de su bolsillo.
Limited Cost Sharing (for members of federally recognized tribes at 300% FPL and above) CSR Code = 03	• Can choose a health plan with lower copayments, coinsurance, and deductibles (cost-sharing reductions) under certain conditions (03). You won't pay any cost-sharing for covered services from the Indian Health Service, but we need more information from you.	• Choose a health plan and make first month's payment. Also, send the Marketplace more information, as required in the eligibility notice. • This notice explains what consumers need to send. Consumers won't pay copayments, coinsurance, or deductibles when they get care from an Indian Health Service provider, or from a Marketplace plan provider when referred by an Indian Health Service provider.
	• Puede elegir un plan médico con copagos, coseguros y deducibles más bajos (reducciones de costos compartidos) bajo ciertas condiciones (03). Cuando se inscribe en este tipo de plan, no tendrá que pagar ningún costo compartido por los servicios proporcionados por el Servicio de Salud Indígena. Para obtener ayuda con los costos por los servicios cubiertos de un proveedor del plan del Mercado, usted necesita un Compras/Referido de Cuidado.	• Elija un plan médico y haga el pago del primer mes. No tendrá que pagar los copagos, coseguros o deducibles cuando recibe atención de un proveedor de Servicio de Salud para Indígenas o de un proveedor del plan del Mercado cuando son referidos por un proveedor de Servicios de Salud para Indígenas. Sin un referido, tendrá que pagar sus costos compartidos regulares de su plan del Mercado.

If consumers are eligible for CSR, discuss the following topics.

Topic 1: Explain to consumers that they must choose a Silver-level plan to take advantage of CSR. If they qualify for a CSR and do not choose a Silver-level plan, they may owe more when they need health care. There is one exception to this rule: members of a federally recognized tribe may take advantage of CSR at any QHP metal level. Consumers who are eligible for CSR will see eligible plans indicated with an "Extra Savings" box in the corner, as illustrated in Exhibit 40.

Exhibit 40. How to Identify CSR-eligible Marketpace Plans Screenshot



Topic 2: Explain that CSR may decrease the following costs: deductibles, coinsurance, and copayments.

Topic 3: Explain that CSR **will not** decrease the following costs: monthly premiums, balances billed by non-network providers, amounts spent on non-covered services.

Topic 4: Explain that consumers need to be aware of their responsibility to notify the Marketplace within 30 days of any changes in their household income level or other application information that may affect their eligibility for CSR.

C. Next Steps

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

SOP 8. Compare, Save, and Select Health Plans

A. Introduction

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

Consumers without a Marketplace account may:

- View key plan details (e.g., premiums, deductibles, estimated APTC and CSR) using the "Health Insurance Plans & Prices" feature on HealthCare.gov
- View, download, or print the plan's Summary of Benefits and Coverage
- View the plan's provider directory and drug formulary
- View Quality Rating information, if the consumer lives in Virginia or Wisconsin (where the new star ratings for plans will be piloted during plan year 2017)
- View the relative breadth of health plans' provider networks for adult primary care providers, pediatricians, and hospitals in the consumer's county if the consumer lives in one of approximately two pilot states selected by CMS

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

If consumers are interested in more detailed information about plans available to them via the Marketplace Pathway, or believe they may be eligible for other coverage programs or options to lower their costs (i.e., Medicaid, CHIP, APTC, and CSR), encourage them to create an online account at HealthCare.gov and complete an eligibility application. To advise these consumers on how to create an account, proceed to SOP-3 Create an Account.

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

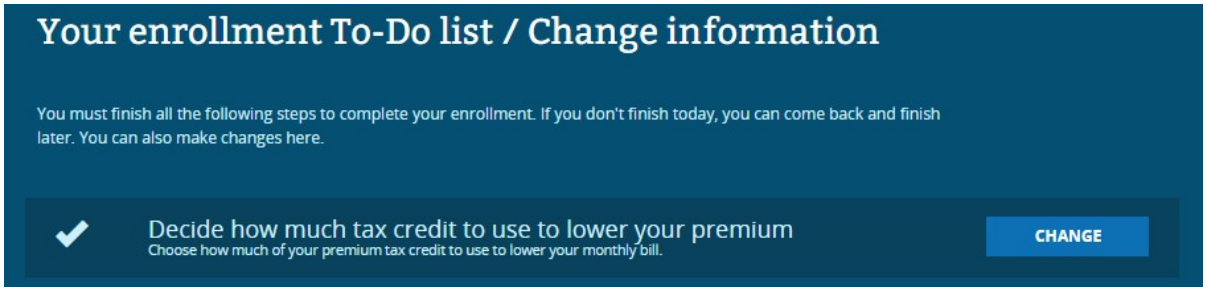
Note: These instructions and screenshots are also relevant for agents and brokers who access HealthCare.gov via the Agent and Broker landing page.

B. Procedures

1. Selecting APTC Amount

Consumers who are determined to be eligible for APTC may choose to use all, some, or none of that amount to lower their monthly premiums. If consumers are eligible for APTC, the system will prompt them to set the amount of APTC that they would like to apply to their monthly premiums before viewing their QHP options, as shown in Exhibit 41.

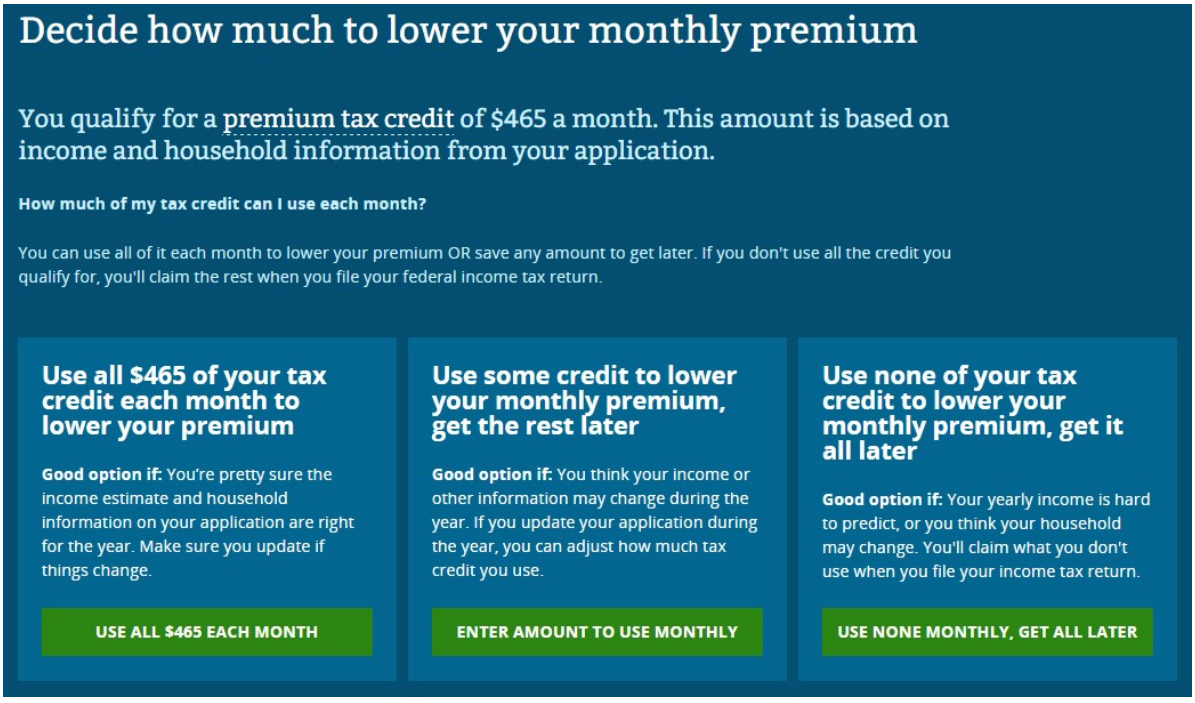
Exhibit 41. Setting the Amount of APTC Screenshot



Step 1. Consumers who are eligible for APTC will see three different options on how to use the APTC for which they are eligible, much like the screen shown in Exhibit 42.

Consumers can generally use all, some or none of the amount for which they are eligible. The three scenarios show how the options affect the consumer's monthly premium cost and, potentially, their tax liability when they file their tax return. After reviewing, the consumer will select his or her preferred amount of premium tax credit and select the "Continue" button.

Exhibit 42. APTC Amount Selection



Step 2. You can help consumers use the APTC amount selection tool shown in Exhibit 42 to set the amount they would like to apply to their premium each month.

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

Step 3. You can help consumers select the amount of APTC that they would like to have made on their behalf. Exhibit 43 provides an explanation of the tax consequences that consumers might encounter.

Exhibit 43. Tax Consequences for APTC

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

Step 4. It is important to remind consumers that they are required to report changes to eligibility information, such as certain income and household–related changes, to the Marketplace within 30 days, and should do so as soon as possible. The amount of PTC and/or CSR for which they are eligible, may be affected.

2. Comparing QHPs

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

Step 1. Explain to consumers the factors that might affect their available QHP options and the costs of the QHPs:

a. Place of residence
b. Age
c. Family size
d. Tobacco use
e. Eligibility for APTC or CSR

Things You Should Know

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

Step 2. Assist consumers with comparing health plans using the "Metal Table," which summarizes plans by:

a. Metal level
b. Displaying premium ranges (after application of APTC)
c. Cost sharing (e.g., deductibles)

Once the consumer is on the Plan Results page, summary information about individual plans is presented, including the cost of premiums.

Step 3. Assist consumers with filtering and sorting QHPs to find plans that best meet their needs and budget.

Encourage consumers to consider different aspects of coverage, including costs (premiums, copayments, coinsurance, deductible, out-of-pocket maximums, etc.), coverage (e.g., services, devices, medications), and provider network (ensuring preferred medical providers are covered in the plan's network). Consumers should review all aspects they think are important before choosing and enrolling in a plan.

a. The Marketplace can provide consumers with an estimate for their total health plan costs

for the year, based on how much medical care the consumers think they will use (low, medium, or high). This estimate can help consumers consider and compare different types of health insurance and health care costs beyond just monthly premiums. It is important to remind the consumer that these are estimates only, and that actual costs to the consumer can vary, based on actual health care use throughout the plan year.

b. The Marketplace initially sorts plans from the lowest to highest premium amount. Consumers may filter and view QHPs by other sorting criteria, such as alphabetically by QHP name or by maximum out-of-pocket costs. Consumers may also filter QHPs to narrow the results to display only plans that meet selected criteria.

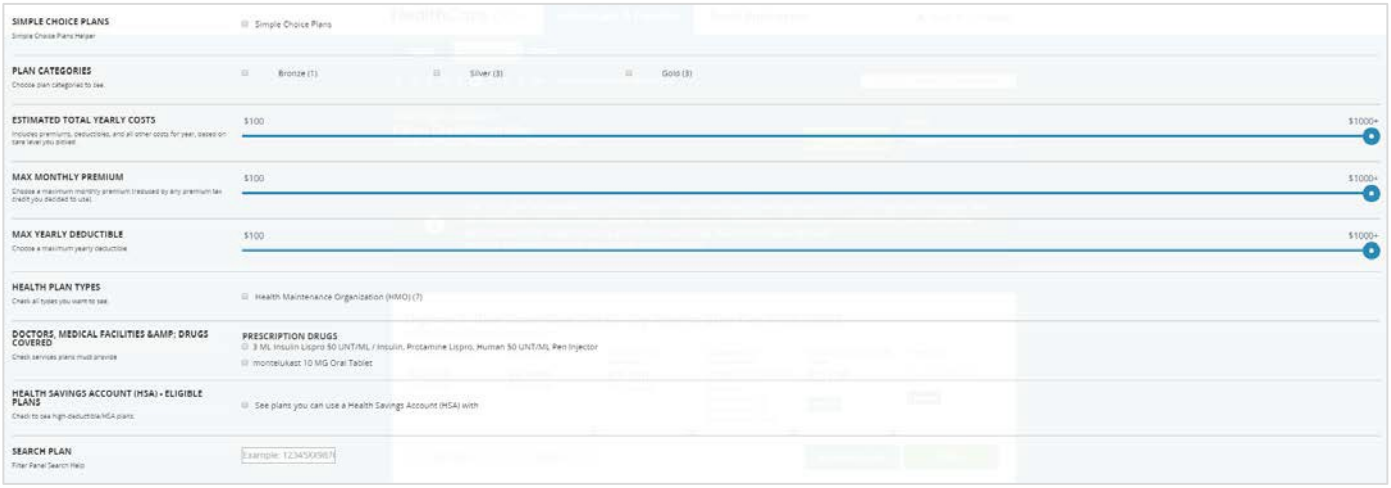
c. Exhibit 44 specifies the various filtering options available to consumers for customizing their QHP lists and lists examples of when to use each filtering option. It may be helpful to review the chart with consumers and identify the filtering options that are most important to them. Exhibit 45 shows filtering of plans by metal level.

Exhibit 44. Filtering Options

Filtering Option	Examples of Consumer Scenarios	Description of Filtering Option
Plan Categories	Consumers want to view only those plans that can be expected to cover, on average, 70% or more of their health care costs (i.e., a Silver-level plan or higher).	• Assignment of plan categories designated by metal level: Bronze, Silver, Gold, Platinum, and Catastrophic (e.g., a Platinum category plan, on average, will cover a higher percentage of costs of care than a Bronze category plan, but will generally have a higher premium). • You may want to remind consumers eligible for CSR that they can only take advantage of those reductions if they pick a Silver-level plan.
Max Monthly Premium	Consumers are concerned about monthly premium costs.	• Price range that consumers pay monthly for their QHPs.
Max Yearly Deductible	Consumers want to view only those plans that have a deductible amount within a certain range.	• The required amount consumers must pay before their health coverage begins to cover most health care costs.
Estimated Yearly Costs	Consumers are interested in the estimated total yearly cost for the plan premiums, deductible, copayments, and other costs.	• Estimated total yearly costs, from lowest to highest.
Health Plan Types	Consumers are concerned with flexibility of access to providers inside and outside of a network or are interested in coverage in multiple states.	• Types of provider access, such as Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point of Service (POS), and multi-state or national provider networks. • Stand-alone dental plans are available to purchase.*
Health Savings Account (HSA) Eligible Plans	Consumers are considering enrolling in a high deductible health plan (HDHP).	• Tax-advantaged medical savings account available to consumers who are enrolled in an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit.
Search Plan	Consumers who already know which plan they want can search for it by the plan number	• Enter the plan number to find a preferred plan quickly.

**Under the Affordable Care Act, dental insurance is treated differently for adults and children age 18 and under. Dental coverage or children is a category of essential health benefit. All stand-alone dental plan QHPs offer through the Marketplace must cover the pediatric dental essential health benefit, but are not required to cover adult dental services.*

Exhibit 45. Filter Plans by Metal Level Screenshot



Step 4. Once consumers identify QHPs in which they are interested in enrolling, consumers may make direct plan-to-plan comparisons using the side-by-side function.

a. To select QHPs for comparison, consumers can click the "Compare & Save" box listed below the QHP name.

