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Department of Health and Human Services

Centers for Medicare & Medicaid Services

Health Insurance Marketplace Navigator Standard Operating Procedures Manual

Version 1.0

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1.0 Introduction & Instructions for Use

1.1 Welcome

The United States (U.S.) Department of Health and Human Services (HHS) welcomes grantees to the Navigator program. HHS aims to ensure that all consumers have access to high-quality, affordable health coverage options through the Health Insurance Marketplace.

As a Navigator, you will serve as a trusted resource that will educate consumers and answer their questions about health coverage through the Marketplace. Navigators' dedication and commitment ensure that consumers have a positive and seamless health coverage enrollment experience.

1.2 Purpose of the Manual

The Health Insurance Marketplace Navigator Standard Operating Procedures Manual (manual) is an instructional guide intended for Navigator Program grantees. This manual also contains standard operating procedures (SOPs) that detail the required Navigator activities. The SOPs reflect applicable policies contained within the Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act); 45 CFR Parts 155, 156, and 157 of the Establishment of Exchanges (now referred to as the "Marketplace"); qualified health plans (QHP); and the Exchange Standards for Employers. This manual also reflects policies contained within 45 CFR Part 155 of the Standards for Navigators and Non-Navigators Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange; and Certified Application Counselors (Final Rule).

The instructions and information included in this manual provide guidance on the consumer assistance process for the Individual and the Small Business Health Options Program (SHOP) Marketplaces, which includes the following procedures:

- Preparing, completing, and updating health coverage applications;
- Reviewing eligibility determinations for enrollment in health coverage;
- Enrolling in health coverage;
- Renewing health coverage eligibility and enrollment; and
- Completing exemption and appeal requests.

The Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS) maintains this manual in its entirety. CCIIO may alter, delete, suspend, or discontinue any part of the procedures in the manual at any time.

1.3 Instructions for Use

You may use this manual either as a stand-alone paper document or as an electronic document. The manual allows for easy navigation in either format. The next section defines the manual structure.

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1.3.1 General Document Use

The manual is comprised of the following seven sections:

Section 1.0: Introduction & Instructions for Use (i.e., the current section)

This section provides instructions on using the manual and the SOPs contained herein.

Section 2.0: Consumer Support Overview

This section provides an overview of the consumer support guidelines and requirements, including:

- Customer Service Guidelines
- Customer Service Best Practices
- Navigator Responsibilities
- Security and Privacy Guidelines
- Consumer Accommodations
- Complaint/Grievance Process
- Support Resources

Section 3.0: Navigator Activities

This section details the nine Navigator job functions, which include:

- Consumer Assessment
- Consumer Education
- Account Creation & Maintenance
- Application & Renewal of Coverage
- Eligibility
- Enrollment
- Exemptions
- Appeals
- Consumer Outreach
- Navigator Reporting

Section 4.0 Individual Marketplace SOPs

This section includes the SOPs necessary to assist consumers who are interested in purchasing health coverage through the Individual Marketplace for themselves and/or their family members.

Section 5.0: Small Business Employee SOPs

This section includes the SOPs necessary to assist employees with enrolling in a QHP selected by their employer through the SHOP Marketplace.

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Section 6.0 Small Business Employer SOPs

This section includes the SOPs necessary to assist employers with choosing a plan that works for their budget, their business, and their employees through the SHOP Marketplace.

Section 7.0 Appendices

This section contains additional resources with information related to the Navigator program, FAQs, acronyms, and definitions of key terms.

1.3.2 Electronic Document Use

When using the electronic version of the manual, use words or phrases to jump to a new document, a new section within the current document, or a website (i.e., hyperlinks).

To identify hyperlinks in the body of the manual, look for underlined words in a 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.

To navigate using hyperlinks, hold down the "Ctrl" button on the keyboard and then click on the hyperlink to navigate to the referenced document, section, or website.

1.4 Standard Operating Procedure (SOP) Overview

Use the SOPs outlined in this manual when performing consumer assistance activities. Section 3.0 provides high-level information on the routine assistance activities and the corresponding SOPs in Sections 4.0 – 6.0 provide more detailed guidance on how to assist consumers with these activities.

Exhibit 1 illustrates the organizational structure for SOPs contained in this manual. Each SOP has four sections:

- Introduction
- Consumer Education
- Procedures
- Next Steps

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Exhibit 1 – Navigator SOP Template

SOP-#. Title

A Introduction

Outlines the relevant task(s), and describes the topic covered in the SOP.

B Consumer Education

Lists relevant information that the Navigator can use to educate consumers, employers, and employees regarding the SOP topic of interest.

C Procedures

Provide narrative, step-by-step instructions, tables and graphics for a Navigator to successfully complete the SOP topic of interest.

D Next Steps

Identify next steps or associated SOPs within the manual that the Navigator can reference to further assist consumers with Marketplace functions.

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2.0 Consumer Support Overview

When providing consumer assistance, you should educate consumers about the health insurance Marketplace, answer health coverage-related questions, and facilitate consumers' selection of affordable health coverage through the Marketplace. In addition, you must provide assistance to all consumers, including individuals with disabilities and those with limited English proficiency (LEP). You should abide by the following mission statement:

> *"[Navigators] play an integral role in ensuring that Marketplace consumers receive engaging, respectful, and seamless assistance when enrolling in qualified health plans and insurance affordability programs through the Marketplace."*

This section provides an overview of consumer support guidelines and requirements, including:

- Customer service guidelines
- Customer service best practices
- Navigator responsibilities
- Privacy and security guidelines
- Consumer accommodations when providing customer service
- The complaint and grievance process
- Additional support resources to help Navigators fulfill customer service functions

If consumers have questions that fall outside of the Navigator activities (see Section 3.0, Navigator Activities), refer to Manual Section 2.8, Support Resources. If external resources cannot meet consumers' needs, refer consumers to the call center for additional guidance.

2.1 Customer Service Guidelines

Your goal is to provide consumers with friendly and impartial customer service that meets their needs. Customer service includes the following:

- Making consumers feel welcome, important, heard, and respected by listening and responding to their requests
- Communicating in a way that supports consumers' understanding and needs
- Assisting consumers in a culturally-sensitive manner, using language translation services as appropriate
- Responding appropriately to consumers' needs and accommodation requests in a timely manner
- Referring consumers to other entities when their needs cannot be met by the Navigator program
- Empowering consumers through open and trustworthy interactions and communication

2.2 CUSTOMER SERVICE BEST PRACTICES

Whether serving customers in a retail environment or assisting consumers in the Marketplace, a set of basic principles applies to establishing and maintaining positive relationships. Use the following tips when interacting with consumers.

2.2.1 Smile -- Maintain a Positive Demeanor

This is the most simple and most powerful tip for consumer assistance (and most interpersonal interactions). Smile. Smiles are contagious; usually when you smile at somebody they will smile back at you. Do not pretend to smile, or produce a false smile; these are easy to spot and send the wrong messages. Relax, gain eye-contact, and smile naturally. This will help consumers to feel at ease and welcomed. You will come across as friendly and approachable, setting the scene for positive interaction.

If you are talking to somebody on the telephone, you can still smile; your voice sounds different when you smile and are happy. Consumers are more likely to want to talk to a cheerful person with an enthusiastic personality and by smiling while you talk you can help to project this.

2.2.2 Make the Consumers Feel Welcome

Use an appropriate greeting to make your consumers feel welcome. Start positively with a warm welcome; “Good Morning,” “Welcome,” and “Thanks for stopping by” are all simple introductions. You can follow up with, “How can I help?” Continue communicating as appropriate, relax, and be as natural as possible. Respond in a genuine way.

Do not come on too strongly. Respect a consumer's personal space. Let the assistance move at the consumer’s pace. People are more responsive when they are comfortable and at ease.

2.2.3 Listen

You are unlikely to be able to help consumers effectively if you do not listen to their needs. By not listening you can become very frustrating to consumers. Listen, empathize, and make a genuine effort to find the best solutions. Make sure consumers have an opportunity to tell you everything they wanted to say. Interrupting is a waste of time. It frustrates the speaker and limits full understanding of the message. Do not interrupt with countering arguments. Remember the details of what they have said.

Allow the speaker to finish each point before asking questions. When consumers are finished speaking, paraphrase what consumers have said. "What I'm hearing is …" and "Sounds like you are saying …" are great ways to confirm that you understand. Ask questions to clarify certain points. "What do you mean when you say…?" "Is this what you mean?" Summarize the speaker's comments periodically.

Pay attention to non-verbal communication while listening:

- Look at the speaker directly.

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- Put aside distracting thoughts.
- Do not mentally prepare a response.
- Avoid distraction by environmental factors, like side conversations.
- Notice the speaker's body language.
- Nod occasionally. Smile and use other facial expressions.
- Note your posture and make sure it is open and inviting.

2.2.4 Build Trust—Be True to Your Word

Be candid, open, and honest in your responses to consumers. Treat consumers in ways that you think they would want to be treated.

Be open with mistakes. Be aware of your responsibility in any situation or outcome. Apologizing when things go wrong demonstrates that you care about consumers and their experiences.

Only offer consumers something that you are sure you can give them. Don't promise timelines you are not sure you can fulfill. Stick to deadlines, make sure you turn up promptly for any appointments and never make promises you cannot keep. If situations change, let consumers know as soon as possible.

2.2.5 Learn your Business – Be an Expert

Learn the advantages and disadvantages of the various options available so that you can readily present options which best suit consumers' needs. Make sure that you know about your subject and that you can answer questions about the Marketplace and health coverage even if unrelated to your normal field of work. If you don't know the answer to a question, then say so. NEVER lie or make up an answer. Find someone who does know the answer. Do not hesitate to ask consumers clarifying questions that will give you a better understanding of their needs.

2.2.6 Be Memorable – For the Right Reasons

People remember positive and negative experiences more vividly than average day-to-day ones. Try to make consumers' experiences positive ones that they will remember and share with others. Be helpful, be courteous and polite, and give a little extra if possible.

2.2.7 Say Thank You

Kindness and gratitude can improve the quality of any relationship.

2.3 NAVIGATOR RESPONSIBILITIES

The Marketplace will determine consumers' eligibility for health coverage and options to lower health plan costs. To assist consumers through the eligibility and enrollment process, you will perform the following activities:

- Assess consumers' needs.
- Address consumers' needs appropriately.

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- Assist consumers in completing and submitting an eligibility application for health coverage.
- Review consumers' eligibility determinations for enrollment in health coverage and premium tax or cost-sharing reductions.
- Facilitate the comparison and selection of QHPs.
- Assist individuals, employees, and employers with enrollment.
- Educate consumers about eligibility and enrollment through the Marketplace.
- Assist consumers in applying for exemptions or appeals.

2.4 Privacy & Security Guidelines

When you assist consumers with applying for health coverage in the Marketplace, they provide personal information to you. Consumers trust the Marketplace to handle their sensitive personal information with care. Some of this information will be personally identifiable information (PII). To maintain consumers' trust, the Marketplace will set specific Privacy and Security Standards to guide you in protecting consumers' privacy.

Per the Executive Office of the President, Office of Management and Budget (OMB), and the U.S. Department of Commerce's Office of the Chief Information Officer, the term "personally identifiable information" refers to information used to distinguish or trace an individual's identity. Examples of PII include name, Social Security Number, date of birth, address or physical location (past, present, or future), biometric records (such as a fingerprint), and income information, including tax information. Another way to think about PII is that this information alone or when combined with other personal or identifying information, links, or can link, to a specific person.

It is your responsibility to:

- Protect consumers' privacy.
- Be aware of the Marketplace Privacy and Security Standards and Internal Revenue Service (IRS) Safeguards.
- Be able to recognize consumers' PII and tax return information.
- Use best practices to protect consumer's PII and tax return information.

You may come across consumers' PII or tax return information when you:

- Obtain consumers' authorization to provide assistance;
- Assist consumers with creating an account with the Marketplace;
- Assist consumers with the eligibility application for health insurance; or
- Assist consumers with the application for an exemption from the individual responsibility mandate or requesting an eligibility appeal.

2.4.1 Identifying Personally Identifiable Information

You need to be able recognize PII in order to know when to protect it. Some examples of consumers' PII that you may collect or come across include:

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- Name
- Date of birth
- Social Security Number (SSN)
- Protected health information such as the individual's past, present, or future physical or mental health or condition
- Physical or e-mail address
- Tax information (See section 2.4.2 of this manual for special IRS safeguards)
- Mother's maiden name

While you are assisting consumers to access, understand, and correct their information, you must:

- Make sure that your PII-related policies, procedures, and any technology you ask consumers to use or follow are easy for consumers to understand.
- Share consumers' PII only for a valid reason, with individuals or organizations authorized to receive the information; never discriminate against consumers.
- Keep your knowledge up-to-date on all Marketplace Privacy and Security Standards, the federal health care law, and the IRS Data Standards; understand how to apply these laws to protect consumers' PII.
- Assist consumers to keep their PII up-to-date and correct and, as requested, change or destroy it properly.

2.4.2 IRS Data Safeguards

As mentioned above, one form of PII is tax return information. You must protect and keep this information confidential. You must follow the IRS Data Safeguards to keep the tax return information confidential. Before you assist consumers, you should become familiar with a tax return's structure and the information it contains. For your purposes, tax return information is any information that relates to consumers' tax returns such as the following:

- Identifying information such as consumers' names, addresses, or SSNs
- Information about consumers' incomes, personal finances, debts, deductions and exemptions
- Any action taken by the IRS against consumers, such as investigations or penalties
- Any private written agreements (such as a pricing agreement) with the IRS and any background information about these agreements
- Relevant information, even if not found on the return (e.g., expenses)

Once you have the tax return information, you have to protect it. The IRS Data Safeguards protect information through:

- Restricting Access. Only authorized people who need to know should have access to the information.
- Recordkeeping. Keep excellent records on the information (e.g., sources of income and expenses).
- Employee Awareness. Train employees how to safeguard information.

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- Reporting Requirements. Be ready to provide reports on how you protected the information if HHS or the IRS asks for reports.
- Disposal. Know how to get rid of the information safely.
- Need and Use. Only handle the information you need to use.
- Computer Security. Make sure the information on your computer is as safe as the paper information.

2.4.3 Tips for Protecting PII and Tax Return Information

Here are some tips that will help you protect consumers' PII and tax return information.

Handling PII

- Do not keep hard copies of consumers' PII (e.g., birth certificates, Social Security cards, and financial account numbers).
- Do not keep electronic copies of consumers' PII (e.g., copy of a passport, copy of a voided check, copy of an insurance card).
- Do not leave documents that contain PII or tax return information on printers and fax machines.
- Do not leave files or documents containing PII or tax return information unsecured on your desk when you are not there.
- When mailing PII or tax return information, use an opaque envelope or container and, if possible, use a traceable delivery service.
- When faxing PII or tax return information, double-check that the recipient's fax number is correct and that someone is able to pick up the faxed information immediately.
- Always return originals or copies of PII to consumers.
- Remind consumers that they must keep their PII locked and in a safe place that they will remember.

Accessing PII

- Do not send or forward e-mails with PII or tax return information to personal accounts (e.g., Yahoo, Gmail). Only transmit PII or tax return information in the direct service of consumers' health insurance needs.
- Do not upload PII or tax return information to unauthorized websites (e.g., Wikis).
- Lock up portable devices (e.g., laptops, cell phones) or use an unauthorized mobile device to access PII or tax return information.
- Clear web browser history to avoid other users' accessing PII.
- Password protect accounts that may grant access to PII. Remind consumers to do the same.

2.5 FRAUD PREVENTION GUIDELINES

The Marketplace is committed to providing accurate information about coverage options and providing enrollment assistance to consumers. However, there are a few individuals who are intent on abusing or defrauding consumers and the government.

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Most payment/reporting errors are simple mistakes and are not the result of an issuer or enrollee trying to take advantage of consumers or the Marketplace. Fraud occurs when someone intentionally falsifies information.

Identity theft is a serious crime. Identity theft occurs when someone uses consumers' insurance identity numbers and/or personal information without permission to incur medical expenses, get medical care, or commit other crimes.

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

2.5.1 Preventing Fraud

To prevent fraud from occurring, encourage consumers to:

- Protect their SSN numbers.
- Shred documents containing healthcare information or other personal information before throwing them away.
- Not give out information over the telephone or Internet unless the requestor has proven they have authority to have this information (e.g., an insurance company or the Marketplace).
- Review information from health plans to make sure only services, equipment and prescriptions used by consumers, or their household members, are listed.
- Not give their personal information to anyone who calls or comes to their home uninvited.
- End any suspicious call or visit immediately.
- Report suspicious calls or visits.

2.5.2 Recognizing Fraud

Use these examples to help recognize potentially fraudulent situations.

- Someone has used another person's information to get health insurance coverage through the Marketplace.
- An Agent/Broker/Navigator has used false information to mislead a consumer into joining a health plan.
- Someone has made an unsolicited request for a consumer's personal information in order to enroll them in QHPs sold through the Marketplace.
- Someone has requested payment to enroll a consumer in the Marketplace.
- Someone claiming to be an Agent/Broker/Navigator sent a customer an e-mail about entry into the Marketplace that asked for personal information

2.5.3 Reporting Fraud

If you or consumers think fraud may have occurred, use the following resources to report it:

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Exhibit 2 - Resources to Report Fraud

Resource	Contact Information	Description
The Federal Trade Commission (FTC)	• Online: Secure Complaint Form • Phone: 1-877-ID-THEFT (1-877-438-4338); TTY: 1-866-653-4261	To report identity theft
The HHS Office of the Inspector General (OIG)	• Online: OIG Hotline Operations	To report that a consumer's information was used to enroll someone else in the Marketplace
State Department of Insurance (SDI)	• Your local State Department of Insurance	To report Agent/Broker fraud
Federally-facilitated Marketplace Call Center	• 1-800-318-2596; TTY: 1-855-889-4325 (all languages available)	To report a complaint about a Navigator

2.6 Consumer Accommodations

When assisting consumers, you should have a general understanding of the traditions, perspectives, demographic groups, and cultural and community practices in your service area. This includes being aware of groups of individuals who may have disabilities and/or limited English proficiency (LEP). This knowledge will enable you to communicate better with consumers, demonstrate respect for cultural diversity, and provide information in a relatable and understandable manner. You should always follow the National Culturally and Linguistically Appropriate Services (CLAS) Standards to assist consumers. For more information, visit HHS Office of Minority Health.

Under law, the Marketplace protects all consumers seeking services from a Navigator against discrimination due to their race, color, national origin, disability, age, sex, gender identity, or sexual orientation. As such, consumers with physical limitations should receive accommodations so that they receive the same level of assistance as consumers without physical limitations. For more information on consumer protections and the requirements to provide reasonable accommodations to persons with physical limitations, visit the following websites:

- Americans with Disabilities Act (ADA): ADA.gov
- Section 504 of the Rehabilitation Act: HHS Office of Civil Rights

The following sections provide information on how to accommodate consumers while showing support and patience, and avoiding negative judgment or discrimination.

2.6.1 Limited English Proficiency

Consumers may have LEP and require additional language services. Provide consumers with the following accommodations, when requested:

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- Written translations; ensure that translation services are available for key documents (e.g., applications and information about insurance plans)
- Signs displayed with taglines in a variety of common languages
- Bilingual staff members who are available to communicate directly with consumers in their preferred language
- Access to interpretation services or telephone-based translation services through the call center

In addition, consumers may request to use their families or friends as oral interpreters. Consumers' friends and families may serve as interpreters only at consumers' requests.

2.6.2 Physical Limitation

You should provide accommodations for consumers with physical limitations so that they receive the same level of assistance as consumers without limitations. To give adequate assistance to consumers with physical limitations, provide the following accommodations:

- Access to assistance, regardless of mental impairment or physical disability
- Removal of barriers to access per ADA guidelines
- Access to assistance via modified computer or telecommunication services, such as alternative keyboards, speech recognition software, and speakerphone or gooseneck receiver holder adaptations

2.6.3 Visual Limitation

Consumers may have varying degrees of vision impairment and require additional services. To assist consumers with visual limitations, provide the following accommodations:

- Signs displayed with taglines in Braille to inform consumers with visual impairments of the service availability, and
- Access to information via:
  - Voice or large-print output computer with word processing software
  - Clear black print on white or pale yellow paper
  - Videos with audio description

2.6.4 Hearing Limitation

Consumers may have varying degrees of hearing acuity and require additional services. To assist consumers with hearing limitations, provide the following auxiliary aids and services at no cost to consumers:

- Video teleconference capabilities (VTC) to access sign language interpreters
- Speech that is clear and understandable for those consumers that might use a hearing aid
- Pads and pencils used to communicate with consumers

Only use writing to communicate with consumers if oral speech, lip reading, sign language, gestures, and finger spelling have failed, as this often isolates consumers with a hearing limitation from the group.

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2.6.5 Mental or Intellectual Disability

Consumers seeking assistance may have varying levels of mental or intellectual capacity. To assist consumers with mental or intellectual disabilities, provide the following accommodations:

- Permit consumers to use authorized representatives to help consumers make health care decisions
- Communicate with consumers' representatives, guardians, family members, or support person if requested by the consumer
- Refer consumers to additional resources and entities that may be able to provide specialized assistance to consumers with certain mental or intellectual disabilities

2.7 Complaint/Grievance Process

If consumers request assistance with filing a complaint related to the eligibility and enrollment process, direct consumers to contact the call center for assistance with filing a complaint or grievance with the Marketplace.

2.8 Support Resources

If consumers require assistance that is outside of Navigator activities, refer consumers to other organizations and resources, as appropriate. Exhibit 3 provides a list of external resources.

Exhibit 3 – External Resources

Resource	Contact Information	Description
Center for Consumer Information and Insurance Oversight (CCIIO)	http://www.cms.gov/cciio/index.html	An entity that implements many provisions of the Affordable Care Act, the health reform bill signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance.
Federally-facilitated Marketplace Call Center	1-800-318-2596 TTY: 1-855-889-4325 (all languages available)	An entity that provides assistance to consumers who need information or want to enroll in health coverage through the Marketplace.
HealthCare.gov	https://www.HealthCare.gov/	A website where consumers can access information about the Affordable Care Act and start the enrollment process.

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Indian Health Service	http://www.ihs.gov/	A division within HHS that is dedicated to providing federal health services to American Indians and Alaska Natives.
IRS	http://www.irs.gov/	Federal agency that collects taxes from individuals and businesses in the U.S.
Medicaid	http://medicaid.gov/	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 program, so Medicaid varies state-by-state and may have a different name in your state.
Medicare	http://www.medicare.gov/	Federal program run by the Centers for Medicare and Medicaid Services (CMS) that provides health coverage to qualified individuals who are 65 years of age or older and/or have a disability.
Employer Call Center	1-800-706-7893; 1-800-706-7915 (TTY)	A service administered by the SHOP to assist employers
State Health Insurance Assistance Program (SHIP) Office	https://shiptalk.org/public/home.aspx?ReturnUrl=%2f	A state-based program that offers one-on-one counseling and assistance to people covered by Medicare and their families.
Social Security Administration	http://www.ssa.gov/	A division of HHS that administers Social Security, a social benefits program consisting of retirement, disability, and survivors' benefits.

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Veterans Affairs Health Benefits	http://www.va.gov/	A program under the U.S. Department of Veterans Affairs that provides health coverage through the Veterans Health Administration (VHA) for eligible military veterans.

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3.0 Navigator Activities

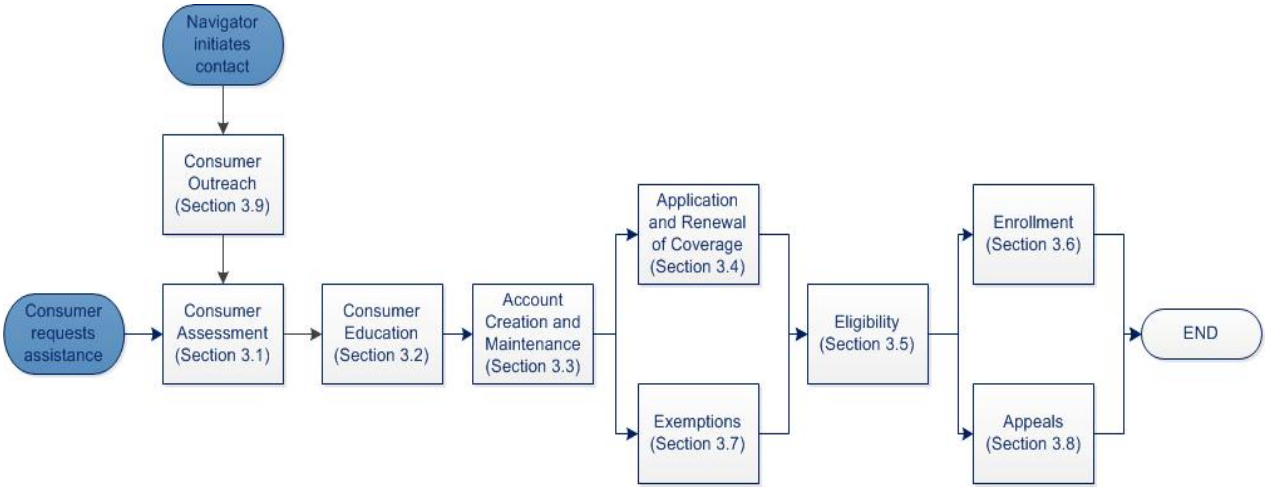
You will assist consumers with eligibility and enrollment activities within the Individual and SHOP Marketplaces. This section covers the ten types of activities that you may perform as a Navigator. This section also provides specific guidance to complete each activity and refers to the SOPs related to that activity. Exhibit 4 lists the ten types of Navigator activities.

Exhibit 4 – Navigator Activities

Manual Section	Navigator Activity
3.1	Consumer Assessment
3.2	Consumer Education
3.3	Account Creation and Maintenance
3.4	Application and Renewal of Coverage
3.5	Eligibility
3.6	Enrollment
3.7	Exemptions
3.8	Appeals
3.9	Consumer Outreach
3.10	Navigator Reporting

Your responsibilities begin when a consumer approaches a Navigator office or when you perform consumer outreach activities. It is your responsibility to assess consumers' level of knowledge of health insurance and the Marketplace and educate them as needed. You must also assess consumers' needs and determine the appropriate steps to address their needs. Exhibit 5 demonstrates the sequence and relationship of each Navigator job function.

Exhibit 5 – Consumer Assistance Activities



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3.1 Consumer Assessment

Consumers will require assistance with understanding health coverage and navigating the Marketplace. The intake and assessment process outlines the steps needed to assess consumers' knowledge, understand their needs, and identify the next steps to assist them. Exhibit 6 describes this process.

Exhibit 6 – Consumer Intake and Assessment Process

Complete each step of the process in order, as shown in Exhibit 6.

3.1.1 Greet Consumers

When consumers arrive, welcome them, and introduce yourself. Explain that you will:

- Provide information about the Marketplace and health coverage
- Assist them with obtaining health coverage through the Marketplace
- Keep all personal, health, and financial information absolutely confidential

Assure consumers that you are:

- Unaffiliated with any insurance providers, and
- Neutral and that you will not influence consumers' health coverage decisions.

After greeting consumers, ask consumers a general question about the purpose of their visit, for example:

- *What brings you into the office today?*
- *How may I help you?*

Consumers may identify specific areas of concern or request assistance with particular activities (e.g., filling out an eligibility application, submitting an appeal). However, consumers might not be able to identify their specific needs without a basic understanding of health coverage and the Marketplace. Perform an assessment to identify any unstated needs and ensure you provide thorough assistance.

3.1.2 Assess Consumers' Knowledge

After greeting consumers, assess their general knowledge. The health care law extends affordable health coverage to individuals who did not have coverage in the past. Many consumers may be obtaining health coverage for the first time. To make informed decisions when purchasing their own health coverage, they will need to understand:

- Health Coverage

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- The Affordable Care Act (the health care law)
- The Marketplace

Hold a conversation with consumers to gauge their understanding. Exhibit 7 lists some sample questions and criteria for assessing consumers' knowledge for each topic.

Exhibit 7 – Knowledge Assessment Guide

Knowledge Category	Knowledge Checks	Sample Questions
Health Coverage	Determine if consumers: • Understand the basics of health insurance (health coverage) • Know that insurance companies AND consumers pay for health care • Understand that insurance companies contract with different networks of doctors, and that their doctor may not be covered by some insurance companies	• What questions do you have about health insurance (health coverage)? • How have you managed your health care costs in the past? • How do you plan to pay your monthly premiums? • How would you feel if you had to see a new doctor?
Affordable Care Act	Determine if consumers: • Understand the Affordable Care Act • Know the impact of the Affordable Care Act • Are aware of the major deadlines • Are aware of the consumer protection provisions under the law	• What have you heard about the new health care law? • What questions do you have about the impacts of the health care law on you and your family? • What are your questions about the new health care law?
Marketplace	Determine if consumers: • Understand the Marketplace eligibility and enrollment process • Understand their eligibility requirements for health coverage, tax credits and cost savings • Are aware of the different health coverage options • Are aware of the available programs to lower costs of health coverage.	• What is important to you when it comes to health coverage? • What factors are important to you and your family when choosing a health plan? • How can I help you apply for health coverage? • What are your concerns about paying for coverage?

3.1.3 Assess Consumers' Needs

After consumers have a basic understanding of health coverage, conduct a needs assessment to learn more about consumers' health coverage status, any questions they might have about the enrollment process and problems they might have with completing applications. Based on the assessment, you can identify the specific assistance that consumers require.

Hold an informal conversation with consumers about their general health coverage needs. During this discussion, find out the following information:

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- Whether consumers have existing health coverage and whether that coverage continues to meet their needs (e.g., if it is ending, benefits are changing, costs are changing)
- Who is in need of health coverage (e.g., consumers, employees, and/or family members)
- How consumers intend to pay for the coverage (e.g., with premium tax credits, personal income, through their employer)
- The features that consumers are looking for in a health plan (e.g., affordability, provider networks, coverage for certain illnesses)
- Whether consumers have started the eligibility application process
- What additional information, if any, consumers need to know about the health care law, health coverage or the Marketplace.

Once you understand consumers' general needs, use Exhibit 8 to identify their specific needs.

Exhibit 8- Needs Assessment Guide

Consumer Need Category	Sample Questions
Consumers seeking information	• What questions do you have about the effect of the health care law on your health coverage? • What questions do you have about the Marketplace application process? • What information would you want to have before you choose your health coverage options through the Marketplace?
Consumers seeking health coverage for themselves or their families	• What kind of health coverage have you and your family had in the past? • Who in your family needs health coverage? • What is most important to you in your health coverage (e.g., benefits and services, reduced cost, keeping a doctor)? • How does your employer help you and other employees with your health care costs?
Consumers seeking health coverage for their employees	• How many employees do you currently have? • What do you think your employees would value most in their health coverage (price, availability of doctors, coverage for their families)? • What are you looking for in a health plan for your employees?
Consumers seeking assistance with an existing eligibility application or health plan	• What parts of the eligibility application have you completed? • What notices or messages have you received from the Marketplace since submitting your application? • Do you disagree with any part of your eligibility determination? • What changes do you need to make to your eligibility application or account profile?

3.1.4 Identify Next Steps

After identifying consumers' specific needs, identify the activities required to address their needs. For instance, if consumers are unfamiliar with the impact of the health care law on their health coverage options, educate consumers about the law by referring to the Consumer Education section of this Manual. Similarly, if consumers would like to find out which health

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plans they are eligible for, proceed to the appropriate SOPs (e.g., Create an Account, Apply for Health Coverage).

Exhibit 9 organizes consumers' needs into assistance categories and specifies common consumer needs within each category. The exhibit also provides potential resources to resolve consumers' needs. You may identify additional next steps not listed below, as consumers' needs will vary.

Exhibit 9 - Consumer Needs Assessment

Category	Consumer Need	How to Help
Health Insurance	• Information on the need to get health coverage	➲ Educate Consumers on: Individual Shared Responsibility (Section 3.2.2.3)
Affordable Care Act	• Information on the impact of the Affordable Care Act on health coverage • Information on the deadlines and other requirements under the Affordable Care Act	➲ Educate Consumers on: Affordable Care Act (Section 3.2.2)
Marketplace	• Information on eligibility requirements • Information on options to lower health plan costs	➲ Educate Consumers on: Eligibility Requirements (Section 3.2.3.9) Options to Lower Health Plan Costs (Section 3.2.3.5)
Health Coverage for Consumers or Their Families	• Coverage for an individual • Coverage for a family	➲ Refer to SOP: SOP-1 Create Account SOP-5 Apply for Health Coverage
Health Coverage for Employees	• Coverage for employees • Find out if eligible to purchase coverage under the SHOP Marketplace • Select a health plan for employees	➲ Refer to SOP: SOP-17 Create Employee Account SOP-19 Apply for Employee Health Coverage

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Category	Consumer Need	How to Help
Existing Eligibility Application	• Change password or login information • Submit additional information • Review and compare available health plans • Report change of address, marriage status, income, citizenship and other life changes • Dispute eligibility results	➲ Refer to SOP: SOP-2 Update Account Profile* SOP-8 Review Eligibility Determination* SOP-10 Compare Health Plans (Without Eligibility Determination)* SOP-3 Report Life Changes SOP-16 Request Eligibility Appeal*
Existing Health Plan	• Submit a payment to the insurance company • Review previous account activities • Renew health coverage	➲ Refer to SOP: SOP-13 Pay Health Plan Premium* SOP-4 Review Account History* SOP-14 Renew Health Coverage*

** Refer to the appropriate Small Business SOP when needed.*

After you have identified the steps necessary to address consumers' needs, proceed to the Consumer Education section and/or the appropriate SOP to assist consumers.

3.2 Consumer Education

Before making any health coverage decisions, consumers may need to understand:

- What is the Affordable Care Act?
- How does it impact health coverage?
- What does health insurance entail?
- How do I obtain health coverage through the Marketplace?

This section provides details on topics that Navigators may review with consumers during assistance sessions.

The manual details the specific activities related to these topics in other sections.

3.2.1 Health Coverage

Health coverage protects consumers from the financial liability of an illness. Health insurance is one type of health coverage. Health insurance is part of a contract between consumers and health

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insurance companies. In exchange for a predefined fee (usually a monthly payment), the health insurance company agrees to pay part, or all (in some cases), of the health care costs.

Health care costs paid by the consumer vary depending on the coverage offered, but may include:

- **Premiums:** The amount paid for health coverage. Consumers and/or their employers usually pay it monthly, quarterly, or yearly. Premiums vary depending on the health care costs covered.
- **Deductibles:** The amount consumers owe for health care services before the health insurance or plan begins to pay. For example, if the deductible is $1000, consumers will spend $1000 of their own money on health care services before the insurance company starts to pay for services. The deductible may not apply to all services.
- **Copayments:** A fixed amount (e.g., $15) consumers pay for a covered health care service, usually when consumers receive the service. The amount can vary by the type of covered health care service.