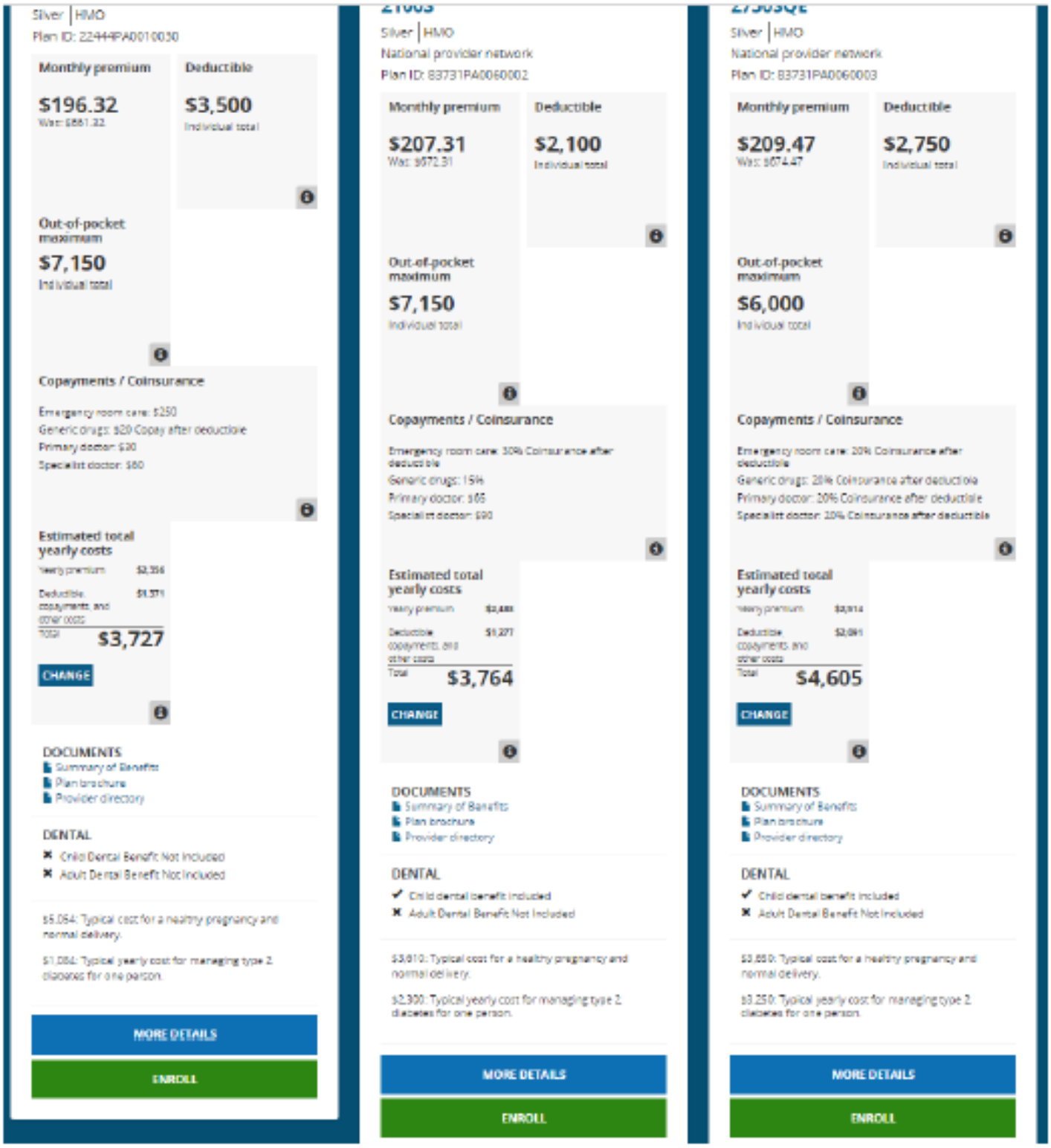
b. Next, select the "Compare & Save Plans" button at the top of the page. See Exhibit 46 for an illustration of this process.

Note: Consumers can select and compare up to three plans at one time. Consumers can also hover their cursor over the "i" icons for explanations about what the different dollar amounts mean.

Exhibit 46. Select a QHP for Plan Comparison Screenshot

c. The side-by-side comparison shown in Exhibit 47 allows consumers to compare QHPs' monthly premiums and annual deductibles, medical and prescription drug benefits, and other key information.

Exhibit 47. Side-by-Side Plan Comparison Screenshot



Step 5. Remind consumers to make sure their doctors or other health providers are in-network for the specific plan they are considering before they enroll. Also remind consumers to enter the information for any medications they take to verify if the medications are on the plan's drug formulary.

The best way for consumers to ensure a provider participates in the specific plan they are selecting is for consumers to call both their doctor/provider and the insurance company to make sure the doctor is in the relevant network. If consumers want a plan that includes their health provider(s) or specific prescription drugs in the plan's formulary, direct them to the following external resources for additional information about the QHPs:

a. Plan websites;
b. Individual plan provider directories; and
c. Summaries of Benefits & Coverage (SBCs). This information may be found by clicking on the "Details" link for the plan on HealthCare.gov.

For more information, see the HealthCare.gov Tools: Consumer Decision Support Tools section of the "Health Insurance Marketplace 2017 Open Enrollment: Operational Updates and Announcements for Agents and Brokers Participating in the Marketplace" webinar slides.

Changes to Plan Comparison

Starting in the 2017 plan year, consumers will have the option to select "Simple Choice plans," which come with a uniform set of deductibles, copayments, coinsurance rates, and annual limitations on certain cost-sharing features. The uniform cost sharing features will allow the consumer to compare plans based on other important factors, such as providers in the plan's network, with the knowledge that cost-sharing for certain categories of covered benefits will be the same across Simple Choice plans. The "Simple Choice plans" will display in Plan Compare.

Additionally, in some states, consumers will see quality star rating information, which will provide consumers information about the quality of health care services and enrollee experiences, and overall patient and consumer experience for health plans offered on the Marketplace in those states. The quality star ratings will only display for QHPs in two states for the 2017 plan year: Virginia and Wisconsin, which use the HealthCare.gov platform. CMS anticipates quality star rating information will be available in all Marketplaces for the 2018 Open Enrollment period.

3. Saving QHP Selections

Step 1. If consumers would like to review certain QHPs at a later time, consumers may save the QHPs to their account by clicking the "Compare & Save" check box, as shown in Exhibit 38. Consumers may view these QHPs at a later time by logging in to their account and clicking the "Saved Plans" button also shown in Exhibit 48.

Exhibit 48. Save QHP Screenshot

4. Selecting a QHP

Step 1. After consumers have reviewed and compared their available QHP options, they may select plans to enroll in for themselves and/or family members included on their application. After selecting "Enroll," different warnings may appear that indicate the consumer may have missed the opportunity to participate in a plan with CSR (e.g., if the consumer has selected a plan that is not a Silver-level plan) or that they selected a plan covering a child that does not provide child dental coverage. One example of this warning message appears in Exhibit 49. Consumers will be asked to confirm their plan selection, as shown in Exhibit 50.

Exhibit 49. Warning Message Screenshot

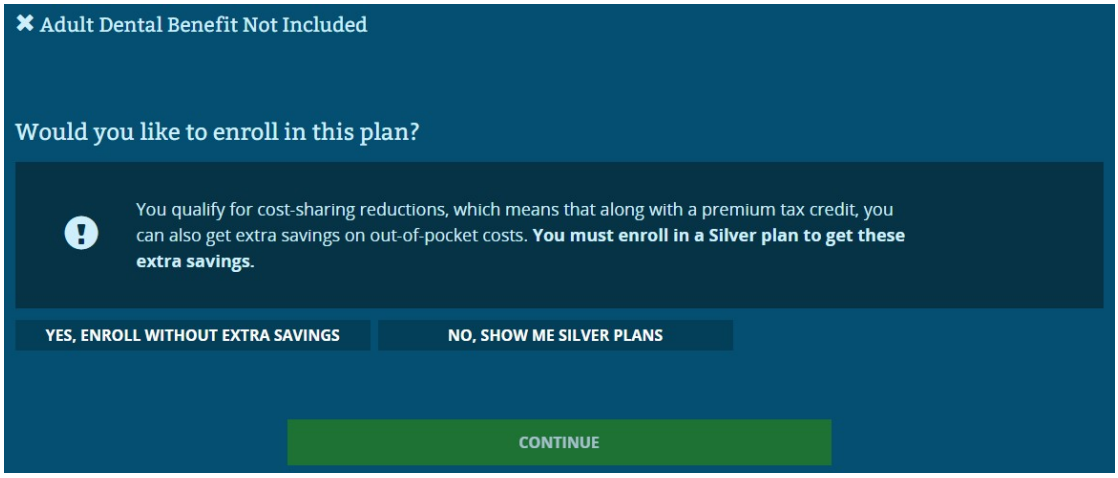
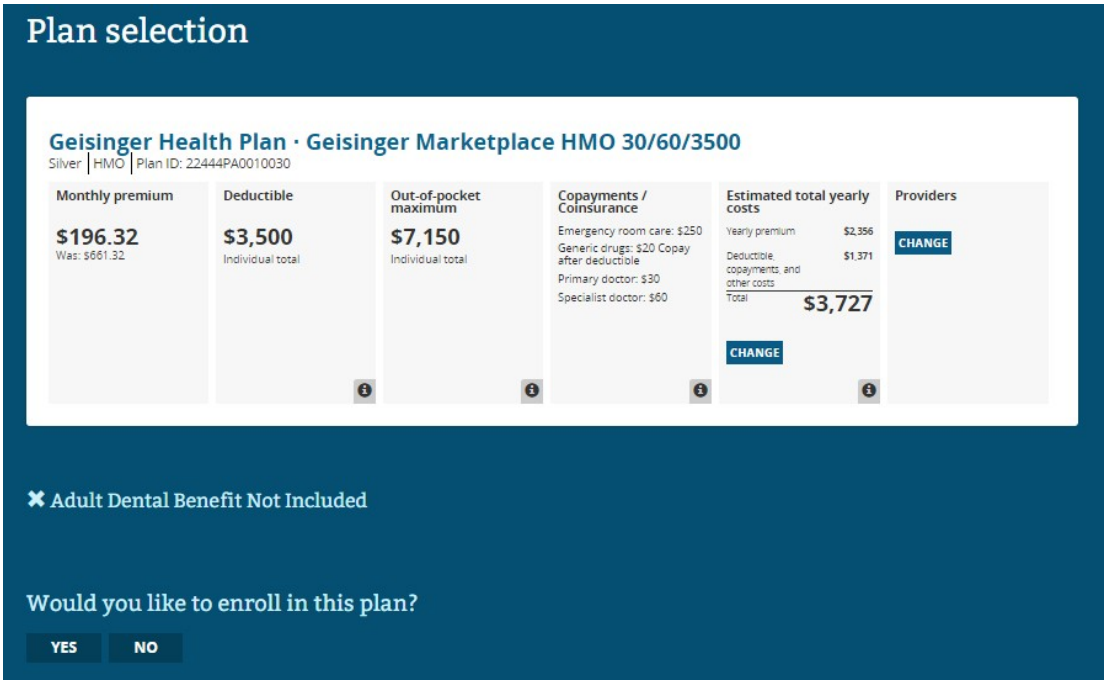


Exhibit 50. Confirm Plan Selection Screenshot



5. Dental Coverage

Step 1. Some medical plans include child and/or adult dental coverage. If consumers want dental coverage, they can select a medical plan that includes dental coverage or select a stand-alone (separate) dental plan.[12] If no separate dental plan is desired, consumers can skip directly to the "Review and Confirm" task. If consumers wish to select a stand-alone dental plan, proceed to Step 2.

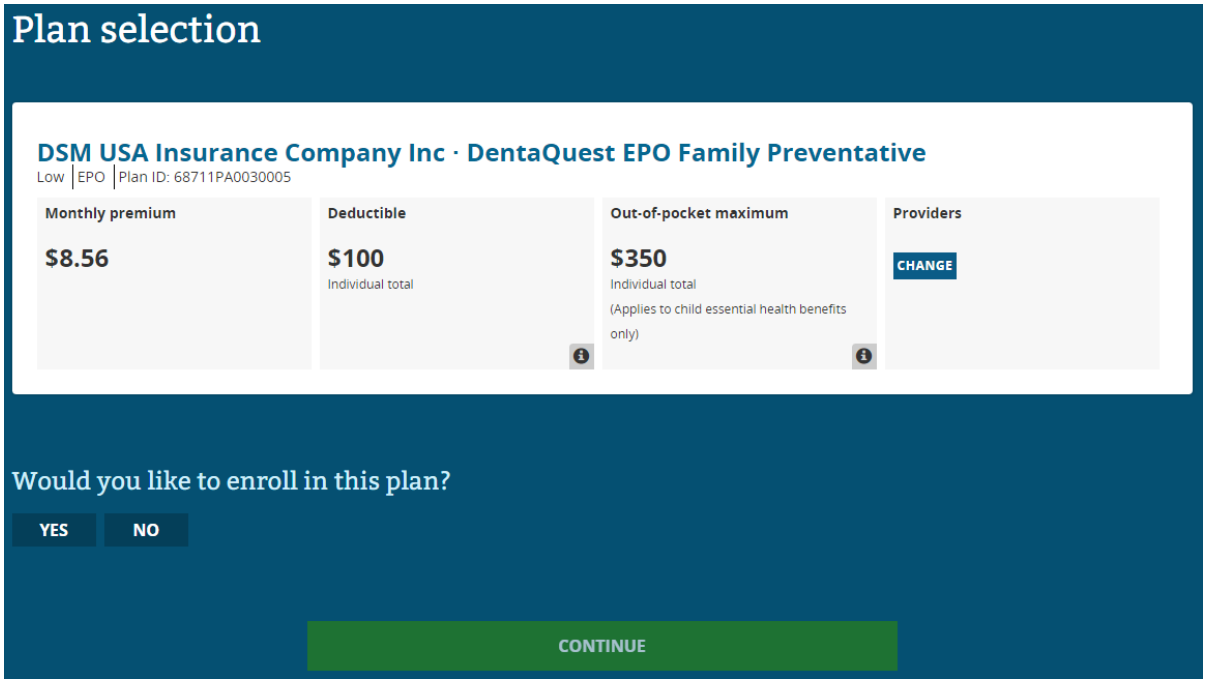
Step 2. You can help consumers indicate they are interested in stand-alone dental coverage. The process will proceed similarly to the medical plan compare and selection process. Once available dental plans appear, you can assist consumers with enrolling in a dental plan.

a. A consumer must enroll in a medical plan in order to enroll in a stand-alone dental plan through an Individual Health Insurance Marketplace[SM].

b. Consumers can enroll in a stand-alone dental plan through the Marketplace even after they have already enrolled in health coverage as long as it is still Open Enrollment or if they have an SEP. To do so, Marketplace operations require that consumers return to the Marketplace, re-select their Marketplace health plan, and then select a dental plan at the same time to add a dental plan. Agents and brokers helping consumers in this situation can remind consumers that the coverage effective date of their dental plan will depend on the date that they enroll, not on the date when they originally selected health coverage.

Step 3. Once consumers select the "Enroll" button, a confirmation window will appear. It will provide a summary of the plan selection and if the consumer agrees, they will select the "Yes" and "Continue" buttons, as shown in Exhibit 51.

Exhibit 511. Confirming Dental Plan Selection Screenshot

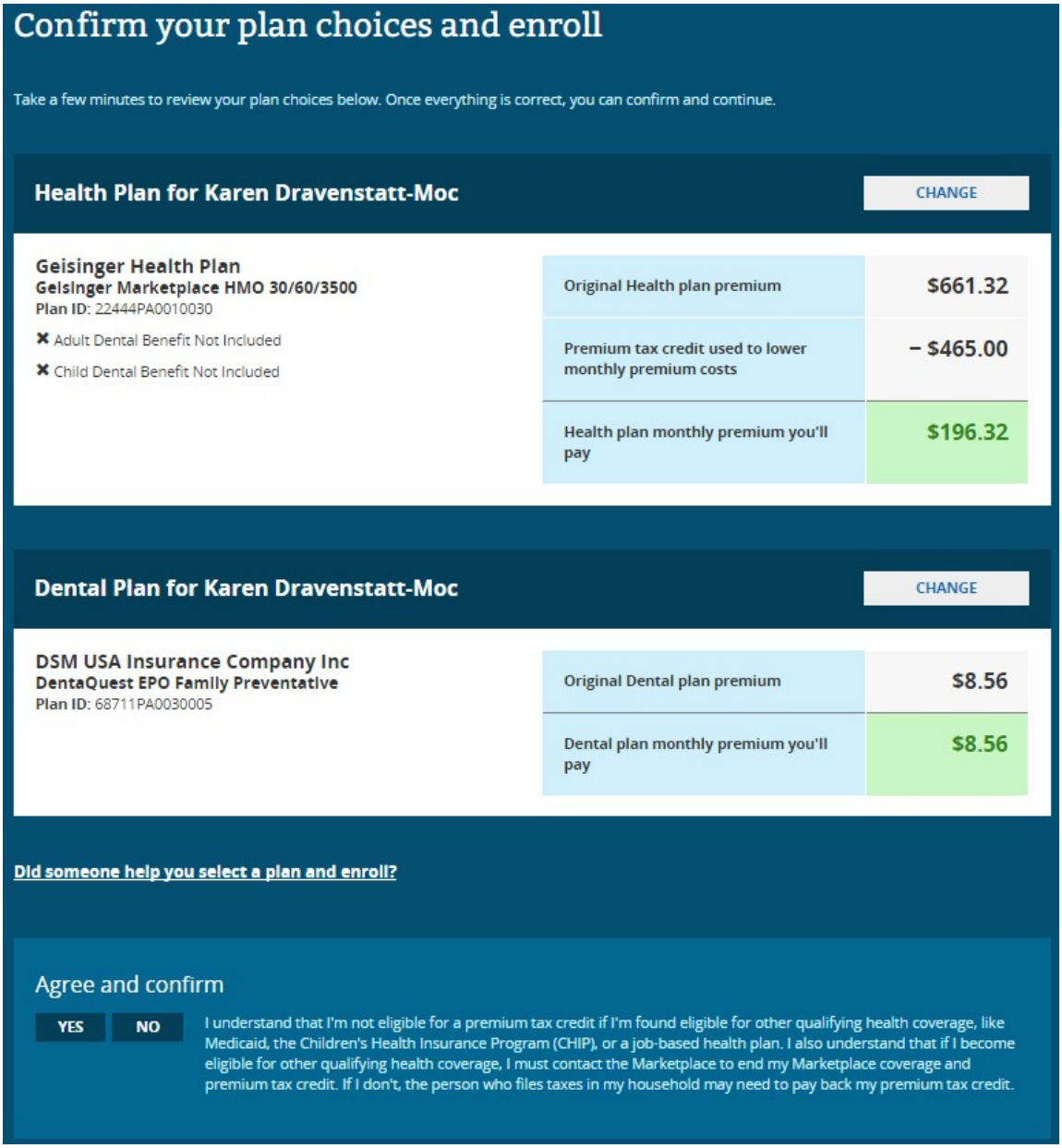


[12] Note that, as adult dental coverage is not an essential health benefit, APTC cannot be used to pay any portion of a premium attributable to coverage of adult dental benefits.

6. Review and Confirm

Step 1. After confirming their dental plan, consumers will be brought to the "Confirm your plan choices and enroll" page, where the consumer can see a summary of the plan(s) he or she selected and must provide a final approval to enroll in the plans. An example of this summary and enrollment appears in Exhibit 52.

Exhibit 52. Review and Confirm Screenshot



Step 2. At the bottom of the "Confirm your plan choices and enroll" page, consumers must attest to their understanding that they may no longer be eligible for APTC if they experience certain life changes; and that the household tax filer may have to pay back the APTC if the consumer fails to take appropriate action.

Next, the consumer will be taken to the "Read these statements and select whether you agree or disagree" page, where they accept eligibility for APTC (if applicable) by agreeing to file a federal income tax return in the upcoming year for the current tax year and/or by attesting to the filing of a joint income tax return with their spouse by the end of the current tax year (if married). Consumers are also attesting that no one else can claim them as a dependent for the current tax year on a federal income tax return. After selecting "Yes," the consumer needs to enter his or her full name and click "Finish Plan Selection."

C. Next Steps

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

SOP 9. Pay Health Plan Premium

A. Introduction

This SOP provides guidance on how to assist consumers with making premium payments once they have selected a QHP.

After the consumer has selected a QHP, the Marketplace will redirect the consumer to the QHP website – when applicable – or will instruct the consumer to contact the QHP issuer directly to make premium payments. Online premium payment is optional and not every health insurance company will accept online payments.

Consumers should contact their health insurance company with any specific questions about acceptable methods or deadlines for premium payment. Please ensure that consumers understand that the individual Marketplace does not accept payments on behalf of insurance companies. All financial transactions that consumers need to make related to their Marketplace QHP coverage are handled directly by their insurance company, not the Marketplace.

QHP issuers in the FFMs are required to accept paper checks, cashier's checks, money orders, electronic fund transfers (EFTs), and all general-purpose prepaid debit cards as methods of payment. The insurance company must present all payment method options equally for a consumer to select the preferred payment method.

Insurance companies may accept payment of the initial premium by a method that is exclusive to the initial premium. For example, online payment ("payment redirect") may allow payment of the initial month's premium by credit card, even though the issuer does not accept credit cards as a method of payment for regular, monthly premiums.

Application of premium payment methods must not improperly discriminate against any consumer or group of consumers. Insurance companies may not offer a discount on premiums to individuals who elect a specific type of premium payment method (e.g., EFT). Additionally, issuers may not apply additional fees to a consumer based on payment method. For example, an issuer may not pass on administrative fees for processing a premium payment via credit card.

Before assisting consumers when they are making a payment, it's important to understand that consumers' financial payment information (e.g., bank account, debit cards, credit cards) must be kept private and secure, just like all consumer PII that you may encounter while helping a consumer. Exhibit 53 specifies appropriate and inappropriate activities related to assisting consumers with information about premium payments.

Exhibit 53. Premium Payment Assistance Do's and Don'ts

Do	Don't
• Assure consumers that the agent or broker will protect any financial information consumers share with the agent or broker, and that an Individual FFM does not collect their financial information, because they will make their payments directly to the issuer of the QHP they selected. • Keep any financial information that consumers give you private and secure. • Turn computers to face consumers to keep information private. • Ask consumers to enter their own financial information.	• Use consumers' financial information for personal gain. • Enter consumers' payment methods (e.g., credit card information) on their behalf unless the consumer requests assistance and is physically present in person.

B. Procedures

1. Make a Premium Payment

If a consumer understands the requirement to make a premium payment and the available payment options, you can

proceed with the following steps to help the consumer submit a premium payment:

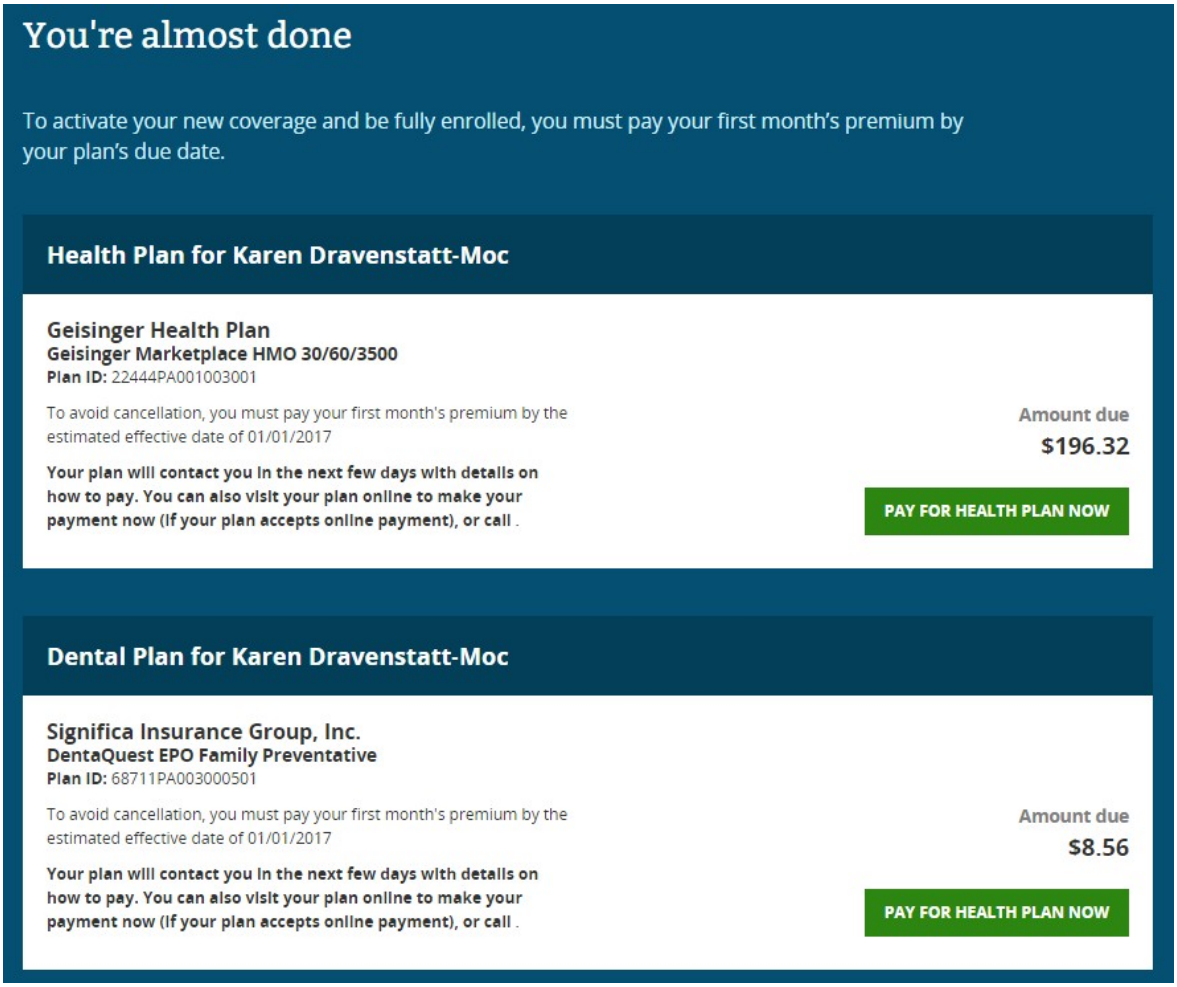
Step 1. Assist consumers with navigating to their Enroll To-Do List on HealthCare.gov to view their selected QHP.

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

a. Pay online/electronically, if available as an option.
b. Mail payments to the appropriate insurance company.

Step 3. If consumers wish to make electronic payments, they may click the "Pay for Health Plan" button (if available) to be redirected to their QHP issuer's website, as shown in Exhibit 54.

Exhibit 54. Pay for Health Plan Screenshot



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

a. Explain to consumers that their enrollment in a QHP is not complete until the insurance company receives the first premium payment.

b. Explain that consumers can follow the prompts on the insurance company's website to complete electronic payments, if available. Consumers should be sure to follow their insurance company's payment policies.

c. Encourage consumers to contact their insurance company's call center with questions about billing.

d. Remind consumers that to protect their PII, they should log out of the insurance company's website after making their premium payments.

Things You Should Know

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

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

a. Explain to consumers that enrollment in their QHP is not complete until the insurance company receives the first premium payment.

b. Direct consumers to the insurance company's call center if they need additional billing information. Consumers should note that it may take a day or two before their QHP selection shows up in the insurance company's system.

c. Encourage consumers to contact their insurance company's call center with questions about billing.

C. Next Steps

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

SOP 10. Request an Eligibility Appeal

A. Introduction

Agents and brokers are not required to help consumers through the entire eligibility appeals process, and must not act as tax advisers or attorneys when providing assistance. This SOP provides guidance on how to assist consumers with understanding the process of filing Marketplace eligibility appeals. The Marketplace allows consumers to request an appeal of the following:

- Eligibility or redetermination of eligibility to: purchase a Marketplace QHP (including a catastrophic plan); a child only plan; or eligibility for an employer to participate in a SHOP employer plan
- An eligibility determination for an SEP
- Eligibility or redetermination of eligibility for APTC or CSR, including the APTC and CSR for which the consumer was determined or re-determined eligible
  - Note that consumers who have outstanding data matching issues (DMIs) will need to resolve those issues or wait for them to expire before they will be able to file an appeal regarding the eligibility determination for which there is a DMI. Consumers cannot appeal eligibility determinations that still have open DMIs.
- Eligibility for an exemption from the individual shared responsibility payment that is granted by the Marketplace
- Eligibility for Medicaid or CHIP[13]
- Eligibility for Basic Health Programs
- A Marketplace individual or SHOP application that had not been acted on with reasonable promptness such that the consumer did not receive timely notice of an eligibility determination
- The appeal decision of a state-based appeals entity or the refusal of a state-based appeals entity to vacate dismissal of an appeal request (that is, to reinstate the appeal)

Consumers who disagree with an eligibility determination made by the Marketplace may appeal to the Federal Marketplace Appeals Entity (Marketplace Appeals Center) within 90 days of the date of their eligibility notice. Upon receipt, the Marketplace Appeals Center will review the appeal request and validate the appeal based on whether it was submitted within the 90-day timeframe and whether it concerns a matter over which the Marketplace Appeals Center has jurisdiction.

[13] Consumers may file appeals from Medicaid and CHIP determinations with the Marketplace only under limited circumstances. (i) MAGI-related Medicaid denials by the Marketplace.

a. The following states have delegated MAGI-related Medicaid determinations to the FFM and delegated authority to conduct appeals to CMS: AL, AK, AR, LA, MT, NJ, TN, WV, WY (for MAGI-related Medicaid, not CHIP). When the FFM denies MAGI-related Medicaid to residents of those states who apply to the FFM, they may appeal those denials to the Federal Marketplace Appeals Entity (Marketplace Appeals Center).

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

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

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

For example, if the appeal request is about a matter where no jurisdiction exists, such as a dispute the consumer has with a QHP issuer over a claim denial, the consumer will receive a notice explaining why the appeal request was invalid and what other options the consumer may have. The Marketplace Appeals Center may accept an untimely appeal if a consumer sufficiently demonstrates within a reasonable timeframe that failure to submit the appeal request timely was due to exceptional circumstances that should not preclude the appeal.

Once an appeal has been validated, the Marketplace Appeals Center will review the appeal, including all documentation provided by the consumer and available in the consumer's Marketplace eligibility record. The consumer may be asked in writing to submit additional information or be contacted by phone to discuss the appeal.

In many cases, the Marketplace Appeals Center will work with the consumer to resolve the appeal informally. If the consumer is satisfied with the informal resolution, a decision will be sent in the mail. Conversely, if the consumer is not satisfied with the informal resolution, the consumer can request a hearing conducted by telephone of the appeal before a federal hearing officer.

After the hearing, the consumer will receive a final appeal decision in the mail. If the appeal decision states that the contested eligibility determination was incorrect, the consumer will be able to choose whether the appeal decision will be effective in the future or retroactively to the coverage effective date associated with the incorrect eligibility determination.

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

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

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

B. Procedures

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

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

Step 1. If consumers choose to complete an appeal request form, they can find the correct appeal request form for their state by visiting HealthCare.gov/Marketplace-Appeals.

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

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

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

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

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

Things You Should Know

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

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

Step 3. Consumers should either mail or fax their completed letter to:

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

Consumers may receive various notices during the appeals process. Exhibit 55 lists sample notices commonly used throughout the appeals process and their corresponding descriptions.

Exhibit 55. Appeals Notices

Notice Type	Description
Acknowledgment of Your Marketplace Eligibility Appeal	Notice explaining the appeal request has been received.

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

For more information on appeals, agent or brokers and consumers can visit HealthCare.gov/Marketplace-Appeals.

For an overview of the appeals process, see the presentation on Internal Claims and Appeals and External Review Processes Overview.

Additional information is available at https://marketplace.cms.gov/outreach-and-education/appeals-eligibility- and-health-plan-decisions.pdf and https://marketplace.cms.gov/technical-assistance-resources/logo-and- infographics/steps-for-a-marketplace-appeal.pdf.

C. Next Steps

1. If consumers require further assistance with the appeals process, consider referring them to the Consumer Assistance Program or legal services program available in their state.[14]
2. For more help answering consumers' specific questions, see Appendix A for Frequently Asked Questions (FAQs) related to SOP-10 Request an Eligibility Appeal.
3. Appellants with questions about their eligibility appeals may call the Marketplace Appeals Center at 1-855-231-1751 (TTY: 1-855-739-2231). The call center is available 7:30 AM to 8:45 PM (EST) Monday through Friday, and 10:00 AM to 5:30 PM (EST) Saturday.

[14] For more information on Consumer Assistance Programs, visit http://www.CMS.gov/CCIIO/Resources/Consumer-Assistance-Grants. For more information on legal services, visit http://www.lsc.gov/find-legal-aid.