Health care costs paid by the insurance company vary depending on the coverage offered, but may include:

- **Preventive Services:** Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.
- **Hospitalization:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.
- **Emergency Services:** Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Insurance companies may limit health care costs from certain facilities, providers, and suppliers, otherwise known as a network. If consumers want to use a particular doctor or health care facility, they should ensure that any plans they are considering include these providers in the network. One of the benefits of the Marketplace is that all plans sold through the Marketplace have to cover ten categories of benefits, called essential health benefits (EHB). These benefits include:

- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices (e.g. occupational and physical therapy)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral care

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3.2.2 Affordable Care Act

The primary goal of the Affordable Care Act is to help millions of uninsured and underinsured Americans obtain health coverage. To achieve this goal, the law provides new health coverage options, gives consumers the tools they need to make informed choices about their health coverage, and creates stronger consumer protections, including:

- Prohibiting health insurance companies from charging consumers higher premiums (monthly payments) based on health status or gender
- Extending health coverage for dependents up to the age 26
- Prohibiting discrimination against consumers seeking coverage who have pre-existing conditions
- Eliminating annual coverage limits from health plans (i.e., some health plans place a cap or limit on the amount of health care costs for which the insurance will pay each year)

The Affordable Care Act's key provisions establish:

- The Marketplace, which allows eligible consumers to shop for, compare, and purchase health coverage for themselves, their dependents, or employees; the Marketplace creates income-based options to make this coverage more affordable for eligible consumers.
- Medicaid Expansion, which expands Medicaid coverage to individuals between 19 and 65 years of age who have household incomes below 138% of the Federal Poverty Level, in states that choose to do so.
- The Individual Responsibility Requirement (INDIVIDUAL RESPONSIBILITY REQUIREMENT), sometimes known as the Individual Mandate, which provides that all citizens obtain basic health coverage starting in 2014, obtain an exemption, or pay a fee when filing a federal income tax return.
- Employer Shared Responsibility (ESR), which requires employers with at least 50 full-time employees (or equivalents) to offer affordable health coverage to their full-time employees (and their dependents) that meet the minimum essential coverage set by the Affordable Care Act or to pay a fee called the Employer Shared Responsibility Payment (ESRP).

3.2.2.1 Health Insurance Marketplace

The health care law creates a Marketplace that consumers can access to learn about and obtain health coverage. In the health care law, the Marketplace is called an "Affordable Insurance Exchange". Consumers and the media also might call it "Obamacare." The Marketplace lets consumers know what types of health coverage and assistance with lowering coverage costs (if requested) for which they qualify. Consumers can also compare these options before purchasing health coverage to ensure that the plan covers the health care services they need and to minimize out-of-pocket costs.

There are two ways to obtain health coverage through the Federally-facilitated Marketplaces:

- **Individual Marketplace** – A Marketplace for individuals to shop for, compare, and purchase health coverage for themselves or their families.

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- **SHOP Marketplace** – A Marketplace through which a small business can elect to provide its employees and their dependents with access to one or more QHPs. Small employers (with fewer than 50 or 100 full-time equivalent [FTE] employees, depending on the state) may offer full-time employees (working on average 30 hours or more per week) a QHP option through the SHOP Marketplace. Employees may then obtain health coverage through that job-based QHP. Employers must first be eligible to participate in the SHOP and select a QHP for their employees.

3.2.2.2 Medicaid Expansion

Medicaid is a state-administered health coverage 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 program, so Medicaid varies state by state and may have a different name in each state. The Affordable Care Act provides states with the option to expand their Medicaid programs to cover individuals who are 19 to 65 years of age with household incomes of up to 138% of the Federal Poverty Level (FPL). In states that have chosen to expand Medicaid coverage, more people will have access to affordable health care.

3.2.2.3 Individual Responsibility Requirement

Under the Affordable Care Act, the federal government, state governments, health insurance companies, employers, and individuals have a shared responsibility to reform and improve the availability, quality, and affordability of health coverage in the U.S. This provision is also referred to as the individual mandate. Consumers can obtain coverage through their jobs, through the Marketplace, or directly from an insurance company. If consumers do not obtain basic health coverage (known as minimum essential coverage [MEC] by 2014, they may have to pay a fee through their federal income tax returns. There are exemptions from this fee available, some of which are available through the Marketplace and others through the tax filing process.

Consumers may meet the MEC requirements through the following coverage options:

- Purchasing individual coverage through the Marketplace
- Enrolling in an employer-sponsored plan or group plan
- Enrolling in a public health care program such as Medicare (Parts A and C), Medicaid, CHIP, Veteran's Affairs (VA) health benefits, or TRICARE
- Maintaining an existing health plan (grandfathered health plans)
- Self-funded student health coverage (until January 1, 2015)
- State high-risk pool coverage (until January 1, 2015)
- Other health plans designated as meeting the MEC requirement by the Secretary of HHS

Consumers who have specialized coverage only, such as dental coverage, workers' compensation, or disability insurance will not satisfy the MEC requirement.

Consumers may apply for an exemption if they can show that they fall under one of the following categories:

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- Member of a religion that is opposed to accepting health insurance benefits
- Not lawfully present in the U.S
- Member of an Indian tribe
- Not a member of federally-recognized American Indian tribe, but is eligible for services from an Indian health care provider or the Indian Health Service
- Member of a health care sharing ministry
- Individuals who have a short health coverage gap (did not have health coverage for less than three consecutive months during the year)
- Currently incarcerated
- Under a hardship which prevents the consumer from obtaining health coverage
- Family income below the threshold required for filing an annual tax return

Starting January 1, 2014, if consumers don't have a health plan that qualifies as MEC, they may have to pay a fee that increases every year: from 1% of income (or $95 per adult, whichever is higher) in 2014 to 2.5% of income (or $695 per adult) in 2016. The fee for children is half the adult amount. Consumers pay the fee as part of the 2014 federal income tax, which they will file in 2015. People with very low incomes, and others, may be eligible for waivers.

3.2.2.4 Employer Shared Responsibility

The health care law provides that certain employers must provide affordable health coverage to their full-time or full-time equivalent employees by 2015. While no employers are required to offer coverage to their employees, those with 50 or more FTEs may have to pay a fee starting in 2015 if they do not provide affordable coverage to their FTEs. The Employer Shared Responsibility Payment applies to some large employers who don't offer insurance that meets certain minimum standards. Large employers have 50 or more FTEs, and at least one of their employees qualifies to save money on monthly premiums in the Marketplace. Employees won't be able to save money on monthly premiums in the Marketplace, if the coverage a business offers its full-time employees in 2015 is affordable and meets minimum value. Small businesses (fewer than 50 employees) also have access to the SHOP Marketplace. However, small businesses are not subject to a fee if they do not offer their employees affordable health coverage.

3.2.2.5 Exemptions

Starting in 2014, the individual responsibility requirement calls for each individual to have health insurance coverage. If consumers do not obtain health coverage, they must qualify for an exemption, or pay a responsibility fee. Exemptions release a consumer from the obligation to pay a fee for not maintaining minimum essential coverage. All consumers may seek an exemption either through the Marketplace or by claiming an exemption during the tax filing process.

Some exemptions are available through the Marketplace, others through the tax filing process, and some are available through both channels.

The religious conscience exemption and most hardship exemptions are available only through the Marketplace. Individuals can only claim exemptions for unaffordable coverage, short

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coverage gaps, certain hardships, and individuals who are not lawfully present in the United States, as part a federal income tax filing. The exemptions for members of Indian tribes, members of health care sharing ministries, and incarcerated individuals are available either by through the Marketplace or by claiming the exemption as part of filing a federal income tax return. Although consumers may submit applications for more than one exemption, only one exemption is required to excuse consumers from the obligation to purchase health coverage or pay a fee. Exhibit 10 lists the exemptions that consumers may apply for through the Marketplace.

Exhibit 10 – Exemptions Available Through the Marketplace

Exemption	Requirements	Duration
Health Care Sharing Ministry	• Consumers who participate in a health care sharing ministry (a non-profit organization whose members have similar religious or ethical beliefs and pay for one another's health care costs), can receive an exemption. • The ministry must be approved and active during the timeframe that consumers claim participation.	Available only for months in the past
Incarceration Status	• Consumers currently incarcerated may qualify for an exemption. • Consumers must provide the dates of their incarceration. • If consumers have a pending a disposition of charges, they are not eligible for the exemption.	Available only for months in the past
Indian Status	• Consumers who are members of a federally-recognized Indian tribe may qualify for an exemption. • Consumers who are not members of a federally recognized tribe but are Indians eligible for services from an Indian health care provider or the Indian Health Service.	Available for months in the past and future
Religious Conscience	• Consumers who are members of a recognized religious sect or division described under section 1402(g)(1) of the Internal Revenue Code may qualify for an exemption. • Consumers may present a completed Form 4029, "Exemption from Social Security and Medicare Taxes and Waiver of Benefits". • Consumers without Form 4029 may provide information about their religious sect or division that they attest membership in so that the Marketplace can verify their attestation. • Exempt consumers under 21 years of age must re-apply for the exemption after their 21st birthday to renew the exemption.	Available for months in the past and future

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Exemption	Requirements	Duration
Hardship	• Consumers for whom it is a hardship to obtain coverage through a QHP, due to financial or domestic (household) circumstances (including an unexpected natural or human-caused event, that increases consumers' expenses and prevents them from affording health coverage). Examples of hardships include: o Homelessness o Recent eviction (six months) or pending eviction or foreclosure o Receipt of a shut-off notice from a utility company o Domestic violence victim o Death in of a close family member o Recent bankruptcy (six months) o Unexpected expenses due to caring for an ill or disabled family member. • Consumers who are required by court order to provide medical support to children, the consumers are parties other than the parties who expect to claim the children as tax dependents, and the children have been determined ineligible for Medicaid and CHIP (Children's Health Insurance Program). This exemption is only applicable for the months during which the medical support order is in effect. • Consumers who are determined eligible for enrollment in QHPs, premium tax credits, or cost-sharing reductions as a result of eligibility appeal decisions. This exemption is only applicable for the period of time affected by the appeals decision. • Consumers who lack affordable coverage based on projected income when the cost of health coverage (whether through an employer plan that meets the minimum value standard or a Marketplace plan) exceeds 8% of their projected annual household income. This exemption is available prospectively for all remaining months of the coverage year. • Consumers who are ineligible for Medicaid based on a state's decision not to expand under the health care law. This exemption is available prospectively or retrospectively for a calendar year. • Consumers (and their families) who are members of a non-federally-recognized Indian tribe and are eligible to receive services through Indian health care providers or the Indian Health Services. This exemption is available prospectively (for future months) or retrospectively (for past months) on a continuing basis until consumers report that they are no longer eligible to receive services.	Available for months in the past and future months

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Navigators may not assist consumers with completing applications for IRS exemptions. Instead, consumers can claim IRS exemptions through the tax filing process or by contacting the IRS. Exhibit 11 lists the IRS exemptions.

Exhibit 11 – IRS Exemptions

Exemption	Requirements
Lack of Affordable Coverage	• Consumers whose cost of health coverage (whether through an employer plan or a Marketplace plan) exceeds 8% of their projected annual household income. • Exemption is available retrospectively.
Lawful Presence	• Consumers who are neither U.S. citizens, nor U.S. nationals, nor aliens lawfully present in the U.S. • Exemption applied retrospectively.
Short Coverage Gap	• Consumers who did not have coverage for less than three consecutive months during the year. • Exemption available only for consumers' first coverage gap in one year. • Exemption applied retrospectively.
Indian Status	• Consumers who are members of federally recognized Indian tribes. • The exemption for other individuals who have access to Indian health care services (including spouses and descendants of tribal members, and members of non-federally-recognized tribes) is only available through the Marketplace.
Hardship (only in limited categories)	• Consumers whose household incomes are below the minimum threshold for filing tax returns. The requirement to file a federal tax return depends on filing status, age, and types and amounts of income. Consumers may use the IRS (http://www.irs.gov/uac/Do-I-Need-to-File-a-Tax-Return%3F) (ITA) to find out if they are required to file a federal tax return. • Consumers, as well as one or more employed members of their families, are eligible for affordable self-only, employer-sponsored coverage through their respective employers for one or more months during the calendar year, but the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8% of household income for that calendar year will receive an exemption from the IRS. • Exemption is available retrospectively.

When applying for a Marketplace exemption, consumers must provide certain information to determine whether they qualify for an exemption. Exhibit 12 provides detailed information on the available Marketplace exemptions and the information required to apply for each exemption.

Exhibit 12 – Information Collected for HHS/Marketplace Exemptions

Exemption	Required Information
Hardship	• Detailed information about consumers' hardship that prevents them from affording health coverage.
Health Care Sharing Ministry	• Ministry Information: o Ministry Name o Proof of Membership (membership card, letter, certificate).

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Exemption	Required Information
Incarceration Status	• Incarceration Status Information: o Applicant Name o Institution Name o Dates of Incarceration • Proof of Incarceration (court order; institutional records).
Indian Status	• Indian Tribe Membership Information: o Applicant Name o Tribe Name • Proof of Membership (tribal card; other tribal documents).
Religious Conscience	• Religious Membership Information o Applicant Name o Religious Sect (Religion) • Proof that religious sect is recognized by the Social Security Administration (IRS Form 4029).

3.2.3 Marketplace Health Coverage Options

Individuals may apply for a QHP, programs to help reduce the cost of health coverage, Medicaid, and CHIP programs. Small business employers may apply to select a QHP to offer to their employees and those employees may enroll in the employer-offered insurance.

3.2.3.1 Qualified Health Plans

Under the Affordable Care Act, a health plan that is certified by a Marketplace, provides essential health benefits (see Exhibit 13 below), follows established limits on cost-sharing (e.g., deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements is referred to as a qualified health plan (QHP). The Marketplace, where consumers purchase health plans, (either federal or state), certifies QHPs.

3.2.3.2 Essential Health Benefits

The Affordable Care Act requires all health plans, both inside and outside of the Marketplace, to cover a comprehensive package of items and services, known as Essential Health Benefits (EHB). All QHPs offer a core package of items and services that include at a minimum the ten EHB described in Exhibit 13. The Marketplace uses EHB to determine whether a plan outside the Marketplace meets the MEC standards.

Dental benefits, including pediatric dental, may be included in a QHP, but if there are stand-alone dental plans available in a state, QHPs offered in that state are not required to cover dental benefits. In these instances, individuals who want dental coverage, including pediatric dental care, would need to enroll in a stand-alone dental plan.

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Exhibit 13 – Essential Health Benefits

Essential Health Benefit	Description
Ambulatory patient services	Care provided without admission to a hospital – for example, at a clinic, physician's office, or same-day surgery center.
Emergency services	Care provided for conditions that, if not immediately treated, could lead to serious disability or death.
Hospitalization	Care you get as a patient in a hospital, such as room and board, care from doctors and nurses, and tests and drugs administered during your stay.
Maternity and newborn care	Care provided to women during pregnancy, childbirth, and after childbirth.
Mental health and substance abuse disorder services, including behavioral health treatment	Care to evaluate, diagnose, and treat mental health and substance abuse issues.
Prescription drugs	Drugs prescribed by a doctor to treat an acute illness, like an infection, or an ongoing condition, like high blood pressure.
Rehabilitative and habilitative services and devices	Services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills.
Laboratory services	Testing of blood, tissues, etc., from a patient to help a doctor diagnose a medical condition and monitor the effectiveness of treatment.
Preventive and wellness services and chronic disease management	Preventive or wellness services include routine physicals, screenings, and immunizations. Chronic disease management is an integrated approach to managing an ongoing condition, like asthma or diabetes.
Pediatric services, including oral care	The nine essential benefits listed above, but provided to children. (Services and common conditions treated vary for different age groups.) Health plans covering children cover dental care.

3.2.3.3 Health Plan Categories

To assist consumers and employers with selecting health coverage options, the health care law defines five categories of health plans. Under each category, plans cover a certain percentage of the cost of care.

For example, at the bronze category, if a consumer's medical treatment costs $100, the bronze plan covers approximately 60%, or $60, of that cost. The consumer is then responsible for $40 in out-of-pocket expenses for that treatment. The five health plan categories are:

- Bronze Health Plans– Insurance company pays 60% of covered medical expenses.
- Silver Health Plans– Insurance company pays 70% of covered medical expenses.
- Gold Health Plans– Insurance company pays 80% of covered medical expenses.
- Platinum Health Plans– Insurance company pays 90% of covered medical expenses.

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- Catastrophic Health Plans – Health plans that meet all of the QHP requirements but cover only three primary care visits each year until consumers meet the plan's deductible. To qualify, consumers must be under 30 years of age or receive a hardship exemption.

3.2.3.4 Health Care Options Outside of the Marketplace

Consumers may obtain health coverage from sources other than the Marketplace, such as:

- An employer-sponsored plan or group plan
- A public health care program such as Medicare, Medicaid, CHIP, veterans' health benefits, or TRICARE
- An existing health plan (grandfathered health plans)

Consumers should ensure that any plan purchased outside the Marketplace meets MEC standards to avoid the shared responsibility fee.

3.2.3.5 Options to Lower Health Plan Costs

Two programs are available to eligible consumers to help reduce the cost of purchasing health coverage through Marketplace:

- **Premium Tax Credit (also called advanced premium tax credit or APTC)** – A program that reduces the cost of QHP premiums to eligible consumers. Consumers can either claim premium tax credits during the tax filing process or request payment directly to insurance companies (as "advance payments"). Advance payments of the premium tax credit are reconciled during the tax filing process. Household size, income and the cost of available plans determine premium tax credit eligibility. Therefore, if consumers make more money over the course of the year than projected at the time they requested advance payments of the premium tax credit, consumers will need to repay the extra amount via their annual tax return. If consumers make less money, they can receive additional tax credits on their tax returns. The Marketplace provides documentation to the tax filer and to the IRS to support this process. If consumers request advance payments, they must file a tax return.
- **Cost-sharing Reductions (CSR)** – A program that limits the out-of-pocket costs for health benefits (like deductibles and copayments) associated with a QHP through the Marketplace. There are several categories of cost-sharing reductions based on annual household income and family size. Each insurance company applies these differently, based on their specific health plan design. Consumers who are eligible for cost-sharing reductions can review the reduced costs when they compare their available health plans. In general, CSRs are only available for consumers who select a plan at the Silver level of coverage.

To help consumers understand the difference between the premium tax credit and cost-sharing reductions, review Exhibit 14 with them and explain that they may be eligible to receive both options to lower costs.

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Exhibit 14 – Premium Tax Credit vs. Cost-Sharing

Premium Tax Credit	Cost-Sharing Reductions
• Premium tax credits lower the premium owed by the consumer. • The Marketplace determines eligibility for premium tax credit, and the amount allowed. • Any amount paid on an advance basis is reconciled at the end of the year, so a consumer could pay more (if income goes up) or receive a refund (if income goes down). • The amount of premium tax credit can be adjusted (up to maximum allowed), by the consumer, at the time of plan selection. • To receive premium tax credits, a consumer must file a tax return at the end of the year.	• Cost-sharing reductions limit consumers' maximum out-of-pocket costs (i.e., deductibles, coinsurance, or copayments). • The Marketplace determines eligibility for cost-sharing reduction. • Consumers cannot adjust the amount of cost-sharing assistance they receive. • In general, if a consumer is eligible for cost-sharing reductions, they must enroll in a Silver plan.

3.2.3.6 Eligibility & Enrollment Process

To purchase health coverage through the Marketplace, consumers will conduct some, or all, of the following actions:

- Create accounts with the Marketplace.
- Submit eligibility applications (paper or electronic).
- Review eligibility determinations.
- Review options to lower health plan costs.
- Compare and select QHPs.
- Enroll in QHPs.
- Pay health plan premiums.
- Renew health coverage annually.
- Report changes to personal information when necessary.
- Request exemptions.
- Request appeals, if dissatisfied with eligibility results.

Exhibit 15 outlines the eligibility and enrollment process from beginning to end.

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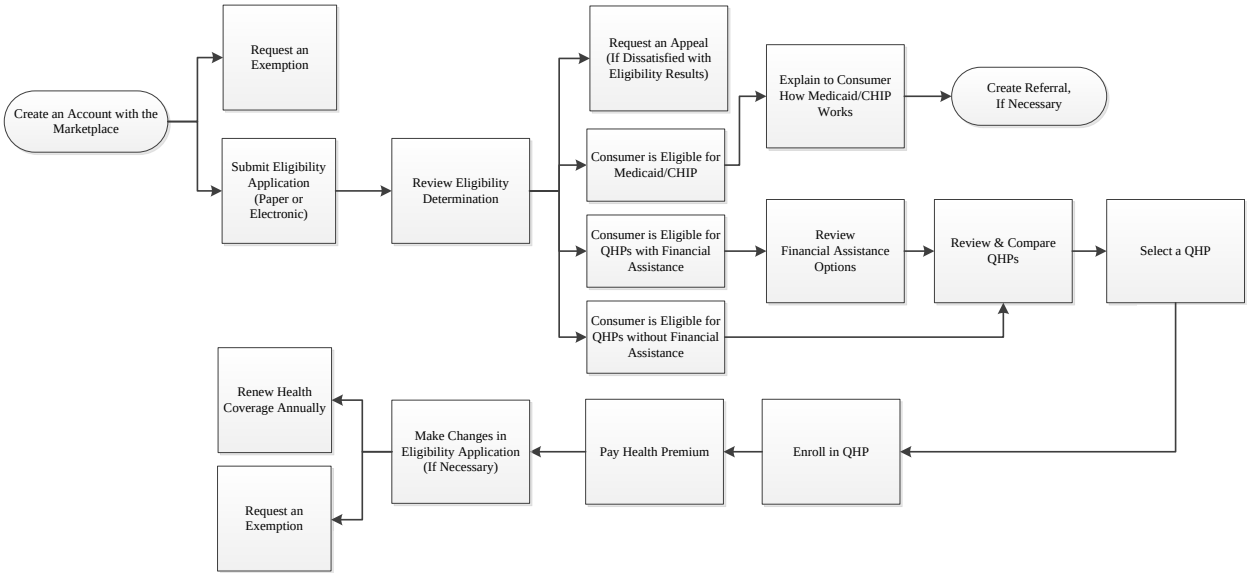
Exhibit 15 - Eligibility and Enrollment Process



3.2.3.7 Account Creation & Maintenance

Consumers may create an account with the Marketplace to perform the following tasks:

- Manage account information at any time.
- Apply for coverage electronically.
- Get “real-time” or near “real-time” processing versus the extended amount of time to receive eligibility results when completing paper applications.
- Receive electronic notifications about health coverage eligibility.

Account Creation

Consumers may create electronic accounts with the Marketplace to apply for and enroll in QHPs. Beginning October 1, 2013, electronic accounts will have two levels of access.

At the lowest access level, consumers may:

- View QHP options and services.
- Complete Marketplace applications.
- NOT receive “real-time” or near “real-time” processing and eligibility results.

After consumers verify their accounts by entering sufficient personal data and successfully proving their identity, the Marketplace grants a higher level of access.

At the higher access level, consumers may:

- View QHP options and services
- Complete and submit eligibility applications
- Receive “real-time” or near “real-time” processing and eligibility determinations

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At a minimum, consumers must supply the following required information:

- E-mail
- Username
- Password
- Four Security Questions

If consumers wish to apply for health coverage or designate an authorized representative for their accounts, consumers must supply the following information:

- First Name (required)
- Middle Name
- Last Name (required)
- Suffix
- Physical Address (required)
  - Street
  - City
  - State
  - ZIP Code
  - Apartment Number
- Mailing Address
- Social Security Number
- Date of Birth (required)
- Phone Number (required)

Consumers may prove their identity by:

- Successfully answering a series of real-time questions in the online application,
- Successfully answering a series of real- time questions through the call center, or
- Mailing in paper documentation.

Authorized representatives

Consumers may designate authorized representatives to act on their behalf. When consumers designate authorized representatives, representatives receive notices about the consumer's account and are able to act as the consumers. Consumers may designate authorized representatives by:

- Naming authorized representatives in their online accounts
- Naming authorized representatives in their paper eligibility applications
- Mailing in power of attorney authorizations

Account History

Consumers may access their account histories to review their previous transactions or eligibility records to confirm their eligibility statuses for particular health coverage options.

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Account Profiles Updates

Consumers can make certain updates to their account profiles without affecting their eligibility determinations, including changes to their passwords, e-mail addresses, and authorized representatives.

Employer Account Updates

Employers may make a number of account updates that can affect their participation in the SHOP Marketplace and the QHP options available to their employees. Exhibit 16 lists the types of account updates that employers may perform.

Exhibit 16 – Account Update Descriptions

Account Update	Description
Employee Roster	Any updates the employer makes to the employee roster
Employee Coverage	Any updates the employer makes that impact employee coverage
Employer Associates	Any updates the employer makes to his/her primary/secondary contacts and/or associated Agent/Broker

3.2.3.8 Eligibility Application

Electronic Application vs. Paper Application

Consumers can complete electronic eligibility applications once they create accounts. The electronic application functions will allow consumers to make real-time updates to their eligibility applications. Exhibit 17 details the additional benefits of using electronic applications as opposed to paper applications.

Exhibit 17 – Electronic vs. Paper Applications

Electronic Application	Paper Application
• Application prompts guide the completion of only pertinent sections and required data fields. • Determinations are faster due to more immediate electronic responses. • The Marketplace identifies required supporting documentation in "near real time" and notifies consumers electronically of potential errors.	• Consumer determines which sections to complete per instructions provided. • Application processing is slower due to time for mailing, paper conversion, and system determination. • The Marketplace notifies consumers by mail of potential errors or need for supporting documentation.

Information Collected on an Individual Eligibility Application

Consumers must supply certain information to the Marketplace to determine their eligibility to enroll in QHPs and receive premium tax credits and cost-sharing reductions. The Marketplace verifies consumers' application information before determining eligibility. When individuals begin eligibility applications, they must provide the information listed in Exhibit 18.

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Exhibit 18 – Information Collected on the Eligibility Application

Section	Information Collected
Get Started	• Contact Information o Name o Date of birth o E-mail o Home and mailing addresses (P.O. boxes are acceptable) o Language references o Method of communication (e.g., text, e-mail, mail) o Authorized representative o Help Paying for Coverage indication o Who is applying for coverage o Whether premium tax credits and cost-sharing reductions are desired o Personal information on each applicant (e.g., name, date of birth, relationship to person filing application) o More information about the household (e.g., Physical Disability, Tribal Membership)
Family & Household	• Family and household structure (i.e., tax household, if applicable, and other household relationships)
Income*	• Monthly and Annual Income • Current Benefits (e.g., Social Security, Unemployment, etc.) • Other Sources of Income
Additional Information	• Current Health Coverage Information o Whether enrolled in other coverage o Whether employer offers coverage, and if so, the cost of coverage • Employer information (if coverage offered) • Current coverage status • Coverage information (if enrolled in insurance)

**Income is required if consumers would like to see their options to lower health plan costs. The Marketplace will automatically project income based on consumers' previous application information. If there is a change in income, consumers must submit supporting documentation to reflect this change.*

Information Collected on an Employee Eligibility Application

Exhibit 19 - Information Collected on Employee Eligibility Application

Section	Information Collected
Who is your employer?	• Employer Contact Information o Name o Address
Interested in Coverage through Employer (Step 1)	• Employee Contact Information o Name o Social Security Number/Tax ID Number o Home Address o Mailing Address (if different) o E-mail

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Section	Information Collected
	• Additional Information o Notification Preferences (e.g., electronic or via mail) o Language Preference o Race o Tribal Membership
Read and Sign Application (Step 2)	• Employee Signature
Not Interested in Coverage through Employer (Step 3)	• Confirm that coverage through employer is not desired • Preference for other form of health coverage • Confirm that employer's dental coverage is not desired (if offered) • Signature

Information Collected on the Employer Eligibility Application

Exhibit 20 - Information Collected on Employer Eligibility Application

Section	Information Collected
About the Employer Offering Coverage (Step 1)	• Employer Information o Name o Federal Employer Identification Number o Doing Business As (if employer has a different company marketing name) o Employer Type (e.g., private, church, state or local government) o Primary Business Address • Employer Coverage Information o Number of full time employees o Whether employer is offering health coverage to employees
Who to Contact about This Application (Step 2)	• Primary Contact Information o Name o Title o Mailing Address o Phone Number o Fax Number o E-mail • Additional Information o Notification Preferences (e.g., electronic or via mail) o Language Preferences • Secondary Contact Information o Name o Title o Mailing Address o Phone Number o Fax Number o E-mail
List All Employees Who'll Get an Offer of Coverage (Optional) (Step 3)	• Employee Information o Name o Date of Birth

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Section	Information Collected
	o Social Security Number/Tax ID Number o E-mail o Employment Status (e.g., full time, part time, owner) o Date of Hire
Read and Sign Application (Step 4)	• Applicant Signature

Verification Process and Supporting Documentation (Individual Marketplace)

When consumers submit eligibility applications to enroll in health plans through the Marketplace, they must attest to the accuracy of the information provided. The Marketplace will review consumers' application information to verify its accuracy. If some information is potentially inaccurate, consumers will receive a notice from the Marketplace requesting additional documentation to complete their applications. The notices will specify the timeframe to provide the documentation. The supporting documentation will help the Marketplace verify the application information and make eligibility determinations.

While the Marketplace verifies consumers' application information, the Marketplace will provide the ability for consumers to view, compare and select QHPs and view qualifications for premium tax credits and cost-sharing reductions.

Good Faith Extension

If consumers are unable to supply their supporting documentation within the timeframe stated on their notices, consumers may request good faith extensions from the Marketplace. Good faith extensions may give consumers additional time to provide the supporting documentation for their applications. The additional time may vary depending on the circumstances of the request.

Notices

During the eligibility and enrollment process, consumers will receive notices from the Marketplace that inform them of their progress through the eligibility and enrollment process. The Marketplace may send notices through the mail or electronically. These notices may:

- Explain available health coverage options.
- Request additional information to support information attested to in applications.

Eligibility Determinations

Once the Marketplace has assessed all application information, consumers will be able to view their eligibility determinations. (Note: For paper applications, consumers will receive eligibility determination notices via the mail.) The eligibility determinations indicate if consumers are eligible to enroll in QHPs, Medicaid, or CHIP and lower their health coverage costs through premium tax credits or cost-sharing reductions.

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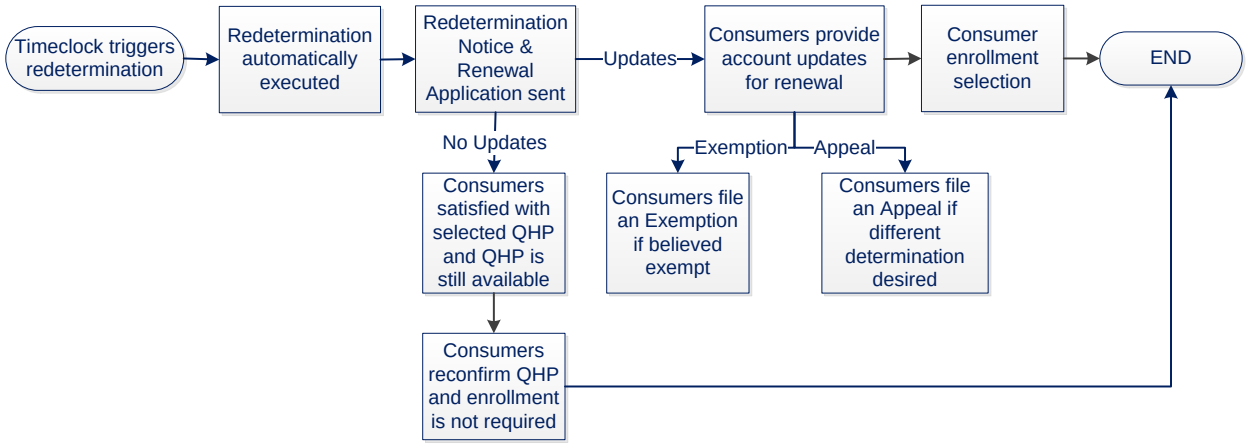
Life Changes

Consumers must report life changes (like marriage, changes in income, relocation, etc.) to the Marketplace. Consumers may report changes at any time. Life changes may or not have an effect on consumers' eligibility, depending on multiple factors, such as the type of change and the time that consumers report a change. The Marketplace will re-assess consumers' eligibility after any reported change and notify consumers of any resulting changes in eligibility and next steps.

Annual Redetermination & Renewal Process (Individual Marketplace)

Each year, the Marketplace will complete an automatic eligibility redetermination for all consumers. The Marketplace completes redeterminations using the information available in consumers' accounts. Exhibit 21 outlines the process for the annual redetermination and renewal process.

Exhibit 21 – Individual Annual Redetermination & Renewal Process



The Marketplace will review the income information in consumers' accounts and notify them of any resulting changes in eligibility and next steps. Consumers are responsible for notifying the Marketplace of any changes in their information. If consumers do not report changes to the Marketplace, they may receive the incorrect amount of premium tax credits, which may result in more tax owed.

Annual Redetermination & Renewal Process (Employee)

The Marketplace will automatically complete a redetermination for employees during each open enrollment period. The Marketplace completes the redetermination using the employees' current account information. Below, Exhibit 22 outlines the redetermination and renewal process for employees.

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Exhibit 22 - Employee Annual Redetermination & Renewal Process

Annual Redetermination & Renewal Process (Employer)

Once employers are eligible for SHOP, they remain eligible unless they change work locations. The Marketplace uses the employers' attestation of this information to complete the annual redetermination. Exhibit 23 lists the redetermination factors for employers.

Exhibit 23 - Employer Annual Redetermination Factors

Contributing Factor	Explanation
Attestation of Work Location	• The work location must fall within the Marketplace service area.
Attestation to at Least One Full-Time Employee	• The employer must have at least one full time employee.
Attestation to Cover All Full-Time Employees	• The employer must offer coverage to all full-time employees.

3.2.3.9 Eligibility Requirements

The Marketplace determines consumers' eligibility for a QHP and determines or assesses consumers' eligibility for Medicaid or CHIP.

Consumers are eligible to enroll in QHPs through the Marketplace if they:

- Live in the state in which they are applying
- Are citizens of the U.S. (or are lawfully present)
- Are not currently incarcerated

Eligibility for Premium Tax Credits and Cost-Sharing Reductions

Consumers may be eligible for assistance to lower their health plan premiums and their overall costs, if they meet the following criteria:

- Their projected annual income meets the Federal Poverty Level guidelines (see Appendix C: 2013 Federal Poverty Guidelines).
- They are eligible for enrollment in a QHP through the Marketplace.
- They are legally present in the United States and not incarcerated.

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- They are ineligible for other qualifying coverage, such as Medicare, Medicaid, CHIP, veterans' health benefits, TRICARE, Peace Corps, or affordable employer-sponsored coverage that meets MEC requirements.
- They file a joint federal income tax return with a spouse for the coverage year, if married.

Eligibility for Medicaid

Consumers may qualify for health coverage through a joint federal and state program called Medicaid. Medicaid helps pay medical costs for consumers who have limited income and meet other requirements. Under the health care law, some states have expanded their Medicaid programs to cover a greater number of people.

Generally, Medicaid covers adults whose household incomes are less than 133% of the FPL in states that have expanded their Medicaid programs. However, states have flexibility in setting the income requirements for Medicaid, so income limits may differ from state to state. All states cover young children and pregnant women with family incomes of less than 133% of the FPL, and also cover older children and parents, though usually with a lower income limit. Not all states have expanded their Medicaid programs to cover additional population groups. In these states, the income limits for adults are lower. There are also different income limits for people with disabilities or in need of long-term care.

For non-citizens who wish to enroll in Medicaid, there are stricter rules for immigration status. For example, non-citizens who are lawfully present in the U.S. may have to maintain their immigration statuses for at least 5 years before they can be eligible for Medicaid.

Eligibility for the Children's Health Insurance Program (CHIP)

CHIP provides health coverage for children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage. Like Medicaid, the states administer CHIP with joint funding from the federal government and states. Children may qualify for health coverage through CHIP if their family's income exceeds the Medicaid income limits. Children up to 19 years of age may be eligible for CHIP health coverage if their family income meets state requirements. About half of state CHIP programs cover children with family incomes up to 250% of the FPL or higher. Pregnant women may also be eligible in some states.