SOP 11. Exemptions

A. Introduction

The Affordable Care Act requires applicable individuals to either have minimum essential coverage (MEC) for the entire year, pay a fee when filing a federal income tax return, or obtain an exemption from the requirement to maintain MEC. Refer to Exhibit 56 to learn more about the various exemptions for which consumers may qualify.

Please remember: It's important to remind consumers that you cannot provide tax advice within your capacity as an agent or broker and that you are not acting as a tax adviser or attorney when providing assistance as an agent or broker. However, you should be able to help consumers generally understand that some exemptions can be claimed through the tax filing process and how to request them.

Exhibit 56. Descriptions of Exemptions

When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption	For More Information on This Exemption
Type of Exemption: Hardship Exemption				
Consumers can use this exemption if they experience a life situation that keeps them from getting health insurance (e.g., homeless, facing eviction or foreclosure, and experienced domestic violence).	• SSNs, if they have them • Information about people in their tax household • Documents that support their claim of hardship (see page 1 of the hardship exemption application), if applying through the Marketplace.	Application for Exemption from the Shared Responsibility Payment for Individuals who Experience Hardships	In most cases, this exemption will be claimed through the Marketplace. Consumers who are ineligible for Medicaid based on a state's decision not to expand Medicaid may apply for this exemption either through the Marketplace or when filing their federal income tax returns.	https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/
There are multiple types of categories of hardship exemptions. Hardship exemptions usually cover the month before the hardship, the months of the hardship, and the month after the hardship. But in some cases, the Marketplace may provide the exemption for additional months, including up to a full calendar year.	Note: If consumers can't obtain documents to support hardship, call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325			

When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption	For More Information on This Exemption
Type of Exemption: Membership in a Health Care Sharing Ministry				
Consumers can use this exemption if they are a member of a religious sect that is recognized by the Social Security Administration as conscientiously opposed to accepting any insurance benefits, including Social Security and Medicare, and has been in existence since December 31, 1950. Consumers who get this exemption won't have to reapply for an exemption unless they turn 21 or leave their religious sect.	• Name and address of their religious sect • SSNs, if they have them • Copy of an approved IRS Form 4029 with required signatures (Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits), if they have one	https://marketplace.cms.gov/applications-and-forms/religious-sect-exemption.pdf	Marketplace exemption application	https://www.healthcare.gov/exemptions-tool/%23/results/2016/details/religion
Type of Exemption: Short Coverage Gap				
Consumers can use this exemption if anyone in their tax household experienced a gap in health coverage of no more than 2 consecutive months. If a consumer has more than one short coverage gap during a year, the short coverage gap exemption only applies to the first gap.	SSNs, if they have them	IRS Form 8965: https://www.irs.gov/pub/irs-pdf/f8965.pdf	Claim on tax return	https://www.healthcare.gov/exemptions-tool/%23/results/2016/details/short-gap

When to Use This Exemption	Information Consumers Need When Applying for This Exemption	Link to Exemption Application	How to Claim This Exemption	For More Information on This Exemption
Type of Exemption: U.S. Citizens Living Abroad				
Consumers can use this exemption if they're a U.S. citizen who either spent at least 330 full days outside of the U.S. during a 12-month period or was a bona fide resident of a foreign country for a full tax year. Consumers can claim the coverage exemption for any month during their tax year that's included in the 12-month period.	SSNs, if they have them	IRS Form 8965: https://www.irs.gov/pub/irs-pdf/f8965.pdf	Claim on tax return	https://www.healthcare.gov/exemptions-tool/#/results/2016/details/citizen-abroad For more information on the requirements to qualify for this exemption: https://www.irs.gov/individuals/international-taxpayers/foreign-earned-income-exclusion-physical-presence-test
Type of Exemption: Certain Non-U.S. Citizens				
Consumers can use this exemption if they are a resident alien who is a citizen or national of a foreign country with which the U.S. has an income tax treaty with a nondiscrimination clause and a bona fide resident of a foreign country for the tax year. Consumers can claim this exemption for the entire year. Consumers who are not lawfully present in the United States, but who file a tax return can also use this exemption.	SSNs, if they have them	IRS Form 8965: https://www.irs.gov/pub/irs-pdf/f8965.pdf	Claim on tax return	https://www.healthcare.gov/exemptions-tool/#/results/2016/details/citizen-abroad For more information on the requirements to qualify for this exemption: https://www.irs.gov/individuals/international-taxpayers/foreign-earned-income-exclusion-bona-fide-residence-test

Exemptions that must be claimed through the Marketplace can be claimed at any time during the year. Exemptions available through the federal tax filing process must be claimed when applicants file their federal income taxes for the tax year. The exemption for unaffordable coverage processed by the Marketplace is available prospectively ONLY. After the tax year ends, consumers must claim this exemption on their tax return.

For more information on exemptions from the IRS, please visit: https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions.

The sections that follow in this SOP provide guidance on how to assist consumers with understanding exemptions and applying for exemptions from the individual responsibility payment that are granted through the Marketplace.

B. Procedures

1. Hardship Exemptions to Purchase Catastrophic Coverage

Consumers may be eligible for an exemption based on financial or other circumstances that prevented them from obtaining coverage in a QHP. If consumers qualify for and receive one of these hardship exemptions, they may enroll in a catastrophic plan.

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

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

Step 2. The Marketplace will review the exemption application and determine consumers' eligibility for an exemption. The Marketplace may request more information or documentation from consumers as part of this review. The consumer has 90 days from the date the notice is sent to provide additional information if requested by the Marketplace.

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

Step 4. Consumers should read and understand the notice. Consumers should keep the notice because the ECN will be required when the consumer files their federal income tax return. The notice will direct consumers to view Catastrophic Plan Information or call the Marketplace Call Center at 1-800-318-2596 for assistance with shopping for a plan, if they're interested in purchasing coverage.

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

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

If consumers have been notified that their health plan has been cancelled due to lack of compliance with Affordable Care Act standards, and consumers believe that the QHP options available through the Individual Marketplace in the area are unaffordable, consumers may be eligible for a hardship exemption and may be able to enroll in catastrophic coverage if it is available in their area.[15]

Consumers whose coverage was cancelled may enroll using the steps in the section immediately above or they can choose to enroll in a catastrophic plan directly with the insurer of their choice by following the steps outlined below. For information, QHP options, and insurer contact numbers, visit Catastrophic Plan Information or call 1-866-837-0677, a special phone number for people whose plans have been canceled.[16]

Step 1. Consumers should download and fill out the form for a hardship exemption.[17] Consumers should be sure to answer that their reason for applying is that the consumer's individual policy was canceled and they feel

[15] Catastrophic plans are not available in all states.

[16] 9 AM – 7 PM EST, Monday – Friday and 9 AM – 5 PM EST Saturday – Sunday

[17] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ARR-2017-Guidance-051016-508.pdf

that available coverage is not affordable.

Step 2. Consumers can view a list of catastrophic plans available through HealthCare.gov and should be prepared to submit the following items to an issuer of catastrophic coverage in their area:

a. The hardship exemption form
b. Supporting documentation indicating that the previous policy was cancelled, such as your cancellation letter

Step 3. The health insurance issuer will send the consumer's information to CMS; and CMS will verify that the consumer is eligible for the hardship exemption. If the consumer does not submit the supporting documentation with the exemption form, CMS may contact the consumer to notify him or her that the application is incomplete and cannot be processed until the supporting documentation is provided.

Step 4. The consumer can enroll in a plan. Consumers interested in pursuing this option are advised to contact the Marketplace Call Center at 1-866-837-0677.

3. Other Exemptions

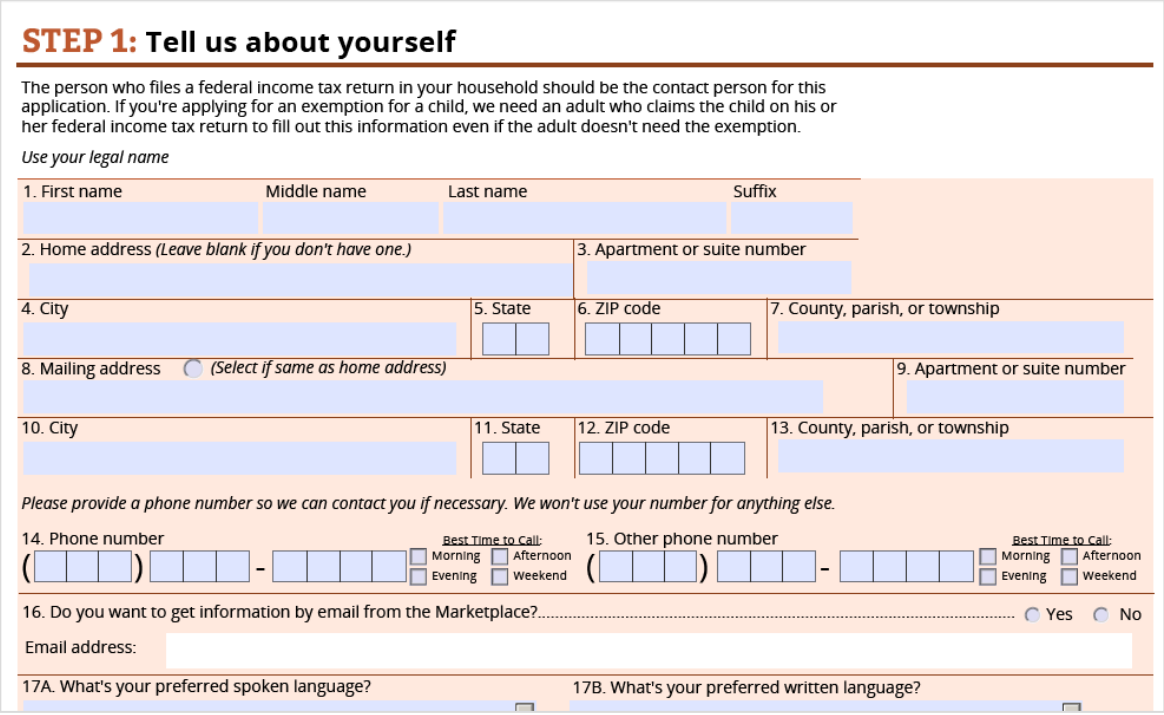
Depending on the type of exemption, consumers may apply for an exemption via the Marketplace or claim it when filing their federal tax returns. Use the information and instructions below to help consumers with applying for exemptions.

Step 1. If consumers have not yet started an application for an exemption, they should determine the appropriate exemption application, download the application with the link provided, and determine what information is required to complete the application.

Step 2. The following guidance may be helpful to consumers completing exemption applications:

a. In Step 1 of the application, consumers input their name, address, phone number, preferred language, and other personal information, as shown in Exhibit 57.

Exhibit 57. Step 1 of Exemption Application



STEP 1: Tell us about yourself

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

Use your legal name

1. First name | Middle name | Last name | Suffix

2. Home address *(Leave blank if you don't have one.)* | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County, parish, or township

8. Mailing address ○ *(Select if same as home address)* | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County, parish, or township

Please provide a phone number so we can contact you if necessary. We won't use your number for anything else.

14. Phone number ( ) - Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend

15. Other phone number ( ) - Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend

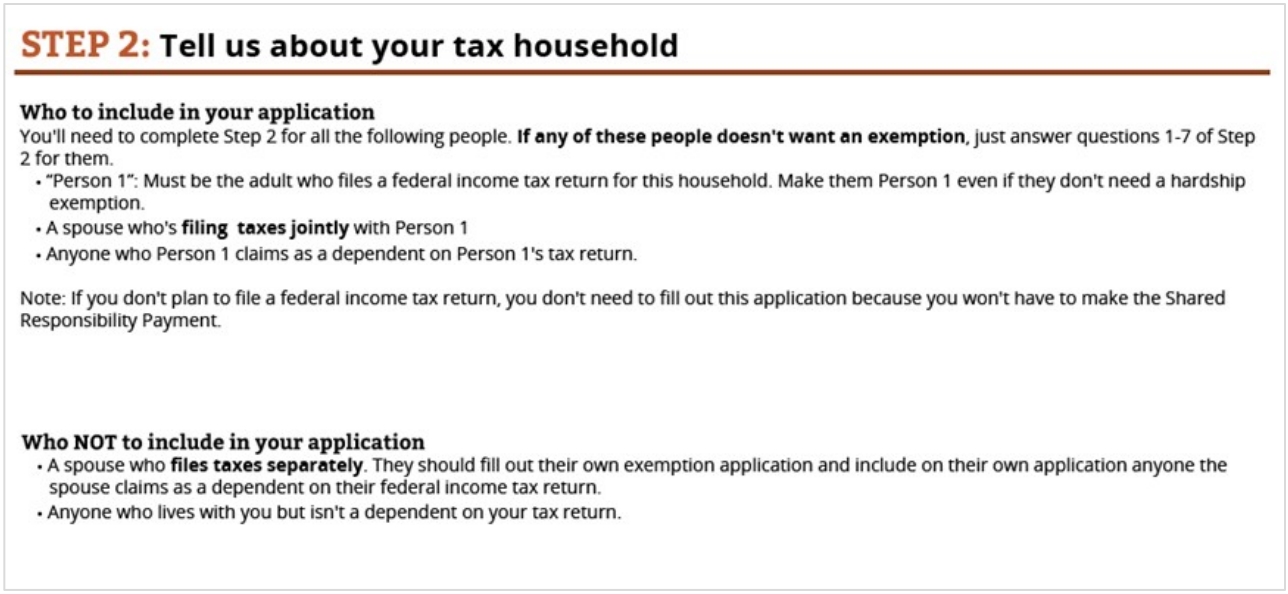
16. Do you want to get information by email from the Marketplace? ○ Yes ○ No

Email address:

17A. What's your preferred spoken language? | 17B. What's your preferred written language?

b. In Step 2 of the application, consumers input the information required for the specific exemption application, such as information about members of the applicant's tax household (e.g., Social Security number, demographic information, financial information), as shown in Exhibit 58. Be sure to complete a Step 2 page for *every* person in the consumer's tax household.

Exhibit 58. Step 2 of Exemption Application



STEP 2: Tell us about your tax household

Who to include in your application

You'll need to complete Step 2 for all the following people. **If any of these people doesn't want an exemption**, just answer questions 1-7 of Step 2 for them.

- "Person 1": Must be the adult who files a federal income tax return for this household. Make them Person 1 even if they don't need a hardship exemption.
- A spouse who's **filing taxes jointly** with Person 1
- Anyone who Person 1 claims as a dependent on Person 1's tax return.

Note: If you don't plan to file a federal income tax return, you don't need to fill out this application because you won't have to make the Shared Responsibility Payment.

Who NOT to include in your application

- A spouse who **files taxes separately**. They should fill out their own exemption application and include on their own application anyone the spouse claims as a dependent on their federal income tax return.
- Anyone who lives with you but isn't a dependent on your tax return.

STEP 2: Person 1

Person 1 must be the person who files the federal tax return for your household even if they don't need this exemption.

1. First name	Middle name	Last name	Suffix

2. Relationship to you	3. Date of birth (mm/dd/yyyy)	4. Sex
SELF	/ /	Male Female

5. Social Security Number (SSN) - -

If you're applying for an exemption for yourself and you have an SSN, you must provide it.
If you don't have an SSN, you can still qualify for an exemption. If you're not applying for an exemption for yourself, providing your SSN can speed up the process. We use SSNs to match exemptions with the right tax returns. To get an SSN, visit **socialsecurity.gov** or call **1-800-772-1213** (TTY: 1-800-325-0778).

6. Do you plan to file a federal income tax return? Yes No

a. Will you file jointly with a spouse? Yes No

Full name of Spouse (unless No is selected for Question 6A

b. How many dependents will you claim on your tax return (Don't count a spouse as a dependent)?