Medicaid and CHIP Eligibility Determination Process

As Medicaid and CHIP eligibility vary by state, some states allow the Marketplace to determine consumers' eligibility for these programs. In states that do not allow the Marketplace to determine Medicaid or CHIP eligibility, consumers will receive *eligibility assessments.*

Depending on the state in which consumers apply, consumers will receive one of the following results related to their Medicaid/CHIP eligibility:

- *Assessed as Potentially Eligible*: The Marketplace makes an initial decision that consumers are *potentially* eligible for Medicaid or CHIP. The Marketplace will then transfer consumers' information to their state Medicaid or CHIP agencies for a *final* determination of eligibility.

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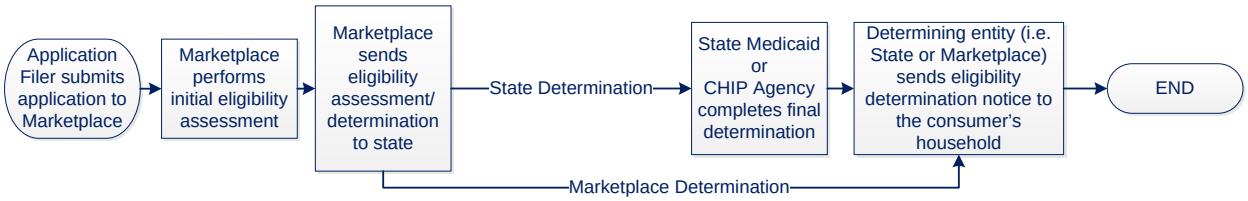
- *Determined Eligible*: The Marketplace makes final determinations of consumers' eligibility for Medicaid or CHIP. The Marketplace then transfers the determination information to the state Medicaid or CHIP agencies.

Exhibit 24 illustrates the Medicaid or CHIP eligibility determination process.

Exhibit 24 – Medicaid or CHIP Eligibility Determination Process



Eligibility for Coverage through Employer

Full-time or full-time-equivalent employees may obtain health coverage through a group health plan sponsored by their small employer (the business must have fewer than 50 full-time equivalent employees). Employees may access the SHOP Marketplace only when their employers are eligible for SHOP participation and they are on an employers' employee roster submitted to the SHOP Marketplace.

Eligibility for Employer Participation in the SHOP Marketplace

To participate in the SHOP Marketplace, small businesses must attest to the following:

- Employers are located in the service area (state in which they are seeking to offer coverage to employees).
- Employers have at least one full-time employee.
- Employers have fewer than 50 employees.
- Employers agree to offer health coverage to all FTEs.

3.2.3.10 Enrollment

Once individual consumers are determined eligible for QHPs, they may select plans, and make premium payments directly to the insurance companies.

Individual consumers eligible for Medicaid or CHIP may complete the enrollment process for Medicaid or CHIP through state agencies.

Employers eligible for the SHOP Marketplace may select a QHP to offer their employees.

Employees enroll in employer-sponsored coverage through the employee application.

Enrollment in the Individual Marketplace

Comparing Health Plans –Consumers may choose from a variety of QHP options. While each plan must cover the essential health benefits, QHPs may vary in cost, level of coverage, and provider network. They must understand how to compare these options to find a plan that best

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meets their needs. As a Navigator, you must show consumers information on all plan options for which they are eligible.

Open Enrollment Periods for the Individual Marketplace – Consumers may enroll in QHPs during the open enrollment period. This period begins on October 1 and ends on March 31 of the following year. Consumers must enroll in a QHP or otherwise obtain health coverage that meets MEC requirements by March 31 to meet the requirements of the health care law and avoid paying a fee.

Special Enrollment Periods – Consumers may qualify to enroll in QHPs outside of the open enrollment period if they have special circumstances (e.g., marriage, birth a child, loss of exemption). The Marketplace will consider consumers' circumstances and determine whether consumers are eligible for a special enrollment period.

Enrollment in the SHOP Marketplace

Full-time or full-time-equivalent employees of employers participating in the SHOP Marketplace may enroll in the selected QHPs and qualified dental plans (QDP). If, however, the plans' monthly premiums are greater than 9.5% of the employees' household incomes, employees may choose to apply for coverage through the Individual Marketplace, where they may qualify for assistance to lower health coverage costs.

Open Enrollment Periods for SHOP Marketplace – Employees must enroll in their employer-selected QHP within the enrollment window set by their employers. Employers will notify employees when this period occurs. If an employee misses the employer-established enrollment window, the employee may not be able to enroll until the employer's next open enrollment period.

Special Enrollment Periods – Employees may qualify to enroll in employer-sponsored coverage outside of the open enrollment period if they have special circumstances (e.g., marriage, birth a child, loss of exemption). The Marketplace will consider consumers' circumstances and determine whether consumers are eligible for a special enrollment period.

Effective Dates of Coverage

The effective date of coverage for QHPs purchased through the Marketplace is based on:

- The date the Marketplace gets consumers' QHP selections
- The date that the insurance company receives the first payment

Exhibit 25 outlines the effective dates of coverage based on the date of QHP selection. These dates only apply if consumers make their first premium payments by the date set by the insurance companies.

Exhibit 25 – Effective Dates of Coverage

Date QHP Selection is Received	Effective Date of Coverage
On or before December 15, 2013	• January 1, 2014

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Date QHP Selection is Received	Effective Date of Coverage
Between the 1st and 15th day of a month	• The 1st day of the following month
Between the 15th and last day of a month	• The 1st day of the second following month

- Example 1: If the Marketplace receives the QHP selection on December 15, 2013, consumers' coverage begins on January 1, 2014.
- Example 2: If the Marketplace receives the QHP selection on February 10, 2014, the consumers' coverage begins on March 1, 2014.
- Example 3: If the Marketplace receives the QHP selection on March 21, 2014, the consumers' coverage begins on May 1, 2014.

3.2.3.11 Post-Enrollment

Premium Payments – Consumers who obtain coverage through the Individual Marketplace must make premium payments directly to their QHPs. Those who obtain coverage through the SHOP Marketplace will make their payments through payroll deductions to their employers. Premium payment amounts reflect the total amount owed to insurance companies after any advanced payments of premium tax credits are applied. The Marketplace does not accept premium payments. Consumers must comply with the insurance companies' payment policies.

After consumers select their QHPs, the Marketplace will direct consumers to their insurance companies' websites to make the initial premium payments. Insurance companies must accept different forms of payment so that they do not discriminate against consumers who do not have credit cards or bank accounts. The insurance companies must receive and process payments at least one day before that coverage begins. Consumers should make sure they understand their insurance companies' specific payment requirements and deadlines to ensure that consumers follow the companies' payment policies.

Termination of Coverage

Consumers' health coverage can be terminated for the following reasons:

- Death of consumer
- Consumer's request
- Coverage period expires
- Employer terminates coverage
- Employer fails to pay premium
- Employer request
- Consumer no longer employed by company or organization that offered coverage

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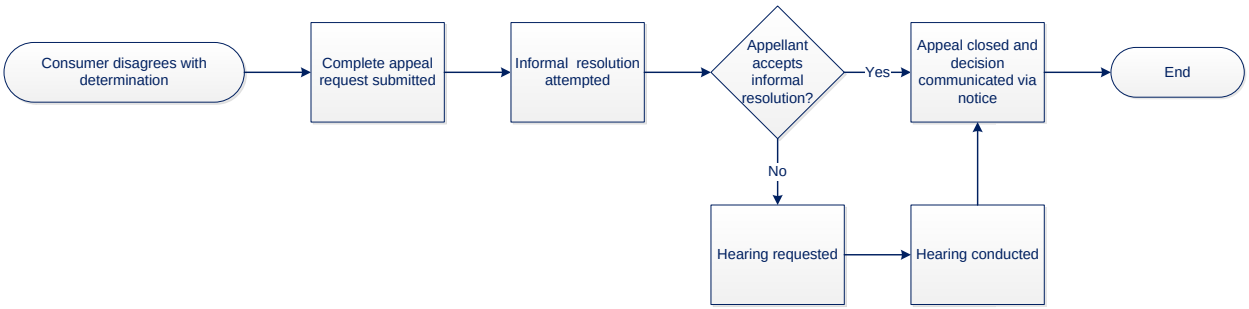
3.2.3.12 Appeals

Individuals, employers, and employees have the right to appeal all Marketplace determinations. Exhibit 26 displays the appeals process that the Marketplace follows to address consumers' appeal requests.

Exhibit 26 – General Appeals Process



Requesting an Appeal (Individual)

Consumers may submit appeal requests to the Marketplace when they are dissatisfied with a Marketplace decision. Exhibit 27 lists some reasons consumers may wish to file appeals.

Exhibit 27 – Appeal Reasons for Individuals

Appeal Reasons	Description
Disagree with an initial determination or redetermination	Consumers may file an appeal if they disagree with an eligibility determination made by the Marketplace, including eligibility for enrollment in QHPs, the amount of premium tax credit, etc.
Denied exemption	Consumers may request an appeal if they are denied an exemption.
Untimely notice of eligibility results	Consumers may request an appeal if they did not get notice of their eligibility determination in a timely manner.

For appeals in the Individual Marketplace, consumers must submit specific information to complete the requests. At a minimum, they should provide contact information requested for an appeal request.

Exhibit 28 - Information Requested in Appeal Request

Field	Required (Y/N)
First Name	Yes
Last Name	Yes
Middle Initial	No
Phone Number	No
Address	Yes
Eligibility Notice Date	No

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Field	Required (Y/N)
Eligibility Decision	No
Appeal Reason	Yes

Filing an Appeal (Employees)

Employees may submit an appeal request if they have been determined not eligible for the employer-sponsored QHP and they disagree with the determination.

Filing an Appeal (Employers)

Similarly, employers may appeal decisions made by the Marketplace.

3.3 Account Creation and Maintenance

You are responsible for assisting consumers with account creation and maintenance activities. Consumers perform these tasks in the same way for individuals, employers, and employees who are interested in obtaining health coverage through the Marketplace.

3.3.1 Individual Account Creation & Log-In

Navigators must determine whether consumers have an existing account, or if they need to help consumers create an account. Consumers need an account to start an electronic application, to report changes, to view historical information and to complete other eligibility and enrollment activities.

For further details, access the following SOP:

Exhibit 29 – Required SOP to Create an Account

SOP Title	Description	Page #
Create Account	Assist consumers with creating an account to proceed with a Marketplace application	64

3.3.2 Employee Account Creation & Log-In

Employees may need assistance with creating an account. Determine if employees have an existing account, or if they need to create an account. If requested, assist employees with the following tasks:

- Help the employee initiate an electronic application.
- Link the account to an existing application.
- Perform other SHOP Marketplace functions listed in this manual.

For further details, access the following SOP:

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Exhibit 30 – Required SOP to Create SHOP Employee Account

SOP Title	Description	Page #
Create Employee Account	Assist employees with creating an account to proceed with a Marketplace application	125

3.3.3 Employer Account Creation & Log-In

Employers may need assistance with creating an account. Determine if employers have an existing account, or if they need to create an account. If requested, assist consumers with the following tasks:

- Help the employer initiate an electronic application.
- Link the account to an existing application.
- Perform other SHOP Marketplace functions listed in this manual.

For further details, access the following SOP:

Exhibit 31 – Required SOP to Create Employer Account

SOP Title	Description	Page #
Create Employer Account	Assist consumers with creating employers' accounts to proceed with a Marketplace application	143

3.3.4 Individual Account Updates

Consumers may need assistance with making the following updates to their account information:

- Correct inaccuracies in their account information.
- Make changes that may affect consumers' eligibility results or enrollment (e.g., changes in income or change of address).

For further details, access the following SOP:

Exhibit 32 – Required SOP to Update Account or Application

SOP Title	Description	Page #
Update Account Profile	Assist consumers with making their account maintenance or application updates	68

3.3.5 Employee Account Updates

Employees may need assistance with making the following updates to their account information:

- Correct inaccuracies in their account information.
- Make changes that may affect employees' eligibility results or enrollment (e.g., changes in income or change of address).

For further details, access the following SOP:

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Exhibit 33 – Required SOP to Update Employee's Account or Application

SOP Title	Description	Page #
Update Employee Account or Application	Assist consumers with updating their employee accounts	129

3.3.6 Employer Account Updates

Employers may need assistance with making the following updates to their account information:

- Correct incorrect information in their accounts.
- Make changes that may affect employers' eligibility results or enrollment (e.g., change in the number of FTE or change in the business location).

For further details, access the following SOP:

Exhibit 34 – Required SOP to Update Employer's Account or Application

SOP Title	Description	Page #
Update Employer Account or Application	Assist employers with updating their employer accounts	147

3.3.7 Review Account History

The Marketplace stores an electronic record of each consumer's account history. The history includes detailed information about each transaction performed on the account, including eligibility results. If requested, assist consumers with the following tasks:

- Provide historical Marketplace eligibility information, for previous years.
- Provide Medicaid eligibility information if the Marketplace is making Medicaid determinations for a state.

For additional details in reviewing account history of all consumer types (individuals, employees, and employers access the following SOP:

Exhibit 35 – Required SOP to Review Account History

SOP Title	Description	Page #
Review Account History	Assist consumers with reviewing their account histories	73

3.3.8 Individual Payment Assistance

After consumers select a health plan, they may need assistance with making premium payments to their QHPs. If requested, assist consumers with the following activities related to their premium payments:

- Understand the insurance company's deadlines for premium payments and other requirements established by the insurance company.

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- Make payments directly to the insurance company.

For further information, access the following SOP:

Exhibit 36 – Required SOP to Make Premium Payment

SOP Title	Description	Page #
Pay Health Plan Premium	Assist consumers with paying their premiums	113

3.3.9 Employer Payment Assistance

After selecting a health plan for their employees, employers may need assistance with making premium payments to their QHPs. If requested, assist employers with the following activities related to their premium payments:

- Understand the deadlines and other requirements established by the insurance company.
- Make payments directly to the insurance company.

For further information, access the following SOP:

Exhibit 37 - Required SOP Make Employer's Premium Payment

SOP Title	Description	Page #
Make Employer Premium Payment	Assist employers with making a premium payment to the insurance company.	160

3.4 Application and Renewal of Coverage

Consumers are able to complete and submit applications through the Marketplace. This section addresses the processes for successfully submitting applications.

3.4.1 Individual Application Assistance

Consumers must submit applications to find out whether they are eligible to enroll in health plans, receive premium tax credits, receive cost-sharing reductions, or participate in Medicaid or CHIP. If consumers are unfamiliar with the eligibility process, educate consumers on eligibility requirements. Then, help them complete and update their applications, as needed. If requested, assist consumers with the following activities:

- Complete and submit electronic eligibility applications.
- Complete and submit paper eligibility application.
- Scan, upload, and attach supporting documentation to their account.

For further information, access the following SOP:

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Exhibit 38 – Required SOP to Apply Health Coverage

SOP Title	Description	Page #
Apply for Health Coverage	Assist consumers with applying for health coverage	75

3.4.2 Employee Application Assistance

Employees must complete applications to enroll in their employer-selected health plan through the SHOP Marketplace. If employees are not familiar with the SHOP Marketplace eligibility process or the SHOP Marketplace, educate them on these topics, as needed. If requested, assist employees with the following activities:

- Complete and submit electronic applications.
- Scan, upload, and attach supporting documentation to employees' accounts.

For further information, access the following SOP:

Exhibit 39 – Required SOP to Apply for Employee's Health Coverage

SOP Title	Description	Page #
Apply for Employee Health Coverage	Assist employees with applying for health coverage.	132

3.4.3 Employer Application Assistance

Employers must submit applications to find out if they are eligible to participate in the SHOP Marketplace. If employers are not familiar with the SHOP Marketplace eligibility process or the SHOP Marketplace, educate them on these topics, as needed. If requested, assist employers with the following activities:

- Complete and submit electronic employer eligibility applications.
- Scan, upload, and attach supporting documentation to employers' accounts.

For further information, access the following SOP:

Exhibit 40 – Required SOP to Apply for Employer Participation

SOP Title	Description	Page #
Apply for Employer Participation in the SHOP	Assist employers with applying to participate in the SHOP Marketplace	150

3.4.4 Individual Renewal Assistance

Each year, the Marketplace redetermines the eligibility for consumers enrolled in QHPs. The Marketplace determines if changes to consumers' application information affects their eligibility for the upcoming year. If requested, help consumers complete the following activities to renew their health coverage:

- Read and understand the eligibility redetermination notice provided by the Marketplace.

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- Report changes to consumers' application information.

For further details, access the following SOP:

Exhibit 41 – Required SOP to Renew Health Coverage

SOP Title	Description	Page #
Renew Health Coverage	Assist consumers with renewing their health coverage	116

3.4.5 Employee Renewal Assistance

Each year, the SHOP Marketplace redetermines employees' eligibility to remain enrolled in an employer-selected health plan. If requested, help employees complete the following activities to renew their health coverage:

- Confirm and renew employees' eligibility to enroll in their employer-selected health coverage.
- Report changes to consumers' application information.

For further details, access the following SOP:

Exhibit 42 – Required SOP to Renew Employee's Health Coverage

SOP Title	Description	Page #
Renew Employee Health Coverage	Assist employees with renewing their eligibility for health coverage through the SHOP Marketplace	134

3.4.6 Employer Renewal Assistance

Each year, the SHOP Marketplace redetermines employers' eligibility to participate in the SHOP Marketplace. If requested, help employers complete the following activities to renew their participation in the SHOP Marketplace:

- Confirm employers' eligibility to participate in the SHOP Marketplace.
- Report changes to employers' account information.
- Confirm employers' plan offering.

For further details, access the following SOP:

Exhibit 43 – Required SOP to Renew Employer's Health Coverage

SOP Title	Description	Page #
Renew Employer Coverage	Assist employers with renewing their eligibility to participate in the SHOP Marketplace	163

3.5 ELIGIBILITY

Consumers may need assistance with reviewing their eligibility determinations. Consumers who request electronic notices will receive their eligibility determinations through their accounts.

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Consumers who submit paper applications, or request to receive notices via mail, will receive eligibility determinations in the mail.

3.5.1 Individual Eligibility Determination

Consumers may need help with the following activities to understand their eligibility determination notices:

- Find out whether they are eligible to enroll in a QHP and/or receive premium tax credits or cost-sharing reductions.
- Track the status of their Marketplace applications by accessing the "To Do" list and taking steps to complete the application process.

For further details, access the following SOP:

Exhibit 44 – Required SOP to Review Eligibility Determination

SOP Title	Description	Page #
Review Eligibility Determination	Assist consumers with reviewing their eligibility determination notice	86

3.5.2 Employee's Eligibility Determination

Employees may need help with the following activities when reviewing their eligibility determinations:

- Find out whether they are eligible to enroll in their employer-selected health plan.
- Track the status of their eligibility determinations through their accounts if the determination notice is not yet available on their accounts.

For further details, access the following SOP:

Exhibit 45 – Required SOP to Review Employee Eligibility Determination

SOP Title	Description	Page #
Review Employee Eligibility Determination	Assist employees with reviewing their eligibility determination notice	134

3.5.3 Employer's Eligibility Determination

Employers may need help with the following activities when reviewing their eligibility determinations:

- Find out whether they are eligible to participate in the SHOP Marketplace and select a health plan to offer employees.
- Track the status of their eligibility determinations through their accounts if the eligibility determination notice is not yet available on their accounts.

For further details, access the following SOP:

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Exhibit 46 – Required SOP to Review Employer Eligibility Determination

SOP Title	Description	Page #
Compare Employer Plans & Elect Plan	Assist employers with reviewing their eligibility determination notices	152

3.6 ENROLLMENT

Eligible consumers may enroll in QHPs. Ensure that consumers have the information they need to make educated health decisions. Provide them with the information and resources they need to make decisions. However, do not steer, or otherwise influence, consumers' decisions about their health coverage.

3.6.1 Individual Plan Comparison & Selection

After consumers find out the health plans for which they are eligible and whether they qualify for options to lower their plan costs, they may need help comparing and selecting a health plan. If requested, assist consumers with the following activities:

- Adjust the amount of premium tax credits, if needed.
- Answer the screening questions used with the plan compare tool.
- Filter the available health plan options based on their specific needs.
- Review the details of each available health plan.
- Submit plan selections.

For further details, access the following SOPs:

Exhibit 47 – Required SOPs to Compare Plans

SOP Title	Description	Page #
Compare Health Plans (Without an Account)	Assist consumers with the plan compare tool to review available health plans when consumers do not have an account.	90
Compare Health Plans (Without Eligibility Determination)	Assist consumers with the plan compare tool to review available health plans when consumers have not received eligibility results.	96
Compare, Save & Select Health Plans (With Eligibility Determination)	Assist consumers with the plan compare tool to review available health plans and select a health plan when consumers have received eligibility results.	102

3.6.2 Employer Plan Comparison & Election

After employers receive eligibility results, they may need help with comparing and selecting a health plan to offer their employees. If requested, assist employers with the following activities:

- Answer screening questions to use with the plan compare tool.
- Filter the available health plans based on employers' needs.

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- Review the details of each available health plan.
- Submit employers' plan selections.

For further details, access the following SOP:

Exhibit 48 – Required SOP to Compare Employer Plan Comparison & Selection

SOP Title	Description	Page #
Compare Employer Plans & Elect Plan	Assist employers with comparing and selecting health plans to offer employees	152

3.6.3 Lowering Health Plan Costs

When reviewing coverage options, you must educate consumers about their options to lower their health plan costs. If requested, assist consumers with the following activities:

- Understand premium tax credits, cost-sharing reductions and the effect of these options on consumers' income taxes.
- Review consumers' eligibility determinations to find whether options to lower their health plan costs are available to them.
- Compare consumers' health plans based on the amount of premium tax credits and cost-sharing reductions.

For further details, access the following SOP:

Exhibit 49 – Required SOP to Lower Costs of Health Plan

SOP Title	Description	Page #
Lower Costs of Health Plan	Assist consumers with selecting the amount of premium tax credits they want to apply to their health premiums	79

3.6.4 Referral to State Medicaid or CHIP

During the eligibility determination process, the Marketplace may determine or assess consumers, and/or their dependents, potentially eligible for Medicaid or CHIP. When this happens, assist consumers with the following activities, if requested.

- Understand consumers' eligibility results.
- Assist consumers with contacting state Medicaid or CHIP agencies or call center if there is an issue with consumers receiving notification from state agencies.

For further details, access the following SOP:

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Exhibit 50 – Required SOP to Refer Consumers to State Medicaid/CHIP and Other Consumer Assistance Programs

SOP Title	Description	Page #
Refer to State Medicaid/CHIP	Refer consumers to Medicaid/CHIP and other consumer assistance programs, if consumers qualify for these programs	109

3.7 EXEMPTIONS

Starting in 2014, the individual responsibility requirement calls for each individual to have health insurance coverage, qualify for an exemption, or pay a fee when filing federal income tax. All consumers may seek exemptions, either through the Marketplace and/or by claiming an exemption through the tax filing process. Educate consumers on the types of exemptions they may apply for and then assist them with the following activities, if requested:

- Understand the types of exemptions that may be available.
- Complete the appropriate exemption application(s).
- Attach and submit supporting information to complete the exemption eligibility process.

Consumers may complete and submit exemption applications, even if the Navigator concludes they may not qualify.

For further details on assisting with exemption applications for all consumer types, access the following SOP:

Exhibit 51 – Required SOP to Apply for Exemption

SOP Title	Description	Page #
Apply for Exemption	Assist consumers with applying for an exemption	119

3.8 APPEALS

Consumers may request appeals if they disagree with any Marketplace decision or if they do not receive timely notices of their eligibility determinations.

3.8.1 Individual Appeal Assistance

Consumers may request appeals to challenge the following Marketplace determinations:

- Eligibility for enrollment in a QHP
- Eligibility for, or amount of, premium tax credits or cost-sharing reductions
- Eligibility for an exemption
- Untimely (late) notice of eligibility determination

For further details, access the following SOP:

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Exhibit 52 – Required SOP to Appeal Eligibility Determination

SOP Title	Description	Page #
Request Eligibility Appeal	Assist consumers with completing an appeal request if they disagree with their eligibility determination	121

3.8.2 Employee Appeal Assistance

Employees may request appeals if they are denied eligibility to participate in the SHOP Marketplace. If requested, assist employees with submitting appeal requests of their eligibility determinations by using the following SOP:

Exhibit 53 – Required SOP to Appeal Employee Eligibility Determination

SOP Title	Description	Page #
Request Employee Eligibility Appeal	Assist employee with completing an appeal request if they disagree with their eligibility determination	138

3.8.3 Employer Appeal Assistance

Employers may request appeals if they are not eligible to participate in the SHOP Marketplace. If requested, assist employers with submitting appeal requests to their eligibility determinations by using the following SOP:

Exhibit 54 – Required SOP to Appeal Employer Eligibility Determination

SOP Title	Description	Page #
Request Employer Eligibility Appeal	Assist employers with completing an appeal request if they are not eligible to participate in SHOP.	165

3.9 Consumer Outreach

You are responsible for conducting public education and outreach activities to help consumers understand their health coverage options, eligibility and enrollment rules, and the application process for health coverage. To increase awareness of the Navigator program, you must promote yourself as a community resource for Marketplace information and enrollment activities. You must also be knowledgeable about the community you serve and target your outreach and assistance activities to meet the needs of underserved and vulnerable populations.

The outreach goals of the Navigator program are to:

- Increase awareness of the requirement to obtain health coverage by January 1, 2014
- Identify the Marketplace as a trusted resource for choosing health coverage
- Educate consumers about the eligibility and enrollment processes
- Empower consumers to make informed decisions about purchasing health coverage
- Help consumers with health care enrollment activities, including completing an application and selecting a QHP; and

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- Provide information on the location and contact information for your Navigator office.

3.9.1 Planning Activities

To perform successful outreach, conduct planning activities to understand the needs of your service area and leverage community resources. Further detailed in Exhibit 55, these outreach planning efforts include:

- Performing regular assessments to identify community needs
- Identifying outreach strategies to best connect with the community
- Establishing partnerships with community-based organizations to reach more consumers
- Distributing informational resources to populations to increase knowledge of the Marketplace; and
- Targeting communication strategies to effectively provide assistance to specific populations.

Exhibit 55 – Outreach Planning Efforts

Outreach Planning Effort	Outreach Activities
Perform regular assessments to identify community assistance needs	• Analyze the target population's demographic and income levels • Identify the informational needs of each population and their levels of health knowledge

Identify outreach strategies to best connect with the community	• Identify best practices to reach a variety of audiences
	• Engage in outreach strategies, including:
	  • In-Person activities
	  o Community meetings, town hall meetings, public meeting forums
	  o Health conferences, fairs, open houses and/or exhibits
	  o Conferences/Teleconferences
	  • Media
	  o Print, broadcast, digital
	  o Newspapers, newsletters, radio, TV, videos, billboards, posters, exhibits, mass mailings, flyers, and social networking

Establish partnerships with community-based organizations to reach more consumers	• Partner with community organizations that serve consumers, including underserved and vulnerable populations • Become familiar with local community partnership processes (e.g., what does partnering involve? Are there forms, contracts, or memoranda of understanding to complete?) • Partner with organizations that have similar missions, values, goals, and desired outcomes as the Navigator program • Provide clear, open, and accessible communication between partners, making it an ongoing priority to listen to the needs of each partner, develop a common language, and clarify the meaning of terms • Identify community health events in which to participate and perform outreach efforts

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Outreach Planning Effort	Outreach Activities
Distribute informational resources to increase knowledge of the Marketplace	• Identify and reuse resources already in place in the community (e.g., pamphlets or brochures from state Medicaid or CHIP Agencies) • Develop new pamphlets and other materials that meet the needs of the community
Target communication strategies to effectively provide assistance to specific populations	• Identify the most popular and effective methods of communication that best meet the needs of the local population • Identify culturally sensitive means of communication

3.9.2 Outreach Guidelines

When conducting outreach activities, ensure that outreach activities meet the guidelines listed in Exhibit 56.

Exhibit 56 – Consumer Outreach Guidelines

Guideline Category	Description
Consumer Accommodations	• Provide assistance to consumers with physical or mental limitations • Provide information that suits the cultural and linguistic needs of the community • Provide information that is accessible to individuals with disabilities. • Offer service and information in a variety of locations
Event Planning	• Record the number of people in attendance at outreach events • Avoid the distribution or sharing of consumers' personal information (i.e., names, contact information, etc.) • Supply enough materials to distribute to attendees, and ensure that materials are available in appropriate languages • Supply computer equipment when needed and abide by building regulations • Abide by event guidelines (i.e., meeting minimum participation thresholds, providing consumer education handouts) • Abide by registration deadlines when attending community events, such as fairs or local conferences • Abide by facility and infrastructure regulations (e.g., when holding events in local buildings, etc.)

3.10 Navigator Reporting

To assist the Marketplace in improving the Navigator program, all Navigator grantees must submit quarterly and annual reports on their consumer assistance and outreach activities to CCIIO. Grantees will receive additional information from CCIIO regarding the required timeframes to submit reports.

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3.10.1 Quarterly Progress Reports

The Marketplace requires quarterly progress reports that provide information on the number of consumers who have received assistance with eligibility and enrollment functions. In general, the Marketplace will use the progress reports to confirm that grantees are fulfilling their responsibilities and meeting all the Navigator program requirements. Exhibit 57 lists the specific information that must be included in quarterly progress reports.

Exhibit 57 – Information Collected in Quarterly Progress Reports

Category	Description
Consumers receiving eligibility and enrollment assistance	• Include an estimate of the number of consumers who received assistance with the following: o Creating an account o Applying for PTC and CSRs o Completing and submitting an application o Selecting a QHP o Completing the Medicaid/CHIP enrollment process • Include an estimate of consumers who declined to select either a health plan or Medicaid/CHIP for their health coverage • Include an estimate of the number of consumers who required multiple assistance sessions • Estimates will include the number of consumers who were represented by one family member (e.g., one adult receives assistance enrolling three family members in a health plan)
Consumers requesting assistance after enrolling in a health plan	• Include an estimate of the consumers who were referred to a program providing consumer assistance for further help *after* enrollment is complete (e.g., refer consumers to the State Department of Insurance to address their complaints against an insurance company)
Consumers requiring assistance outside of Navigator activities	• Provide an estimate of the consumers who were referred to other health care programs for assistance (e.g., TRICARE, Medicare, VA health benefits)
Navigator Training	• Include the number of Navigator staff (individual staff members employed by the grantee) who completed Navigator training • Of the staff who received training, include the number of staff that completed the certification or recertification process • Provide at least one example of how the grantee avoids conflicts of interest • Provide at least one example of how the grantee adheres to CLAS standards, including: o Plans to address consumers' translation needs o Number of consumers assisted whose primary language was not English o The top five primary languages of consumers who have received assistance from the grantee • Include information on how the grantee provides accommodations to ensure access to assistance for consumers with disabilities

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Category	Description
Specific Examples of Assistance *Examples should not include names or any other personally identifiable information of the consumer who received the assistance*	• Describe up to three examples of how the grantee has helped a consumer get health coverage • Describe up to three examples of how the grantee's assistance positively affected a consumer's situation
Privacy and Security	• Describe in detail how the grantee is meeting privacy and security standards and whether grantee has experienced any security breaches during the quarter. (*Note: You must report all security breaches to HHS immediately.)*

3.10.2 Annual Progress Reports

Grantees must also submit annual progress reports to the Marketplace. Exhibit 58 describes the information that must be included in each annual report.

Exhibit 58 – Information Collected in Annual Progress Reports

Information	Description
Consumer Assistance Data from Quarterly Reports	• Provide annual totals of all information collected in Quarterly Progress Reports (see Exhibit 60) including: o Number of Consumers Receiving Eligibility and Enrollment Assistance o Number of Consumers Requiring Assistance outside of Navigator Activities o Navigator Training o Privacy and Security
Consumer Contacts	• List all consumer outreach and education events by date • Provide an estimate of the number of consumers who were reached through consumer outreach and education events • (Optional) Provide additional information or materials related to consumer outreach and education events (e.g., brochures, toolkits, social media campaigns)
Lessons Learned	• Describe the lessons learned from consumer assistance and outreach activities conducted over the performance year
Major Accomplishments	• Describe the grantee's major accomplishments during the performance year
Policy Changes	• Describe policy changes that were established as a result of information that grantee provided to CMS
Examples of Successful Consumer Assistance	• Provide up to three examples of how grantee helped consumers understand their options to lower their health plan costs

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3.10.3 Bi-Annual Reports on Sub Awards

To monitor the use of federal funds to support the Navigator program, CCIIO also requires grantees to report information on sub awards offered by grantees. This report is only required for grantees that receive sub-awards to perform their activities. For example, a grantee might share some of its award funds with another entity or individual to carry out consumer assistance or outreach activities. The grantee must then report these *sub-award* activities. Grantees who use sub-awards must report the information listed in Exhibit 59 to CMS twice a year.

Exhibit 59 – Information Collected for Bi-Annual Reports

Information	Description
Name(s)	• Provide the names of any sub-awardees who received funds to perform activities under the Navigator program.
Description of Activities	• Provide a written description of the activities performed by sub-awardees

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4.0 Individual Marketplace SOPs

The SOPs contained in this section provide guidance to assist individuals who select and purchase their health coverage through the Individual market. Individuals may request assistance with the process to identify, compare, and select QHPs for themselves or their family members. This section lists SOPs in the order of the eligibility and enrollment process as shown below.

SOP-1. Create Account 64
SOP-2. Update Account Profile 68
SOP-3. Report Life Changes 70
SOP-4. Review Account History 73
SOP-5. Apply for Health Coverage 75
SOP-6. Lower Costs of Health Plan 79
SOP-7. Extend Deadline to Submit Supporting Documentation 83
SOP-8. Review Eligibility Determination 86
SOP-9. Compare Health Plans (Without an Account) 90
SOP-10. Compare Health Plans (Without Eligibility Determination) 96
SOP-11. Compare, Save & Select Health Plans (With Eligibility Determination) 102
SOP-12. Refer to State Medicaid/CHIP Office 109
SOP-13. Pay Health Plan Premium 113
SOP-14. Renew Health Coverage 116
SOP-15. Apply for Exemption 119
SOP-16. Request Eligibility Appeal 121

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SOP-1. Create Account

A. Introduction

The Marketplace allows consumers to create accounts to access the Marketplace online, submit applications for health coverage, and select QHPs with the help of the Navigator. This SOP provides guidance on how to assist consumers in creating accounts. Topics include:

- **Consumer Education** (Section B) provides general information about marketplace eligibility and enrollment, and specific education concerning the process for and value of creating an account. If consumers understand the value of the creating accounts and the process involved, proceed to Section C, Procedures.
- **Procedures** (Section C) provides detailed instructions for creating an account.

B. Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment .

Based on consumers' level of familiarity with the Marketplace and the eligibility and enrollment process, provide more detailed information (as needed) about the following topics before proceeding to the next section:

- Affordable Care Act (3.2.2)
- Health Coverage (3.2.1)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)

C. Procedures

1. Create Account

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

Step 1. Receive consent to assist consumers.

Step 2. Assist consumers with entering the following information:

a. First name

> Consumers may change their passwords at any time, but consumers cannot change their usernames. If consumers need additional password or username assistance, direct them to the call center.

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b. Last name

c. E-mail (required to create an account)

d. Username (required to create an account)

e. Password (required to create an account)

f. Four security questions (required to create an account)

Step 3. Explain to consumers that they must answer security questions to protect their accounts from unauthorized access.

Step 4. Inform consumers that they must verify their e-mail address within 48 hours to activate their accounts.

a. If consumers wish to verify their e-mails immediately, assist them with accessing their e-mail accounts.

> Once consumers have activated their accounts, they may begin Marketplace applications, or browse QHP options. If they wish to submit an application or select and enroll in a plan, the system will prompt them to provide additional account information.

Step 5. If consumers would like to submit Marketplace applications, designate authorized representatives, or select a QHP, assist consumers with providing the following additional information:

a. Physical Address (required to process an eligibility application)
   i. Street
   ii. City
   iii. State
   iv. ZIP code
   v. Apartment number

b. Mailing address

c. Social Security Number

d. Date of birth (required to process an eligibility application)

e. Phone number (required to process an eligibility application)

Step 6. Assist consumers (as necessary) with completing the “challenge questions” that are generated to validate their identities. Explain that the identity validation process generates “real-time” questions based on submitted PII to verify that consumers are who they say they are.

a. If identity validation is successful, follow the system prompts to assist consumers in retrieving their login information to begin the application process

b. If identity validation is unsuccessful, proceed to Step 7.

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Step 7. Inform consumers that they must validate their identities before they can receive final eligibility determinations or designate authorized representatives. Direct them to the Experian call center to complete identity validation.

a. If identity validation is successful, assist consumers in retrieving their login information to begin the application process

b. If identity validation is unsuccessful, proceed to Step 8.

Step 8. Inform consumers that they must submit supporting documentation to the Marketplace to complete the identity verification process. Consumers can submit the following documents, as long as they have photos or other identifying information:

a. Driver's license issued by a state or territory

b. School identification card

c. Voter registration card

d. U.S. military card or draft card

e. Identification card issued by the federal, state, or local government, (e.g., a U.S. passport)

f. Military dependent's identification card

g. Native American or Tribal document

h. U.S. Coast Guard merchant mariner card

Step 9. If consumers cannot submit the documents listed above, they may submit two items from the documents listed below to complete the verification process:

i. Birth certificate

j. Social Security card

k. Divorce decree

l. Employer identification card

m. High school or college diploma

n. Property deed or title

2. Troubleshooting

Consumers may receive error messages during the account creation process. Exhibit 60 provides reasons for errors encountered and steps to assist consumers in resolving the encountered errors.

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Exhibit 60 – Encountered 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 account. • Explain that the information may be associated with a family member's existing account, which will prevent consumers from applying for their own QHP.	Assist consumers with ensuring that login information is correct and ensure there is not an existing account. Direct consumers to the call center to retrieve login information if an account does exist.
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 it deems missing or invalid so that 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 deemed missing or invalid and help them to correct the information or show them how to cancel the entire account creation activity.

B. Next Steps

1. Educate consumers on how to manage their accounts.
2. If consumers would like to complete eligibility applications, proceed to SOP-5 Apply for Health Coverage.
3. If consumers would like to perform account maintenance activities (e.g., password reset, designate authorized representative), proceed to SOP-2 Update Account Profile.

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SOP-2. Update Account Profile

A Introduction

Consumers can update their Marketplace account profiles. This SOP provides guidance on how to assist consumers in updating existing profiles. Topics include:

- **Consumer Education** (Section B) provides guidance on the benefits of having an account and the various types of updates consumers might have.
- **Procedures** (Section C) provides detailed instructions for assisting consumers with completing account updates.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

In addition to any other topics discovered during the assessment, ensure that consumers understand:

- Account Creation & Maintenance (3.2.3.7)

C Procedures

1. Update Account Profile

To assist consumers with updating their account profiles, complete the following steps:

Step 1. Receive consent to assist consumers.

Step 2. Confirm that consumers have existing accounts.

Step 3. Determine what information consumers would like to update within their accounts. See Exhibit 61 for the types of account profile updates consumers can make.

Exhibit 61 – Account Information Available for Updates

Information Type	Information to Update
Personal	• Primary and secondary phone • E-mail • Language preferences (spoken and written) • Notice preferences • Authorized representative • Account password

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Information Type	Information to Update
	• Mailing address (if moving out of state, consumers eligibility may change) • Security questions

Step 4. Assist consumers with completing their account profile updates by following system prompts.

Step 5. Assist consumers with saving their account profile updates.

D Next Steps

1. If consumers want to update their applications because there is a new life event (e.g., birth of a child, significant income increase) proceed to SOP-3 Report Life Changes.

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SOP-3. Report Life Changes

A Introduction

Consumers may experience life changes during the year. The Marketplace requires consumers to update their account information when life changes happen (e.g., marriage, relocation, birth of a child, change in income, citizenship). This SOP provides guidance to assist consumers with updating their eligibility application information. Topics include:

- **Consumer Education** (Section B) provides guidance on general health coverage concepts, the eligibility and enrollment process, and the options for applying for health coverage.
- **Procedures** (Section C) provides detailed instructions for updating consumers' information.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with health coverage concepts and the eligibility and enrollment process, provide more detailed information about the following topics before proceeding to the next section.

- Health Coverage (3.2.1)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)
- Eligibility Application (3.2.3.8)
- Eligibility Requirements (3.2.3.9)

C Procedures

1. Reporting Life Changes

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

Step 1. Receive consent from consumers to assist them with reporting life changes.

Step 2. Assist consumers with logging into their accounts.

Step 3. Review the list of categories of possible life changes with consumers in Exhibit 62.

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Exhibit 62 – Life Changes

Life Event	Potential Updates
Citizenship/Lawful Presence Status Change	• Claim U.S. citizenship • Claim lawful presence in U.S.
Residency Changes	• Report a new residential address
Incarceration Status Change	• Claim current incarceration • Claim end of incarceration period • Claim pending incarceration order
Indian Status Change	• Claim tribal membership
Student Status Change	• Claim student status in a college or university • Claim end of student status in a college or university
Expected Tax Filing Status Change	• Claim new tax filing status (married, single, divorced, etc. • Claim to be dependent on another individual's tax return
Pregnancy Status Change	• Claim current pregnancy status • Claim end of pregnancy status
Household Member Change	• Update the dependents claimed *(Date of birth, sex, Social Security Number, citizenship, language and race[optional])* • Children of dependents (if applicable) • Divorce
Change in Request to Lower Health Plan Costs	• Request APTC and CSR • End request for APTC and CSR
Income Change	• Change projected annual household income • Change current monthly household income
Employer-Sponsored Insurance (ESI) Minimum Essential Coverage (MEC) Change	• Claim job-based health coverage • Update job-based health coverage information
Non-ESI MEC Change	• Update current health coverage information

Step 4. If consumers request to make a change, direct them to select "Report a Change" in their accounts.

Step 5. Assist consumers with submitting their life changes.

Step 6. Verify and review the list of required supporting documentation with consumers, if applicable.

a. If supporting documentation is required and **consumers have** supporting documentation with them, assist consumers with uploading it to their accounts.

b. If supporting documentation is required and **consumers do not have** the documentation with them, provide the deadlines to submit any and all documents, and the instructions

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

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for submitting these documents.

D Next Steps

1. If consumers receive a new eligibility determination after reporting life changes, proceed to SOP-11: Compare, Save & Select Health Plans (With Eligibility Determination).

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SOP-4. Review Account History

A Introduction

The Marketplace allows consumers to obtain detailed account histories, which include consumers' eligibility records, with the help of the Navigator. This SOP provides guidance on how to assist consumers with obtaining their account histories. Topics include:

- **Consumer Education** (Section B) provides guidance on the various reasons for which consumers may request account histories or eligibility records. If consumers understand the reasons for which account histories or eligibility are necessary proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Request Account History – Provides guidance on assisting consumers with accessing their account histories.
  - Request Eligibility Record – Provides guidance on assisting consumers with accessing and reviewing their eligibility records.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with the Marketplace eligibility and enrollment process, provide more detailed information about the following topics before proceeding to the next section:

- Account Creation & Maintenance (3.2.3.7)
- Appeals (3.2.3.12)

C Procedures

1. Request Account History

To assist consumers with reviewing their account histories, complete the following procedures:

Step 1. Receive consent to assist consumers.

Step 2. Assist consumers with logging into their accounts.

> If consumers require proof of health plan coverage, refer them to the health insurance company.

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Step 3. Assist consumers with accessing their account histories and determine the purpose of obtaining the account histories.

Step 4. Determine whether consumers want to review specific transactions from their account histories or their complete account histories.

Step 5. To print the account history, choose the appropriate transactions (if applicable) and print the transactions requested.

> Explain that consumers may print a copy of their account histories from their accounts at any time.

2. Request Eligibility Record

If consumers request information from their eligibility record, complete the following steps:

Step 1. Receive consent to assist consumers.

Step 2. Log in to consumers' account.

Step 3. Navigate to consumers' eligibility records and determine the purpose of obtaining the eligibility records (see above).

Step 4. Determine which sections consumers need from their eligibility records and assist consumers with understanding those sections of their eligibility records.

Step 5. To print the eligibility record, choose the appropriate record sections and generate a copy of the eligibility record for consumers.

> Explain that consumers may print an eligibility record from their accounts at any time.

D Next Steps

1. If consumers request appeal assistance, proceed to SOP-16 Request Eligibility Appeal.
2. If consumers would like to create applications, proceed to SOP-5 Apply for Health Coverage (or the SHOP Marketplace equivalent).
3. If consumers would like to make account updates, proceed to SOP-2 Update Account Profile (or the SHOP Marketplace equivalent).

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SOP-5. Apply for Health Coverage

A Introduction

The Marketplace allows consumers to apply for health coverage with the help of the Navigator. Consumers can apply for enrollment in QHPs with or without premium tax credits and cost-sharing reductions. When they apply, the application will also check for consumers' eligibility for Medicaid or CHIP. This SOP provides guidance to assist consumers in completing their applications. Topics include:

- **Consumer Education** (Section B) provides guidance on general health coverage concepts, the eligibility and enrollment process, and applying for health coverage.
- **Procedures** (Section C) details instructions for the following:
  - Complete Electronic Application – Provides guidance on assisting consumers with completing an electronic Marketplace application and submitting supporting documentation.
  - Complete Paper Application – Provides guidance on assisting consumers with completing a paper Marketplace application, submitting supporting documentation, and mailing their applications and documentation to the Marketplace.

> Encourage consumers to use the electronic application feature.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with the health coverage concepts and the eligibility and enrollment process, provide more detailed information about the following topics before proceeding to the next section.

- Health Coverage (3.2.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)
- Eligibility Application (3.2.3.8)

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C Procedures

1. Complete Electronic Application

To assist consumers with their electronic eligibility applications, complete the following steps:

> The Marketplace verifies some personal information against external data sources, such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security.

Step 1. Receive consent to assist consumers.

Step 2. Determine if consumers have previously started their Marketplace applications online by going to their accounts.

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

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

c. Guide consumers through the application process by following the application prompts to gather consumers' responses.

Step 3. Save or submit the Marketplace applications.

a. Inform consumers that they may save and resume the eligibility applications to submit at a later date during their enrollment periods, or

b. Submit the Marketplace applications to view eligibility results.

Step 4. Assist consumers with reviewing their "To Do" list in their online accounts.

a. The "To Do" list will notify consumers if they need to submit supporting documentation or perform additional activities to complete the application process.

b. If consumers have the necessary supporting documentation, assist them in 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 electronic devices (e.g., printers and scanners).

c. If consumers do not have the supporting documentation, explain their options to provide it within the required timeframe (see "To Do" list or notice on consumers' accounts):

i. Scan and upload documents from home, or

ii. Return to the Navigator office with the supporting documentation to scan and upload the documents with assistance.

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2. Complete Paper Application

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

Step 1. Receive consent to assist consumers.

Step 2. Determine if consumers have previously started their applications.

> Encourage consumers to transfer their paper application to the electronic format.

a. If consumers have brought previously started applications, proceed to the section where assistance is required.

b. If consumers do not have existing applications, encourage them to complete electronic applications.

c. If consumers would still like to complete paper applications, follow the format provided.

Step 3. Assist consumers with submitting their applications to Marketplace.

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

Step 4. Assist with providing supporting documentation, if required in response to a notice from the Marketplace. (Refer to the Marketplace notice for acceptable documentation to complete the application.)

a. Explain that consumers must mail in copies of all necessary supporting documentation for the Marketplace to verify the documentation.

b. Provide consumers with the address to mail the exemption application. You may not mail exemption applications for consumers.

D Next Steps

1. If consumers are not ready to submit their eligibility applications, explain that they may save their electronic applications to their accounts and resume their applications at a later point in time.

2. If consumers receive automatic eligibility determinations and are eligible to enroll in QHPs through the Marketplace, proceed to SOP-11 Compare, Save & Select Health Plans (With Eligibility Determination).

3. If consumers receive notices from the Marketplace to submit supporting documentation after submitting their eligibility applications, explain the notices to consumers, and inform them that they must supply supporting documentation to complete their application.

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4. If consumers complete their paper applications, inform them that they will receive their eligibility results by mail, which will include additional instructions for enrollment or completion of their applications.

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SOP-6. Lower Costs of Health Plan

A Introduction

When consumers receive their eligibility results, the Marketplace will inform them of their eligibility for options to lower their health plan costs through premium tax credits or cost-sharing reductions. If eligible, consumers can choose whether to apply these options to the cost of their health plans. When comparing plans, consumers select the amount of their premium tax credits they want to receive in advance (to pay directly to their health insurance company). Consumers can also select health plans that apply cost-sharing reductions if they are eligible.

This SOP provides guidance to assist consumers with understanding premium tax credits and cost-sharing reductions. Topics include:

- **Consumer Education** (Section B) provides guidance on the available options to lower health plan costs, the eligibility process, and premium payments. If consumers understand the distinctions between premium tax credits and cost-sharing reductions, you may proceed to the next section.
- **Procedures** (Section C) details instructions for the following:
  - Select Premium Tax Credit Amount - Provides guidance on helping consumers understand how the premium tax credit is determined and adjusting the premium tax credit amount.
  - Select plans with cost-sharing reductions - Provides guidance on assisting eligible consumers with viewing plans that offer cost-sharing reductions.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with the health insurance concepts and the eligibility and enrollment process, you may need to provide more detailed information on the following topics before proceeding to the next section:

- Health Coverage (3.2.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Post-Enrollment (3.2.3.11)

Determine whether consumers require assistance with adjusting their premium tax credits and/or would like information on cost-sharing reductions, and proceed to the next section.

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C Procedures

1. Select Premium Tax Credit

If consumers are eligible for premium tax credits, they have the option of using all or none of the credits. Before helping them make changes to their accounts, make sure that consumers understand premium tax credits. Exhibit 63 provides information to help answer questions about premium tax credits.

Exhibit 63 – Common Premium Tax Credit Questions and Answers

Question	Answer
What is the premium tax credit?	• Federal assistance that lowers the cost of your monthly premium. If you're eligible to receive this tax credit, the Marketplace will pay the credit directly to your insurance company, or give it to you as a refund at the end of the year when you file your taxes.
Who is eligible for a premium tax credit?	• A consumer whose household income falls between 100-400% of the Federal Poverty Level (see Appendix C: 2013 Federal Poverty Guidelines); and • Is enrolled in a QHP through the Marketplace; and • Is not eligible for other qualifying health coverage, such as Medicare, Medicaid, or affordable employer-sponsored coverage.

2. Selecting the Amount of the Premium Tax Credit

When consumers are eligible to receive premium tax credits, the Marketplace will notify them of the maximum dollar amount avilable to them. Consumers can choose to apply the entire amount to their health plan premiums or a lesser amount of their choice. You can help consumers select the amount of premium tax credit to apply to their monthly premiums:

- Immediately after receiving eligibility results online,
- During plan selection,
- When consumers submit a change in circumstance, or
- When consumers log into their accounts.

To help consumers select the premium tax credit assistance amount, complete the following steps:

Step 1. Review the available premium credits with consumers and explain the maximum premium tax credits for which they are eligible.

Step 2. Explain to consumers that adjusting the amount of premium tax credits affects the cost of their QHP monthly premiums.

Step 3. Explain when the premium tax credits take effect:

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a. If consumers adjust premium tax credits 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 July 8th, the change in premium takes effect on August 1st).

b. If consumers adjust premium tax credits between the 16th and the last day of the month, the change in premium takes effect on the first of the following month (e.g., if the change is made July 17th, the change in premium takes effect on September 1st).

Step 4. Describe the effects of adjusting premium tax credits amount:

a. Premium amount paid by consumers, and

b. Tax consequences (see Exhibit 64).

Step 5. Help consumers select the amount of premium tax credits they would like to apply towards their monthly premium payments. Note that the default setting for the premium tax credit is 100% of the eligible amount. However, consumers' maximum premium tax credit amounts cannot be more than the cost of their monthly premiums.

2.2 Tax Consequences

Explain to consumers that choosing to take more or less of the premium tax credit may impact the amount they owe when they file taxes. Premium tax credits depend on consumers' projected income and household size. The Marketplace verifies consumers' projected incomes against consumers' actual income when they file their tax returns. If consumers' actual incomes differ from the projected income amounts, then this will impact the amount that consumers will pay or receive as a refund when they file their tax returns. Exhibit 64 provides premium tax credit adjustment scenarios and tax consequences for each scenario.

Exhibit 64 – Premium Tax Credit Adjustment Tax Scenarios

Scenario		Tax Consequence
Consumers elect *lower* premium tax credits than the maximum allowed AND their annual household incomes are *less than* projected for the tax year.	→	Consumers may receive the remaining discount as a tax refund.
Consumers elect *lower* premium tax credits than the maximum allowed OR their annual household incomes are *less than* projected for the tax year.	→	Consumers may receive the remaining discount as a tax refund.
Consumers elect the *maximum allowed* premium tax credits AND household income is *more than* consumers projected for the tax year.	→	Consumers may owe taxes.
Consumers elect the *maximum allowed* premium tax credits OR their annual household incomes are *more than* consumers projected for the tax year.	→	Consumers may owe taxes.

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3. Select plans with cost-sharing reductions

If consumers need help paying for their health care, they may be eligible for plans with cost-sharing reductions. Plans with cost-sharing reductions reduce the amount that consumers have to pay out-of-pocket for health care. The Marketplace will determine if consumers are eligible for cost-sharing reductions based on income and other information.

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

Topic 1: Explain to consumers that they must choose a Silver plan to take advantage of the cost-sharing reduction (certain members of federally-recognized tribes may take advantage of cost-sharing reductions at any health plan category).

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

- Deductibles
- Coinsurance
- Copayments

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

- Monthly premiums
- Balances billed by non-network providers
- Amounts spent on non-covered services

D Next Steps

1. If consumers would like to compare plans or make plan selections, proceed to SOP-11 Compare, Save & Select Health Plans (With Eligibility Determination).
2. If consumers need to update their personal information in their accounts, proceed to SOP-2 Update Account Profile.
3. If consumers need to report changes that affect their eligibility results, proceed to SOP-3 Report Life Changes.
4. If consumers feel that they are eligible for more premium tax credits or cost-sharing reductions, proceed to SOP-16 Request Eligibility Appeal.

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SOP-7. Extend Deadline to Submit Supporting Documentation

A Introduction

Consumers may be required to provide documentation to support attestations made on their Marketplace applications. If consumers are unable to provide the supporting documentation during the time periods specified in their notifications, they may request extensions to receive additional time in which to provide the documentation.

This SOP provides the guidance to Navigators in assisting a consumer with requesting extensions. The SOP covers the following topics:

- **Consumer Education** (Section B) provides guidance on the eligibility and enrollment process, eligibility requirements, verification of information, and detailed information about good faith extensions. If consumers understand these topics, then proceed to Section C.
- **Procedures** (Section C) provides detailed instructions for assisting consumers with completing and submitting a request for a good faith extension.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

If consumers are unfamiliar with topics relevant to this SOP, provide them with more detailed information (as needed) on the following topics before proceeding to Section C:

- Exemptions (3.2.2.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Eligibility Application (3.2.3.8)
- Appeals (3.2.3.12)

C Procedures

1. Request Extension

To assist consumers with requesting extensions, complete the following steps:

Step 1. Receive consent to assist consumers.

Step 2. Confirm with consumers that they have received notices requesting supporting documentation from the Marketplace.

Step 3. Review the notices with consumers.

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Step 4. Determine if the time period to submit supporting documentation is still open based on the date that the Marketplace sent the notice.

a. If the time period to submit documentation is still open, assist consumers with requesting extensions to submit the necessary documentation.

b. If the time period is closed, and consumers already have eligibility results, help consumers review their results and take the necessary next steps to enroll in QHPs and/or select premium tax credits or cost-sharing reductions.

Step 5. Review the reasons for extensions from consumers. Refer to Exhibit 65 for potential reasons. Consumers may still complete requests for reasons beyond those in the following exhibit.

Exhibit 65 – Reasons to Request Extension

Reason	Explanation	Example Text from Consumer's Request
Missing Social Security Card	Card is lost, stolen, destroyed and consumers have requested replacement cards	I cannot submit my Social Security card until [date] when I receive my new card.
Missing Birth Certificate	Certificate is lost, stolen, or destroyed and consumers have requested replacements	I cannot submit my birth certificate until [date] when I receive my replacement birth certificate.
Inconsistent Address	Consumers recently moved to a new address and do not yet have documentation to prove new address	I cannot submit proof of my address until [date] when I receive documentation to prove my address.
Inconsistent Income	Consumers recently lost job/ changed jobs and do not yet have pay stubs to prove income	I cannot submit proof of my income until [date] when I receive my pay stub.
Other	Consumers cannot obtain the supporting documentation needed by the deadline (see notice for exact deadline)	I cannot submit the supporting documentation until [date] for [explanation].

Step 6. Determine if consumers would like to submit written extension requests or submit extension requests through the call center. Proceed to Step 7 for written requests or Step 8 for requests via the call center.

Step 7. Assist consumers with submitting written requests for extensions:

a. Review the elements required for extension requests listed in Exhibit 66.

> If consumers have multiple requests for supporting documentation, they must request an extension for each request for documentation.

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b. Assist consumers with submitting extension requests to the Marketplace.

Step 8. Assist consumers with submitting extension requests using the call center:

a. Review the elements required for extension requests listed in Exhibit 66.

b. Assist consumers with providing the required information to the call center to complete the extension request, as needed.

Exhibit 66 – Information Required for Extension Requests

Information	Description
Consumer Name	Consumers' names (Consumers may submit extension requests only for themselves or their dependents)
The Type of Documents Requested	The type of supporting documents requested (e.g., income, citizenship) for which consumers need an extension
Time Period	The original deadline to provide the documentation
Reason for Extension Request	The reason submitted by consumers to request the extension
Length of Extension	The time period that consumers need to supply the supporting documentation

D Next Steps

1. Direct consumers to submit supporting documentation as soon as possible.
2. Direct consumers to review their accounts periodically for additional notices concerning extension requests.
3. Direct consumers to review their eligibility determinations and provide them with assistance as needed (e.g., submitting appeal requests, enrolling in QHPs).

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SOP-8. Review Eligibility Determination

A Introduction

The Marketplace allows consumers to review their eligibility determinations for health coverage with the help of the Navigator. This SOP provides guidance on how to assist consumers in understanding their eligibility determinations. Topics include:

- **Consumer Education** (Section B) provides guidance to assist consumers with understanding their eligibility results. If consumers understand the process, proceed to Section C.
- **Procedures** (Section C) provides detailed instructions for explaining consumers' eligibility determinations.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment .

Based on consumers' level of familiarity with the eligibility process and options to lower health plan costs, provide more detailed information (as needed) on the following topics before proceeding to the next section:

- Qualified Health Plans (3.2.3.1)
- Health Plan Categories (3.2.3.3)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Eligibility Application (3.2.3.8)
- Eligibility Requirements (3.2.3.9)
- Appeals (3.2.3.12)

> Premium tax credits are determined on a household-basis; Medicaid/CHIP eligibility is determined on an individual basis and might be available to children and not their parents.

C Procedures

1. Review Eligibility Results

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

Step 1. Receive consent to assist consumers.

Step 2. Confirm with consumers that they have received eligibility notices.

Step 3. Review the notices with consumers.

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Step 4. Explain the eligibility results to consumers. Use Exhibit 67 to help consumers understand the results.

Exhibit 67 – Eligibility Results

Eligibility Summary	Information Displayed
Qualified health plans	• Marketplace health plans • Annual premium tax credits • Cost-sharing reduction
Medicaid	• Eligible individuals within consumers' households
CHIP	• Eligible individuals within consumers' households
Not Eligible For	• Ineligible individuals and the program for which they are not eligible • Explanation (describes why the individual is not eligible) • Next Steps (specifies the next steps to address ineligibility)
Separate Application Required	• List applicants for whom a separate application is required because they are outside the limits of who can be on an application together.
Not Applying for Coverage	• List applicants who are on the application for eligibility purposes but are not applying for coverage.

Proceed with Sections 1.1 through 1.3 to explain eligibility results.

1.1 Options to Lower Health Plan Costs

If consumers are eligible for premium tax credits and cost-sharing reductions, discuss the differences in the two programs. Exhibit 68 outlines these distinctions.

Exhibit 68 – Options to Lower Health Plan Costs

Premium Tax Credit	Cost-Sharing Reductions
• Lowers premiums owed by consumers • Eligibility and the amount allowed are determined by the Internal Revenue Service (IRS) • The amount received in advance can be adjusted (up to maximum allowed) by consumers within their accounts • Also referred to as the Advanced Payment of the Premium Tax Credit (APTC) • The amount consumers save will be the same no matter how much consumers use medical services	• Limit the plan's maximum costs, i.e., deductibles, coinsurance or copayments • Eligibility is determined by the IRS • Consumers cannot adjust the amount of savings they receive • The total amount consumers save will depend on how often they use medical services covered in their plan

For further information, proceed to Section 3.2.3.5, Options to Lower Health Plan Costs, to discuss the financial impacts of these programs.

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1.2 Medicaid/CHIP Eligibility

If consumers or household members are eligible for Medicaid or CHIP, complete the following steps to explain their eligibility determinations:

Step 5. Review whether consumers are assessed or determined to be eligible for Medicaid or CHIP. Exhibit 69 highlights the differences between an assessment and a determination of eligibility.

Exhibit 69 – Eligibility Assessment vs. Determination

Consumers Who are Assessed as Potentially Eligible for Medicaid/CHIP	Consumers Who are Determined Eligible for Medicaid/CHIP
• Although consumers may be eligible for Medicaid or CHIP, their state Medicaid agencies make final determinations. • Consumers' state Medicaid/CHIP agencies may follow-up with them to collect additional information, if needed. • Consumers' state Medicaid/CHIP agencies will notify them about the results of final determinations and next steps. • In some states, Medicaid coverage may apply back to three months prior to the month of application.	• Consumers have been determined eligible for Medicaid or CHIP and no further eligibility determinations are needed. • Consumers' state Medicaid/CHIP agencies will notify them about next steps. • In some states Medicaid coverage may apply back to three months prior to the months of application.

Step 6. Provide the contact information for the state Medicaid/CHIP agency. See SOP-12 Refer to State Medicaid/CHIP to facilitate communication between consumers and their state agencies, regardless of whether or not they submitted their applications through the State or Marketplace.

1.3 Ineligibility

Consumers may question why the Marketplace has found them ineligible to participate in the Marketplace or for programs to lower costs of health coverage. Exhibit 70 provides potential reasons the Marketplace may find consumers ineligible.

Exhibit 70 – Reasons for Ineligibility

Reason	Explanation
Coverage through Medicaid/CHIP	Consumers who have Medicaid or CHIP can generally purchase a qualified health plan in Marketplace, but they will not be eligible for premium tax credits or cost-sharing reductions.
Insufficient Information	Consumers have not provided sufficient documentation to support information in their applications within the time frame specified by the Marketplace
Extension Period Non-Existent	Consumers have not applied for, or were denied an extension of, time in which to provide sufficient documentation to support information in their applications

If consumers think that they ineligible due to an error discuss the following options:

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- Making an account update, see SOP-2 Update Account Profile.
- Filing an eligibility appeal, see SOP-16 Request Eligibility Appeal.

D Next Steps

1. If consumers and/or others on their application are found ineligible, determine their needs:
    - Proceed to SOP-16 Request Eligibility Appeal if the eligibility determination is final.
    - Proceed to SOP-3 Report Life Changes if consumers need to report life changes such as marriage, change in residence, change in income, etc.

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SOP-9. Compare Health Plans (Without an Account)

A Introduction

The Marketplace allows consumers to compare the full range of QHP options, including estimated premium amounts. This SOP provides guidance on how to assist consumers who do not have accounts with comparing QHP options available through the Marketplace. Topics include:

> If consumers are eligible for Medicaid or CHIP, direct them to their State Medicaid or CHIP agency for information about available health insurance options.

- **Consumer Education** (Section B) provides guidance to educate consumers about the health insurance and options to lower costs available through the Marketplace. If consumers understand their health insurance options, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Compare QHPs – Provides guidance on the activities associated with the plan comparison process, including:
    - Screening Questions: How initial screening questions impact consumers' QHP options.
    - Comparison Methods: How consumers can sort and filter QHP options.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

Based on the consumers' level of familiarity with the Marketplace and available coverage options, provide more detailed information about the following topics before proceeding to the next section:

- Affordable Care Act (3.2.2)
- Essential Health Benefits (3.2.3.2)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility Requirements (3.2.3.9)

> Encourage consumers to create an account and complete an electronic application for a robust plan comparison experience.

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C Procedures

1. Compare QHPs

Consumers have different ways to compare plans, depending on where the consumers are in the process of applying for health coverage. If consumers have not created an account, they may view and compare some health plan options. However, until they submit applications, consumers may not select health plans.

Exhibit 71 provides more detailed information on the plan comparison options available to consumers during the application process.

Exhibit 71 – Consumer Account Status and Plan Compare Functions

Consumer Account Status	Plan Comparison Functions	Potential Next Steps
No Account	• View plans • Compare plans • Print plans • Download plans Note: The displayed cost of coverage depends on the information provided by the consumer, and thus it may not be accurate.	1. To save plan options, proceed to SOP-1 Create Account. 2. To see full eligibility and plan costs, proceed to SOP-5 Apply for Health Coverage and submit an application to receive eligibility results.

1.1 Plan Comparison Functions

While consumers may view and compare general plan information, the actual plan costs will not be available without submitting applications and receiving eligibility determinations. Review the available plan information with consumers.

If consumers are interested in more detailed plan information, or believe they may be eligible for more coverage options (like Medicaid, CHIP, premium tax credits, or cost-sharing reductions), encourage them to create accounts and/or to begin eligibility applications. To create accounts or begin applications, proceed to SOP-1 Create Account or SOP-5 Apply for Health Coverage

If consumers choose to proceed without accounts, explain the available plans and costs depend on general criteria. More specific criteria are available after consumers complete applications and receive eligibility determinations.

The following factors will have an effect on consumers' available QHPs and costs:

- Residency
- Current health coverage
- Age
- Family size
- Income
- Tobacco use

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1.2 Screening Questions

Ask consumers what is important to them when making decisions about health coverage (such as cost or dental benefits). Assist consumers with answering questions about their health coverage preferences to tailor the plan comparison results. Explain that the responses to the questions affect which QHPs, and their associated costs, are displayed. Exhibit 72 lists the information requested form consumers for plan comparison.

Exhibit 72 – Information Collected for Plan Compare without an Account

Information Collected	Required (Y/N)
ZIP code	Y
County name	If Needed
Number of family members seeking coverage	Y
Dates of birth for family members	Y
Estimated household Income (income range)	Y
Availability of employer sponsored coverage	Y
Recent tobacco use for each family member	Y

1.3 Comparison Methods

After consumers answer their screening questions, help them to compare the tailored plans using the plan compare tool. Instruct consumers on how to use the tool to customize their views and refine QHPs to reflect those plans that best meet their needs.

Filtering & Sorting

The Marketplace sorts plans by the lowest to highest premium, although consumers may rearrange QHPs by other criteria, such as maximum out-of-pocket costs.

> Never steer consumers to choose specific plans.

Consumers may also filter QHPs to show only QHPs that meet additional criteria listed in Exhibit 73. Review the descriptions with consumers and identify the filtering options that are most important to them.

Exhibit 73 – Filtering Options

Relevance to Consumer	Filtering Option	Description
Consumers want to view only those plans that cover 70% or more of their health care costs.	Health Plan Categories	Assignment of plan categories designated by cost and coverage of medical expenses: Bronze, Silver, Gold, Platinum, and Catastrophic *(e.g., Platinum covers more health expenses than Bronze, but is more expensive).*

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Relevance to Consumer	Filtering Option	Description
Consumers are interested in viewing only those plans that can offer savings to consumers.	Cost-Sharing Reduction Available	Plans with special CSRs.
Consumers are concerned about monthly costs.	Premium Price Range	Price range that consumers pay for their QHPs
Consumers want to view only those plans that have a certain deductible amount or lower.	Annual Deductible	The required amount consumers must pay before their health insurance begins to cover health care costs
Consumers receive a lot of health care each year, and are concerned about their out-of-pocket costs.	Out-of-Pocket Maximum	The maximum amount consumers will have to pay under a health plan per year
Consumers are seeking to enroll only in a plan that offers dental coverage.	Dental Coverage	Dental care is covered under the health plan
Consumers are concerned with flexibility of access to providers inside and outside of a network.	Doctor Choice/Plan Type	Types of provider access, such as Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Point of Service (POS) HMOs require that consumers receive most or all of health care from a single network provider. PPOs contract with a “network” of preferred providers and consumers have the ability to select from whom to receive care under the network.
Consumers request a plan by name.	Insurance Provider	Health care company providing health coverage to consumers
Consumers have chronic medical conditions that require coordinated management.	Medical Management Programs	The medical management programs available by QHP *(e.g., asthma, diabetes, etc.)*
Consumers are interested in coverage in multiple states.	Multistate Network Availability	Health care provider’s health services availability spans across multiple states

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Relevance to Consumer	Filtering Option	Description
Consumers are considering enrolling in an HDHP.	Health Savings Account (HSA) Eligible	Tax-advantaged medical savings account available to consumers who are enrolled in a high-deductible health plan (HDHP) The funds contributed to the account are not subject to federal income tax at the time of deposit.

1.3.1 Side-by-Side Comparison

Consumers may make direct plan to plan comparisons using the side-by-side function. Exhibit 74 lists the attributes available to consumers for side-by-side comparisons.

Exhibit 74 – Comparing Coverage and Benefits

Comparison Category	Information Displayed
General Information	• Estimated premium amount • Deductible • Maximum annual out of pocket costs • Dental coverage
Costs for Medical Care	• Primary care provider • Specialist • Referrals needed • Labs and outpatient services • Professional Services • X-Ray services • Emergency room visits • Inpatient surgery • Hearing aids • Eye exam & glasses for children • HSA eligible • CSR eligible • Medical loss ratio
Prescription Drug Coverage	• Generic drug • Preferred brand drug • Specialty drugs • Non-preferred brand • List of covered drugs
Health Plan Quality	• Accreditation status • Member satisfaction survey data • Additional quality information
Coverage Examples	• Displays cost scenarios for pregnancy and diabetes
Adult Dental	• Routine dental care • Major care • Orthodontics • Dentist directory

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Comparison Category	Information Displayed
Child Dental	• Dental check-up • Basic care • Major care • Orthodontia • Dentist directory
Medical Management Programs	• Asthma • Heart disease • Depression • Diabetes • High blood pressure/high cholesterol • Low back pain • Pain management • Pregnancy • Weight management
Other Services	• Acupuncture • Chiropractic • Infertility service • Mental health outpatient • Mental health inpatient • Habilitative services • Outpatient rehabilitative services • Bariatric services • Skilled nursing • Private-duty nursing

If consumers request plans that include their health provider(s), prescription drugs, etc., direct them to the following resources for additional information about the QHPs:

- Plan websites
- Individual plan provider directories
- Summaries of Benefits & Coverage (SBC) Disclosure

D Next Steps

1. If consumers wish to have more accurate information available on their plan comparison view, proceed to SOP-1 Create Account.
2. If consumers wish to enroll in Medicaid/CHIP, proceed to SOP-12 Refer to State Medicaid/CHIP Agency.