Name(s) of dependents

7. Do you want this exemption? **YES.** Answer all questions below. **NO.** Skip to question 9.

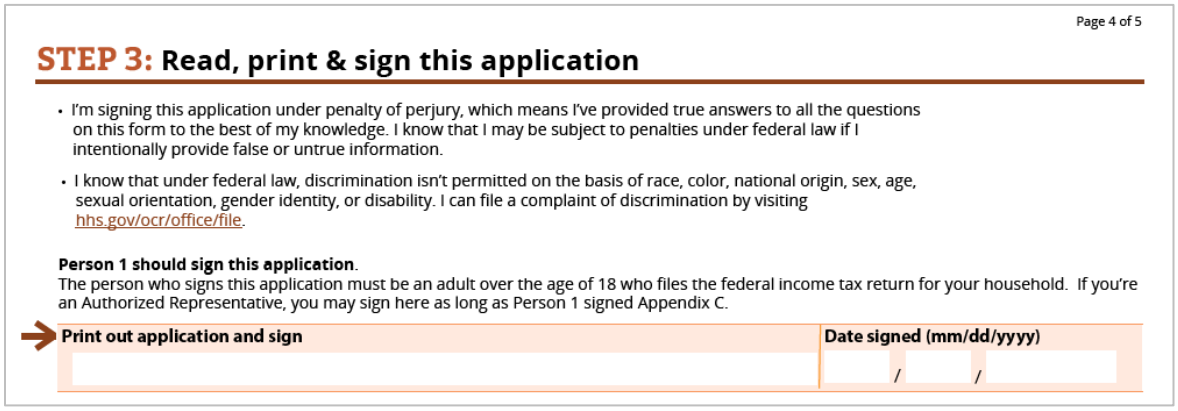
8. Select the type of hardship(s) you're applying for below. Note the date the hardship started, when it will end, or if it's ongoing. You need only one exemption for any given time period. You may apply for more than one hardship if the hardship events were at different times during the year. **If you're applying for more than one hardship, you must submit documentation for EACH hardship.**

Type of hardship *(Select all that apply.)*	Tax year for which you need this exemption (YYYY)	Date hardship started *(Note: If your hardship started before 01/01/2014, list the first date you didn't have required health coverage.)*	Date hardship ended	Check if ongoing
1. Homeless	20			
2. Eviction/foreclosure	20			
3. Shut-off notice	20			
4. Domestic violence	20			
5. Death of family member	20			
6. Disaster	20			
7. Bankruptcy	20			
8. Medical Expenses	20			
9. Increase in expenses to care for family member	20			
10. Medical support for child	20			
11. Eligibility appeals decision	20			
12. Ineligible for Medicaid	20			
13. Cancellation of individual coverage	20			
14. You experienced another hardship	20			

Please explain how this hardship prevented you from getting health insurance:

c. In Step 3 of the application, consumers should review the information provided, confirm that the answers they provided are accurate, and sign their application, as shown in Exhibit 59.

Exhibit 59. Step 3 of Exemption Application



Page 4 of 5

STEP 3: Read, print & sign this application

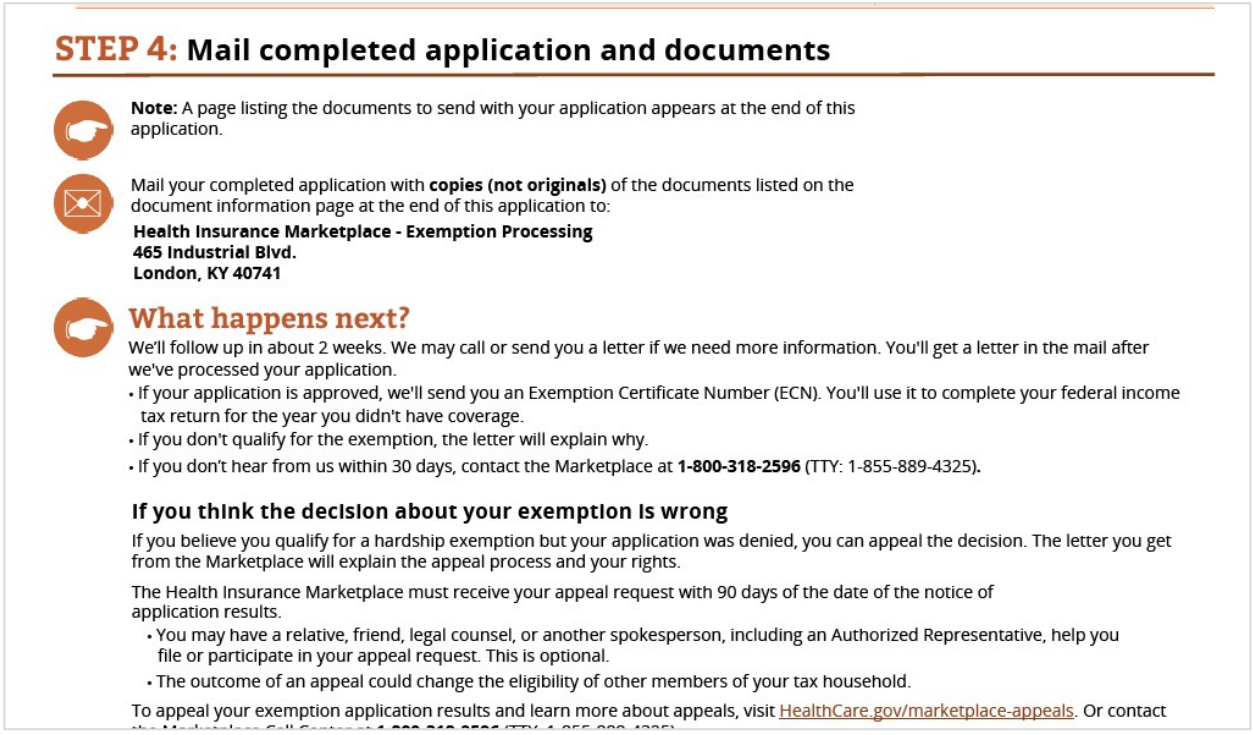
- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.

Person 1 should sign this application.
The person who signs this application must be an adult over the age of 18 who files the federal income tax return for your household. If you're an Authorized Representative, you may sign here as long as Person 1 signed Appendix C.

Print out application and sign	Date signed (mm/dd/yyyy)
	/ /

d. In Step 4 of the application, consumers should review the instructions for mailing their completed application and copies of any supporting documentation. Documentation is required for most exemptions (see Exhibit 60).

Exhibit 60. Step 4 of Exemption Application



STEP 4: Mail completed application and documents

Note: A page listing the documents to send with your application appears at the end of this application.

Mail your completed application with **copies (not originals)** of the documents listed on the document information page at the end of this application to:
Health Insurance Marketplace - Exemption Processing
465 Industrial Blvd.
London, KY 40741

What happens next?
We'll follow up in about 2 weeks. We may call or send you a letter if we need more information. You'll get a letter in the mail after we've processed your application.
- If your application is approved, we'll send you an Exemption Certificate Number (ECN). You'll use it to complete your federal income tax return for the year you didn't have coverage.
- If you don't qualify for the exemption, the letter will explain why.
- If you don't hear from us within 30 days, contact the Marketplace at **1-800-318-2596** (TTY: 1-855-889-4325).

If you think the decision about your exemption is wrong
If you believe you qualify for a hardship exemption but your application was denied, you can appeal the decision. The letter you get from the Marketplace will explain the appeal process and your rights.

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

To appeal your exemption application results and learn more about appeals, visit HealthCare.gov/marketplace-appeals. Or contact

e. Depending on the type of exemption application, consumers may need assistance completing additional steps, inputting information in the appendices of the application, or gathering any required supporting documentation. You can provide consumer assistance as needed with applications for exemptions granted through the Marketplace. You can provide general information on exemptions claimed through the tax filing process, and can help consumers access IRS resources on this topic, but you should not help consumers claim exemptions on their tax returns or fill out IRS forms.

Step 3. Consumers should mail Marketplace exemption applications and any supporting documentation to:

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

C. Next Steps

1. After consumers submit an exemption application to the Marketplace, the Marketplace will notify them about any additional supporting documentation needed and the status of their exemption application.
    - The consumer has 90 days from the date the notice is sent to provide additional information if requested by the Marketplace.
2. If consumers receive an exemption, they will be assigned an ECN for exemptions granted by the Marketplace. Consumers will need their ECN:
    - If they qualify for a hardship exemption and plan to enroll in a catastrophic health plan in the Marketplace.
    - If they plan to file a federal income tax return, so the IRS knows that they have an exemption. The federal income tax return will include instructions for where consumers should provide their ECN in their federal income tax return forms.
    - Starting with the 2016 tax year, the following exemption types will not be issued an ECN because they will only be available through the tax filing process: Health Care Sharing Ministry, members of Indian tribes and individuals eligible for services from an Indian health care provider and individuals who were incarcerated.
3. If consumers do not receive an exemption, you can assist them with applying for health coverage by referring to SOP-3 Create an Account.
4. For more help answering consumers' specific questions, see Appendix A for Frequently Asked Questions (FAQs) related to SOP-11 Exemptions.

SOP 12. Update Account Profile

A. Introduction

Consumers can update their Marketplace account information through the "My Profile" tab. In general, the Marketplace uses the consumer's contact information and preferences to send Marketplace communications, such as notices. However, the consumer's plan only receives consumer information that is provided on the application, either initially at enrollment or through a reported life change.

Some changes, such as those made to communication preferences or a consumer's account password, will have no effect on a consumer's eligibility determination. Other updates to application information (which can be made using the "Report a life change" function), such as updating a state of residence or a change in income, may affect a consumer's eligibility to obtain coverage through the Marketplace or for help paying for coverage. This SOP provides guidance on how to assist consumers in updating their account profiles.

B. Procedures

1. Update Account Profile

Consumers updating their account profiles should complete the following steps:

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

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

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

**To update addresses to a new ZIP code, county, or state, consumers must report a life change. This address change may affect consumers' eligibility.*

Things You Should Know

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

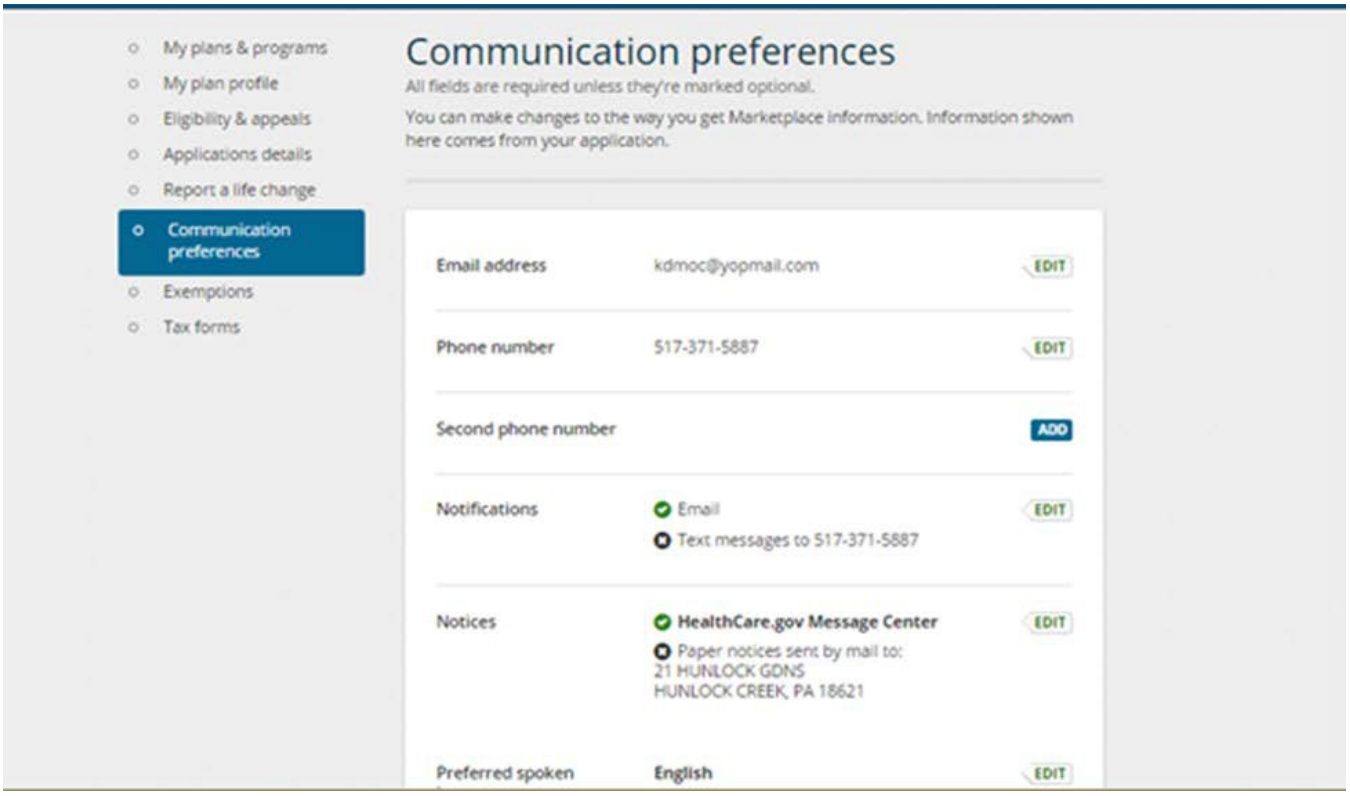
2. Update Communication Preferences

Consumers updating their communication preferences should complete the following steps:

Step 1. Consumers can log in to their accounts on HealthCare.gov and select the "My Applications & Coverage" tab. Consumers then select the application to update.

Step 2. Consumers should select the "Communication Preferences" tab, as shown in Exhibit 61.

Exhibit 61. Communication Preferences Screenshot



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

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

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

C. Next Steps

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

SOP 13. Report Life Changes

A. Introduction

This SOP provides guidance on how to assist consumers with updating their eligibility application information. Consumers may experience life changes (e.g., marriage, relocation, birth of a child, or change in household income, citizenship or immigration status) during the year. It is important for consumers to report a life change as soon as possible to the Marketplace because: (1) this information may change the coverage or savings for which consumers are eligible or (2) consumers may be eligible for an SEP as a result of the life change.

Consumers must report changes to their application information within 30 days of the change. The Marketplace will re-determine consumer eligibility after any changes are reported and will notify consumers of any resulting changes in eligibility and next steps. If consumers qualify for an SEP, they generally have 60 days to enroll in or change their Marketplace coverage.

B. Procedures

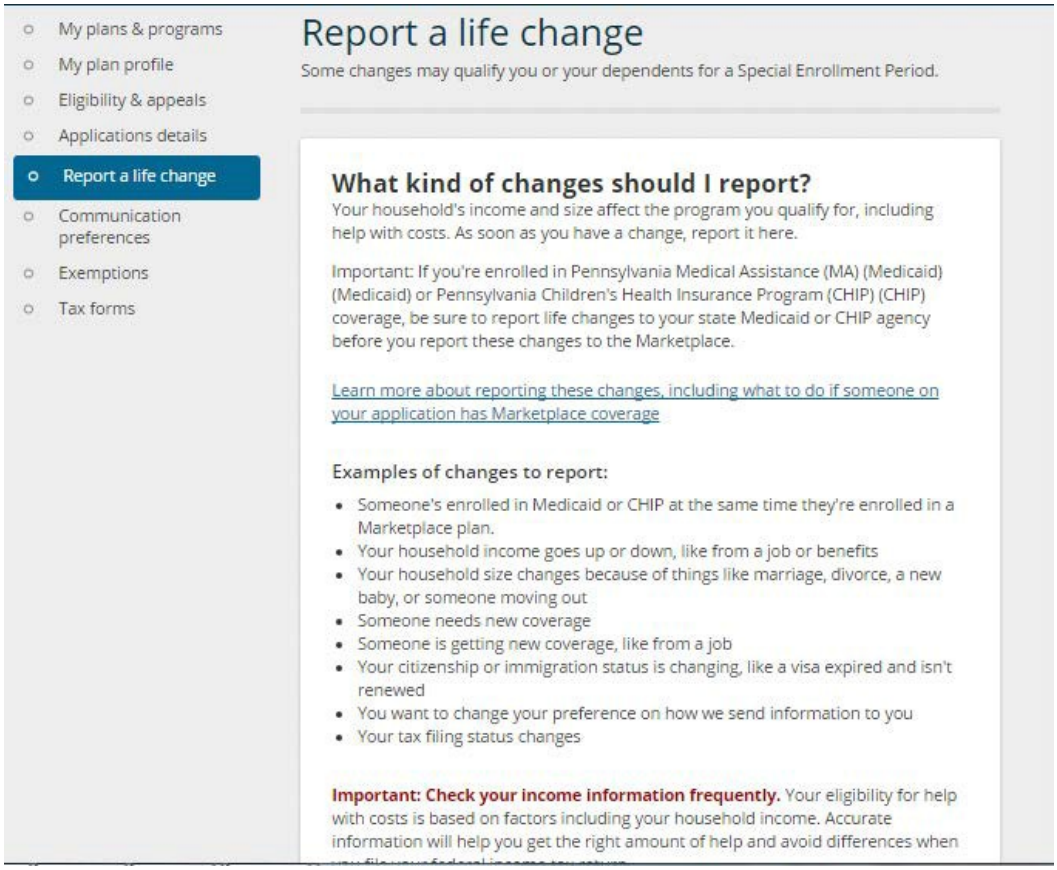
1. Reporting Life Changes

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

Step 1. Consumers should log in to their accounts on HealthCare.gov and select the "My Applications & Coverage" tab. Then select the application that needs to be updated to reflect life changes.