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SOP-10. Compare Health Plans (Without Eligibility Determination)

A Introduction

The Marketplace allows consumers to compare the full range of QHP options, including estimated premiums and other costs. This SOP provides guidance on how to assist consumers who have created accounts, but have not received eligibility determinations, with comparing their QHP options. Topics include:

- **Consumer Education** (Section B) provides guidance to educate consumers about the health coverage and their options to lower their health plan costs through the Marketplace. If consumers understand their health coverage options, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Comparing QHPs: Provides guidance on the activities associated with the plan comparison process, including:
    - Screening Questions: How initial screening questions impact the QHP options displayed to the consumer.
    - Comparison Methods: How different means of comparison can facilitate QHP selection.

> Direct consumers to their state Medicaid or CHIP agencies for information about their available health coverage options.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

Based on the consumers' level of familiarity with the Marketplace and available coverage options, provide more detailed information about the following topics before proceeding to the next section:

- Affordable Care Act (3.2.2)
- Qualified Health Plans (3.2.3.1)
- Essential Health Benefits (3.2.3.2)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility Requirements (3.2.3.9)

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C Procedures

1. Comparing QHPs

Step 1. Receive consent to assist consumers.

Step 2. Assist consumers with comparing the available QHPs.

Consumers have different ways to compare plans, depending on where consumers are in the process of applying for health coverage. Consumers can compare plans at any point in their application process.

Exhibit 75 provides more detailed information on the plan comparison options available to consumers during the application process.

> Encourage consumers to create an account and complete an application for a robust plan comparison experience.

Exhibit 75 – Consumer Status and Plan Compare Functions

Consumer Account	Plan Comparison Functions	Potential Next Steps
Unverified Accounts	• View plans • Compare plans • Print plan comparisons • Download plan comparisons • **Save plan comparisons** Note: The displayed cost of coverage depends on the information provided by consumers, and thus it may not be accurate.	1. To select a plan for enrollment, complete identity verification process and create a full account, proceed to SOP-1 Create Account. 2. To see full eligibility, plan costs, and options to lower health plan costs, proceed to SOP-5 Apply for Health Coverage and submit an application to receive eligibility results.
Verified Account	• View plans • Compare plans • Print Plan Comparisons • Download Plan Comparisons • **Save Plan Comparisons** • **Save Plan Selections (if eligibility results available)**	1. To enroll in a plan, proceed to SOP-5 Apply for Health Coverage and submit an application to receive eligibility results.

2. Plan Comparison Functions

Step 1. Explain the plan comparison options to consumers:

While consumers may view and compare general plan information, complete information on their available health coverage options (e.g., actual costs, options to lower health plan costs) will not be available before consumers receive their eligibility determinations.

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If consumers are interested in more detailed plan information, or believe they may be eligible for more coverage options (like Medicaid or CHIP), encourage them to verify their accounts and/or to complete the eligibility process. To verify accounts or begin eligibility applications, proceed to SOP-1 Create Account or SOP-5 Apply for Health Coverage.

If consumers choose to proceed without accounts, explain the available plans and costs depend on general criteria. More specific criteria are available after consumers receive eligibility determinations.

The following are key factors in plan availability and cost:

- Completion and processing of the application
- Residency
- Current health coverage
- Age
- Family Size
- Income
- Tobacco use

3. Screening Questions

Step 1. Determine what is important to consumers in selecting their health plans.

Ask consumers what is important to them when making decisions about health coverage (such as cost or dental benefits). Assist consumers with answering questions about their health coverage preferences to tailor the plan comparison results based on the answers provided. Exhibit 76 lists the information collected.

Exhibit 76 – Information Collected for Plan Compare without Eligibility Results

Applicant Screening Questions	Required (Y/N)
Premium tax credit amount (Use all, some, or none)	N
Recent tobacco use	Y
Need for dental coverage	Y
Number of health plans needed (number of enrollment groups)	N

4. Comparison Methods

Once consumers have answered their screening questions, help them to compare the tailored plans using the plan compare tool. Instruct consumers on how to use the tool to customize their views and refine QHPs to reflect those plans that best meet their needs.

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Filtering & Sorting

The Marketplace initially sorts plans from the lowest to highest premium, though consumers may rearrange QHPs by other criteria, such as maximum out-of-pocket costs. Review the information below with consumers and identify the filtering options that are most important to them.

> Never steer consumers to choose specific plans.

Exhibit 77 – Filtering Options

Filtering Option	Description	Relevance to Consumer
Health Plan Categories	Assignment of plan categories designated by cost and coverage of medical expenses: Bronze, Silver, Gold, Platinum, and Catastrophic *(e.g., Platinum covers health expenses at a higher percentage than Bronze, but is more expensive)*	Consumers want to view only those plans that cover 70% or more of their health care costs.
Cost-Sharing Reduction Available	Plans with special CSRs	Consumers are interested in viewing only those plans that can offer cost-sharing reductions.
Premium Price Range	Price range that consumers pay for his/her QHP	Consumers are concerned about monthly costs.
Annual Deductible	The required amount consumers must pay before their health coverage begins to cover health care costs	Consumers want to view only those plans that have a certain deductible amount or lower.
Out-of-Pocket Maximum	The maximum amount consumers will have to pay under a health plan per year	Consumers receive a lot of health care each year, and have concerns about costs.
Dental Coverage	Dental care is covered under the health plan	Consumers are seeking to enroll only in plans that offer dental coverage.
Doctor Choice/Plan Type	Types of provider access, such as Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) and Point of Service (POS) HMOs require that consumers receive most or all of health care from a single network provider. PPOs contract with a “network” of preferred providers and consumers have the ability to select from whom to receive care under his/her network.	Consumers have concerns about the flexibility of access to providers inside and outside of a network.
Insurance Provider	Health care company providing health coverage to t consumers	Consumers request a plan by name.

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Filtering Option	Description	Relevance to Consumer
Medical Management Programs	The medical management programs available by QHP *(e.g., asthma, diabetes, etc.)*	Consumers have chronic medical conditions that require coordinated management.
Multistate Network Availability	Health care provider's health services availability spans across multiple states	Consumers are interested in coverage in multiple states.
Health Savings Account (HSA) Eligible	Tax-advantaged medical savings account available to consumers who are enrolled in a high-deductible health plan (HDHP) The funds contributed to the account are not subject to federal income tax at the time of deposit	Consumers are considering enrolling in an HDHP.

4.1 Side-by-Side Comparison

Consumers may make direct plan to plan comparisons using the side-by-side function. Exhibit 78 lists the attributes available to consumers for side-by-side comparisons.

Exhibit 78 – Comparing Coverage and Benefits

Comparison Category	Information Displayed
General Information	• Estimated premium amount • Deductible • Maximum annual out of pocket costs • Dental coverage
Costs for Medical Care	• Primary care provider • Specialist • Referrals needed • Labs and outpatient services • Professional Services • X-Ray services • Emergency room visits • Inpatient surgery • Hearing aids • Eye exam & glasses for children • HSA eligible • CSR eligible • Medical loss ratio
Prescription Drug Coverage	• Generic drug • Preferred brand drug • Specialty drugs • Non-preferred brand • List of covered drugs
Health Plan Quality	• Accreditation status • Member satisfaction survey data • Additional quality information
Coverage Examples	• Displays cost scenarios for pregnancy and diabetes

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Comparison Category	Information Displayed
Adult Dental	• Routine dental care • Major care • Orthodontics • Dentist directory
Child Dental	• Dental check-up • Basic care • Major care • Orthodontia • Dentist directory
Medical Management Programs	• Asthma • Heart disease • Depression • Diabetes • High blood pressure/high cholesterol • Low back pain • Pain management • Pregnancy • Weight management
Other Services	• Acupuncture • Chiropractic • Infertility service • Mental health outpatient • Mental health inpatient • Habilitative services • Outpatient rehabilitative services • Bariatric services • Skilled nursing • Private-duty nursing

If consumers request a plan that includes their health provider(s), prescription drugs, etc., direct them to the following external resources for additional information about the QHPs:

- Plan websites
- Individual plan provider directories
- Summaries of Benefits & Coverage (SBC) Disclosure

D Next Steps

1. If consumers are interested in more detailed information, encourage them to create accounts and/or to begin eligibility applications and proceed to SOP-1 Create Account.
2. If consumers wish to enroll in QHPs, proceed to SOP-5 Apply for Health Coverage.
3. If consumers wish to enroll in Medicaid/CHIP, proceed to SOP-12 Refer to State Medicaid/CHIP Agency.

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SOP-11. Compare, Save & Select Health Plans (With Eligibility Determination)

A Introduction

The Marketplace allows consumers to compare the full range of QHP options, including estimated premiums and other health care costs. This SOP provides guidance on how to assist consumers, with eligibility determinations, to compare QHP options available through the Marketplace. Topics include:

- **Consumer Education** (Section B) provides guidance to educate consumers about health coverage and their options to lower their health plan costs through the Marketplace. If consumers understand their health coverage options, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Selecting Premium Tax Credit – Provides guidance on adjusting premium credit to the available QHPs.
  - Comparing QHPs – Provides guidance on the activities associated with the plan comparison process, including:
    - Screening Questions: How initial screening questions impact the QHP options displayed to the consumer.
    - Comparison Methods: How different means of comparison can facilitate QHP selection.

> Direct consumers to their State Medicaid or CHIP agency for information about available plans if they qualify for Medicaid or CHIP.

B Consumer Education

Before assisting consumers, assess consumers' general understanding using Manual Section 3.1, Consumer Assessment.

Based on the consumers' level of familiarity with the Marketplace and available coverage options, provide more detailed information about the following topics before proceeding to the next section:

- Affordable Care Act (3.2.2)
- Qualified Health Plans (3.2.3.1)
- Essential Health Benefits (3.2.3.2)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility Requirements (3.2.3.9)

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C Procedures

1. Selecting Premium Tax Credit

If consumers are eligible for a premium tax credit, the system will prompt them to set the tax credit amount before viewing their QHP options. Assist consumers with setting their tax credit amounts. The setting that consumers choose at this stage is not permanent; however, when consumers view and compare their QHPs, the Marketplace will reduce premium amounts according to the amount they select. At any time before enrolling in a plan, consumers may adjust their premium credit amounts.

Step 1. Explain that opting to take more or less premium tax credit assistance may affect the amount that consumers owe on their tax returns. Note that the default setting for the premium tax credit is 100% of the eligible amount.

Step 2. Select the premium tax credit amount.

Step 3. Clarify that it is important to adjust the selected amount immediately, if there is a change in circumstances. Exhibit 79 provides an explanation of the tax consequences that consumers might encounter.

Exhibit 79 – Premium Tax Credit Tax Consequences

Scenario		Tax Consequence
Consumers elect *lower* premium tax credits than the maximum allowed AND their annual household incomes are *less than* projected for the tax year.	→	Consumers may receive the remaining discount as a tax refund.
Consumers elect *lower* premium tax credits than the maximum allowed OR their annual household incomes are *less than* projected for the tax year.	→	Consumers may receive the remaining discount as a tax refund.
Consumers elect the *maximum allowed* premium tax credits AND household income is *more than* consumers projected for the tax year.	→	Consumers may owe taxes.
Consumers elect the *maximum allowed* premium tax credits OR their annual household incomes are *more than* consumers projected for the tax year.	→	Consumers may owe taxes.

2. Comparing QHPs

Consumers have different ways to compare plans, depending on where consumers are in the process of applying for health coverage. Consumers can compare plans at any point in the application process.

Exhibit 80 provides more detailed information on the plan comparison options available to consumers during the application process, once they have received their eligibility results.

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Exhibit 80 – Consumer Status and Plan Compare Functions

Consumer Account Status	Plan Comparison Function	Potential Next Steps
Verified Account with Eligibility Determination	• Compare plans • Save a plan comparison • Save a plan selection • **Select a plan for enrollment**	1. To enroll in a plan, direct consumers to SOP-13 Pay Health Plan Premium to pay their health plan premium and begin their health coverage.

2.1 Plan Comparison Function

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

- Completion and processing of the application
- Residency
- Current health coverage
- Age
- Family size
- Income
- Tobacco use

2.2 Screening Questions

Ask consumers what is important to them when making decisions about health coverage (e.g., cost or dental benefits). Assist consumers with answering questions about their health coverage preferences to tailor the plan comparison results based on the answers provided. Explain that the responses to the questions tailor the QHPs and the costs displayed. Exhibit 81 lists the information provided.

Exhibit 81 – Information Collected for Plan Compare with Eligibility Results

Applicant Screening Questions	Required (Y/N)
Family Size	N
Family Grouping	N
CSR Only Plans	N
Tobacco Use	Y
Dental Coverage	N

2.3 Comparison Methods

Once consumers answer the screening questions, help them to compare the tailored plans using the plan compare tool. Instruct consumers on how to use the tool to customize their views and refine QHPs to reflect those plans that best meet their needs.

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Filtering & Sorting

The Marketplace initially sorts plans from the lowest to the highest premium amount, although consumers may rearrange QHPs by other criteria, such as maximum out-of-pocket costs.

> Never steer consumers to choose specific plans.

Consumers may also filter QHPs to narrow the results to only display plans that meet the additional criteria. Exhibit 82 specifies the various filtering options available to consumers for customizing their QHP lists. Review the descriptions with consumers and identify the filter options that are most important to them.

Exhibit 82 – Filtering Options

Filtering Option	Description	Relevance to Consumer
Health Plan Categories	Assignment of plan categories designated by cost and coverage of medical expenses: Bronze, Silver, Gold, Platinum, and Catastrophic *(e.g., Platinum covers health expenses at a higher percentage than Bronze, but is more expensive)*	Consumers want to view only those plans that cover 70% or more of their health care costs.
Cost-Sharing Reduction Available	Plans with special CSRs	Consumers are interested in viewing only those plans that can offer cost-sharing reductions.
Premium Price Range	Price range that consumers pay for his/her QHP	Consumers are concerned about monthly costs.
Annual Deductible	The required amount consumers must pay before their health coverage begins to cover health care costs	Consumers want to view only those plans that have a certain deductible amount or lower.
Out-of-Pocket Maximum	The maximum amount consumers will have to pay under a health plan per year	Consumers receive a lot of health care each year, and are concerned about their costs.
Dental Coverage	Dental care is covered under the health plan	Consumers are seeking to enroll only in a plan that offers dental coverage.
Doctor Choice/Plan Type	Types of provider access, such as Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) and Point of Service (POS) HMOs require that consumers receive most or all of health care from a single network provider. PPOs contract with a “network” of preferred providers and consumers have the ability to select from whom to receive care under their network	Consumers are concerned with flexibility of access to providers inside and outside of a network.

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Filtering Option	Description	Relevance to Consumer
Insurance Provider	Health care company providing health coverage to consumers	Consumers request a plan by name.
Medical Management Programs	The medical management programs available by QHP *(e.g., asthma, diabetes, etc.)*	Consumers have chronic medical conditions that require coordinated management.
Multistate Network Availability	Health care provider's health services availability spans across multiple states	Consumers are interested in coverage in multiple states.
Health Savings Account (HSA) Eligible	Tax-advantaged medical savings account available to consumers who are enrolled in a high-deductible health plan (HDHP). The funds contributed to the account are not subject to federal income tax at the time of deposit	Consumers are considering enrolling in an HDHP.

2.3.1 Side-by-Side Comparison

Consumers may make direct plan to plan comparisons using the side-by-side function. Exhibit 83 lists the attributes available to consumers for side-by-side comparisons.

Exhibit 83 – Comparing Coverage and Benefits

Comparison Category	Information Displayed
General Information	• Estimated premium amount • Deductible • Maximum annual out of pocket costs • Dental coverage
Costs for Medical Care	• Primary care provider • Specialist • Referrals needed • Labs and outpatient services • Professional services • X-Ray services • Emergency room visits • Inpatient surgery • Hearing aids • Eye exam & glasses for children • HSA eligible • CSR eligible • Medical loss ratio
Prescription Drug Coverage	• Generic drug • Preferred brand drug • Specialty drugs • Non-preferred brand • List of covered drugs
Health Plan Quality	• Accreditation status • Member satisfaction survey data • Additional quality information
Coverage Examples	• Displays cost scenarios for pregnancy and diabetes

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Comparison Category	Information Displayed
Adult Dental	• Routine dental care • Major care • Orthodontics • Dentist directory
Child Dental	• Dental check-up • Basic care • Major care • Orthodontia • Dentist directory
Medical Management Programs	• Asthma • Heart disease • Depression • Diabetes • High blood pressure/high cholesterol • Low back pain • Pain management • Pregnancy • Weight management
Other Services	• Acupuncture • Chiropractic • Infertility service • Mental health outpatient • Mental health inpatient • Habilitative services • Outpatient rehabilitative services • Bariatric services • Skilled nursing • Private-duty nursing

If consumers request a plan that includes their health provider(s), prescription drugs, etc., direct them to the following external resources for additional information about the QHPs:

- Plan websites
- Individual plan provider directories
- Summaries of Benefits & Coverage (SBC) Disclosure

2.3.2 QHP Selection

After consumers have reviewed and compared their available QHP options, they may select plans to enroll in for themselves and/or their family members.

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D Next Steps

1. If consumers wish to pay their health plan premium, proceed to SOP-13 Pay Health Plan Premium.
2. If consumers wish to enroll in Medicaid/CHIP, proceed to SOP-12 Refer to State Medicaid/CHIP Office.

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SOP-12. Refer to State Medicaid/CHIP Office

A Introduction

The Marketplace allows consumers to apply for private insurance coverage, as well as Medicaid and/or CHIP. Consumers may require assistance from their Medicaid or CHIP Agencies. Other times, consumers may need assistance from other consumer assistance programs (CAP). This SOP provides guidance on referring consumers to the appropriate resource.

Navigators should make a referral in the following cases:

- Consumers are eligible for Medicaid or CHIP and are seeking assistance with enrollment.
- Consumers are eligible for Medicaid or CHIP and need assistance while determinations are pending.
- Consumers are enrolled in other public benefits programs and require assistance.

Topics in this SOP include:

- **Consumer Education** (Section B) provides guidance on general health insurance concepts, the Medicaid and/or CHIP eligibility process, and the eligibility process for premium tax credits and cost-sharing reductions. If consumers understand the referral process, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Refer Consumers to State Medicaid and/or CHIP – provides guidance on referring consumers to their respective state Medicaid or CHIP agency.
  - Declining Medicaid or CHIP – provides guidance on educating consumers about the consequences of declining Medicaid or CHIP benefits.
  - Refer Consumes to Other Assistance Programs – provides guidance on referring consumers to external assistance programs.

B Consumer Education

Before assisting consumers with referrals to their State Medicaid and/or CHIP agencies, assess consumers' general understanding of health insurance concepts and the eligibility process for state health programs based on Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with the health insurance concepts and the eligibility process for state health programs, provide more detailed information (as needed) on the following topics before proceeding to the next section:

- Health Coverage (3.2.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility Requirements (3.2.3.9)

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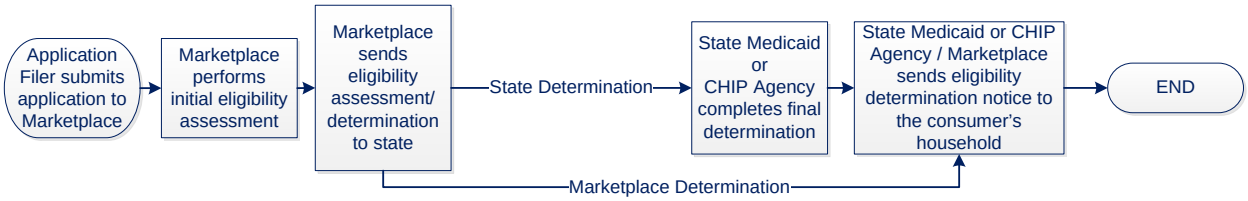
Consumers may be eligible for the Medicaid and/or CHIP programs at different stages of the eligibility and enrollment process. In some states, the Marketplace can make a final determination of consumers' eligibility for Medicaid and/or CHIP. In other states, however, the Marketplace can make only an initial finding, or an *assessment*, of eligibility for Medicaid and/or CHIP. Exhibit 84 lists the type of consumers that you may refer to Medicaid and/or CHIP. Exhibit 85 illustrates the Medicaid and/or CHIP eligibility determination process.

Exhibit 84 – Types of Medicaid and/or CHIP Consumers Requiring Assistance

Type of Consumer	Description
Assessed as potentially eligible	Consumers *assessed by the Marketplace* as potentially eligible for Medicaid and/or CHIP; final determination is made by the state Medicaid or CHIP agencies
Determined eligible	Consumers who are *determined by the Marketplace* as eligible for Medicaid and/or CHIP.
Enrolled in Medicaid and/or CHIP	Consumers *already enrolled* in Medicaid and/or CHIP

Exhibit 85 – Medicaid and/or CHIP Eligibility Determination Process



If consumers wish to contest their eligibility determinations, they can choose to file appeals. To provide consumers with assistance filing appeals, refer to SOP-16 Request Eligibility Appeal.

C Procedures

1. Refer Consumers to State Medicaid and/or CHIP Offices

To review consumers' Medicaid and/or CHIP eligibility and refer them to their state Medicaid and/or CHIP agencies, complete the following steps:

Step 1. Receive consent to assist consumers.

Step 2. Review consumers' eligibility determination notices to find if they are eligible for Medicaid and/or CHIP. Exhibit 86 lists the information in the eligibility determination notices.

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Exhibit 86 – Contents of Eligibility Determination Notice

Contents of Eligibility Determination Notice
Applicant(s) eligible for Medicaid or CHIP
Applicant(s)' eligibility status (assessment or determination)
Reason for the referral
Outstanding verification issues (if any)
Note that the state Medicaid or CHIP agency contacts the applicant(s) with more information about benefits and services
Contact information for the state Medicaid or CHIP agency • Phone number • Address • E-mail address

Step 3. Review the eligibility status and determine if the contact information for the Medicaid/CHIP agencies are on the notices.

Step 4. If eligibility determination notices do not provide enough information, direct consumers to contact their local Medicaid or CHIP agencies.

Step 5. Refer consumers to the state Medicaid or CHIP agencies by providing the contact information and instructions for requesting additional assistance.

> As appropriate, facilitate the consumers' calls with the state Medicaid or CHIP agencies.

2. Declining Medicaid and/or CHIP

If consumers who are found eligible for Medicaid or CHIP communicate that they would rather enroll in QHPs, explain that they may decline Medicaid and/or CHIP benefits; however, they are not be eligible for premium tax credits and cost-sharing reductions for enrollment in a QHP through the Marketplace.

If consumers want to decline coverage for everyone on their application, assist them with updating their applications to indicate they don't want help paying for health coverage. Then, proceed through the rest of the application. If consumers want to decline coverage for only one person on the applications, assist them with removing those persons from their applications and submit separate, applications for those persons who want QHP coverage without using premium tax credits or cost-sharing reductions.

3. Referring Consumers to Assistance Programs

Consumers may have questions about benefits through programs outside of the ones described in this manual. For instance, consumers might receive benefits from the Ryan White HIV/AIDS program or have questions about their benefits through the Social Security Administration or Veterans Affairs. To help consumers with questions about programs outside the Marketplace,

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you should create your own directory of local programs that may be useful to consumers in your area.

In addition, you may refer consumers to the Consumer Assistance Program (CAP). CAP is administered by the federal government and is available in some states to help consumers understand their rights in the Marketplace.

D Next Steps

1. If consumers are determined as ineligible for Medicaid and/or CHIP and believe that they are eligible, refer to the appropriate state agency or SOP-16 Request Eligibility Appeal.
2. If consumers' eligibility for Medicaid or CHIP is pending the state's determination, inform them that the state will provide a final determination to consumers. The timeline for the state's determination varies from state to state.

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SOP-13. Pay Health Plan Premium

A Introduction

After selecting QHPs, the Marketplace will redirect consumers to their QHPs' websites or to call the QHPs directly to make premium payments. Online payment is optional, and not every insurance company will accept online payment. If consumers choose not to make online payments, or the insurance companies do not offer online payments, the Marketplace will inform the insurance company of consumers' preferences. The insurance companies will then send billing statements to consumers. This SOP provides guidance on how to assist consumers with making premium payments once they have selected QHPs.

Before providing premium payment assistance, you must understand how to properly handle consumers' financial payment information (e.g., bank account, debit cards, credit cards). Exhibit 87, below specifies appropriate and inappropriate activities related to assisting consumers with premium payments.

Exhibit 87 – Premium Payment Assistance Do's and Don'ts

Do	Don't
• Assure consumers that the Marketplace will protect their financial information. • Encourage consumers to enter their own financial information. • Assist consumers with entering their financial information only if they request assistance. • Return financial information to consumers immediately. • Turn computers to face consumers to keep information private.	• **DO NOT** ask consumers for their financial information. • **DO NOT** make copies of consumers' financial information. • **DO NOT** share consumers' information with anyone. • **DO NOT** use consumers' financial information for personal gain.

Topics in this SOP include:

- **Consumer Education** (Section B) provides a description of general health coverage concepts and premium payments. .
- **Procedures** (Section C) details instructions for the following:
  - Make a Premium Payment – Provides guidance on how to complete payments for consumers' health plan premiums.

> The Marketplace redirects consumers to the QHPs' websites for payment after they select plans.

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B Consumer Education

Before assisting consumers with making their premium payments, assess consumers' general understanding of the Marketplace and general health coverage concepts based on the Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with premium payments and general health insurance concepts, provide more detailed information (as needed) about the following topics before proceeding to the next section:

- Health Coverage (3.2.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Post-Enrollment (3.2.3.11)

C Procedures

1. Make a Premium Payment

If consumers understand the need to make a premium payment and the available payment options, proceed with the following steps to complete a premium payment:

> Do not enter or handle consumers' payment methods (e.g., credit card information).

Step 1. Receive consent to assist consumers.

Step 2. Go to consumers' "Enroll To Do List" to view their selected QHPs.

Step 3. Determine how consumers would like to make payments:

a. Pay online/electronically

b. Mail payments to insurance companies

> Direct consumers to the health insurance company for further assistance in updating financial information.

Step 4. If consumers wish to make electronic payments, direct consumers to the insurance companies' websites, and complete the following steps:

a. Explain to consumers that their enrollment in QHPs is not complete until the insurance companies receive the first premium payments.

b. Instruct consumers to follow the prompts on the insurance companies' websites to complete electronic payments.

c. Be available to consumers for general questions about paying their premiums.

> Insurance companies must accept many methods of payment, even if consumers do not have bank accounts or credit cards.

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d. Remind consumers to always log out of the insurance companies' websites after making their premium payments.

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

a. Explain to consumers that their enrollment in QHPs is not complete until the insurance companies receive the first premium payments.

b. Direct consumers to the insurance companies' call center to request additional billing information (for those not paying online, the insurance companies will not receive their selections until the end of the day, so it may be a day or two before the consumers' selections show up in the insurance companies' systems).

c. Be available to consumers for general questions about making premium payments.

D Next Steps

1. If consumers do not have their payment information (e.g., credit card or bank account routing info), provide consumers with instructions to access the insurance companies' websites.
2. If consumers update their payment information successfully, inform them that consumers may make future updates with the insurance companies via the websites or call centers.
3. If consumers have questions or issues with making a payment, refer them to their health insurance companies.

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SOP-14. Renew Health Coverage

A Introduction

The Marketplace allows consumers to renew their enrollment in QHPs through the Marketplace with the help of a Navigator. This SOP provides guidance on how to assist consumers with their annual redeterminations and completing the renewal process. Topics include:

- **Consumer Education** (Section B) provides guidance on general health insurance concepts, the eligibility and enrollment process, and specific criteria for various health coverage options.
- **Procedures** (Section C) provides detailed instructions for renewing enrollment in a QHP.

B Consumer Education

Before assisting consumers with renewing their enrollment in QHPs through the Marketplace, assess consumers' understanding of general health insurance concepts and the eligibility and enrollment process based on Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with general health insurance concepts and the eligibility and enrollment process, provide more detailed information (as needed) on the following topics before proceeding to the next section:

> Explain that monthly health plan premiums may have changed from the last benefit year.

- Health Coverage (3.2.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Eligibility Application (3.2.3.8)
- Eligibility Requirements (3.2.3.9)

If consumers wish to change QHPs or update their account information, proceed to the "Mid-Year Changes" tab in the application. Explain that making account updates may affect their eligibility determination.

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C Procedures

> Renewal notices will be available in 2014. Please reference this section when it becomes available.

1. Renew Health Coverage

2. Annual Redetermination Review

The exhibit below lists sample information that may be included in the annual redetermination notice for consumers.

Exhibit 88 – Annual Redetermination Notice

Summary Information	Details
New income data	• Updated income data (if available)
Other eligibility information in Marketplace records	• The information in consumers' most recent eligibility determination
Eligible programs	• QHP o APTC o CSR • Medicaid/CHIP
Availability of QHPs	• If current QHP is available in upcoming year • Other QHP options
Next steps	• Request to report changes

2.1 Renewal

If the Marketplace finds consumers eligible during the annual redetermination, they may confirm their reenrollment in QHPs.

2.1.1 Electronic Renewal Assistance

> This renewal process does not apply to Medicaid or CHIP renewals.

Step 1. Receive consent to assist consumers.

Step 2. Explain to consumers that an annual renewal notice is automatic.

Step 3. Ask consumers to log in to their accounts and navigate to the renewal notices.

Step 4. Review the notices with consumers.

Step 5. Explain to consumers that they should update their eligibility applications with any new information about themselves, or their households; or, if no information has changed and they wish to continue their coverage as is, no action is needed.

Step 6. Consumers log out of their accounts.

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2.1.2 Renewal Assistance via Mail

If consumers request assistance with responding to a renewal notice via mail, follow the steps below:

Step 7. Receive consent to assist consumers.

Step 8. Explain to consumers that an annual renewal notice is automatic.

Step 9. Review the notices with consumers.

Step 10. Explain to consumers that they should update their eligibility applications with any new information about themselves, or their households; or, if no information has changed and they wish to continue their coverage as is, they can sign and return the notices.

Step 11. Provide consumers with the appropriate mailing information to submit their renewal notices to the Marketplace.

D Next Steps

1. If consumers wish to change QHPs or update QHP coverage options, proceed to "Mid-Year Changes" tab in the application.
2. If consumers would like to complete an exemption application, proceed to SOP-15 Apply for Exemption.
3. If consumers would like to file an appeal request, proceed to SOP-16 Request Eligibility Appeal.

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SOP-15. Apply for Exemption

A Introduction

The Marketplace allows consumers to apply for an exemption from the individual responsibility requirement. This SOP provides guidance to assist consumers in completing their exemption application. Topics include:

- **Consumer Education** (Section B) provides guidance on the reasons consumers might file an exemption. If consumers understand the reasons to complete an exemption application, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Paper Exemption Application – Provides guidance on assisting consumers with the completion of a paper exemption application, details on submitting supporting documentation, and mailing options.

B Consumer Education

Prior to starting the exemption application process, assess consumers' understanding of the health care law and what types of exemptions are available, based on Manual Section 3.1, Consumer Assessment.

Based on consumers' understanding of these concepts, provide them with additional information on the following topics, as needed, before proceeding to the next section:

- Health Coverage (3.2.1)
- Affordable Care Act (3.2.2)
- Exemptions (3.2.2.5)
- Eligibility Application (3.2.3.8)

C Procedures

Determine if consumers would like to proceed with the electronic or paper exemption application, and advance to the corresponding section of this SOP.

1. Paper Exemption Application

To assist consumers with the paper exemption application, complete the following steps:

Step 1. Receive consent to assist consumers.

Step 2. Assist consumers with completing the paper application.

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a. If consumers have brought a previously started exemption application, proceed to the section in the application where assistance is required.

Step 3. If consumers have not started an application, provide them with a paper exemption application and help them complete the application with the required information.

Step 4. Discuss with consumers the next steps for providing supporting documentation, if required.

a. Explain that consumers must mail in copies of all necessary supporting documentation for the Marketplace to verify the documentation.

Step 5. Provide consumers with the address to mail the exemption application. You may not mail applications for consumers.

D Next Steps

1. After consumers submit their exemption applications, explain to consumers that the Marketplace will notify them about the status of their exemption.
2. If consumers do not receive an exemption, assist them with applying for health coverage by referring to SOP-1 Create Account.

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SOP-16. Request Eligibility Appeal

A Introduction

The Marketplace allows consumers to submit requests for appeals with the help of a Navigator. This SOP provides guidance on how to assist consumers with submitting an appeal request. Topics include:

- Consumer Education – Provides guidance on general health care concepts and the Marketplace eligibility process. If consumers understand these concepts, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Request Appeal: Provides guidance on how to complete appeal requests.
  - Review Appeal Notices: Provides guidance on the various types of notices consumers may receive relating to appeal requests.

B Consumer Education

Before assisting consumers with submitting appeal requests, assess consumers' general understanding of health insurance concepts and the Marketplace eligibility process based on Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with the health insurance concepts and the Marketplace eligibility process, provide more detailed information (as needed) about the following topics before proceeding to the next section:

- Health Coverage (3.2.1)
- Affordable Care Act (3.2.2)
- Exemptions (3.2.2.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Eligibility Application (3.2.3.8)
- Appeals (3.2.3.12)

C Procedures

1. Request Appeal

Determine if consumers would like to proceed with appeal requests, and advance to the appropriate section below.

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1.1 Appeals Request

Step 1. Receive consent to assist consumers.

Step 2. Determine if consumers have previously started appeal requests.

a. If consumers have brought previously started appeal requests, proceed to the section where assistance is required.

b. If consumers do not have existing appeal requests, encourage consumers to complete electronic appeal requests. Refer to SOP-1 Create Account if consumers wish to complete electronic appeal requests.

c. If consumers would still like to complete paper appeal requests, follow the format provided on the paper appeal requests.

Step 3. Discuss the next steps for providing supporting documentation, if required.

a. Explain that consumers can mail in all necessary supporting documentation to be reviewed by the appeals worker, or

b. Explain that consumers can scan and upload the required documentation by creating accounts. Consumers may create an account from home or with the Navigator's assistance. Refer to SOP-1 Create Account, if consumers require assistance.

Step 4. Provide consumers with the address to mail appeal requests, if needed. You may not mail appeal requests for consumers.

1.2 Update Appeal Case File

Consumers may need to update their appeal case file for multiple reasons. Review the list provided in Exhibit 89 to explain to consumers why they might need to update their appeal files.

Exhibit 89 – Reasons to Update an Appeal Case File

Update Reason	Description
Supporting Documentation	Consumers may wish to submit supporting documentation for complete appeal request submissions.
Eligibility/Appeals Case Record Request	Consumers may request paper copies of their eligibility or appeals case records.
Request a Hearing	Consumers may decide to request hearings if they disagree with their informal resolution decisions.
Reschedule Hearing	Consumers may reschedule hearings due to conflicts by contacting Appeals Support.
Withdraw Appeals Request	Consumers may wish to withdraw their appeal requests.
Request Special Accommodations	Consumers may request special accommodations (e.g., translation services, TTY).

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Update Reason	Description
Designate Authorized Representative	Consumers may designate authorized representatives to act on their behalf throughout the appeals process.
Request to Vacate Dismissal	Consumers may request to reopen dismissed cases.

2. Review Appeal Notices

Consumers may receive various notices during the appeal process. Exhibit 90 lists the potential notices and the corresponding descriptions.

Exhibit 90 – Appeal Notices

Notice Type	Description
Appeal Acknowledgment	Notice explaining the appeal request has been received
Informal Resolution Decision	Notice explaining the outcome of an informal resolution
Dismissal	Notice explaining why the appeal has been dismissed
Notice of Hearing	Notice explaining a hearing request has been received and details on the hearing (e.g., format, date, and time)
Appeal Decision	Notice explaining the outcome of the hearing
Ad Hoc Notices	Notice providing the appellant with information not included in the above notices
Vacate Dismissal	Notice explaining whether an appellant demonstrated 'good cause' to reopen an appeal

D Next Steps

1. Assist consumers with reviewing their appeal notices in response to their appeal requests.

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5.0 Small Business Employee SOPs

The SOPs contained in this section provide guidance to assist small business employees who select their health coverage through their employer the SHOP market. Employees of an employer may request assistance in reviewing and enrolling in the QHP and QDP selected by their employer. This section lists SOPs in the order of the eligibility and enrollment process.

SOP-17. Create Employee Account 125
SOP-18. Update Employee Account or Application 129
SOP-19. Apply for Employee Health Coverage 132
SOP-20. Review Employee Eligibility Determination 134
SOP-21. Renew Employee Health Coverage 136
SOP-22. Request Employee Eligibility Appeal 138

SOP-17. Create Employee Account

A Introduction

The Marketplace allows small business employees to enroll in QHPs offered by their employers. This SOP provides guidance on how to assist employees with creating accounts so that they may enroll in QHPs. Topics include:

- **Employee Education** (Section B) provides guidance on the Affordable Care Act, health insurance concepts, and the benefits of creating an account. If employees understand the value of creating an account and the process involved, proceed to Section C.
- **Procedures** (Section C) provides detailed instructions for the steps required to create an account.

B Employee Education

Before assisting employees with creating accounts, assess the employees' general understanding of the Affordable Care Act and health coverage based on the Manual Section 3.1, Consumer Assessment.

Based on the employees' level of familiarity with the Affordable Care Act and health coverage, provide more detailed information on the following topics before proceeding to Section C:

- Affordable Care Act (3.2.2)
- Health (3.2.1)
- Affordable Care Act (3.2.2)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)
- Eligibility Requirements (3.2.3.9)

C Procedures

1. Create Account

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

Step 1. Receive consent to assist employees.

Step 2. Assist employees with entering the following

> Consumers may change their passwords at any time, but consumers cannot change their usernames. If consumers need additional password or username assistance, direct them to the call center.

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information:

a. First name

b. Last name

c. E-mail (required to create an account)

d. Username (required to create an account)

e. Password (required to create an account)

f. Four Security Questions (required to create an account)

Step 3. Explain to employees that they must answer security questions to protect their accounts from unauthorized access.

Step 4. Inform employees that they must verify their e-mail addresses within 48 hours to activate their accounts.

a. If employees wish to verify their e-mail addresses immediately, assist them with accessing their e-mail accounts.

Step 5. If employees would like to submit Marketplace applications, designate authorized representatives, or enroll in their job-based QHPs, assist consumers with providing the following additional information:

a. Physical Address (required to process an eligibility application)
   i. Street
   ii. City
   iii. State
   iv. ZIP code
   v. Apartment number

b. Mailing address

c. Social Security Number

d. Date of birth (required to process an eligibility application)

e. Phone number (required to process an eligibility application)

Step 6. Assist employees (as necessary) with completing “challenge questions” to validate their identities. Explain that the identity validation process generates “real-time” questions based on submitted PII to verify that employees are who they say they are.

a. If identity validation is successful, follow the system prompts to assist employees in retrieving their login information to begin the application process.

b. If identity validation is unsuccessful, proceed to Step 7.

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Step 7. Inform employees that they must validate their identities before they can receive final eligibility determinations or designate authorized representatives. Direct them to the call center to complete identity validation.

a. If identity validation is successful, follow the system prompts to assist employees in retrieving their login information to begin the application process.

b. If identity validation is unsuccessful, proceed to Step 8.

Step 8. Inform employees that they must submit supporting documentation to the Marketplace to complete the identity verification process. Consumers can submit the following documents, so long as they have photos or other identifying information:

a. Driver's license issued by a state or territory

b. School identification card

c. Voter registration card

d. U.S. military card or draft card

e. Identification card issued by the federal, state, or local government, (e.g., a U.S. passport)

f. Military dependent's identification card

g. Native American or Tribal document

h. U.S. Coast Guard merchant mariner card

Step 9. If consumers cannot submit the documents listed above, they may submit two items from the documents listed below to complete the verification process:

a. Birth certificate

b. Social Security card

c. Divorce decree

d. Employer identification card

e. High school or college diploma

f. Property deed or title

2. Troubleshooting

You may encounter error messages while assisting employees with the account creation process. Exhibit 91 provides reasons for errors encountered and steps to take to assist employees in resolving them.

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Exhibit 91 – Encountered Account Errors and Action Items

Error/Condition	Explanation & Discussion	Action Items
Message indicating an account already exists for that user	• Explain that if the employee has previously created an account, it is stored in the Marketplace, and the employee can access the account with the correct login information; *employees can create only one account*. • Explain that if consumers enter information in error, the flawed information may be redundant.	Assist employees to determine their correct login information or review the entered information with them to ensure that it is correct and not redundant with an existing account.
Message indicating that an account cannot be successfully created with the information entered	• Explain that the Marketplace requires consumers to enter certain information enter that the information in a valid format. • Explain that the system identifies each piece of information that it deems missing or invalid so that consumers can corrected it. • Explain that the employee has the option to cancel the account creation activity.	Walk employees through each piece of information that the system has deemed missing or invalid and help them correct the information or show them how to cancel the entire account creation activity.

D Next Steps

1. Educate employees on how to manage their accounts.
2. If employees would like assistance with the application process, proceed to SOP-19 Apply for Employee Health Coverage.
3. If employees would like to perform account maintenance activities (i.e., password reset, designate an authorized representative), educate employees on how to manage their account and proceed to SOP-18 Update Employee Account or Application.
4. If employees would like to view their health care options in the Individual Marketplace, refer to SOP-5 Apply for Health

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SOP-18. Update Employee Account or Application

A Introduction

The Marketplace allows the employee to update their account information with the help of the Navigator. This SOP provides guidance on assisting employees and/or their authorized representative(s) in updating an account after their application has been completed and submitted. Topics include:

> Employees may update their account at any time.

- **Employee Education** (Section B) provides guidance on employee eligibility for enrollment, options to lower health plan costs, and types of account updates, including which updates may impact the employees' eligibility. If employees understand which type of update they would like to make, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Update Account– Provides guidance on updating information within the employees' account, including:
    - Account Holder(s)
    - Authorized Representative(s)
  - Report Life Changes-Provides guidance on reporting changes to employees' information that may affect their eligibility to enroll in a job-based QHP.

B Employee Education

Before assisting employees with updating their accounts, assess employees' general understanding of the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employees' level of familiarity with the Marketplace, provide more detailed information on the following topics (as needed) before proceeding to the next section:

- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)
- Eligibility Requirements (3.2.3.9)

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C Procedures

1. Update Account

1.1 Account Holder(s)

To make account changes related to primary account holders and secondary account holders, identify who and what information needs to be updated and proceed to the corresponding sections of the account to make the changes. Exhibit 92 details potential updates by type of account holder.

Exhibit 92 – Information Updates by Account Holder Role

Account Holder	Information Available for Update
Primary Account Holder	Identify if the primary account holder requires updates to the following: • Name • Password • Security screening questions (TBD) • Address (TBD) • Mailing address (if different, TBD) • Contact numbers • E-mail • Preferred spoken and written languages • Communication preference (e-mail, Postal Service)
Secondary Account Holder	Identify if a secondary account holder requires addition or modification. • Designate secondary account holder status to other filers associated with the employee's application (if necessary). • Select access level for each secondary account holder.

1.2 Authorized Representative(s)

If the employee would like to add/modify an authorized representative, refer to Exhibit 93 for further information.

Exhibit 93 – Updates to authorized representatives

Authorized Representative Updates
• Designate an individual as an authorized representative • Modify authorized representative status.

2. Report Life Changes

> Reporting life changes is mandatory.

To assist employees in reporting new life event, proceed with the following steps:

Step 1. Go to the employee's Report a Change page.

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Step 2. Review the list of available changes in circumstance with consumers by referring to Exhibit 94.

Exhibit 94 – Life Changes

Life Event	Potential Updates
Residency change	• Report a change in address/residency
Marriage status	• Report marriage • Report divorce
Indian status	• Report a change in Indian status/Tribal membership
Add a child	• Report a new child to receive coverage under QHP
Loss of coverage	• Seek to add coverage outside of the open enrollment period

Step 3. After consumers select the appropriate changes, follow the system logic to make the account updates.

Step 4. Verify and review the list of required supporting documentation with employees, if needed.

a. If documents are required and employees have the supporting documentation, upload it to their account.

b. If documents are required and employees do not have the documentation to upload, provide the deadlines to submit any and all documents.

> The system returns a list of the supporting documents required by account update type. Depending on the account updates made, the Marketplace returns an itemized list of both previously uploaded documents and documents that still require uploading.

D Next Steps

1. If supporting documentation is required and employees do not currently have the documentation, educate employees on providing supporting documentation at a later time.
2. If the account updates result in a redetermination, review the employees' eligibility determination.

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SOP-19. Apply for Employee Health Coverage

A Introduction

The Marketplace allows employees to apply for health coverage in a QHP with the help of the Navigator. This SOP provides guidance to assist employees in completing their eligibility application. Topics include:

> An application is only available to employees if their employer elects to participate in SHOP and the employer identifies them as an employee on the employer's roster.

- **Employee Education** (Section B) provides guidance on general health insurance concepts and the Marketplace eligibility and enrollment process. It also offers guidance on the SHOP Marketplace application process and details for completing the employee application. If employees have an understanding of the application process, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Electronic Eligibility Application – Provides guidance to assist employees with completing the paper eligibility application.

B Employee Education

Before assisting employees with applying for health coverage, assess employees' general understanding of health insurance and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employees' level of familiarity with the health insurance concepts and the Marketplace eligibility and enrollment process, provide more detailed information about the following topics before proceeding to Section C:

- Health Coverage (3.2.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)

C Procedures

Proceed to the appropriate section below to assist employees with their eligibility applications.

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1. Electronic Eligibility Application

To assist employees with the electronic eligibility application, complete the following steps:

Step 1. Receive consent to assist employees.

Step 2. Determine if employees have previously started their eligibility applications online.

a. If employees have previously started and saved their eligibility applications, determine where assistance is required and proceed to that section of the application. Ensure that employees complete all fields accurately.
b. If employees do not have an existing application, assist them with beginning a new application. Follow the system logic with the employees' responses to the information requested. Ensure that employees complete all the required fields accurately.

Step 3. Save or submit the eligibility application.

a. Inform employees that they may save and resume their eligibility applications to submit at a later date during their enrollment period.
b. Assist employees with submitting their eligibility applications to request eligibility results.

D Next Steps

1. If employees are not ready to submit their application, explain that employees may save their electronic eligibility applications for up to 90 days and resume the application at a later point in time.

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SOP-20. Review Employee Eligibility Determination

A Introduction

The Marketplace allows employees to review their eligibility determinations for health coverage through their accounts or mailed eligibility notices, with the help of the Navigator. This SOP provides guidance on how to assist employees in understanding their eligibility determination. Topics include:

- **Employee Education** (Section B) provides guidance on general health insurance concepts, the Marketplace, and the enrollment appeals process. If employees understand these factors, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Review Eligibility Determination – Explains the employees' eligibility determination.

B Employee Education

Before assisting employees with their eligibility determinations, assess employees' general understanding of the health insurance concepts and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employees' level of familiarity with health insurance concepts and the Marketplace, provide more detailed information (as needed) on the following topics before proceeding to the next section:

- Qualified Health Plans (3.2.3.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Enrollment (3.2.3.10)
- Appeals (3.2.3.12)

C Procedures

1. Review Eligibility Determination

1.1 QHP Eligibility

Review and explain the eligibility determination summary page or eligibility determination notice with employees.

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Exhibit 95 lists the information included on the eligibility summary page or notice for each applicant and non-applicant.

Exhibit 95 – Eligibility Summary

Summary Information	Explanation
Qualified Individual Name	• List of applicants and their eligibility for QHP
Eligibility Period	• Start date and end date of eligibility for each applicant

1.2 QHP Ineligibility

Employees may have questions about their ineligibility for health coverage through their employers. Exhibit 96 provides potential reasons as to why they may be ineligible.

Exhibit 96 – Reasons for Ineligibility

Reason	Explanation
Change in Employment Status	• Employer reports a change in the employee's employment status, deeming them ineligible for coverage in the QHP (i.e., no longer employed at company or change in full-time to part-time employment status)

If employees feel they are ineligible for coverage due to an error, discuss the following options:

- Updating account information. Refer to SOP-18 Update Employee Account or Application to assist employees.
- Requesting an eligibility appeal. Refer to SOP-22 Request Employee Eligibility Appeal.

> In 2014, employees only have one employer-sponsored QHP to select. However, after 2014, employees will have multiple QHPs to compare based on their employers' QHP selections.

D. Next Steps

1. If employees are eligible to enroll in their employers' QHP, explain to employees that they may select their employers' QHP for enrollment.

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SOP-21. Renew Employee Health Coverage

A Introduction

The Marketplace allows employees to renew their health coverage with the help of a Navigator. This SOP provides guidance on how to assist employees in understanding the Marketplaces annual redetermination process and renewing their health coverage. Topics include:

- **Employee Education** (Section B) provides guidance on general health coverage concepts, the Marketplace, and the eligibility criteria for various health care options.
- **Procedures** (Section C) provides detailed instructions for completing a health plan renewal.

B Employee Education

Before assisting employees with renewing their health coverage, assess employees' general understanding of health insurance and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employees' level of familiarity with health insurance and the Marketplace, provide more detailed information (as needed) on the following topics before proceeding to the next section.

- Health Coverage (3.2.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Eligibility Requirements (3.2.3.9)

If employees wish to change QHPs or their account information, follow guidance in SOP-18 Update Employee Account or Application. Explain to employees that certain changes to their account may affect their eligibility determination.

C Procedures

1. Renew Employee's Health Care Coverage

1.1 Annual Redetermination Review

Review the electronic or paper annual redetermination notices with employees.

Exhibit 97 lists the information included in the annual redetermination notice for each applicant.

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Exhibit 97 – Notice Redetermination Eligibility Summary

Summary Information	Details
Eligible Programs	Applicants eligible for health coverage
Eligibility Period	Start and end date

1.2 Renewal

If employees are eligible for their QHP during the annual redetermination, they will receive a renewal notice to inform them of their eligibility.

1.2.1 Electronic Renewal Assistance

Step 1. Receive consent to assist employees.

Step 2. Explain to employees that the annual redetermination is automatic and they are automatically renewed into their current QHPs, if the QHPs are still available

Step 3. If employees elect to change their current QHP, ask employees to log in to their accounts and navigate to the renewal notice.

Step 4. Follow the system logic to assist employees in completing the required information and submitting the renewal notice.

D Next Steps

1. If employees wish to update their account information, proceed to SOP-18 Update Employee Account or Application.
2. If employees wish to file an appeal request, proceed to SOP-22 Request Employee Eligibility Appeal.

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SOP-22. Request Employee Eligibility Appeal

A Introduction

The Marketplace allows employees to appeal denials of their eligibility determinations. This SOP provides guidance on how to assist employees with submitting an appeals request. Topics include:

- **Employee Education** (Section B) provides guidance on general health insurance concepts, the Marketplace, and the appeals process. If employees understand these concepts, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Request Appeal – Provides guidance on how to complete an eligibility appeal request.
  - Review Appeal Notices – Provides guidance on the various types of notices that employees may receive relating to an appeal request.

B Employee Education

Before assisting employees with appealing their eligibility determinations, assess employees' general understanding of health insurance concepts and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on consumers' level of familiarity with general health insurance concepts and the eligibility and enrollment process, provide more detailed information on the following topics before proceeding to the next section:

- Qualified Health Plans (3.2.3.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Enrollment (3.2.3.10)
- Appeals (3.2.3.12)

C Procedures

1. Request Appeal

Employees may not need background information on the appeal request process and may be ready to submit their appeals request. Determine if employees would like to continue with their appeal requests, and advance to the corresponding section of this SOP.

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1.1 Paper Appeals Request

Step 1. Receive consent to assist employees.

Step 2. Determine if employees have previously started the appeal request.

a. If the employees bring a previously started appeal request form, proceed to the section where assistance is required.
b. If the employees would still like to complete a paper appeal request, follow the format provided.

Step 3. Discuss the next steps for providing supporting documentation, if required.

a. Explain that the employees must mail in all necessary supporting documentation to the Marketplace, or
b. Explain that if they would like to scan and upload the required documentation, they need to create an account. The employees may create an account from home or with the Navigator's assistance. Refer to SOP-17 Create Employee Account if employees require assistance.

> Explain to employees that they must submit appeal requests within 90 days after they receive an eligibility determination notice.

Step 4. Provide the employees with the address for mailing the eligibility appeal request. You may not mail appeal requests for consumers.

1.2 Electronic Appeal Request

Step 5. Receive consent to assist employees.

Step 6. Determine if employees have previously started the appeal request.

a. If employees have previously started and saved their appeal requests, proceed to the section where assistance is required. Ensure that employees complete all fields accurately.
b. If employees do not have existing appeal requests, assist employees with initiating the appeals request. Assist the employees with entering the requested information. Ensure that employees complete all fields accurately.

> Electronic appeal requests will not be available on October 1, 2013. Please reference this section when it becomes available.

Step 7. Assist employees with scanning and uploading supporting documentation.

a. If employees have supporting documentation to complete, assist them with scanning and uploading the documents. Be sure to return all original documents to consumers

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b. If employees do not have the supporting documentation to scan and upload, explain that they may upload the documents at a later date.
   i. Scan and upload documents from home, or
   ii. Return to the Navigator with the supporting documentation to scan and upload the documents with assistance.

Step 8. Save or submit the appeal request.

a. Inform the employees that if they choose to save their appeal requests for a later date, they have up to 90 days from the date of their eligibility determination to submit an appeal request.
b. Assist employees with submitting their appeal requests.

1.3 Updating an Appeal Case File

Employees may need to update their appeal case file for multiple reasons. Review the list provided in Exhibit 98 to explain to employees why they might need to update their appeal file.

Exhibit 98 – Reasons to Update an Appeal Case File

Update Reason	Description
Supporting Documentation	Employee may need to submit supporting documentation.
Withdraw Appeals Request	Employee may wish to withdraw their appeal request.
Authorized Representative	Employee may designate an authorized representative to act on their behalf throughout the appeals process.
Request to Reopen Dismissed Case	Employee may request to reopen a dismissed case.
Eligibility/Appeals Case Record Request	Employee may request a paper copy of their eligibility or appeals case record.

2. Review Appeal Notices

Employees may receive various notices from the Appeals Worker during their appeal request process. Exhibit 99 lists the different notices available and corresponding descriptions.

Exhibit 99 – Appeal Notices

Notice Type	Description
Appeal Decision	Notice explaining the outcome of your appeal request
Appeal Acknowledgment	Notice explaining the appeal request has been received
Dismissal	Notice explaining why the appeal has been dismissed
Ad Hoc Notices	Notice providing the appellant with information not included in the above notices
Vacate Dismissal	Notice explaining whether an appellant demonstrated ‘good cause’ to reopen the case

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D Next Steps

1. If employees wish to submit an appeal request electronically, but do not have an account, proceed to SOP-17 Create Employee Account.
2. If employees have received an appeal notice, refer to the appropriate appeals notices listed above in Section C (2).

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6.0 Small Business Employer SOPs

The SOPs in this section provide guidance to help small business employers apply for and select their QHP to offer their full-time employees through the SHOP Marketplace. Employers may need help with identifying, comparing, and selecting a QHP for their employees. This section lists SOPs in the order of the eligibility and enrollment process.

SOP-23. Create Employer Account 143
SOP-24. Update Employer Account or Application 147
SOP-25. Apply for Employer Participation in the SHOP Marketplace 150
SOP-26. Compare Employer Plans & Elect Plan 152
SOP-27. Review Employer Eligibility Determination 157
SOP-28. Make Employer Premium Payment 160
SOP-29. Renew Employer Participation in the SHOP Marketplace 163
SOP-30. Request Employer Eligibility Appeal 165

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SOP-23. Create Employer Account

A Introduction

The Marketplace allows employers to create an account to participate in the SHOP Marketplace and offer health insurance to their employees with the help of a Navigator. This SOP provides guidance on how to assist employers with creating an account. Topics include:

- **Employer Education** (Section B) provides guidance on the Affordable Care Act, health insurance concepts, and the benefits of creating an account. If employers understand the value of creating an account, proceed to Section C.
- **Procedures** (Section C) provides instructions on the steps required to create an account.

B Employer Education

Before assisting employers, assess their general understanding using Manual Section 3.1, Consumer Assessment.

Based on employers' level of familiarity with the Affordable Care Act and health insurance, provide more detailed information on the following topics before proceeding to the next section.

- Health Coverage (3.2.1)
- Affordable Care Act (3.2.2)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)
- Eligibility Requirements (3.2.3.9)

C Procedures

1. Create Account

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

Step 1. Receive consent to assist employers.

Step 2. Assist employers with entering the following information:

a. First name

b. Last name

> Consumers may change their passwords at any time, but they may not change their usernames. If consumers need additional password or username assistance, direct them to the call center.

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c. E-mail (required to create an account)

d. Username (required to create an account)

e. Password (required to create an account)

f. Four security questions (required to create an account)

Step 3. Explain that employers must answer security questions to protect their accounts from unwanted access.

Step 4. Inform employers that they must verify their e-mails within 48 hours to activate their accounts.

a. If employers wish to verify their e-mails immediately, assist them with accessing their e-mail accounts.

> Once employers have activated their accounts, they may begin Marketplace applications, or browse QHP options. If they wish to submit an application or select and enroll in a plan, the system will prompt employers to provide additional account information.

Step 5. If employers would like to submit Marketplace applications, or select a QHP, assist employers with providing the following additional information:

a. Physical address (required to process an eligibility application)
   i. Street
   ii. City
   iii. State
   iv. ZIP code
   v. Apartment number

b. Mailing address

c. Social Security Number

d. Date of birth (required to process an eligibility application)

e. Phone number (required to process an eligibility application)

Step 6. Assist employers (as necessary) with completing "challenge questions" to validate their identity. Explain that the identity validation process generates real-time questions based on employers' PII to verify that employers are who they say they are.

a. If employers are unable to answer their challenge questions, direct them to contact the call center for assistance.

b. After employers have successfully answered their challenge questions, they will be able to submit Marketplace applications.

c. Follow the system prompts to assist employers in retrieving their log-in information to begin the application process.

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Step 7. Inform employees that they must validate their identities before they can receive final eligibility determinations or designate authorized representatives. Direct them to the call center to complete identity validation.

a. If employers are unable to answer their challenge questions, proceed to Step 7.

b. After employers have successfully answered their challenge questions, they will be able to submit Marketplace applications.

c. Follow the system prompts to assist employers in retrieving their login information to begin the application process.

Step 8. If employers are unable to answer the challenge questions, inform them that they may submit supporting documentation to the Marketplace before they can complete applications or designate authorized representatives. Employers can submit the following documents so long as they have photos or other identifying information:

a. Driver's license issued by a state or territory

b. School identification card

c. Voter registration card

d. U.S. military card or draft card

e. Identification card issued by the federal, state, or local government, (e.g., a U.S. passport)

f. Military dependent's identification card

g. Native American or Tribal document

h. U.S. Coast Guard merchant mariner card

Step 9. If employers cannot submit the documents listed above, they may submit two items from the documents listed below to complete the verification process:

a. Birth certificate

b. Social Security card

c. Divorce decree

d. Employer identification card

e. High school or college diploma

f. Property deed or title

2. Troubleshooting

Employers may encounter error messages while assisting employers in the account creation process. Exhibit 100 provides reasons for error messages and steps to assist employers with resolving the encountered errors.

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Exhibit 100 – Encountered Account Errors and Action Items

Error/Condition	Explanation & Discussion	Action Items
A profile already exists for that user	• Explain that if the employer has previously created an account, it is stored in the Marketplace, and they can access the account with the correct login information; *employers may only create one account.* • Explain that the employer may have entered information incorrectly which could have been linked to another account. • Explain that the employer's information may be associated with a family member's existing account, which will prevent the employer from applying for their own QHP.	Assist the employer to ensure that login information is correct and ensure there is not an existing account. Direct the employer to the call center to retrieve log-in information if an account does exist.
An account cannot be successfully created with the information entered	• Explain that the Marketplace requires employers to enter certain information in a valid format. • Explain that the system identifies each piece of information that it deems missing or invalid so that they can correct it. • Explain that employers have the option to cancel the account creation activity.	Walk employers through each piece of information that the system has deemed missing or invalid and help him/her to correct the information or show employers how to cancel the entire account creation activity.

D Next Steps

1. Explain how employers can update their accounts and proceed to SOP-24 Update Employer Account or Application if employers request assistance.
2. If employers would like help with the application process, proceed to SOP-25 Apply for Employer Participation in the SHOP Marketplace.

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SOP-24. Update Employer Account or Application

A Introduction

The Marketplace allows employers to update their account information with the help of the Navigator. This SOP provides guidance on how to help employers and/or their authorized representatives with updating their accounts.

- **Employer Education** (Section B) provides guidance on employer eligibility to participate in the SHOP Marketplace, and the types of account updates, including which updates may impact employers' eligibility. If employers understand which type of update they would like to make, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Update Account – Provides guidance on updating information within employers' accounts, including:
    - Roster Management
    - Change in Circumstances

B Employer Education

Before assisting employers, assess their general understanding using Manual Section 3.1, Consumer Assessment.

Based on employers' level of familiarity with the Marketplace, provide more detailed information on the following topics (as needed) before proceeding to the next section:

- Health Coverage (3.2.1)
- Health Insurance Marketplace (3.2.2.1)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)
- Eligibility Requirements (3.2.3.9)

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C Procedures

1. Update Account

1.1 Roster Management

To make account changes related to the employee roster, determine what information employers would like to modify and proceed to the corresponding sections of the account. Exhibit 101 details the information that employers may change.

Exhibit 101 – Changes to Employee Roster

Account Update	Information Available to Update
Employee Roster	• Update employees' information within roster - individually or in bulk via the web interface • Remove employees from roster – individually or in bulk via the web interface • Add new employee(s) to roster

1.1.1 Health Insurance Management

Employers may only make changes to their insurance options during open enrollment. To make account changes related to health insurance, identify what information employers would like to modify. Exhibit 102 lists the information that employers may change.

Exhibit 102 – Changes to Coverage Options

Account Update	Information Available to Update
QHP Coverage Options	Employer Contribution: • Dependent coverage • Enrollment periods • Responses to SEP requests • Benchmark plan sections • Dental coverage • COBRA coverage • Domestic partner coverage • New employee waiting period

1.2 Change in Circumstance

To assist employers in reporting a change in circumstance, proceed with the following steps:

Step 1. Explain to employers the three specific changes that qualify as changes in circumstance and how they may impact eligibility to participate in the

> Reporting changes in employee roster are mandatory. Note that employers may only report employee level changes (i.e. whether someone is on payroll or not) within employee roster—not "life changes."

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SHOP Marketplace. Exhibit 103 details the three possible qualifying updates.

a. Employers will not lose eligibility to participate in the SHOP Marketplace unless they no longer have employees.

Exhibit 103 – Eligibility Information Available for Update

Contributing Factor	Explanation
Work Location	If employers move out of a state prior to renewing their participation in the SHOP, the employers will not be eligible to participate in that state's SHOP Marketplace.
Employee Information	Employers can add or remove employees from their rosters. To maintain eligibility for SHOP participation, employers must continue to employ at least one employee.
Employee Coverage	Employers must offer coverage to all full-time equivalent employees

Step 2. Navigate to the appropriate sections of the account to make the requested updates.

D Next Steps

1. If the change results in a change to the employer's eligibility determination, proceed to SOP-26 Compare Employer Plans & Elect Plan.

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SOP-25. Apply for Employer Participation in the SHOP Marketplace

A Introduction

The Marketplace allows employers to submit an application to participate in the SHOP Marketplace with the help of the Navigator. This SOP provides guidance to help employers with completing their eligibility application. Topics include:

- **Employer Education** (Section B) provides guidance on general health insurance concepts and the Marketplace eligibility and enrollment process.
- **Procedures** (Section C) details instructions for the following:
  - Electronic Eligibility Application – Provides guidance to help employers with completing electronic eligibility applications and submitting supporting documentation.

B Employer Education

Before assisting employers with applying for health insurance for their employees, assess employers' understanding of health insurance and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employers' level of familiarity with the health insurance concepts and the Marketplace eligibility and enrollment process, provide more detailed information about the following topics before proceeding to Section C:

- Health Coverage (3.2.1)
- Health Insurance Marketplace (3.2.2.1)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)
- Eligibility Requirements (3.2.3.9)

C Procedures

1. Electronic Eligibility Application

To assist employers with electronic eligibility applications, complete the following steps:

Step 1. Receive consent to assist employers.

Step 2. Determine if employers have previously started eligibility applications online.

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a. If employers have previously started and saved their eligibility applications, determine where assistance is required and proceed to that section of the application. Ensure that employers complete all fields accurately.
b. If employers do not have an existing application, begin a new application. Follow the system logic with inputting the employers' responses to the information requested. Ensure that employers complete all fields accurately.

Step 3. Save or submit the eligibility application.

a. Inform employers that they may save and resume their eligibility applications to submit at a later date during the enrollment period.
b. Submit the eligibility application to request eligibility results.

D Next Steps

1. If employers are not ready to submit their applications, explain that they may save an electronic eligibility application and resumed at a later point in time prior to the 15th of the month. The enrollment deadline is always the 15th of the month prior to the coverage effective date.

2. If employers are determined eligible, proceed to SOP-26 Compare Employer Plans & Elect Plan.

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SOP-26. Compare Employer Plans & Elect Plan

A Introduction

Employers who have applied to participate in the Marketplace to offer health coverage to their employees may conduct a comparison of health plans and make a final plan election with the help of the Navigator. This SOP provides guidance on how to assist employers with QHP comparison and election. Topics include:

- **Employer Education** (Section B) provides guidance on general health insurance concepts, on the Marketplace, and on eligibility criteria for the SHOP Marketplace. If employers understand how the Marketplace determines their eligibility determination, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Comparing Plans – Provides guidance on the activities associated with the plan comparison process, including:
    - Employee Worksheet: Provides guidance on completing employee worksheet which will impact the types of plans available to offer to employees.
    - Comparison Methods: Explains how consumers can use different means of comparison to select a QHP. If employers know which plan they prefer, proceed to Plan Election.
  - Plan Election – Provides guidance on how to select a QHP for the employees.

B Employer Education

Before helping employers compare the available QHPs, assess employers' general understanding of the health insurance concepts and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employers' level of familiarity with general health insurance concepts and the Marketplace, provide more detailed information (as needed) about the following topics before proceeding to Section C:

- Health Coverage (3.2.1)
- Health Insurance Marketplace (3.2.2.1)
- Qualified Health Plans (3.2.3.1)
- Essential Health Benefits (3.2.3.2)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Account Creation & Maintenance (3.2.3.7)

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- Eligibility Requirements (3.2.3.9)
- Enrollment (3.2.3.10)
- Appeals (3.2.3.12)

C Procedures

1. Comparing Plans

To help employers compare QHP coverage options, assist employers with the plan compare tool.

Step 1. To understand how to tailor employers' plan comparison, ask what they need in a QHP.

Step 2. Begin the plan comparison.

a. Complete screening questions to tailor the view of offered plans.
b. Compare plans through sorting and filtering the results based on the employer's needs.

1.2 Employee Worksheet

Instruct employers to complete the employee worksheet before they begin the plan compare function. The employee worksheet helps employers describe their employees' health insurance needs to filter the available QHPs to suit their needs.

Exhibit 104 – Information Requested on Employee Worksheet

Information Requested	Description
Employee name	Name of each employee that will be offered job-based coverage
Date of birth	Date of birth for each employee offered job-based coverage (prepopulated from employee roster)
Accepting coverage?	Information on whether employees are opting to accept job-based coverage
Other coverage?	Information on whether employees have existing health coverage
Estimated age of spouse	Information on employees' marriage status and the age of employees' spouses
Estimated age of child(ren)	Information on employees' dependents and the estimated age of their dependents

1.3 Comparison Methods

Help employers filter and sort the available QHPs and refine the QHP list to reflect those plans that best meet their needs.

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1.3.1 Filtering & Sorting

Employers can filter the QHPs based on their employees' preferred coverage options. Exhibit 105 specifies the various filtering options available to employers to customize their QHP lists.

Exhibit 105 – Filtering Options

Filtering Options	Description	Relevance to Employee's Needs
Premium Price Range	Price range that employers pay monthly/annually for their QHPs	Employees are concerned about monthly/annual set costs
Issuer	Health care company providing health coverage to employees	Employees request a specific insurance company
Geographic Availability	The areas covered by the provider network	Employees need coverage in specific geographic locations
Plan Type	Types of provider access, including HMO, PPO, and POS	Employees want access to certain doctors
Medical and Dental Benefits	Medical or dental health insurance available for select plans	Employees need medical and/or dental health care
Prescription Drugs	Types of prescription drug coverage available for select plans	Employees need prescription drug coverage
Health Plan Categories	Platinum, Gold, Silver, and Bronze - Each category provides different levels of health expense coverage (e.g., Platinum covers health expenses at a higher percentage than Bronze, but is more expensive)	Employees use health services on a frequent basis, require more than preventive care, and may want a platinum plan

For sorting, show the employer how to view plans by lowest/highest average premium.

1.3.2 Save & Print

Regardless of the comparison method used, explain that any account holder may save the plan comparison so that they can easily recall their comparisons across multiple plans compare sessions and print their comparisons to view them offline.

2. Plan Election

To help employers with QHP enrollment, navigate to the Plan Election page.

Step 1. Receive consent to assist employers.

Step 2. Ask employers if they have:

a. Conducted comparing plan process
b. Saved plan comparison

> If employers do not set a contribution amount, the default percentage is set to 0%.

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c. Saved plan selection.

Step 3. Proceed with Plan Selection.

Step 4. Help employers with setting the amount they wish to contribute to the cost of the QHP.

a. Explain the contribution percentage to employers, noting that it can range from 0% (no employer contribution) to 100% as selected by employers.
b. Explain to employers that their employees will be able to view the contribution amount when employees select their health plans in the Marketplace.
c. Instruct employers to input a contribution amount.
d. Review the dollar amount of the contribution.

> Remind employers the Marketplace automatically sends a notification to employees on the employee roster when they make a contribution level change during an enrollment period.

Step 5. Proceed with a final review, and instruct employers to confirm the plan election and make updates as necessary.

a. When prompted to conduct a final review of the plan summary with all selected/saved customizations, explain all of the components of the QHP to ensure that employers have a clear understanding of their election. Exhibit 106 lists the elements included in the QHP confirmation summary.