Step 2. Consumers should select the "Report a Life Change" tab, as shown in Exhibit 62.

Exhibit 62. Report a Life Change Screenshot



Step 3. Review the types of possible life changes, listed in Exhibit 63, with consumers.

Exhibit 63. Life Changes

Life Event	Potential Updates
Citizenship/Immigration Status Change	• Change in citizenship or immigration status for a household member needing coverage
Residency Changes	• Report a new residential address
Incarceration Status Change	• Claim current incarceration (in detention or jail) for household member • Claim end of incarceration period for household member
Tax Filing Status Change	• Claim new tax filing status (e.g., married, single, divorced) • Add, remove, or change tax dependents
Pregnancy Status Change	• Claim current pregnancy status • Claim end of pregnancy status
Household Member Change	• Add or remove member of household (including through birth, adoption or placement of child for adoption) • Change household members' names • Update household contact • Correct date of birth, or SSN • Update marital status or other family relationships • Report that a household member has a physical disability or mental health condition that limits their ability to work, attend school, or take care of daily needs • Remove member of household from coverage • Change in status as an American Indian/Alaska

Life Event	Potential Updates
	• Native or tribal member
Change in Request to Lower Health Plan Costs	• Request APTC and CSR • End request for APTC and CSR
Income Change	• Increase or decrease in income
Employer-Sponsored MEC Change	• Changes to job-based coverage (e.g., changes to premiums, coverage no longer offered by employer) • Changes to employment status • Member of the household gets a new offer of job- based coverage
Other MEC Changes	• Gained or lost health coverage (e.g., Medicaid, CHIP, Medicare) in the last 60 days • Will gain or lose health coverage in the next 60 days • Gained eligibility for Medicare coverage on 65 birthday or receives disability benefits

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

Step 5. Assist consumers as they update their application to account for any life changes. Remind consumers that their eligibility results may change as a result of the life change and how this may affect their coverage options.

Step 6. Help consumers submit any required supporting documentation and review updated eligibility results.

2. Special Enrollment Confirmations

The special enrollment confirmation process requires consumers who apply for coverage outside of the Open Enrollment period and use certain SEPs to enroll in Marketplace coverage to subsequently provide proof of their eligibility for the SEP to the Marketplace. Consumers should submit required documents to the Marketplace by the deadline date provided in their Eligibility Determination Notice. Consumers will generally have 30 days to submit documentation.

CMS will follow up with consumers by mail and by phone if there is a question or concern about the documents submitted by the consumer. Consumers who submit documents and do not hear back from the Marketplace do not need to take any further action. If consumers don't respond at all, or don't provide sufficient documentation, they could be found ineligible for their SEP and lose their coverage.

Things You Should Know

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

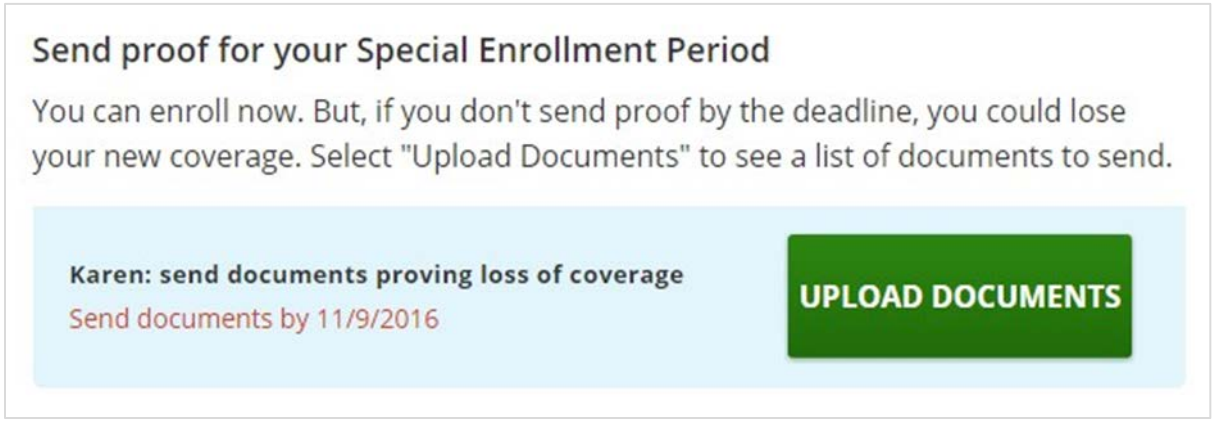
Consumers enrolling through five common SEPs will need to submit documentation to verify their eligibility to use an SEP. These SEPs are:

- Loss of minimum essential coverage
- Change in primary place of living if the consumer was enrolled in coverage while living at the original place of residence[18]
- Birth
- Gaining a dependent through adoption, placement for adoption, placement in foster care, or a child support or other court order
- Marriage

Consumers who applied for Marketplace coverage will be asked to provide documentation to verify eligibility for an SEP, as shown in Exhibit 64.

[18] Consumers must prove they had qualifying health coverage for one or more days in the 60 days before their move, unless they're moving from a foreign country or United States territory. Note, however, that moving only for medical treatment or staying somewhere temporarily without intending to reside there (e.g., for a vacation) doesn't qualify a consumer for an SEP.

Exhibit 64. Proving Eligibility for Special Enrollment Period



C. Next Steps

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

SOP 14. Renew Health Coverage

A. Introduction

As an agent or broker, you can help consumers renew their enrollment in QHPs through the Marketplace. The process for renewal of health coverage begins with the Marketplace's annual eligibility redetermination process for all consumers who were determined eligible for enrollment in a QHP in the previous year.

Consumers are responsible for notifying the Marketplace within 30 days of any changes in their application information during the year. This helps ensure an accurate redetermination of eligibility. Any changes in coverage or eligibility as a result of the annual eligibility redetermination will be effective on January 1 of the next year.

If consumers requested help paying for health coverage, agreed to allow the Marketplace to re-check their tax return information on an annual basis, and have properly reconciled any APTC received for the 2015 benefit year with the IRS, the Marketplace will then check the consumer's income data from the IRS and use it to re-determine their eligibility for help paying for health coverage. For consumers covered by Medicaid or CHIP, their states' Medicaid or CHIP agencies will generally re-determine their eligibility for these programs on an annual basis.

The Marketplace will send consumers a Marketplace Open Enrollment Notice (MOEN) before Open Enrollment for the coming year. All consumers are encouraged to come back to the Marketplace and log into their HealthCare.gov account to update their application information, compare plan options, and enroll in coverage for the coming year. Consumers should also check to be sure they are receiving the correct amount of help paying for coverage and are still enrolled in the coverage for 2017 that works best for them.

If consumers do not agree to allow the Marketplace to re-check their tax return information on an annual basis when they filed an eligibility application, the Marketplace will still send consumers a notice. The notice will tell consumers that if they want to receive, or continue to receive, APTC or income-based CSR for 2017, consumers must contact the Marketplace or go to HealthCare.gov to update their information and select a QHP in time for a January 1 effective date.

Otherwise, consumers' APTC or income-based CSR will end on December 31, 2016. Similarly, if a tax filer receiving APTC or income-based CSR in 2014 or 2015, failed to file a 2014 or 2015 tax return (respectively), and did not return to the Marketplace to obtain an updated eligibility determination, enrollees in that tax filer's tax household will lose any help paying for coverage after December 31, 2016.

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

In addition to MOENs, all consumers currently enrolled in a QHP will get a notice from their health insurance company before Open Enrollment. If the health insurance company does not have information about the estimated APTC amount before it sends the notice, it will provide the information before or during Open Enrollment.

The plan's renewal letter notice will identify a plan that is the same as or similar to the enrollee's 2017 plan, if available. The plan notice will describe any changes to the enrollee's QHP. If the QHP will be discontinued or coverage in that QHP non-renewed, the issuer will send a notice to tell consumers which plan, if any, the consumers will be enrolled in for 2017 unless they return to the Marketplace and change plans. If the consumer will not have plans offered by their 2016 health insurance issuer available to them through the FFM in 2017, the consumer may be automatically enrolled in a plan with a

different health insurance issuer. However, the consumer should be encouraged to return to the Marketplace to make sure that the new plan with the new health insurance company will meet the consumer's needs—or see if there is another plan that would be a better fit.

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

B. Procedures

Step 1. All consumers who are currently enrolled in a QHP through the Marketplace for the current plan year will be sent an MOEN before Open Enrollment that contains the following information:

a. A note explaining when the Open Enrollment period begins and ends.

b. A description of the annual eligibility redetermination and renewal process.

c. The requirement to report changes affecting eligibility and the timeframe and channels to report changes.

d. The key dates for ensuring coverage is effective on January 1, 2017.

e. The reconciliation process for consumers receiving APTC and/or CSR.

f. Special instructions for those consumers receiving APTC or CSR. For more information on these instructions, see Step 4.

Step 2. Assist consumers with reviewing their MOEN.

Step 3. Explain to consumers that they should update their eligibility application with any new or changed information about themselves or their households. If there are no changes, consumers should still return to their account on HealthCare.gov to review the application and confirm the information is correct and review their financial assistance and plan options.

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

a. If consumers who applied for, but were determined ineligible for APTC or income-based CSR contact the Marketplace to report any changes or select a new QHP, they will also get an updated eligibility determination based on updated guidelines (e.g., FPL) for the new plan year.

b. If consumers who <u>are not</u> receiving APTC or income-based CSR <u>do not</u> contact the Marketplace within the specified timeframe, generally, the Marketplace will automatically re-enroll them in the coverage for the next benefit year without APTC or CSR.

c. Consumers who <u>are</u> receiving APTC or income-based CSR and agreed to allow the Marketplace to re-check their tax return information on an annual basis and have filed a 2014 or 2015 tax return (if they received APTC in 2014 or 2015, as applicable) should be aware of the following key points about their annual eligibility redetermination and renewal process:

i. If consumers have provided updated eligibility information to the Marketplace, the eligibility redetermination notice will be based on their most recent eligibility information on file.

ii. If consumers have not provided updated eligibility information, the notice will encourage them to contact the Marketplace to get an updated eligibility determination by December 15, 2016.

iii. If consumers do not update their information, the Marketplace generally will renew their QHP enrollment for the benefit year with the same level of help selected in the previous year. Income-based CSR and APTC will be updated based on the consumer's most recent income and household size data reported to the Marketplace, updated FPL tables, and plan premiums.[19, 20] However, if data sources show that the a consumer's household income is over 500% FPL, the consumer will get a notice that his or her APTC and CSR will be discontinued unless the consumer takes action. The consumer may still be auto re-enrolled in a health plan on the Marketplace, but will lose APTC and CSR.

d. Consumers who are receiving APTC or income-based CSR and did not agree to allow the Marketplace to re-check their tax return information on an annual basis should be aware of the following key points about their annual eligibility redetermination and renewal process:

   i. The MOEN will ask consumers to contact the Marketplace to get an updated eligibility determination.

   ii. In general, if consumers do not contact the Marketplace by December 15, their financial assistance (APTC or CSR) will end on December 31.

   iii. If consumers are still eligible for QHP coverage, the Marketplace generally will renew their coverage for the next benefit year, but without financial assistance to help lower costs. Federal guidance explains how the Marketplace will decide which QHP the consumer will be automatically enrolled in for 2017 coverage.[21]

e. For consumers who are receiving APTC or CSR and did not file a tax return for the 2015 coverage year (and received APTC for 2015), APTC and/or CSR will end on December 31, 2016. Here are key points about their annual eligibility redetermination and renewal process:

   i. The MOEN will ask consumers to take action to ensure they file a 2015 tax return and then return to the Marketplace to update their application and attest to having filed a tax return. If consumers attest to having filed a tax return by December 15, the Marketplace generally will renew their coverage for the next benefit year.

   ii. In general, if consumers do not return to the Marketplace to attest to having filed a tax return or updated information from the IRS does not indicate that they have filed a 2015 tax return by December 15, their financial assistance will end on December 31, 2016.

Step 5. If consumers are unsure if they agreed to allow the Marketplace to re-check their tax return information on an annual basis, tell consumers that they can return to the Marketplace to give this authorization when they update their 2017 eligibility and plan selection.

Step 6. Enrollment.

Changes submitted on a 2017 application generally don't take effect unless consumers complete the process by continuing to enrollment and selecting a plan. If returning consumers want to keep their Marketplace plan for next and it remains available, they should select the plan labeled "Your Current Plan" at the top of the

[19] The amount of premium tax credits consumers receive in the new plan year depends on their income and the premium cost for the second lowest cost Silver-level plan available on the Marketplace.

[20] Guidance on annual eligibility redetermination and re-enrollment for Marketplace coverage for 2017 can be found here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ARR-2017-Guidance-051016-508.pdf.

[21] 17 See 45 C.F.R. § 155.335(a)(2).

plan results in Plan Compare.

Even if consumers are satisfied with their 2016 plan, it is still a good idea for consumers to compare plans to see what's covered; and whether desired providers, services, and prescription drugs are still covered by the plan; and to compare costs.

C. Next Steps

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

APPENDICES

Appendix A: Frequently Asked Questions (FAQs)

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

SOP-1 Receive Consent to Access Consumer Information

The FAQs below are designed to help agents or brokers answer consumers' specific questions on giving consent. For more information on this topic, see SOP-1 Receive Consent before Accessing Consumer PII.

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

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

SOP-2 Assess Consumers' Knowledge & Needs

The FAQs below are designed to help agents or brokers answer consumers' specific questions on how agents or brokers assess consumers' knowledge of and needs within an Individual Marketplace. For more information on this topic, see SOP-2 Assess Consumers' Knowledge & Needs.

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

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

FAQ 3. How do agents or brokers assess my knowledge and needs?

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

SOP-3 Create an Account

The FAQs below are designed to help agents or brokers answer consumers' specific questions on creating an eligibility account through the Individual Marketplace. For more information on this topic, see SOP-3 Create an Account.

FAQ 4. Why do I need an account?

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

FAQ 5. Can I set up multiple accounts?

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

FAQ 6. What if I do not have an email account?

Answer: You may create an email account with an email service provider of your choice or choose to submit a paper application to participate in the Marketplace or by calling the Marketplace Call Center.

FAQ 7. What if my password is not accepted?

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

FAQ 8. What if my user name is not accepted?

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

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

Answer: If you have submitted a paper application and wish to set up an online account, you should contact the Marketplace Call Center to obtain an application ID number after you receive your eligibility notice in the mail, if available. You should then go to the HealthCare.gov website and create an online Marketplace account.

After logging into your account, click the "Find my application" hyperlink on the My Applications & Coverage screen and then enter your application ID number that is linked to the paper application you submitted.

Please remember that all information - first name, last name, city, state, and ZIP code - for the person listed as **the household contact** on the original application must be an exact match for the contact information used for creating an account on HealthCare.gov. From here, you will be able to view your eligibility determinations and continue with the enrollment process.