Exhibit 106 – Confirmation Summary

Confirmation Summary Elements	Description
Proposed Effective Date	Start date of health insurance (pending receipt of payment)
Percent Contribution	Percent contribution to employees' (and dependents') health and dental plans
Dental Plan	Whether or not a standalone dental plan is offered; if dental coverage is not offered, dental contribution percentages are not displayed
Dependent Coverage	Whether or not dependent health insurance is offered; if coverage is not offered, dependent contribution percentages are not displayed
Domestic Partner Coverage	Whether or not same-sex or opposite-sex domestic partner coverage is offered
Plan Names & Type	Name of the elected plan and the plan type (e.g., PPO, HMO, etc.)

Step 6. Proceed to the Education tab with employers.

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a. Employers may use the Education tab to review plan information (e.g., coverage level, reference plan, and contributions) and make an informed decision about the plans offered to their employees.
b. Learning tools are available to employers under the Education tab. This material may help employers provide information to their employees and teach them how to set up employee accounts. Exhibit 107 provides a description of the learning tools available to employers.

Exhibit 107 – Learning Tools

Learning Tools	Description & Examples
Fact Sheets	Facts that may help employers understand their employee health insurance options and the implications for their businesses of these choices *(e.g., starting in 2014, the small business tax credit goes up to 50% (up to 35% for non-profits) for qualifying businesses.)*
Videos	Videos that may help employers understand their employee coverage options
Glossary of Terms	Definitions for terminology used throughout the Marketplace *(e.g., HMO, Health Maintenance Organization -- A form of health insurance combining a range of coverage on a group basis; a group of doctors and other medical professionals offer care through the HMO for a flat monthly rate with no deductibles.)*

D Next Steps

1. If employers select a QHP, explain that they will receive an e-mail notification from the Marketplace that they have completed a plan election.
2. If employers do not select a plan, explain how employers may select a plan at a later time.

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SOP-27. Review Employer Eligibility Determination

A Introduction

The Marketplace allows employers to review their mailed or electronic eligibility determination notice with the help of the Navigator. This SOP provides guidance on how to help employers understand their eligibility determination to participate in the SHOP Marketplace to provide health insurance to their employees. Topics include:

- **Employer Education** (Section B) provides guidance on health insurance concepts and Marketplace eligibility and enrollment processes. If employers understand these concepts, proceed to Section C.
- **Procedures** (Section C) provides detailed instructions for employers' eligibility determinations.

B Employer Education

Before helping employers with their eligibility determinations, assess their general understanding of health insurance concepts and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employers' knowledge of health insurance concepts and the Marketplace, provide more detailed information (as needed) on the following topics before proceeding to the next section:

- Qualified Health Plans (3.2.3.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Enrollment (3.2.3.10)
- Appeals (3.2.3.12)

C Procedures

1. Review Eligibility Determination

1.1 Eligibility to Participate in the SHOP Marketplace

Review and explain the eligibility determination summary page or notice with employers.

Exhibit 108 lists the information included on the eligibility summary page or notice for each applicant and non-applicant.

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Exhibit 108 – Eligibility Summary

Summary Information	Explanation
Qualified Employer Name	• Employer and Employee Names
Eligibility Period	• Start date and end date of eligibility for employees

1.2 Ineligibility to Participate in the SHOP Marketplace

Employers may have questions about why the Marketplace found them ineligible to participate in the SHOP Marketplace. Exhibit 109 provides potential reasons why employers may be ineligible.

Exhibit 109 – Ineligibility Reasons, Explanations & Action Items

Reason	Explanation	Action Item
Work location does not fall under the Marketplace service area	The work location for the employer is not in the Marketplace service area	• Inform employers that eligibility is contingent upon work location; update employers' work location under their account, if applicable.
Number of employees exceeds the state requirement	Employer exceeds the maximum number of employees set by their state	• Explain to employers that their state has a maximum of 50 employees and if they exceed this, they are not eligible for participation in the SHOP Marketplace. • Update the employer's number of employees in their account, if applicable.
Attestation was not provided	Employer failed to complete and/or submit an attestation	• Explain to employers that they are required to a complete an attestation that the business meets the requirements to participate in the SHOP Marketplace: o Located in a SHOP's service area o At least one common law employee o Fewer than 50 FTEs o Offer coverage to all FTEs • Help employers complete and/or submit their attestation, if applicable.

If employers think they are ineligible for coverage due to an error, discuss options for:

- Making an account update, or
- Filing an eligibility appeal.

> If employers are ineligible to participate in the SHOP, the employees will also be ineligible to participate in the SHOP.

D Next Steps

1. If employers are found ineligible, determine their 'employers' needs and either:
   - Proceed to SOP-30 Request Employer Eligibility Appeal if the eligibility determination is final.

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- Proceed to SOP-24 Update Employer Account or Application if the employers need to:
    i. Complete required application fields,
    ii. Provide supporting documentation, and/or
    iii. Report life changes.

2. If employers are eligible to participate in the Marketplace, determine the employers' needs and either:
    - Proceed to SOP-26 Compare Employer Plans & Elect Plan to enroll them into the SHOP Marketplace.
    - Proceed to SOP-24 Update Employer Account or Application to report the employer's change in circumstance.

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SOP-28. Make Employer Premium Payment

A Introduction

The Marketplace allows employers to make premium payments to their health insurance company. This SOP provides guidance on how to help employers make premium payments once they have selected the QHP to offer to their employees.

In 2014, employers may make their first premium payments through the SHOP Marketplace. Employers must make all subsequent payments directly to the insurance company.

Before providing premium payment assistance, the Navigator must understand how to properly handle employers' financial payment information (e.g., bank account, debit cards, credit cards). Exhibit 110 specifies both appropriate and inappropriate activities related to helping consumers with premium payments.

Exhibit 110 – Premium Payment Assistance Do's and Don'ts

Do	Don't
• Assure employers that their financial information is protected • Encourage employers to enter their own financial information • Assist employers with entering their financial information only if they request assistance • Return financial information to employers immediately • Turn computers to face consumers to keep information private.	• **DO NOT** ask employers for their financial information • **DO NOT** make copies of employers financial information • **DO NOT** share employers information with anyone • **DO NOT** use employers financial information for personal gain

Topics in this SOP include:

- **Employer Education** (Section B) describes the requirements for making monthly premium payments. If employers understand these concepts, proceed to Section C.
- **Procedures** (Section C) provides detailed instructions for completing a payment for the employers' health plan premium.

B Employer Education

Before assisting employers with making their premium payment(s), assess employers' general understanding of health insurance concepts and the Marketplace based on Manual Section 3.1:,Consumer Assessment.

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Based on employers' understanding of the requirement for making monthly premium payments, provide more detailed information (as needed) about the following topics before proceeding to the next section:

- Health Coverage (3.2.1)
- Post-Enrollment (3.2.3.11)

C Procedures

1. Make Employer Premium Payment

Assist employers with paying their health insurance premium by completing the following steps:

Step 1. Receive consent to assist employers.

Step 2. **Navigate to employers' Plan Election to view premium payment amount.**

Step 3. Determine how employers would like to make a premium payment. (The Premium issuer redirect is only available during initial setup.)

Step 4. If employers wish to make a premium payment using the insurance company's website, direct employers to access the insurance company's website and follow the payment instructions.

Step 5. If employers wish to access the Premium Aggregator to make a one-time payment, complete the following steps:

> The premium aggregator will not be available in 2014.

a. Navigate to the employer's health plan information within their account and review details:
   i. Premium amount
   ii. Frequency of payment (e.g., monthly)

b. Explain that employers must log in to the insurance company's website with a previously-established password.

c. Be available to answer general QHP premium questions for employers.

d. Remind employers to log out of the Premium Aggregator when they have finished making the premium payment.

D Next Steps

1. If employers do not have their payment information (i.e., credit card or bank account routing info), provide instructions on accessing their providers, the Premium Aggregator, or the SHOP employer call center at a later time.

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2. If employers update their payment information successfully, inform them they may make future updates with the insurance company via website or call center.
3. If employers have problems with providing their payment information, refer them to the insurance company's call center.

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SOP-29. Renew Employer Participation in the SHOP Marketplace

A Introduction

The Marketplace allows employers to renew their participation in the SHOP Marketplace and update their QHP selections with the help of a Navigator. This SOP provides guidance on how to help employers understand their annual redetermination and renewal of coverage application. Topics include:

- **Employer Education** (Section B) provides guidance on general health insurance concepts, on the Marketplace, and on the eligibility criteria for various health care options.
- **Procedures** (Section C) details instructions for completing a health plan renewal.

B Employer Education

Before assisting employers with renewing their health coverage, assess employers' general understanding of health insurance and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employers' level of familiarity with health insurance and the Marketplace, provide more detailed information (as needed) on the following topics before proceeding to the next section:

- Qualified Health Plans (3.2.3.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Enrollment (3.2.3.10)
- Post-Enrollment (3.2.3.11)

C Procedures

1. Renew Employer's Health Care Coverage

1.1 Annual Redetermination Review

Review the electronic or paper annual redetermination notice with employers. Exhibit 111 lists the information included in the annual redetermination notice for employers.

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Exhibit 111 – Notice Redetermination Eligibility Summary

Summary Information	Details
Qualified Employer Name	Name of employer
Eligibility Period	Start Date and End Date

If the employers receive a negative annual redetermination, explain that they may submit missing documentation or information.

1.2 Renewal

Eligible employers may respond to their renewal notice through their accounts after the Marketplace completes the annual redetermination.

1.2.1 Electronic Renewal Assistance

Step 1. Receive consent to assist employers.

Step 2. Explain that employers must respond to a renewal notice to move forward with the same health care plan as the previous year, if available.

Step 3. Log into the employers' account and navigate to the renewal notice.

Step 4. Follow the system logic to help employers in complete the required information and submit the electronic renewal application.

Step 5. Log out of the employers' account

D Next Steps

1. If employers wish to update their QHP coverage options, proceed to SOP-24 Update Employer Account or Application.
2. If employers wish to change the QHP they offer to their employees, proceed to SOP-26 Compare Employer Plans & Elect Plan.
3. If employers would like to file an appeal request, proceed to SOP-30 Request Employer Eligibility Appeal.

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SOP-30. Request Employer Eligibility Appeal

A Introduction

The Marketplace allows employers to submit a request for an appeal with the help of a Navigator. This SOP provides guidance on how to help an employer submit an appeals request. Topics include:

- **Employer Education** (Section B) provides guidance on general health insurance concepts, on the Marketplace, and on the appeals process. If employers understand these concepts, proceed to Section C.
- **Procedures** (Section C) details instructions for the following:
  - Appeal Request – Provides guidance on how to complete an eligibility appeal request.
  - Appeal Notices – Provides guidance on the various types of notices an employer may receive related to an appeal request.

B Employer Education

Before helping employers appeal their eligibility determination, assess employers' general understanding of health insurance concepts and the Marketplace based on Manual Section 3.1, Consumer Assessment.

Based on employers' familiarity with general health insurance concepts and the Marketplace, provide more detailed information (as needed) on the following topics before proceeding to the next section:

- Health Coverage (3.2.1)
- Qualified Health Plans (3.2.3.1)
- Options to Lower Health Plan Costs (3.2.3.5)
- Eligibility & Enrollment Process (3.2.3.6)
- Enrollment (3.2.3.10)
- Appeals (3.2.3.12)

C Procedures

1. Appeal Request

Employers may not need background information on the appeal request process and may be ready to submit their appeals request. Determine if employers would like to proceed with the appeals request, and advance to the corresponding section of this SOP.

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1.1 Electronic Appeal Request

> Electronic appeal requests will not be available on October 1, 2013. Please reference this section when it becomes available.

Step 1. Receive consent to assist employers.

Step 2. Determine if employers have previously started an appeal request via their account.

a. If employers have previously started and saved an appeal request, proceed to the section where assistance is required. Ensure that employers complete all fields accurately.
b. If employers do not have an existing appeals request, initiate the appeals request. Follow the system logic with the responses from the employers. Ensure that employers complete all fields accurately.

Step 3. Assist employers with scanning and uploading supporting documentation.

a. If employers have the necessary supporting documentation, assist them in scanning and uploading the documents. Return all documents to employers.
b. If employers do not have the supporting documentation to scan and upload, explain that they may upload the documents at a later date:
   i. Scan and upload documents from home, or
   ii. Return to the Navigator with the supporting documentation to scan and upload the documents with assistance.

Step 4. Save or submit the appeal request.

a. Inform employers that they may save their appeal requests and resume at a later date for submission.
b. Assist employers with submitting their appeal requests.

1.2 Paper Appeals Request

Step 1. Receive consent to assist employers.

Step 5. Determine if employers have previously started appeal requests.

a. If employers have previously started appeal requests, proceed to the section where assistance is required.
b. If employers would still like to complete paper appeal requests, follow the format provided.

Step 6. Discuss the next steps for providing supporting documentation, if required:

a. Explain that employers may mail in supporting documentation to the Marketplace, or
b. Explain that if employers would like to scan and upload the required documentation, they need to create an account. Employers may create an account

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from home or with the Navigator's assistance. Refer to SOP-23 Create Employer Account, if employers require assistance.

Step 7. Provide employers with the address to mail their appeal requests. You may not mail appeal requests for employers.

1.3 Updating an Appeal Case File

Employers may need to update their appeal case file for multiple reasons. Review the list provided in Exhibit 112 to explain to employers why they might need to update their appeal file.

Exhibit 112 – Reasons to Update an Appeal Case File

Update Reason	Description
Supporting Documentation	Employers may wish to submit supporting documentation for a complete appeal request submission.
Withdraw Appeals Request	Employers may wish to withdraw their appeal request.
Authorized representative	Employers may designate an authorized representative to act on their behalf throughout the appeals process.
Request to Vacate Dismissal	Employers may request to reopen a dismissed case.
Eligibility/Appeals Case Record Request	Employers may request a paper copy of their eligibility or appeals case record.

2. Appeal Notices

Employers receive various notices from the Appeals Worker during their appeal request process. Exhibit 113 lists the different notices available and corresponding descriptions.

Exhibit 113 – Appeal Notices

Notice Type	Description
Appeal Decision	Notice explaining the outcome of an appeal request
Appeal Acknowledgment	Notice explaining that the appeal request has been received
Dismissal	Notice explaining why the appeal has been dismissed
Ad Hoc Notices	Notice providing the appellant (employer) with information not included in the above notices
Vacate Dismissal	Notice explaining whether an appellant (employer) demonstrated good cause' to reopen the case

D Next Steps

1. If employers wish to submit an appeal request electronically, but do not have an account, proceed to SOP-23 Create Employer Account.

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2. If employers have received an appeal notice, refer to the appropriate appeals notice.

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7.0 Appendices

APPENDIX A: FREQUENTLY ASKED QUESTIONS (FAQS)

Navigators may encounter questions while assisting consumers. This section categorizes the responses to FAQs and serves as an aid the Navigator throughout the assistance process.

Exhibit 114 – FAQs by Assistance Category

Assistance Categories
General
Eligibility
Enrollment
Exemption
Appeals & Eligibility Record Request
Annual Redetermination & Renewal

Eligibility

Create an account

1. Why do I need an account?
    - 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.
2. Can I set up multiple accounts?
    - No, you are only able to create one account.
3. What if I do not have an e-mail?
    - You may create an e-mail with an internet or e-mail service provider of your choice or choose to submit a paper application to participate in the Marketplace.
4. What if my password is not accepted?
    - If you are still unable to create a password after confirming you have followed the field requirements, contact the call center for further assistance.
5. What if my username is not accepted?
    - You cannot select a username if it is already in use by another applicant. You should try another username, or contact the call center for further help.

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6. Do I have to enter my Social Security Number to create an account?
    - No, you do not need to enter your Social Security Number if you are not applying to the Marketplace. If you want health coverage and have a Social Security Number, you must supply it to apply for health coverage.

Eligibility Application

7. How do I convert my paper application to the electronic format?
    - You will need to follow a manual process to convert your paper application to an electronic format. You may set up an account (with or without the assistance of a Navigator) and enter the information collected on the paper application in the fields provided by the Marketplace portal.
8. How do I know when the Marketplace receives the documents I scan from home?
    - You can log into your account and verify that the Marketplace has received your documents.
9. If the document I am scanning has multiple pages, can I upload each page separately?
    - Yes, you may upload pages separately.
10. How much do my assets matter in determining my eligibility for a QHP in the Marketplace?
    - The Marketplace does not consider your assets to determine your eligibility for a QHP in the Marketplace.
11. How much do my assets matter in determining my eligibility for Medicaid and CHIP?
    - In general, your assets won't matter in determining your eligibility for Medicaid and CHIP. There are still some populations for whom assets do matter – specifically, individuals who are seeking Medicaid coverage because they are 65 or over, disabled, or in need of long-term care services. The Marketplace will not ask you for information about assets, and the Medicaid agency will let you know if this is necessary.
12. How much does my income matter in determining my eligibility for Medicaid and CHIP?
    - Medicaid and CHIP eligibility standards primarily consider household size and income. See Appendix C to estimate if you are potentially eligible for Medicaid/CHIP. Please note that there are other non-financial eligibility requirements for Medicaid and CHIP.

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13. How much does my income matter in determining my eligibility for premium tax credits and cost-sharing reductions?
    - Eligibility for premium tax credits and cost-sharing reductions depends on your household size and income. The Marketplace will determine if your household size and income qualifies you for these options. Please note that there are other non-financial eligibility requirements for premium tax credits and cost-sharing reductions.
14. How much does my income matter in determining my eligibility for a QHP through the Marketplace?
    - Your income is not a factor in determining your eligibility to enroll in a QHP through the Marketplace.
15. Can I find out if I qualify for Medicaid without completing the application?
    - Navigators may provide an estimate by referencing Appendix C and factoring in consumers' household size and income. However, only the state Medicaid or CHIP agency can make final eligibility determination, and in some states, the Marketplace.
16. Is the Marketplace application different from the regular Medicaid application?
    - In some states the Medicaid applications differ from the Marketplace application. However, you may also receive a Medicaid determination by completing the Marketplace application, depending on the state you live in. You should get the same determination no matter which application you use.
17. Why do you need to know if I currently have health coverage?
    - If you already have health coverage that meets minimum essential coverage requirements, then you cannot qualify for premium tax credits or cost-sharing reductions. However, if you have job-based coverage but cannot afford it, you can still be eligible for premium tax credits and cost-sharing reductions to lower the cost of your QHP through the Marketplace.
18. I am currently receiving health care services through Veterans' Affairs (VA), am I eligible to participate in the Marketplace?
    - Yes, you may still be eligible to participate in the Marketplace if you are enrolled in health coverage through the VA. However, if you purchase health coverage from the Marketplace, you will not be eligible for premium tax credits or cost-sharing reductions.

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Account Updates

19. How can I change my authorized representative?
    - You can change your authorized representative by accessing your account and updating your account information. You can remove an existing authorized representative and designate a new representative.
20. What account changes/updates will affect my eligibility to participate in the Marketplace?
    - Account maintenance updates, like changing your password or e-mail, will not affect your eligibility. However, certain life changes, like marriage or the birth of a child, may affect eligibility.
21. How do I change my account details (e.g., password, e-mail)?
    - You may log into your account, select the Contact Information tab, and follow the system logic in completing any changes.
22. How do I report life changes (e.g., marriage, birth of a child, death in the family)?
    - You may log into your account, select the Change in Circumstance tab, and follow the system logic in completing any changes.

Review Eligibility Determination

23. What if I did not receive eligibility results?
    - If you have an account, you should log into your account and confirm that an electronic notice is not in your the Message Center. If you are waiting for a paper notice, you may reach out to the call center to receive further assistance.
24. What if I currently have Medicaid/CHIP, but would like a QHP instead?
    - You may opt to reject your Medicaid/CHIP eligibility, and apply for QHP eligibility; however, you may only seek one form of coverage and may not qualify for options to lower your health plan costs for the year in which you reject your Medicaid/CHIP health coverage.
25. I am not satisfied with the amount of premium tax credits or cost-sharing reductions that I received, what can I do?
    - You may file an appeal to determine if you are eligible for more premium tax credits and cost-sharing reductions.

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26. How do I file for an exemption?
    - Depending on the reason for the exemption, you can mail in an exemption application to the Marketplace, or you can claim IRS exemptions during the tax filing process.

Referral to State Medicaid or CHIP

27. How do I select a Medicaid or CHIP plan?
    - If you are determined eligible or assessed eligible for Medicaid or CHIP by the Marketplace, you will be contacted by your local Medicaid or CHIP office for more instructions on selecting and enrolling in either program.
28. How do I contact my state Medicaid or CHIP agency?
    - If your eligibility results refer you to your local state Medicaid or CHIP agency, contact information will be included in the notice.
29. I want a QHP instead of Medicaid. How do I change programs?
    - You may reject your Medicaid/CHIP determination and apply for QHP eligibility; however, you will not be eligible for premium tax credits and cost-sharing reductions to reduce the cost of the QHP.
30. 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?
    - Determination periods vary from state to state. You should contact your local state Medicaid or CHIP agency for detailed information.
31. Do I have to go to my state Medicaid or CHIP agency in person to receive assistance?
    - No, you can contact your local state Medicaid or CHIP agency office via phone and request assistance.

Options to Lower Health Plan Costs

32. Can I adjust my premium tax credit amount to more than I am eligible for?
    - No, the Marketplace determines how much advanced premium tax credit you are eligible to receive. If you feel that you are eligible for a higher amount of premium tax credit, you may file an appeal.
33. I think I am eligible for more premium tax credits or cost-sharing reductions. What do I do?
    - You may file an appeal to determine if you are eligible for more premium tax credits or cost-sharing reductions.

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34. I received my eligibility determination and was not found eligible for premium tax credit and/or cost-sharing reductions, but believe I am entitled to receive assistance. What do I do?
    - You may file an appeal with the Marketplace to determine if you are eligible for more premium tax credits or cost-sharing reductions.
35. If I lose my job, will I qualify for premium tax credits and cost-sharing reductions?
    - You must complete an eligibility application to determine if you are eligible or not.
36. How do I report changes in my income?
    - You may log into your account, select the Change in Circumstance tab, and follow the system logic in completing any changes.
37. When may I adjust my premium tax credit amount?
    - You may adjust your premium tax credit after you receive your eligibility results. You are able to see this amount on the Comparing Plans page at which point you are able to select the premium tax credit amount.
38. What is the cost-sharing reduction?
    - A Federal subsidy, made available to eligible individuals with a household income below 250% of the FPL, and who select a QHP (generally Silver plans). The cost-sharing reduction partially covers the cost of out-of-pocket expenses related to essential health benefits, such as deductibles, coinsurance, copayments, or similar charges. The Marketplace pays the insurance company the amount you have saved through cost-sharing reductions. (Reference: 45 CFR §155.20)
39. What is coinsurance?
    - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the health service provided. You pay your coinsurance plus any deductibles you owe. For example, if the health insurance plan's allowed amount for an office visit is $100 and you meet your plan’s deductible, the coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.
40. Can I adjust my premium tax credit or cost-sharing reductions?
    - Yes, you can adjust your premium tax credit amount on the Comparing Plans page. If you are eligible for cost-sharing reductions, you can see your reduced monthly premium when you view the Silver plans.

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General

41. Why do I need to participate in the Marketplace?
    - In March 2010, Congress passed the Affordable Care Act, which specifies that starting in January 2014 all individuals must obtain basic health coverage, obtain an exemption, or make a payment on their taxes. The Marketplace offers basic health coverage to eligible individuals.
42. What if I do not want to participate in the Marketplace?
    - If you already have basic health coverage, or can get it through an employer or a public program like Medicare, you don't need to purchase coverage in the Marketplace. If you don't have other coverage, you may opt to complete an exemption application, or you may pay a fee if you do not want to complete the exemption request.
43. Do you receive a commission for signing me up?
    - No, Navigators do not receive a commission for providing assistance.
44. If I designate you as my Navigator, can I receive assistance from someone else?
    - Yes, you may reach out to other Navigators, Certified Application Counselors, other in-person assistance personnel, the call center, and Agents and/or Brokers to receive further assistance.
45. Will you keep all my information confidential?
    - Yes, your information will remain confidential and only those individuals you deem appropriate will have access to your information.
46. Who, outside of the Marketplace, has access to my account information?
    - You may assign authorized representatives and account holders to have access to your account information. They will only have access to your account information with your permission. Navigators and other assisters may access your account only when you are present.
47. When is the deadline for applying for health coverage?
    - You can apply whenever you want; however, the periods of time during which you can obtain coverage through the Marketplace are limited. The first Marketplace open enrollment period is from October 1, 2013, through March 31, 2014. If you don't select a plan by March 31, 2014, you may have to wait until October 15, 2014. You have to apply, be found eligible, and select a plan in advance – so if you apply on March 1, select a plan on March 15, and pay any premium by the date specified by the insurance company, you will have coverage on April 1, 2014.

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48. When can I complete an application?

    - You may complete an application when open enrollment begins, October 1, 2013.

      The first open enrollment period is October 1, 2013 through March 31, 2014 (a 6-month period). You must select a plan by the 15th of the month for coverage to start on the 1st of the following month (for coverage starting on January 1, 2014) and make any premium payment by the date specified by your plan. If you choose your health plan after the 15th of the current month, and pay you premium on time, you coverage will start on the first day of the next following month. For example, if you select a plan on February 18, coverage will not start until April 1.

49. How do I get an application? (paper and electronic)

    - You may obtain an electronic application on the Marketplace website once you have created an account. If you would rather complete a paper application, you can get one by calling the Marketplace toll-free call center.

50. What is an authorized representative?

    - Persons or organizations who receive permission from consumers to complete the activities needed to establish, maintain, and appeal eligibility on consumers' behalf. An authorized representative has all the applicable rights and responsibilities of the applicant or enrollee. Examples of authorized representatives include a court-appointed guardian, an individual with durable power of attorney, or an individual formally designated by the applicant or enrollee.

51. How do I designate an authorized representative?

    - You may designate an authorized representative on you eligibility application or through your online account.

52. Will I always receive a confirmation or transaction number when I update my account?

    - Yes, you have access to the Transaction History page to keep track of your account changes and updates. (More details pending further development.)

53. How do I obtain a hard copy of my account notices?

    - If you apply to the Marketplace online, you will receive all notices through your online Message Center. You can access the Message Center through your account and print your notices at any time. If you apply through mail, you will receive notices in the mail, if you select this option on your application.

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54. What information do I need to provide on the eligibility application?

    - The application will request only information necessary to make an eligibility decision. Thus, the exact questions will vary depending on each consumer's circumstances. You may be asked to provide information on the following topics:

        - Household contact information (contact information for the individual submitting an application on behalf of a household or family)
        - Household structure
        - Social Security Number
        - Citizenship and immigration status
        - Household information
        - Personal identification (residence and contact information)
        - Current health coverage status
        - American Indian/Alaska Native status

55. Why do I need to submit supporting documentation?

    - The Marketplace may request supporting documentation to verify the information you provided on your application. The Marketplace verifies information to ensure that only eligible individuals obtain coverage and qualify for options to lower their health plan costs.

Exemption Application

56. How long will it take to know if my exemption application was accepted?

    - 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 call center to find out if your application was accepted.

57. When does my exemption end?

    - 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.

58. I am currently receiving health care services through Veterans Affairs (VA). Am I eligible to participate in the Marketplace? Do I need to file an exemption?

    - If you are receiving VA health benefits, you are eligible to participate in the Marketplace, but you may not be eligible to receive advance payments of the premium tax credit. If you receive VA health benefits, you do not need to apply for an exemption.

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Eligibility Record and Appeals Requests

Eligibility Record Request

59. How do I prove that I have health coverage?
    - Your insurance company can give you Proof of Coverage. You can contact your insurance company or log into your insurance account online to obtain Proof of Coverage.
60. How can I access information on my eligibility history?
    - You may access your eligibility history through your account and by going to the eligibility results page. You may print a paper copy of this record at home or with the assistance of a Navigator.

Eligibility Appeal Request

61. How will I know when the Marketplace receives my appeal?
    - You will receive a notice about your appeal request via mail or through your account in the Message Center. If you do not receive notice, you may contact the call center for assistance.
62. How long will it take to receive a decision on my appeal?
    - The time required to make a decision on your appeal will vary based on the reason for your appeal and the documentation needed to decide the appeal.
63. I cannot attend my hearing request date. Can I reschedule?
    - You may reschedule your hearing but the Marketplace will only reschedule hearings under extenuating circumstances. You may contact the Appeals Worker for more information.

Enrollment

Comparing Plans & Plan Selection

64. May I select more than one health plan?
    - You may only select one plan for each individual. For adults, you may also select separate dental coverage, if available.
65. Can I select a stand-alone dental plan?
    - You may select a stand-alone dental plan, but the plan alone will not meet MEC requirements. If you enroll in a stand-alone dental plan, you must still enroll in a QHP to meet the MEC requirements under the individual responsibility requirement.

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66. Can I select a child-only plan?
    - You may select a health plan that covers your child, but you must have coverage for yourself under the individual responsibility requirement.
67. Can I select a pediatric dental plan?
    - You may select a pediatric dental plan. When comparing plans, you will be able to determine which plans include pediatric dental coverage
68. Does my employer, who is participating in the SHOP Marketplace, give me a choice of plans?
    - No, as an employee, you do not have a selection of plans from which to choose in 2014. You are able to choose whether you would like to participate in your employer's SHOP Marketplace plan. If you choose not to participate, you may still be eligible to participate as an individual in the Marketplace.
69. When can I select my health plan?
    - You may select an insurance plan after you have completed an eligibility application and received eligibility results.
70. Why do I need to prioritize the screening questions?
    - Prioritizing screening questions helps tailor the QHPs from which you can choose and make a selection.
71. After completing the screening questions, how do I prioritize them?
    - You will need to determine what factors are most important to you. Some factors that you may consider are:
        - Costs
        - Provider availability
        - Network regions
72. My business is in the Marketplace area, but some of my employees live outside the area. Are they eligible?
    - Your employees may be eligible for the QHP you select if they are on your employee roster.
73. My business has multiple offices—some outside the Marketplace area. Are those employees eligible?
    - Your employees may be eligible to participate in the Marketplace if they are on the employee roster you submitted to the SHOP Marketplace. You may opt to apply to each state in which the offices are located or select a plan to offer your employees which has a nationwide or multi-state network.

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74. My work location is in the Marketplace area, but I reside outside the Marketplace area. Am I eligible to participate in the SHOP Marketplace?
    - You may be eligible for your employer's QHP if you are on your employer's roster that the employer submits to the SHOP Marketplace, if your employer has opted to offer a plan that has a nationwide or multi-state network.
75. Can I browse health plans in the Marketplace without creating an account?
    - Yes, you may browse and compare plans in Shopper mode. It is important to note, however, that you may not see all details of QHPs (e.g., all benefits and costs) and are encouraged to create an account and submit an application to see the full details of various QHPs.
76. Who decides which health plans are QHPs?
    - The Marketplace, with help from some states, determines which plans are QHPs.
77. When do I see the cost of the health plans?
    - You can see estimated costs of health plans before you apply. If you are determined eligible for a QHP through the Marketplace, you will be able to view your exact plan costs after you apply your premium tax credit or cost-sharing reductions (if you qualify).
78. What's the difference between getting a plan in the Marketplace and getting another private plan?
    - QHPs in the Marketplace must meet a certain level of coverage, quality, and assistance as determined by the federal government.
79. How do I look at the different plans and compare them?
    - You may view and compare plans two ways—via HealthCare.gov and your account.
80. Are all QHP benefits the same despite different QHP costs?
    - No, you will see differences in coverage levels. However, all QHPs meet the MEC requirements determined by the Federal Government.

QHP Enrollment

81. May I enroll in more than one plan?
    - No, you may not enroll in more than one plan.

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82. Can you enroll me in a Medicaid or CHIP plan?
    - No, Navigators are unable to enroll consumers in Medicaid/CHIP. Navigators should refer consumers to the state Medicaid/CHIP agency (Appendix C) to provide contact information to consumers to inquire about the enrollment process.

Pay Health Plan Premium

83. Can I update my financial information in my account?
    - Yes, you can update certain income information in your account. However, you must visit your insurance company's website to update financial information as it affects your monthly premiums (e.g., bank account information, address, credit card information).
84. How do I make payments?
    - You can make payments through your health insurance company's website or via mail directly to the health insurance company.
85. Can I make payments by check? May I pay in cash?
    - Yes, your insurance company will inform you of the acceptable methods of payment. Insurance companies cannot discriminate against consumers who do not have checking accounts or credit cards.
86. What happens if I miss a payment? Does my coverage end?
    - You will need to contact your health insurance company to confirm what happens after missing a payment. Coverage might not end and your insurance company may provide a grace period.
87. Does my premium amount include my premium tax credits and cost-sharing reductions?
    - Yes, the Marketplace automatically deducts your premium tax credit and cost-sharing reductions from your monthly premium amount.

APPENDIX B: ACRONYMS & DEFINITIONS

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

Acronyms

Acronyms	Descriptions
APTC	Advanced Premium Tax Credit
BHP	Basic Health Program

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Acronyms	Descriptions
CCIIO	Center for Consumer Information and Insurance Oversight
COBRA	Consolidated Omnibus Budget Reconciliation Act
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reductions
FAQ	Frequently Asked Questions
FFM	Federally-facilitated Marketplace
FPL	Federal Poverty Level
ID	Identification
IT	Information Technology
MAGI	Modified Adjusted Gross Income
QA	Quality Assurance
QHP	Qualified Health Plan
QIO	Quality Improvement Organization
SHOP	Small Business Health Options Program
SOP	Standard Operating Procedure
SSN	Social Security Number
VA	Veterans Affairs
VHA	Veterans Health Administration
VTC	Video Teleconference

Definitions

The following is a list of terms from HealthCare.gov, CCIIO, and the Affordable Care Act; Establishment of Marketplaces and QHPs; and defines the Marketplace Standards for Employers (Final Rule) in plain language for the Navigator grantees' use.

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

Advanced Premium Tax Credit (APTC or premium tax credit): The Affordable Care Act provides a new tax credit to help you afford health coverage purchased through the Marketplace.

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You can use your advanced payments of the tax credit to lower your monthly premium costs. If you qualify, you may choose how much in advance credits to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your 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 on March 30, 2010. The name "Affordable Care Act" refers to the final, amended version of the law.

Agent: An individual or entity that helps individuals and businesses apply for and enroll in QHPs, and may assist in applying for APTCs and CSRs. States typically grant licenses to agents to sell insurance and they may receive compensation from insurance companies to enroll consumers in a QHP. (Reference: PPACA § 1312(e))

Annual enrollment/election period: The time during which consumers may make changes to their enrollment.

- Annual open enrollment period: The period each year during which a qualified individual may enroll or change coverage in a QHP through a Marketplace for the upcoming benefit year. The annual open enrollment period occurs each year from October 15th to December 7th. (Reference: 45 CFR §155.20)
- Annual SHOP enrollment period: The enrollment period available to employees every 12 months. The enrollment period begins within 30 days from the date that the employer qualifies to participate in the SHOP Marketplace.
- Annual SHOP election period: The election period available to employers who already participate in the SHOP. The annual SHOP election period occurs every 12 months; during this period, employers identify health coverage options that are available to their qualified employees during the next coverage period.

Applicant: An individual seeking eligibility who submits an application (either individually or as part of a household) to the Marketplace for enrollment in a QHP or Medicaid and CHIP. An applicant can also be an employer or employee seeking eligibility for enrollment in a QHP through the SHOP Marketplace. (Reference: 45 CFR §155.20)

Application filer: An individual who is seeking eligibility for him or herself, an adult who is a part of the applicant's household, an adult family member, an authorized representative, or someone acting on behalf of a minor or incapacitated applicant. (Reference: 45 CFR §155.20)

Authorized representative: A person or organization authorized by an applicant or enrollee to apply for any of the health care programs and to perform the duties required to establish, maintain, and appeal eligibility. An authorized representative has all the rights and responsibilities of the applicant or enrollee. Examples of an authorized representative include a

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court-appointed guardian, an individual with durable power of attorney, and an individual formally designated by the applicant or enrollee.

Balance billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance-bill you for covered services. (Reference: HealthCare.gov/glossary/balance-billing)

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

Benefit year: A calendar year for which a health plan provides coverage for health benefits. (Reference: 45 CFR §155.20)

Broker: An entity that helps individuals and businesses apply for and enroll into a QHP, and may assist in applying for APTCs and CSRs. Brokers typically have state license to sell insurance. They may receive compensation from an insurance company to enroll consumers into a QHP. (Reference: Affordable Care Act § 1312(e))

Catastrophic health plan: Health plans that meet all of the requirements applicable to other qualified health plans (QHPs) but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old OR get a hardship exemption because the Marketplace determined that you're unable to afford health coverage. (Reference: HealthCare.gov/glossary/catastrophic-health-plan)

Center for Consumer Information and Insurance Oversight (CCIIO): helps to implement many provisions of the Affordable Care Act, the historic health reform bill that went into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance.

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

Children's Health Insurance Program (CHIP): Insurance program jointly funded by state and federal governments 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 can't afford to purchase private health insurance coverage. (Reference: HealthCare.gov/glossary/childrens-health-insurance-program-chip)

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

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Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plans maximum allowed amount for an office visit is $100 and you've met your deductible, your 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 you to temporarily keep health coverage after your employment ends. You lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Copayment (copay): A fixed amount (for example, $15) you pay for a covered health care service, usually when you 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 you have to pay for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the Silver plan category (See Health Plan Categories). If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits. (Reference: HealthCare.gov/glossary/cost-sharing-reduction)

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

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 dependents. (Reference: HealthCare.gov/glossary/dependent)

Eligibility Appeal: A request by an individual, employer, or employee for a reevaluation of a Marketplace eligibility decision. An employer, employee, individual applicant, or employer of an individual applicant may request an appeal of an eligibility decision.

Employer identification number (EIN): You can find the Employer Identification Number (EIN) on a pay stub or W-2 for this employer. If you don't know this number, ask your employer.

Employer responsibility requirement: The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP. (Reference: HealthCare.gov/glossary/employer-shared-responsibility-payment)

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

Employer contributions: An employer's financial contributions towards an employer-sponsored health insurance plan. (Reference: 45 CFR §155.20)

Enrollee: An individual or employee enrolled in a QHP through the Marketplace. (Reference: 45 CFR §155.20)

End-Stage Renal Disease: Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Essential health benefits: A set of health care service categories that plans must cover starting in 2014.

The Affordable Care Act ensures health plans offered in the individual and small-group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits to be certified and offered in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014.

(Reference: HealthCare.gov/glossary/essential-health-benefits)

Exemption Appeal: A request made by an individual for a reevaluation of a Marketplace exemption decision.

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

Fee: Starting January 1, 2014, if someone doesn't have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee that increases every year, from 1% of income (or $95 per adult, whichever is higher) in 2014 to 2.5% of income (or $695 per adult) in 2016. The fee for children is half the adult amount. If applicable, consumers will pay this fee on their 2014 federal income tax forms, which they will file in 2015. People with very low incomes and others may be eligible for waivers. See "What if someone doesn't have health coverage in insurance in 2014?" for more information. (Reference: HealthCare.gov/glossary/fee)

Full-time employee: An employee who works an average of 30 or more hours per week. (Reference: HealthCare.gov/glossary/full-time-employee)

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Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. This is also called a drug list. (Reference: HealthCare.gov/glossary/formulary)

Good faith extension: An extension granted by the Marketplace to an individual that extends the time period allowed for consumers to submit supporting documentation needed to process their health coverage or exemption applications.

Grandfathered health plan: A group health plan that was created or an individual health insurance policy that was purchased on or before March 23, 2010. Grandfathered plans are exempt from many provisions required under the Affordable Care Act. Plans or policies may lose their grandfathered status if they make significant changes that reduce benefits or increase costs to consumers.

Health coverage: Legal entitlement to payment or reimbursement for your health care costs, 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 your health insurer to pay some or all of your 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 Insurance Marketplace: A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate incomes and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and CHIP. The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. Some states run the Marketplace. In other states, the federal government runs the Marketplace.

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 you 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 Marketplace generally separates health plans into five health plan categories — Bronze, Silver, Gold, Platinum, or Catastrophic — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This isn't the same as coinsurance, in which you pay

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a specific percentage of the cost of a specific service. (Reference: HealthCare.gov/glossary/health-plan-categories)

High deductible health plan: 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 you to pay for qualified medical expenses on a pre-tax basis. (Reference: HealthCare.gov/glossary/high-deductible-health-plan)

Health savings account: A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. 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 you don't spend them. (Reference: HealthCare.gov/glossary/health-savings-account-HSA)

Incarceration status: A criterion for Marketplace or exemption eligibility referring to whether an individual is imprisoned or confined by a State or Federal institution pending the disposition of charges.

Indian status: A criterion for Marketplace or exemption eligibility 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 (Individual insurance market): The marketplace for individuals to purchase health insurance plans for themselves or their families who do not receive coverage through an employer-provided group health plan. (Reference: 45 CFR §1304(a)(2))

Individual responsibility requirement: Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets certain minimum standards. If you aren't, you may be required to pay a penalty. You won't have to pay a penalty if you have very low income and coverage is unaffordable for you or for other reasons, including your religious beliefs. You can apply for a waiver asking not to pay an assessment if you don't qualify automatically.

In-network providers: Doctors, hospitals, pharmacies, and other health care providers that have agreed to provide members of a certain insurance plan with services and supplies at a discounted price. Some plans will only cover your health care if you get it from in-network doctors, hospitals, pharmacies, and other health care providers. (Reference: Medicare.gov/glossary/i.html)

Initial enrollment/election period:

- Initial open enrollment period: The first period of time that the Marketplace allows qualified individuals to enroll in coverage for the 2014 benefit year from October 1, 2013 until March 31, 2014.
- Initial employer election period: The first time that an employer is applying to participate in the SHOP, which can occur at any time of the year.

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- Initial employee enrollment period: The first time that a qualified employee is able to elect coverage through the SHOP.

Insurance affordability program: Any applicable program in which the Affordable Care Act requires health insurance Marketplace to enroll applicants with income under 400% of the FPL and to facilitate seamless transitions between programs when individuals' and families' circumstances change. Insurance affordability programs include Medicaid, CHIP, APTCs, CSRs in the Marketplace, and BHPs, if available. (Reference: 45 CFR §155.300)

Job-based coverage: Coverage that an employer offers to employees (and employees' family members). (Reference: HealthCare.gov/glossary/job-based-health-plan)

Large employer: An employer who employs an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. Large employers are not able to participate in the SHOP Marketplace. If a large employer's employee qualifies for APTC/CSR through the individual Marketplace, the employer may be subject to a penalty from the IRS. (Reference: 45 CFR §155.20)

Marketplace: A health insurance marketplace operated by a governmental agency or non-profit entity that meets applicable government standards. A Marketplace makes QHPs available to qualified individuals, employees, and employers. Unless otherwise identified, this term refers to a state, regional, subsidiary, or Federally-facilitated Marketplace. (Reference: 45 CFR §155.20)

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

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

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

Minimum essential coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual marketplace policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. (Reference: HealthCare.gov/glossary/minimum-essential-coverage)

Minimum value: Beginning in 2014, eligible individuals who purchase coverage under a QHP through an Affordable Insurance Marketplace may receive a premium tax credit, unless they are eligible for other minimum essential coverage, including coverage under an employer-sponsored plan that is affordable to the employee and provides minimum value. A plan fails to provide minimum value if the plan's share of the total allowed cost of benefits provided under the plan is less than 60% of such costs. If the coverage offered by the employer fails to provide minimum value, an employee may be eligible to receive a premium tax credit.

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Modified Adjusted Gross Income (MAGI): A calculation of income, developed by the Federal government, used to determine an individual's eligibility to qualify for APTC and CSR, and participate in the Medicaid and CHIP programs. An individual's MAGI, in relation to the FPL, determines whether an individual may qualify for Medicaid, CHIP, premium tax credits, or cost-sharing reductions.

Navigator: A private or public entity or individual that is certified to provide in-person assistance to help consumers understand their health coverage options and complete the application process for health coverage that fits their needs. Navigators are certified to provide consumer assistance and do not receive compensation from insurance companies or from consumers.

Non-citizen: An individual who is not a citizen or national of the United States. (Reference: 45 CFR §155.300; Immigration and Nationality Act § 101(a)(3))

Optical character recognition (OCR): A software application that converts scanned (digitized) images of printed or handwritten text into a form that can be recognized and manipulated by a word-processing program.

Orphan documentation: Any documentation with missing personally identifying information or is aligned to the wrong record.

Out-of-pocket costs: The expenses for medical care that insurance companies do not reimburse. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered. (Resource: HealthCare.gov/glossary/out-of-pocket-costs/)

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

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

Preferred Provider Organizations (PPO): Types of health plan that contract with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost. (Resource: HealthCare.gov/glossary/preferred-provider-organization-PPO)

Premium: The amount that you must pay for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly. (Resource: HealthCare.gov/glossary/premium)

Premium tax credit: The Affordable Care Act provides a new tax credit to help you afford health coverage purchased through the Marketplace. You can use advanced payments of the tax credit right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the

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excess advance payments with your tax return. (Resource: HealthCare.gov/glossary/premium-tax-credit)

Prevention: Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings. (Resource: HealthCare.gov/glossary/prevention-glossary)

Point-of-service plan (POS): A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor to see a specialist.

Qualifying coverage: In order to avoid the individual responsibility fee under the Affordable Care Act and be eligible for advance payments of the premium tax, an individual must be enrolled in qualifying coverage. Coverage is deemed qualifying if it is an employer-sponsored plan that meets the affordability and minimum value standards specified in section 36B(c)(2)(C) of the Internal Revenue Code. (Reference: 45 CFR §155.300)

Qualified employee: To be eligible for coverage through a small business employer, an individual must be a qualified employee. A qualified employee is a full -time or full-time equivalent employee of an employer that has elected to provide its employees and their dependents with access to one or more QHPs through the SHOP Marketplace. (Reference: 45 CFR §155.20)

Qualified employer: A small employer (<50 or <100 employees, depending on the state) that elects to make, at a minimum, all full time employees eligible for a QHP in the small group marketplace offered through the SHOP Marketplace. (Reference: 45 CFR §155.20)

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

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

Self-employment status: The status of an individual who earns wages directly from his or her own trade or business, rather than as an employee of another.

Service area: A geographical area established by the Marketplace in which consumers may receive health coverage through the Marketplace. Individuals who reside in a service area can seek assistance from Navigators who work in that service area.

Shopper: An individual who is not seeking eligibility to enroll in a QHP or has not yet received a positive eligibility determination, but is seeking to purchase health coverage from the Marketplace.

Small business employer: An employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of plan years beginning before

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January 1, 2016, a state may elect to define small employer by substituting ‘‘50 employees’’ for ‘‘100 employees.” (Reference: 45 CFR §155.20)

Small group marketplace: The marketplace where individuals obtain health coverage on behalf of themselves and their dependents through a group health plan maintained by a small business employer. (Reference: Affordable Care Act §1304(a)(3))

Special circumstance: When consumers submit personal information to complete their eligibility applications, they may supply information concerning their unique characteristics, such as a physician disability or Indian status.

Special enrollment periods (SEP):

- Special enrollment period --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 initial and annual open enrollment periods. For example, individuals who lose employer-provided health coverage, or who lose Medicaid coverage because of an increase in income, can enroll in a Marketplace plan during this period. Other triggering events include marriage, divorce, and the birth or adoption of a child. (Reference: 45 CFR §155.20)
- SHOP special enrollment period -- The enrollment period where an employee qualifies for an SEP if he or she meets the established requirements. A SHOP SEP can occur at any time throughout the year (unlike the Individual Marketplace that requires the SEP period to be outside of the initial and annual enrollment periods).

Summary of Benefits and Coverage: An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company**.** (Reference: HealthCare.gov/glossary/summary-of-benefits-and-coverage)

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

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

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APPENDIX C: 2013 FEDERAL POVERTY GUIDELINES

Exhibit 115- Annual Poverty Guidelines for All States (except Hawaii and Alaska)

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250 %
1	11,490.00	13,788.00	15,281.70	15,511.50	17,235.00	20,107.00	21,256.50	22,980.00	28,725.00
2	15,510.00	18,612.00	20,628.30	20,938.50	23,265.00	27,142.50	28,693.50	31,020.00	38,775.00
3	19,530.00	23,436.00	25,974.90	26,365.50	29,295.00	34,177,50	36,130.50	39,060.00	48,825.00
4	23,550.00	28,260.00	31,321.50	31,792.50	35,325.00	41,212.50	43,567.50	47,100.00	58,875.00
5	27,570.00	33,084.00	36,668.10	37,219.50	41,355.00	48,247.50	51,004.50	55,140.00	68,925.00
6	31,590.00	37,908.00	42,014.70	42,646.50	47,385.00	55,282.50	58,441.50	63,180.00	78,975.00
7	35,610.00	42,732.00	47,361.30	48,073.50	53,415.00	62,317.50	65,878.50	71,220.00	89,025.00
8	39,630.00	47,556.00	52,707.90	53,500.50	59,445.00	69,352.50	73,315.50	79,260.00	99,075.00

*For families with more than 8 members, add $4,020 for each additional family member.

Exhibit 116 - Annual Poverty Guidelines for Alaska Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	14,350.00	17,220.00	19,085.50	19,372.50	21,525.00	25,112.50	26,547.50	28,700.00	35,875.00
2	19,380.00	23,256.00	25,775.40	26,163.00	29,070.00	33,315.00	35,853.00	38,760.00	48.450.00
3	24,410.00	29,292.00	32,465.30	32,953.00	36,615.00	42,717.50	45,158.50	48,820.00	61,025.00
4	29,440.00	35,328.00	39,155.20	39,744.00	44,160.00	51,520.00	54,464.00	58,880.00	73,600.00
5	34,470.00	41,364.00	45,845.10	46,534.50	51,705.00	60,322.50	63,769.50	68,940.00	86,175.00
6	39,500.00	47,400.00	52,535.00	53,325.00	59,250.00	69,125.00	73,075.00	79,000.00	98,750.00
7	44,530.00	53,436.00	59,224.90	60,115.50	66,795.00	77,927.50	82,380.50	89,060.00	111,325.00
8	49,560.00	59,472.00	65,914.80	66,906.00	74,340.00	86.730.00	91,686.00	99,120.00	123.900.00

* For families with more than eight members, add $5030 for each additional family member.

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Exhibit 117 - Annual Poverty Guidelines for Hawaii Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,230.00	15,876.00	17,595.90	17,860.50	19,845.00	23,152.50	24,475.00	26,460.00	33,075.00
2	17,850.00	21,420.00	23,740.50	24,097.50	26,775.00	31,237.50	33,022.50	35,700.00	44,625.00
3	22,470.00	26,964.00	29,885.10	30,334.50	33,705.00	39.322.50	41.569.50	44,940.00	56,175.00
4	27,090.00	32,508.00	36,029.70	36,571.50	40,635.00	47,407.50	50,116.50	54,180.00	67,725.00
5	31,710.00	38,052.00	42,174.30	42,808.50	47,565.00	55,492.50	58,663.50	63,420.00	79,275.00
6	36,330.00	43,596.00	48,318.90	49,045.50	54,495.00	63,577.50	67,210.50	72,660.00	90,825.00
7	40,950.00	49,140.00	54,463.50	55,282.50	61,425.00	71,622.50	75,757.50	81,900.00	102,375.00
8	45,570.00	54,684.00	60,608.10	61,519.50	68,355.00	79,747.50	84,304.50	91,140.00	113,925.00

* For families with more than eight family members, add $4,620 for each additional family member.

Exhibit 118 - Federal Monthly Poverty Guidelines for All States (except Alaska and Hawaii)

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	957.50	1,149.00	1,273.48	1,292.63	1,436.25	1,675.63	1,771.36	1,915.00	2,393.75
2	1,292.50	1,551.00	1,719.03	1,744.88	1,938.75	2,261.88	2,391.13	2,585.00	3,231.25
3	1,627.50	1,953.00	2,164.58	2,197.13	2,441.25	2,848.13	3,010.88	3,255.00	4,068.75
4	1,962.50	2,355.00	2,610.13	2,649.38	2,943.75	3,434.38	3,630.63	3,925.00	4,906.25
5	2,297.50	2,757.00	3,055.68	3,101.63	3,446.25	4,020.63	4,250.38	4,595.00	5,743.75
6	2,632.50	3,159.00	3,501.23	3,553.88	3,948.75	4,606.88	4,870.13	5,265.00	6,581.25
7	2,967.50	3,561.00	3,946.78	4,006.13	4,451.25	5,193.13	5,489.88	5,935.00	7,418.75
8	3,302.50	3,963.00	4,392.33	4,458.38	4,953.75	5,779.38	6,109.63	6,605.00	8,256.25

Exhibit 119 - Federal Monthly Poverty Guidelines for Alaska Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,195.83	1,435.00	1,590.46	1,614.38	1,793.75	2,092.71	2,212.29	2,391.67	2,989.58
2	1,615.00	1,938.00	2,147.95	2,180.25	2,422.50	2,826.25	2,987.75	3,230.00	4,037.50
3	2,034.17	2,441.00	2,705.44	2,746.13	3,051.25	3,559.79	3,763.21	4,068.33	5,085.42
4	2,453.33	2,944.00	3,262.93	3,312.00	3,680.00	4,293.33	4,538.67	4,906.67	6,133.33
5	2,872.50	3,447.00	3,820.43	3,877.88	4,308.75	5,026.88	5,314.13	5,745.00	7,181.25
6	3,291.67	3,950.00	4,377.92	4,443.75	4,937.50	5,760.42	6,089.58	6,583.33	8,229.17
7	3,710.83	4,453.00	4,935.41	5,009.63	5,566.25	6,493.96	6,865.04	7,421.67	9,277.08
8	4,130.00	4,956.00	5,492.90	5,575.50	6,195.00	7,227.50	7,640.50	8,260.00	10,325.00

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Exhibit 120 - Federal Monthly Poverty Guidelines for Hawaii Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,102.50	1,323.00	1,466.33	1,488.38	1,653.75	1,929.38	2,039.63	2,205.00	2,756.25
2	1,487.50	1,785.00	1,978.38	2,008.13	2,231.25	2,603.13	2,751.88	2,975.00	3,718.75
3	1,872.50	2,247.00	2,490.43	2,527.88	2,808.75	3,276.88	3,464.13	3,745.00	4,681.25
4	2,257.50	2,709.00	3,002.48	3,047.63	3.386.25	3,950.63	4,176.38	4,515.00	5,643.75
5	2,642.50	3,171.00	3,514.53	3,567.38	4,624.38	4,624.38	4,888.63	5,285.00	6,606.25
6	3,027.50	3,633.00	4,026.58	4,087.13	5,298.13	5,298.13	5,600.88	6,055.00	7,568.75
7	3,412.50	4,095.00	4,538.63	4.606.88	5,971.88	5,971.88	6,313.13	6,825.00	8,531.25
8	3,797.50	4,557.00	5,050.68	5,126.63	5.696.25	6,645.63	7,025.38	7,595.00	9,493.75

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APPENDIX D: DIRECTORY

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8.0 Attachments

8.1 Training Resources

These external links are not the responsibility of, or under the control of, the Centers for Medicare & Medicaid Services (CMS). Some of these links may be to non-federal government websites (non-.gov websites). CMS disclaims responsibility for the content and privacy policies of non-.gov websites.

#	Course	Info
1	Training Overview	**Assistance Roles to Help Consumers Apply & Enroll in Health Coverage Through the Marketplace:** Provides definitions of the different types of consumer assistance in the Marketplace. http://www.cms.gov/CCIIO/ http://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf **Help Center:** Provides contact information to reach the Help Center. https://www.healthcare.gov/help-center/ **Consumer Assistance Programs (CAPs):** Provides information on state assistance via phone and email to consumers with health insurance problems. http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/
2	Health Insurance Basics	**Healthcare.gov Glossary:** An index to reference key terms about health coverage. http://www.healthcare.gov/glossary/ **Medicaid and CHIP Program Information:** Provides various resources on Medicaid and the Children's Health Insurance Program (CHIP). http://www.medicaid.gov/ http://www.medicaid.gov/Medicaid-CHIP-Program-Information/Medicaid-and-CHIP-Program-Information.html
3	Affordable Care Act Basics	**Timeline of the Health Care Law:** A timeline of implemented and upcoming changes under the Affordable Care Act. https://www.healthcare.gov/timeline-of-the-health-care-law **Health Reform: Frequently Asked Questions:** A quick reference guide on frequently asked questions on the Affordable Care Act. http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/

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#	Course	Info
		The Requirement to Buy Coverage Under the Affordable Care Act: A flowchart that illustrates the individual responsibility requirement. http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/ **Question and Answers on the Individual Shared Responsibility Provision:** A Frequently Asked Questions section from the Internal Revenue Service (IRS) on the individual responsibility requirement. http://www.irs.gov/ http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision **Status of State Action on the Medicaid Expansion Decision:** A table that shows state-by-state information related to actions taken on the Medicaid expansion. http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ **2013 Poverty Guidelines:** A set of tables that displays the federal poverty levels (FPLs) for 2013. http://aspe.hhs.gov/POVERTY/13poverty.cfm
4	Marketplace Basics	**What is the Health Insurance Marketplace?:** A basic overview of the Marketplaces. https://www.healthcare.gov/what-is-the-health-insurance-marketplace **Health Insurance Marketplaces: Training Resources:** A variety of training resources from the Center for Consumer Information and Insurance Oversight (CCIIO) on the Marketplaces. http://www.cms.gov/cciio/Resources/Training-Resources/index.html#Affordable Insurance Exchanges
5	Eligibility and Enrollment	**What key dates do I need to know:** A quick reference on key dates for Marketplace enrollment. https://www.healthcare.gov/what-key-dates-do-i-need-to-know/ **Programs in Your State:** An interactive map from InsureKidsNow.gov to help find children's health coverage. http://insurekidsnow.gov/state/index.html

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#	Course	Info
		Medicaid Enrollment By State: An interactive map offering details on each state's Medicaid program. http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html **What do small businesses need to know?:** A quick reference on key information for small businesses with regard to the Small Business Health Options Program (SHOP) Marketplace. https://www.healthcare.gov/what-do-small-businesses-need-to-know **Get health insurance for your employees:** Provides various resources related to SHOP. https://www.healthcare.gov/small-businesses **Minimum Value Calculator:** A resource for employers to enter information about their health plan's benefits, coverage of services, and cost-sharing terms to determine whether the plan provides minimum value. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm **Minimum Value Calculator Methodology:** A resource to accompany the minimum value calculator. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-methodology.pdf **Veterans Affairs Health Benefits:** Provides information on health coverage through the Veterans Health Administration (VHA) for eligible military veterans and how the Affordable Care Act affects VA health benefits. www.va.gov www.va.gov/aca
6	Standard Operation Procedures Manual	Standard Operation Procedures (SOP) Manual: A guide for providing assistance to consumers with getting access to Individual Marketplace and the SHOP Marketplace. **Marketplace Consumer Applications:** The Centers for Medicare and Medicaid Services (CMS) provides paper applications for consumers to apply for health coverage through the marketplace. Information on family income, household size, and current health coverage is needed. http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/ Individual Short Form Application: Application for individuals to find coverage choices and programs to help with costs.

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#	Course	Info
		http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/AttachmentB_042913.pdf Family Application: Application for families to find coverage choices and programs to help with costs. http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/AttachmentC_042913.pdf Individual Without Financial Assistance: Anyone who needs health coverage can use this application. The individual short form application should be filled out (instead of this one) if assistance with costs is needed. http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/AttachmentD_042913.pdf SHOP Employee Application: Employees of businesses participating in the SHOP use this application to identify eligibility for SHOP health coverage from their employer. http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/shop-employee-application-5-31-2013.pdf SHOP Employer Application: Small business employees who can't apply online or aren't working with a broker can complete this form to find out if they're eligible for the SHOP http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/shop-employer-application-5-31-2013.pdf
7	Assistance in the Individual Marketplace	**Am I eligible for coverage in the Marketplace?** A quick reference on eligibility criteria for the Marketplace. https://www.healthcare.gov/am-i-eligible-for-coverage-in-the-marketplace/ **Will I qualify for lower costs on monthly premiums?** A quick reference on potential savings associated with enrolling in the Marketplace. https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums
8	Assistance in the SHOP Marketplace	**How do my employees sign up for SHOP?:** A quick reference for assisting employees with Small Business Health Options Program (SHOP) Marketplace enrollment. https://www.healthcare.gov/how-do-my-employees-sign-up-for-shop **Can I use an agent or broker to buy health insurance in the Marketplace?:** A quick reference for basic information on the functions of agents and brokers in the SHOP Marketplace. https://www.healthcare.gov/can-i-use-an-agent-or-broker-in-shop

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#	Course	Info
9	Cultural Competence and Language Assistance	**What is Cultural Competency?** A Department of Health and Human Services (HHS) resource on cultural competency that includes a glossary of terms. http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11 **Linguistic Competence Definition:** A full definition of linguistic competence provide by Georgetown University's National Center for Cultural Competence (NCCC). http://nccc.georgetown.edu/ http://www11.georgetown.edu/research/gucchd/nccc **Priority Populations:** A listing of content related to the delivery of health care to priority populations, including inner-city, rural, low income, minority, women, children, elderly, and those with special health care needs. http://www.ahrq.gov/populations/cultcompdef.htm **Think Cultural Health:** This site, sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care. You may access free and accredited continuing education programs, as well as tools to help you and your organization provide respectful, understandable, and effective services. www.thinkculturalhealth.hhs.gov **HHS Action Plan to Reduce Racial and Ethnic Health Disparities:** This document provides a brief overview of racial and ethnic health disparities and unveils the Department of Health and Human Services' (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities ("HHS Disparities Action Plan"). www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf **Limited English Proficiency (LEP) Resources for Effective Communication:** These resources from the Department of Health and Human Services' (HHS) Office of Civil Rights inform effective communication with individuals with limited English proficiency. http://www.hhs.gov/ocr/civilrights/resources/index.html http://www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication/eclep.html **Pathfinder: Cultural and Linguistic Competency:** This listing of guides and research findings from the Agency for Healthcare Research and Quality (AHRQ) offers several resources for improving cultural and linguistic competency in delivering health care. http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/compath.html

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#	Course	Info
10	Serving Vulnerable and Underserved Populations	**Effectively Working With Vulnerable and Underserved Populations** **Office of Minority Health & Health Disparities (OMHD):** The Center for Disease Control and Prevention (CDC) has established the OMHD to help eliminate health disparities for vulnerable populations. This web site provides background on populations, definitions, demographics, and other helpful resources to understand and assist these populations. http://www.cdc.gov/omhd/ **The Health of Lesbian, Gay, Bisexual, and Transgender People (LGBT):** This report provides detailed information on what is known about the health of the LGBT community at different life stages. http://aspe.hhs.gov/ http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx **Plain Language:** Promoting clearer communication between the public and government. This site has resources for writers to attain that goal. http://www.plainlanguage.gov/ **Communications Assistance:** The Capacity Building Division, Office of Minority Health, Department of Health and Human Services (HHS), maintains materials and tools that focus on building an agency's voice in the community through educational and marketing materials development, including the process of engaging, informing, and evaluating the content of specific messages to audiences. https://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=463 **Making Health Communication Programs Work (NCI's Pink Book):** This book is a revision of the original Making Health Communication Programs Work, first printed in 1989, which the Office of Cancer Communications (OCC, now the Office of Communications) of the National Cancer Institute (NCI) developed to guide health communication program planning. http://www.cancer.gov/cancertopics/ **Health Communication, Health Literacy and e-Health:** The Department of Health and Human Services' (HHS) Office of Disease Prevention and Health Promotion (ODPHP) has pulled together key tools, research and reports, and resources for public health and health communication professionals. http://www.health.gov/communication/ **Effectively Serving American Indians** **and Alaska Natives** **Indian Health Services (IHS):** The Department of Health and Human Services' (HHS) Indian Health Services Office provides background on crucial health care issues for American Indians and Alaska Native populations and resources to help

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#	Course	Info
		find affordable care. http://www.ihs.gov/ http://www.hhs.gov/recovery/programs/ihs/fundingdescription.html **Tribal Affairs Group:** The Center for Medicare and Medicaid Services' (CMS) Tribal Affairs Group works closely with American Indian and Alaskan Native communities and leaders to enable access to culturally competent healthcare to eligible Medicare and Medicaid recipients. http://www.cms.gov/Outreach-and-Education/Outreach-and-Education.html http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/index.html **Tribal Directory:** The U.S. Department of the Interior's Bureau of Indian Affairs provides a directory of tribes' names, addresses, phone numbers, and fax numbers for each of the 565 federally recognized tribes. http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/index.htm http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm **Culture Card: A Guide to Build Cultural Awareness: American Indian and Alaska Native:** A guide with basic information health and wellness challenges for American Indian and Alaska Native communities http://www.samhsa.gov/ http://www.samhsa.gov/samhsaNewsletter/Volume_17_Number_2/AmericanIndianCulture.aspx **The American Indian and Alaska Native Population:** This 2012 report prepared by the U.S. Census Bureau provides definitions and population demographic information on American Indian and Alaska Native populations. http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf **The History of Indian Health:** This document from the Indian Health Service offers a historical look at the funding and provision of health care for Native Americans. https://archive.org/details/indianhealthserv00indi **Working Effectively With Older Adults** **If I have Medicare do I need to do anything:** Provides information on the relationship between the Marketplace and Medicare coverage. https://www.healthcare.gov/if-i-have-medicare-do-i-need-to-do-anything/ **State Health Insurance Assistance Program (SHIP**): A national program that offers one-on-one counseling and assistance to people with Medicare and their

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#	Course	Info
		families. https://shiptalk.org/ **Medicare Helpful Contacts:** A resource for finding the phone number of your state Medical Assistance office, State Health Insurance Assistance Program (SHIP), and other local contacts. http://www.medicare.gov/contacts/ **National Center for Benefits Outreach and Enrollment:** Provides help with other public benefits valuable to older adults and people with disabilities. http://www.ncoa.org/enhance-economic-security/center-for-benefits/ http://www.ncoa.org/enhance-economic-security/center-for-benefits/content-library/cultural-competence.html **Extra Help With Medicare Prescription Drug Plan Costs:** A resource for applying for Extra Help with your Medicare prescription drug plan costs. https://secure.ssa.gov/i1020/start **Medigap Insurance:** Information on Medicare supplement insurance (Medigap) that can help pay some of the health care costs that Original Medicare doesn't cover, such as copayments, coinsurance, and deductibles. http://www.medicare.gov/supplement-other-insurance/ http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html **Subsidies to Help Pay for Medicare Premiums and Cost-Sharing:** A quick reference guide on benefits and eligibility for Extra Help and Medicare Savings Programs. **How to Effectively Serve Mixed Immigration Status Families** **Table—A Quick Guide to Immigrant Eligibility for Affordable Care Act (ACA) and Key Federal Means-tested Programs:** This resource provides information about eligibility and other rules governing immigrants' access to federal and state public benefits programs. http://www.nilc.org/access-to-bens.html **Table: Medical Assistance Programs for Immigrants in Various States:** This table from the National Immigration Law Center (NILC) describes state policies for providing health coverage to certain immigrants, under federal options to cover lawfully residing children and pregnant women, regardless of their date of entry into the U.S., or to provide prenatal care to women regardless of status, using Children's Health Insurance Program (CHIP) funds. It also describes immigrant coverage under programs using exclusively state funds. http://www.nilc.org/health.html

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#	Course	Info
11	Working with Consumers with Disabilities	**Disability Rights and Resources:** The Department of Health and Human Services' (HHS) Office for Civil Rights conducts outreach activities and develops products that can be used to understand how to comply with disability laws such as Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act (ADA). http://www.hhs.gov/ocr/civilrights/understanding/ **Individuals With Disabilities (Medicaid):** This Medicaid website provides quick links to helpful information on Medicaid's role in assisting individuals with disabilities. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/People-with-Disabilities/Individuals-with-Disabilities.html **Disability Determination Process:** An overview of the Social Security Administration disability determination process. http://www.ssa.gov/disability/determination.htm **Disability Benefits:** A quick reference for information on Social Security disability. http://www.ssa.gov/pubs/EN-05-10029.pdf **Supplemental Security Income (SSI):** A quick reference for information on Supplemental Security Income (SSI). http://www.ssa.gov/pubs/EN-05-11000.pdf
12	Community Outreach	**Get Official Resources:** Are you planning a local event to help people with the Marketplace? The resources on this page can help you. http://marketplace.cms.gov/getofficialresources/get-official-resources.html **Census Data to Target the Uninsured:** The data here are for outreach targeting purposes. You can filter or sort this data on several population characteristics, including federal poverty level, education, and language. http://marketplace.cms.gov/exploreresearch/census-data.html **Training Materials & Presentations:** Training materials and presentations about the Marketplace that you can use for community outreach. http://marketplace.cms.gov/training/get-training.html
13	Privacy and Security Standards	**Navigator Final Rule:** This final rule addresses various requirements applicable to Navigators and non-Navigator assistance personnel in Federally-facilitated Marketplaces, including State Partnership Marketplaces, and to non-Navigator assistance personnel in State-based Marketplaces that are funded through federal Exchange Establishment grants.

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#	Course	Info
		http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf **The Department of Health and Human Services (HHS) Privacy Awareness Training:** A training course that covers topics such as privacy laws, personal identifiable information, and recognizing potential privacy threats, among others. http://www.hhs.gov/ocio/securityprivacy/awarenesstraining/privacyawarenesstraining.pdf **Publication 1075: Tax Information Security Guidelines For Federal, State and Local Agencies:** A detailed resource from the Internal Revenue Service (IRS) on security guidelines for handling tax information. http://www.irs.gov/ http://www.irs.gov/pub/irs-pdf/p1075.pdf
14	Customer Service Standards	**Designing Navigator Programs to Meet the Needs of Consumers: Duties and Competencies:** A short brief from the Georgetown University Health Policy Institute on strategies for improving consumer-oriented duties and competencies for Navigators. http://ccf.georgetown.edu/ http://ccf.georgetown.edu/wp-content/uploads/2012/09/Navigator-Programs-Duties-and-Competencies.pdf

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9.0 Manual Revision History

The Manual Revision History details updates, reorganization, and/or format changes made to the manual and SOPs that result in a new version.

9.1 Initial Manual

Version Number	Original Publication Date	Date Submitted to CMS	CMS Approval Date	Manual Effective Date	Manual Ending Date
1.0	08/15/13	08/02/13	08/06/13	08/15/13	

9.2 Manual Revisions

Version Number	Original Publication Date	Date Submitted to CMS	CMS Approval Date	Manual Effective Date	Manual Ending Date	Change Reason / Description