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

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

SOP-4 Verify Identity

The FAQs below are designed to help agents or brokers answer consumers' specific questions on identity verification in the Individual Marketplace. For more information on this topic, see SOP-4 Verify Identity.

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

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

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

Answer: HealthCare.gov compares your responses to identity verification questions with information from your

Experian consumer report.

FAQ 13. Why was my identity verification unsuccessful?

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

FAQ 14. Will identity verification affect my credit score?

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

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

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

SOP-5 Apply for Health Coverage

The FAQs below are designed to help agents or brokers answer consumers' specific questions on eligibility applications in the Individual Marketplace. For more information on this topic, see SOP-5 Apply for Health Coverage.

FAQ 16. Do I have to enter my Social Security number (SSN) to apply for health coverage?

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

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

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

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

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

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

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

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

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

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

Answer: Yes, you may upload pages separately.

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

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

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

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

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

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

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

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

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

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

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

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

SOP-6 Review Eligibility Determination

The FAQs below are designed to help agents or brokers answer consumers' specific questions on eligibility determinations received through the Individual Marketplace. For more information on this topic, see SOP-6 Review Eligibility Results.

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

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

Center to receive further assistance.

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

Answer: You may file an appeal if you think you are eligible for a higher APTC and/or CSR, or if you disagree with certain other eligibility determinations. If you are actually eligible for higher APTC you will receive credit for these when you file your taxes, even if you do not file an appeal. For more information on appeals, see SOP-10 Request an Eligibility Appeal.

FAQ 30. How much do my assets matter in determining my eligibility for advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSR)?

Answer: The Marketplace does not consider your assets to determine your eligibility for APTC and CSR.

FAQ 31. How much does my household income matter in determining my eligibility to enroll in a QHP through the Marketplace?

Answer: Your household income is not a factor in determining your eligibility to enroll in a QHP through the Marketplace. If you decide to apply with financial assistance, your household income is only used to help determine your eligibility for APTC and CSR, as well as your eligibility for Medicaid and CHIP. If you decide to submit an application without requesting financial assistance, the Marketplace will not ask for your income.

FAQ 32. Is the Marketplace application different from the regular Medicaid application?

Answer: In all states, you can use the Marketplace application to apply for Medicaid and CHIP, as well as for APTC and CSR. In some states, and for some individuals whose eligibility is based on factors like age, disability, or the need for long-term care services, the Medicaid agency may require an additional, different Medicaid application or ask for additional information.

FAQ 33. How much do my assets matter in determining my eligibility for Medicaid and CHIP?

Answer: For most applicants, your assets won't matter in determining your eligibility for Medicaid and CHIP. There are still some people for whom assets do matter – specifically, individuals who are seeking Medicaid coverage because they are age 65 or over, disabled, or some individuals in need of long-term care services. The Marketplace will not ask you for information about assets, and your state Medicaid agency will let you know if this information is necessary.

FAQ 34. How much does my income matter in determining my eligibility for Medicaid and CHIP?

Answer: Medicaid and CHIP eligibility standards consider household size and income, and the income standards vary by state and by population. In most states that have expanded Medicaid, the eligibility standard is approximately 138% of FPL for adults in Medicaid. Income eligibility levels are often higher for children and pregnant women in all states. There are other non-financial eligibility requirements for Medicaid and CHIP.

Note: See Appendix C: Federal Poverty Guidelines or Appendix D: State Medicaid & CHIP Program Resources to help consumers estimate if they are potentially eligible for Medicaid/CHIP. Please note that there are other non-financial eligibility requirements for Medicaid and CHIP.

FAQ 35. Can I find out if I qualify for Medicaid without completing the Marketplace application?

Answer: Agents or brokers may provide an estimate by referencing and factoring in consumers' household size and income. However, you can only find out for sure if you qualify for Medicaid by completing an application with the Marketplace or your state Medicaid agency. However, I can help you estimate if you are eligible for Medicaid.

Note: Agents or brokers may provide an estimate by referencing Appendix C: Federal Poverty Guidelines or Appendix D: State Medicaid & CHIP Program Resources, and factoring in state Medicaid eligibility thresholds and consumers' household size and income.

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

Answer: If your eligibility results refer you to your local state Medicaid or CHIP agency, specific contact information will be included in the notice.

Note: Agents or brokers can reference Appendix D: State Medicaid & CHIP Program Resources for more information to share with consumers.

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

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

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

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

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

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

SOP-7 Lower Costs of Health Plan

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

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

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

FAQ 41. Can I adjust the amount of income-based cost-sharing reduction (CSR) I receive?

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

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

Answer: No, the Marketplaces determine the amount of APTC for which you are eligible. If you feel that you are eligible for a higher amount of ATPC, you may file an appeal. Even if you do not file an appeal, if you are eligible for a higher premium tax credit, you will receive a credit or refund for the difference between the premium tax credit you are eligible for and the APTC that was paid on your behalf, when you file your taxes for the year.

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

Answer: You may file an appeal if you believe you are eligible for more APTC or CSR, or if you aren't satisfied with certain other eligibility determinations.

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

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

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

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

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

Answer: Eligibility for APTC and CSR depends, in part, on your family size and household income. The Marketplace will determine if your family size and household income qualifies you for these benefits. Please note that there are other non-financial eligibility requirements for APTC and CSR. Visit HealthCare.gov for more information.

SOP-8 Compare, Save, & Select Health Plans

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

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

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

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

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

FAQ 49. When can I select my health plan?

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

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

Answer: You may only select one health plan for each individual. You may also select stand-alone dental coverage, if available. However, you may select different health plans for different people on a single application by forming different enrollment groups in the enrollment section of HealthCare.gov (after submitting the application).

FAQ 51. Can I select a stand-alone dental plan QHP?

Answer: If you want to enroll in a stand-alone dental plan QHP through individual Health Insurance Marketplace℠, you can select a medical plan that includes dental coverage, and you may also select a stand-alone dental plan. You

must be enrolled in a medical plan to enroll in dental coverage in Individual Health Insurance Marketplace[SM] [22].

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

Answer: Yes, you may enroll a child in a child-only plan without enrolling yourself in coverage, but you must include yourself and other members of your tax household as non-applicants on your application if you select that you want to see if you can get help paying for coverage.

However, it's important to remember that if you do not have minimum essential coverage (MEC) for yourself, you may be required to obtain an exemption or pay a fee when you file your annual federal income taxes.

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

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

FAQ 54. Who decides which health plans are QHPs?

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

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

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

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

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

HealthCare.gov offers several different tools to help consumers compare and contrast plans, including filtering and sorting options, yearly cost estimates, and in-network provider and medication coverage look-up tools.

Starting in the 2017 plan year, consumers will have the option to select "Simple Choice plans," which come with uniform cost-sharing features. The uniform cost-sharing features will allow the consumer to compare plans based on important factors, such as providers in the plan's network, with the knowledge that cost-sharing for certain categories of covered benefits will be the same across Simple Choice plans. The "Simple Choice plans" will display in Plan Compare.

SOP-9 Pay Health Plan Premium

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

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

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

[22] If an employee is enrolling through a SHOP Marketplace, and his or her employer offers both medical and stand-alone dental coverage through the SHOP Marketplace, the employee may enroll in a stand-alone dental plan through the SHOP Marketplace without also enrolling in a medical plan.

information, credit card information).

FAQ 58. How do I make payments?

Answer: Your insurance company will inform you of the acceptable methods of payment.

Generally, you can make payments through your health plan's website if the issuer makes online payments available, by phone if the issuer accepts payments by phone, or via mail directly to the health plan. You will not make payments for individual market coverage to the Marketplace, but the Marketplace may help redirect you to your health insurance company's website so you can pay your premium.

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

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

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

Answer: You will need to contact your health insurance company to confirm what happens after missing a payment. Coverage might not end immediately and your health insurance company may provide a grace period. Under Marketplace rules, QHP issuers must provide a grace period of three consecutive months for an enrollee, who when failing to timely pay premiums, is receiving advance payments of the premium tax credit. They must also grant enrollees who do not receive advance payments of the premium tax credit (APTC) a grace period in accordance with state laws. Agents or brokers and consumers may want to contact their State Department of Insurance (DOI) for more information on grace periods based on state rules.

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

Answer: Yes, the Marketplace automatically deducts any APTC for which you are eligible and have chosen to apply from the monthly premium amount displayed for you to pay.

SOP-10 Request an Eligibility Appeal

The FAQs below are designed to help agents or brokers answer consumers' specific questions on eligibility appeals through the Individual FFM. For more information on this topic, see SOP-10 Request an Eligibility Appeal.

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

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

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

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

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

Answer: Yes, you can reschedule if you have a conflict and cannot make the date and time scheduled for your eligibility appeal hearing. As soon as you know you have a conflict with when your hearing is scheduled, you should call the Marketplace Appeals Center to ask for a new date and time. The information on how to do this and the number to call is on your Notice of Hearing.

Hearing Officers carefully prepare for hearings to be ready to appropriately conduct each appellant's hearing and then correctly decide the case. If you do not request a rescheduled hearing and fail to appear at your hearing, your

appeal will be dismissed.

SOP-11 Exemptions

The FAQs below are designed to help agents or brokers answer consumers' specific questions on consumer exemptions through the Individual Marketplace. For more information on this topic, see SOP-11. Exemptions.

FAQ 65. How do I file for an exemption?

Answer: Depending on the reason for the exemption, you may apply for an exemption via the Marketplace or claim it when filing your federal tax returns.

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

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

FAQ 67. When does my exemption end?

Answer: When the Marketplace grants you an exemption, the exemption period may vary in length. The Marketplace grants exemptions on a month-to-month basis, for a calendar year, or on a continuing basis until an individual reports a change related to the eligibility standards.

Consumers may reference their exemption notice for further information. Consumers should note that most exemptions will end at the end of the plan year; thus, consumers will need to re-apply for an exemption each year in most cases.

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

Answer: Consumers who are not required to submit federal income tax returns because they do not meet the filing threshold are automatically exempt from the shared responsibility payment for not maintaining MEC and do not need to do anything else to get an exemption. This is true even if the consumer files a tax return to get a refund. In that case, the consumer can claim the exemption through the tax filing process.

Consumers whose incomes are below the filing threshold, but who choose to file a federal income tax return can claim the exemption through the tax filing process. Note, however, that consumers whose incomes are below the filing threshold but who file a federal income tax return for another reason must apply for an exemption if they do not have MEC.

SOP-12 Update Account Profile

The FAQs below are designed to help agents or brokers answer consumers' specific questions on updating their online accounts through the Individual Marketplace. For more information on this topic, see SOP-12 Update Account Profile.

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

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

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

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

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

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

SOP-13 Report Life Changes

The FAQs below are designed to help agents or brokers answer consumers' specific questions on reporting life changes through the Individual Marketplace. For more information on this topic, see SOP-13 Report Life Changes.

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

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

FAQ 73. When should I report a life change?

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

SOP-14 Renew Health Coverage

The FAQs below are designed to help agents or brokers answer consumers' specific questions on renewing their health coverage through the Individual Marketplace. For more information on this topic, see SOP-14 Renew Health Coverage.

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

Answer: Consumers will get a notice from two different sources before Open Enrollment begins: the Marketplace and their health insurance company. The Marketplace will send an annual eligibility redetermination notice and the health insurance company notice will either tell consumers that they can renew their coverage for 2017 (known as a renewal notice) or that their QHP is being discontinued (known as a discontinuance notice). The health insurance company generally must send a discontinuation notice at least 90 days before the date the coverage will be discontinued.

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

Answer: For the 2017 coverage year, if your QHP is being discontinued and if state law allows, you will be enrolled automatically into a different QHP, possibly with a different insurance company. The new QHP would be chosen based on a set of established rules. You can also return to the Marketplace and select a new QHP.

FAQ 76. Why was I re-determined ineligible for coverage through the Marketplace?

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

Appendix B: Acronyms & Definitions

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

Frequently Used Acronyms

Acronym	Definition
AHCCCS	Arizona Health Care Cost Containment System
APTC	Advance Payments of the Premium Tax Credit
CAC	Certified Application Counselor
CCIIO	Consumer Information & Insurance Oversight
CDO	Counselor Designated Organization
CHAMPVA	(Veterans Administration) Civilian Health and Medical Program
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
COBRA	Consolidated Omnibus Budget Reconciliation Act
DHS	Department of Homeland Security
DOI	Department of Insurance
ECN	Exemption Certificate Number
EHB	Essential Health Benefits
EST	Eastern Standard Time
FAMIS	Family Access To Medical Insurance
FPL	Federal Poverty Level
FSA	Flexible Spending Account
FTC	Federal Trade Commission
HDHP	High Deductible Health Plan
HMO	Health Maintenance Organization
HSA	Health Savings Account
IHS	Indian Health Service
IRS	Internal Revenue Service
MA	Medical Assistance
MAGI	Modified Adjusted Gross Income
MCHP	Maryland Children's Health Connection Program
MEC	Minimum Essential Coverage
MOEN	Marketplace Open Enrollment Notice
NPN	National Producer Number
OIG	Office of the Inspector General
PHI	Protected Health Information
PII	Personally Identifiable Information
POS	Point of Service
PPO	Preferred Provider Organization

Acronym	Definition
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SBC	Summary of Benefits and Coverage
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SHOP	Small Business Health Options Program
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
VA	Department of Veterans Affairs

Definitions

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

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

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

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

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

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

Authorized Representative: Someone whom consumers designate in writing to act on their behalf with the Marketplace, like a family member or other trusted person. (Reference: 45 CFR §155.227)

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

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

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

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

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

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Program (CHIP), as well as the Federally-facilitated Marketplaces. For more information, visit CMS.gov. (Reference: HealthCare.gov/glossary/centers-for-medicare-and-medicaid-services)

Certified Application Counselor (CAC): In an FFM, an individual (affiliated with an organization designated by CMS, as operator of the FFMs) who is trained and able to help consumers as they look for health coverage

options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers. (Reference: HealthCare.gov/glossary/certified-applicant-counselor)

Certified Application Counselor Designated Organization (CDO): In a Marketplace, an organization designated by CMS, as operator of the Marketplace, to certify staff members or volunteers to act as certified application counselors. (Reference: 45 CFR §155.225)

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

Claim: A request for payment that a consumer, his or her authorized representative, or his or her health care provider submits to the consumer's health insurer when the consumer gets items or services he or she thinks are covered. (Reference: HealthCare.gov/glossary/claim)

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

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

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

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

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

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

Employer-sponsored Health Insurance Plan (Group Health Plan): A group health plan or health coverage offered by

an employer which may be a governmental plan or any other plan, or coverage offered in the small- or large-group marketplace within a state. (Reference: IRC §5000A(f)(2))

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

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

The Affordable Care Act ensures that non-grandfathered health insurance plans offered in the individual and small-group markets, both inside and outside of the Health Insurance Marketplaces, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these categories of benefits to be certified as qualified health plans that can be offered in the Health Insurance Marketplaces, and alternative benefit plans offered under Medicaid state plans (which must be offered to the new adult population) must cover these services by 2014. (Reference: HealthCare.gov/glossary/essential-health-benefits)

Federal Poverty Level (FPL): FPL represents a threshold level of household income used by the federal government to determine an individual's eligibility to participate in certain federal programs or qualify for advance payments of the premium tax credit or cost-sharing reduction in a Marketplace when enrolling in a QHP.

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

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

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

Health Maintenance Organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require a consumer to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. (Reference: HealthCare.gov/glossary/health-maintenance-organization-HMO)

Health Plan Categories: The Individual Marketplace generally separates health plans into four health plan categories — Bronze, Silver, Gold, or Platinum,— based on the amount the plan can be expected to pay of the average overall cost of providing essential health benefits to members. The plan category a consumer chooses affects the total amount the consumer will likely spend for essential health benefits during the year. For the four metal category plans, the percentages the plans will spend on average are 60% (Bronze), 70% (Silver), 80% (Gold),

and 90% (Platinum). This is not the same as coinsurance in which a consumer pays a specific percentage of the cost of a specific service. (Reference: HealthCare.gov/glossary/health-plan-categories)

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

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

Incarceration Status: A criterion for eligibility referring to whether an individual is required to be confined to a correctional institution. Applicants are not qualified individuals if they are incarcerated other than pending the disposition of charges. (Reference: 45 CFR §155.305)

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

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

Individual Shared Responsibility Payment (also referred to as a "Fee"): Starting January 1, 2014, if applicable individuals do not maintain health coverage that qualifies as MEC or obtain an exemption, they may have to pay a fee, known as the individual shared responsibility payment, that increases every year from 1% of household income (or $95 per adult, whichever is higher) in 2014, 2.0% of household income (or $325 per adult) in 2015, to 2.5% of household income (or $695 per adult) in 2016, up to a maximum of $2,085. The fee for children is half the adult amount. If applicable, consumers will pay this fee on their annual tax return. People with very low incomes and others may be eligible for exemptions. (Reference: HealthCare.gov/glossary/fee)

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

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

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

Marketplace: A marketplace for health insurance, also known as an "Exchange," operated by a governmental agency or non-profit entity that meets applicable government standards. A Marketplace makes QHPs available to qualified individuals and/or qualified employers. Generally, in CMS documents, this term is often used to refer both to Marketplaces serving the individual market for qualified individuals and to Small Business Health Options

Program (SHOP) Marketplaces serving the small group market for qualified employers, and is often used regardless of whether a Marketplace is established and operated by a State or by HHS. However, in this document, the term Marketplace generally is used to refer only to the Federally-facilitated Marketplaces (FFMs), and frequently is used to refer only to the Individual Marketplace. (Reference: 45 CFR §155.20)

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

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

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

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

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

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

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

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

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

Open Enrollment Period: The period of time during which individuals who are eligible to enroll in a QHP can enroll in a plan through the Marketplace. For coverage starting in 2017, the individual market Open Enrollment

period is November 1 – January 31. Individuals may also qualify for special enrollment periods if they experience certain qualifying events. Consumers can apply for Medicaid or CHIP at any time of the year. (Reference: HealthCare.gov/glossary/open-enrollment-period)

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

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

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

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

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

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

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

Qualified Health Plan (QHP): Under the Affordable Care Act, an insurance plan that is certified by a Health Insurance Marketplace℠, provides essential health benefits, follows established limits on cost sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. Each QHP is certified by the Marketplace through which the plan is offered. (Reference: HealthCare.gov/glossary/qualified-health-plan)

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

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

Special Enrollment Period (SEP): In the individual market, a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual individual market Open Enrollment period. For example, individuals who lose employer-

sponsored health coverage, or who lose Medicaid coverage because of an increase in income, would be eligible for a SEP to enroll in a Marketplace plan, if they otherwise qualify. Other triggering events include marriage, divorce, and the birth or adoption of a child. (Reference: 45 CFR §155.20)

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

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

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

Veterans Affairs Health Care Benefits: Health care benefits for which veterans who served in the active military, naval or air service and were separated under any condition other than dishonorable, may qualify. For more information on how the Affordable Care Act affects veterans' health benefits, visit VA.gov/aca. (Reference: VA.gov)

Appendix C: Federal Poverty Guidelines[23]

Exhibit 65—2017 Annual Poverty Guidelines for the 48 Contiguous States and the District of Columbia (Except Hawaii and Alaska)

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250 %
1	12,060.00	14,472.00	16,039.80	16,281.00	18,090.00	21,105.00	22,311.00	24,120.00	30,150.00
2	16,240.00	19,488.00	21,599.20	21,924.00	24,360.00	28,420.00	30,044.00	32,480.00	40,600.00
3	20,420.00	24,504.00	27,158.60	27,567.00	30,630.00	35,735.00	37,777.00	40,840.00	51,050.00
4	24,600.00	29,520.00	32,718.00	33,210.00	36,900.00	43,050.00	45,510.00	49,200.00	61,500.00
5	28,780.00	34,536.00	38,277.40	38,853.00	43,170.00	50,365.00	53,243.00	57,560.00	71,950.00
6	32,960.00	39,552.00	43,836.80	44,496.00	49,440.00	57,680.00	60,976.00	65,920.00	82,400.00
7	37,140.00	44,568.00	49,396.20	50,139.00	55,710.00	64,995.00	68,709.00	74,280.00	92,850.00
8	41,320.00	49,584.00	54,955.60	55,782.00	61,980.00	72,310.00	76,442.00	82,640.00	103,300.00

**For family units with more than eight members, add $4,180 for each additional family member.*

Exhibit 66—2017 Annual Poverty Guidelines for Alaska Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	15,060.00	18,072.00	20,029.80	20,331.00	22,590.00	26,355.00	27,861.00	30,120.00	37,650.00
2	20,290.00	24,348.00	26,985.70	27,391.50	30,435.00	35,507.50	37,536.50	40,580.00	50,725.00
3	25,520.00	30,624.00	33,941.60	34,452.00	38,280.00	44,660.00	47,212.00	51,040.00	63,800.00
4	30,750.00	36,900.00	40,897.50	41,512.50	46,125.00	53,812.50	56,887.50	61,500.00	76,875.00
5	35,980.00	43,176.00	47,853.40	48,573.00	53,970.00	62,965.00	66,563.00	71,960.00	89,950.00
6	41,210.00	49,452.00	54,809.30	55,633.50	61,815.00	72,117.50	76,238.50	82,420.00	103,025.00
7	46,440.00	55,728.00	61,765.20	62,694.00	69,660.00	81,270.00	85,914.00	92,880.00	116,100.00
8	51,670.00	62,004.00	68,721.10	69,754.50	77,505.00	90,422.50	95,589.50	103,340.00	129,175.00

**For family units with more than eight members, add $5,230 for each additional family member.*

Exhibit 67—2017 Annual Poverty Guidelines for Hawaii Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,860.00	16,632.00	18,433.80	18,711.00	20,790.00	24,255.00	25,641.00	27,720.00	34,650.00
2	18,670.00	22,404.00	24,831.10	25,204.50	28,005.00	32,672.50	34,539.50	37,340.00	46,675.00
3	23,480.00	28,176.00	31,228.40	31,698.00	35,220.00	41,090.00	43,438.00	46,960.00	58,700.00
4	28,290.00	33,948.00	37,625.70	38,191.50	42,435.00	49,507.50	52,336.50	56,580.00	70,725.00
5	33,100.00	39,720.00	44,023.00	44,685.00	49,650.00	57,925.00	61,235.00	66,200.00	82,750.00
6	37,910.00	45,492.00	50,420.30	51,178.50	56,865.00	66,342.50	70,133.50	75,820.00	94,775.00

[23] The Secretary of the Department of Health and Human Services updates the poverty guidelines at least annually. The most recent year tables are provided in the Federal Register: https://www.federalregister.gov/documents/2017/01/31/2017-02076/annual-update-of-the-hhs-poverty-guidelines

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
7	42,720.00	51,264.00	56,817.60	57,672.00	64,080.00	74,760.00	79,032.00	85,440.00	106,800.00
8	47,530.00	57,036.00	63,214.90	64,165.50	71,295.00	83,177.50	87,930.50	95,060.00	118,825.00

"'For family units with more than eight family members, add $4,810 for each additional family member.

Appendix D: State Medicaid & CHIP Program Information

While implementation of the Affordable Care Act brings with it the coordination of state Medicaid and CHIP programs with the Health Insurance Marketplaces, states must still have a single state agency to administer or supervise the administration of the Medicaid program. As an agent or broker, you may be confronted with questions from consumers about specific Medicaid or CHIP eligibility requirements in their states. You may also encounter consumers who have been determined eligible for Medicaid or CHIP by the Marketplace and require assistance with enrollment. In these cases, you may reference Exhibit 68 for links to Medicaid and CHIP programs. Please refer consumers to these websites and agencies to help them find the information and assistance they need.

Exhibit 68—State Medicaid & CHIP Program Contact Information

State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
Alabama	ALL Kids	www.adph.org/allkids	www.medicaid.alabama.gov
Alaska	Denali KidCare	www.dhss.alaska.gov/dhcs/Pages/denalikidcare	http://dhss.alaska.gov/dpa/pages/medicaid
Arizona	Arizona Health Care Cost Containment System (AHCCCS) KidsCare	www.azahcccs.gov/applicants/categories/KidsCare.aspx	www.azahcccs.gov
Arkansas	ARKids First!	www.arkidsfirst.com	www.medicaid.state.ar.us
Delaware	Delaware Healthy Children Program	www.dhss.delaware.gov/dss/dhcp.html	www.dmap.state.de.us
Florida	Florida KidCare	www.floridakidcare.org	www.fdhc.state.fl.us/Medicaid/index.shtml
Georgia	PeachCare for Kids	www.peachcare.org	http://dch.georgia.gov/medicaid
Idaho	Idaho CHIP	www.healthandwelfare.idaho.gov/?TabId=219	http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx
Illinois	All Kids	www.allkids.com	http://www2.illinois.gov/hfs/Pages/default.aspx
Indiana	Hoosier Healthwise Package C	http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise.aspx	www.in.gov/fssa/2408.htm
Iowa	Hawk-I	www.hawk-i.org	http://dhs.iowa.gov/ime/about
Kansas	HealthWave 21	http://www.kancare.ks.gov	https://cssp.kees.ks.gov
Louisiana	LaCHIP	http://new.dhh.louisiana.gov/index.cfm/page/222	www.dhh.louisiana.gov/index.cfm/subhome/1/n/331
Maine	MaineCare	www.state.me.us/dhhs/OIAS/services/cubcare/CubCare.htm	www.maine.gov/dhhs
Michigan	MIChild	www.michigan.gov/mdch/1,1607,7-132-2943_4845_4931---,00.html	www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html
Mississippi	Mississippi Health Benefits CHIP	www.medicaid.ms.gov/programs/childrens-health-insurance-program-chip/	www.medicaid.ms.gov
Missouri	MO HealthNet for Kids	www.dss.mo.gov/mhk/index.htm	www.dss.mo.gov/mhd

State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
Montana	Healthy Montana Kids	www.dphhs.mt.gov/hmk	http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices
Nebraska	Nebraska Kids Connection	http://dhhs.ne.gov/medicaid/Pages/med_CHIP.aspx	http://dhhs.ne.gov/medicaid/Pages/med_medindex.aspx
New Hampshire	New Hampshire CHIP	www.dhhs.nh.gov/ombp/medicaid/nhmedicaid-children.htm	www.dhhs.nh.gov/ombp/medicaid/index.htm
New Jersey	NJ Family Care	www.njfamilycare.org	www.state.nj.us/humanservices/dmahs/clients/medicaid
New Mexico	New MexiKids & New MexiTeens	www.insurenewmexico.state.nm.us/NewMexiKidsandTeens.htm	www.hsd.state.nm.us/mad/HMedicaid.html
North Carolina	NC Health Choice for Children	www.ncdhhs.gov/dma/healthchoice	www.ncdhhs.gov/dma/medicaid
North Dakota	Healthy Steps	www.nd.gov/dhs/services/medicalserv/chip	www.nd.gov/dhs/services/medicalserv/medicaid
Ohio	Healthy Start	http://medicaid.ohio.gov/FOROHIOANS/Programs/ChildrenFamiliesandWomen.aspx	http://medicaid.ohio.gov
Oklahoma	Oklahoma CHIP	www.okhca.org	www.okhca.org/individuals.aspx?id=52&menu=114&parts=11601_7453
Pennsylvania	Pennsylvania CHIP	www.chipcoverspakids.com	http://www.dhs.state.pa.us/foradults/healthcaremedicalassistance/index.htm
South Carolina	Partners for Healthy Children	www.scdhhs.gov/eligibility-groups/children-also-known-partners-healthy-children	www.scdhhs.gov
South Dakota	South Dakota CHIP	http://dss.sd.gov/medicalservices/chip	http://dss.sd.gov/medicaid/
Tennessee	Cover Kids	www.coverkids.com	www.tn.gov/tenncare
Texas	TexCare CHIP	www.chipmedicaid.org	http://www.hhsc.state.tx.us/medicaid
Utah	Utah CHIP	www.health.utah.gov/chip	http://health.utah.gov/medicaid/provhtml/general_info.html
Virginia	Family Access to Medical Insurance (FAMIS)	www.famis.org	www.dss.virginia.gov/benefit/medical_assistance/index.cgi
West Virginia	West Virginia CHIP	www.chip.wv.gov	www.wvdhhr.org/bcf/family_assistance/medicaid.asp
Wisconsin	BadgerCare Plus	www.dhs.wisconsin.gov/badgercareplus/index.htm	www.dhs.wisconsin.gov/medicaid
Wyoming	Kid Care CHIP	http://health.wyo.gov/healthcarefin/chip	http://health.wyo.gov/healthcarefin/medicaideligibility/index.html

Appendix E: Support Resources

If consumers require assistance that is outside of agent and broker activities, refer consumers to other organizations and resources as appropriate. Exhibit 69 provides a list of external resources.

Exhibit 69—External Resources

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Center for Consumer Information & Insurance Oversight (CCIIO)	www.CMS.gov/cciio/index.html	This entity implements many provisions of the Affordable Care Act, the health reform bill signed into law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance.	• To gather more information on the Affordable Care Act by referencing detailed fact sheets, FAQs, and other resources.
Experian Help Desk	1-866-578-5409	The Experian Help Desk assists consumers with verifying their identity over the phone so that they may proceed with eligibility and enrollment activities after creating an account on HealthCare.gov.	• To verify their identity over the phone if they were unsuccessful in their attempt to verify their identity on HealthCare.gov. When necessary, the Marketplace will give consumers a unique identity verification code and instruct them to contact the Experian Help Desk.
Marketplace Call Center	1-800-318-2596 TTY: 1-855-889-4325 (all languages available)	The Marketplace Call Center provides assistance to consumers who need information or want to enroll in health coverage through the Marketplace.	• To get answers to questions while applying for health coverage using the online or paper application. • To apply for health coverage over the phone.
HealthCare.gov	www.HealthCare.gov	This website allows consumers to access information about the Affordable Care Act and to enroll in health coverage through the Marketplace.	• To find out about health coverage options available through the Marketplace. • To apply for health coverage online. • To get real-time answers to questions using the online chat function.
Indian Health Service (IHS)	www.IHS.gov	This division of HHS is dedicated to providing federal health services to American Indians and Alaska Natives.	• To learn more about the Affordable Care Act provisions that apply to American Indians or Alaskan Natives. • To learn more about exemptions and lower health coverage costs available to American Indians or Alaskan Natives.
Internal Revenue Service (IRS)	www.IRS.gov	This federal agency collects taxes from individuals and businesses in the U.S.	• To learn more about the effects of the Affordable Care Act on consumers' tax returns.

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Medicaid	www.Medicaid.gov	This state-administered health insurance program is for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state-by-state and may have a different name in your state.	• To find answers to questions about health coverage through Medicaid or CHIP. • To get further information about their state's Medicaid program and agency contact information.
Medicare	www.Medicare.gov	This federal program is run by CMS and provides health coverage to qualified individuals who are 65 years of age or older and/or have a disability.	• To learn more about eligibility for Medicare or apply for Medicare online. • To learn more about or make changes to existing Medicare benefits.
State Health Insurance Assistance Program (SHIP) Office	www.shiptacenter.org	This state-based program offers one-on-one counseling and assistance to people covered by Medicare and their families.	• To receive free in-person or telephone counseling on navigating the health care system and Medicare program.
Social Security Administration (SSA)	www.SSA.gov	This independent federal agency administers Social Security, A system that distributes financial benefits to retired or disabled people, their spouses, and their dependent children based on their reported earnings.	• To learn more about available social security benefits for which consumers might be eligible. • To apply for a Social Security number, which is necessary to apply for health coverage through the Marketplace (except for legal immigrants, who can provide a document number).
Veterans Affairs (VA) Health Benefits	www.VA.gov www.VA.gov/health/aca	The Department of Veterans Affairs Provides comprehensive health care programs, services and benefits to Veterans and other beneficiaries who are enrolled in the following programs: Veterans Health Care Program, VA Civilian Health and Medical Program (CHAMPVA), or Spina Bifida Health Care Benefits Program.	• To learn more about or apply for VA health benefits.

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