

Health Coverage Basics



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Course Introduction

Welcome



Hello, my name is Neha. I am here to help you learn the answers to these questions and more as we review the basics of health coverage. Ready? Let's go!

Can you answer these questions?

- What costs are associated with health coverage?
- What are the different ways that consumers can get coverage?
- What are Medicaid, the Children's Health Insurance Program (CHIP), and Medicare?

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Disclaimers

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Disclaimers

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You need to be aware of these training disclaimers.
Select each menu item below to read each disclaimer.

Disclaimers

- Assister Training Content
- Coronavirus
- Standards Related to Essential Health Benefits
- Remote Application Assistance
- FFM Navigator Duties

FFM Navigator Duties:

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with all of the following topics:

- Understanding the process of filing Marketplace eligibility appeals;
- Understanding and applying for hardship and affordability exemptions granted through the Marketplace for consumers age 30 and older seeking to enroll in a Catastrophic plan;
- Marketplace-related components of the premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;
- Understanding basic concepts and rights related to health coverage and how to use it; and
- Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process and premium tax credit reconciliations.

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

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Assister Training Content:

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

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

Coronavirus (COVID-19):

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

- To learn more about how we're responding to coronavirus, visit [HealthCare.gov/coronavirus/](https://www.healthcare.gov/coronavirus/).
- For preventive practices and applicable state/local guidance, visit [CDC.gov/coronavirus](https://www.cdc.gov/coronavirus).

Standards Related to Essential Health Benefits:

Navigators in Federally-facilitated Marketplaces (FFMs) must be prepared to inform consumers of the essential health benefits (EHB) that qualified health plans (QHPs) must cover in the FFM(s) they service. For plan years beginning on or after January 1, 2020, states may select which benefits will be EHB in their state. All plans offered in the Marketplace must cover the [10 essential health benefits categories](#), but the specific items and services covered within each benefit category may vary based on state requirements and plan design.

Remote Application Assistance:

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

Certified application counselors in FFMs may also provide remote application assistance if such assistance is

permissible with their certified application counselor designated organization (CDO).

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

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You and Assister

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



Navigators

in Federally-facilitated Marketplaces



Certified application counselors

in Federally-facilitated Marketplaces

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

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

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Course Goal

Some consumers you help may be new to health insurance and other types of health coverage. For example, they might be getting health insurance or Medicaid coverage for the first time. Each consumer will have different levels of understanding and comfort with health insurance, its terminology, and the types of health insurance available.

As you get started, basic information about health insurance and other types of health coverage will help you develop your skills to support consumers using the FFMs. Don't worry if you need some more time before you feel comfortable using this information. You'll learn to explain how all of these terms and costs work together in the Coverage to Care Assistance course.



Goal:

This course will help you understand basic health coverage information so you can help consumers find the coverage that best fits their needs.



Topics:

By the end of this course, you will understand:

- Common terms associated with health plans and health coverage;
- Purpose and types of health insurance in the private market, including managed care plans;
- Costs associated with health and prescription drug coverage;
- Information required in a Summary of Benefits and Coverage; and
- Public health insurance programs for eligible consumers including Medicaid, the Children's Health Insurance Program (CHIP), and Medicare.

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Overview of Health Insurance

Introduction

Many people have existing health insurance coverage and won't need to buy health insurance through the Marketplace. However, both insured and uninsured people may need your help understanding more about the Marketplaces and the application process. Your job is to help consumers understand the coverage options available to them through the FFMs and to help them decide which coverage option best fits their budgets and specific needs.



What is ...

Define "health coverage" and "health insurance"



Importance

State why health coverage is important



How Does it Work?

Describe how health insurance works to provide health coverage for consumers

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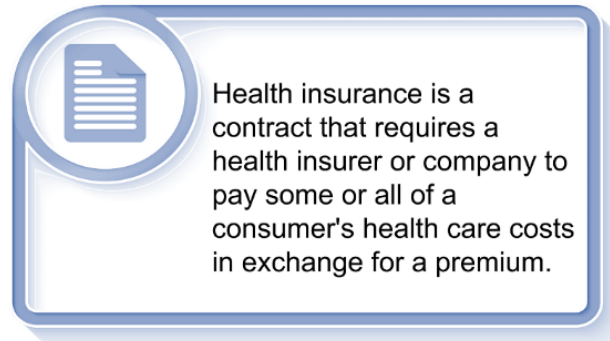
How Does it Work?

Describe how health insurance works to provide health coverage for consumers

Definitions

The terms **health coverage** and **health insurance** have two distinct meanings even though they are often used interchangeably.

In this training, **health coverage** is defined as payment or reimbursement for health care costs that consumers are legally entitled to when enrolled in health coverage programs. Health insurance companies offer one way for consumers to get health coverage, but consumers can also get health coverage through government programs like Medicaid, CHIP, and the Veterans Affairs (VA) Health Benefits Program.



Note: Some health coverage programs provide their benefits through managed care plans. For example, Medicaid programs in many states contract with managed care plans to provide or arrange for covered Medicaid benefits. When states contract with managed care plans, the beneficiary generally does not pay a premium to the plan issuer.

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Health insurance is a contract that requires a health insurer or company to pay some or all of a consumer's health care costs in exchange for a premium.

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Health Insurance Overview

Health insurance can be confusing. Here's one way that you can explain it to consumers.

In general, insurance is a contract that's meant to protect you financially if something bad happens that is expensive to fix or to recover from. When you have insurance, you pay a little bit each month. If there is an accident, an insurance company will help cover some of the costs.

Health insurance and health coverage programs do even more. They pay for the big, unexpected events but also for some of the smaller, more expected things. For example, they help with the cost if you're in the hospital and also when you get a routine check-up. Having health insurance or coverage lets you take care of small health problems as soon as you notice them rather than waiting until the problems get worse and you become really sick.

Health insurance plans can be purchased through the Marketplaces, private insurance companies, online insurance sellers, or agents and brokers. Many people also get health insurance through their jobs.

There are many kinds of private health insurance policies. They may offer very different kinds of benefits. Some types of policies may limit which doctors, hospitals, or other providers consumers can use.



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Why is Health Coverage Important?



There are several reasons why having health insurance or other health coverage is important:

- Health coverage often gives consumers access to preventive health care services to help them stay healthy. Most insurance plans and health coverage programs must cover many preventive services without cost sharing under the Affordable Care Act (ACA).
- Health coverage helps consumers pay for health care services if they become sick or injured.
- Without health coverage, costs for health services can be extremely high and may result in serious financial hardship.

The ACA requires consumers to have health coverage that is considered minimum essential coverage (MEC), but, beginning with tax year 2019, they are no longer required to report on their health coverage enrollment when they file their taxes. They are also no longer required to file for an exemption if they didn't have MEC for part or all of a tax year. This will be explained in more detail in other training courses.

The ACA prohibits health insurance companies from refusing coverage to consumers or charging consumers more because of [pre-existing conditions](#).

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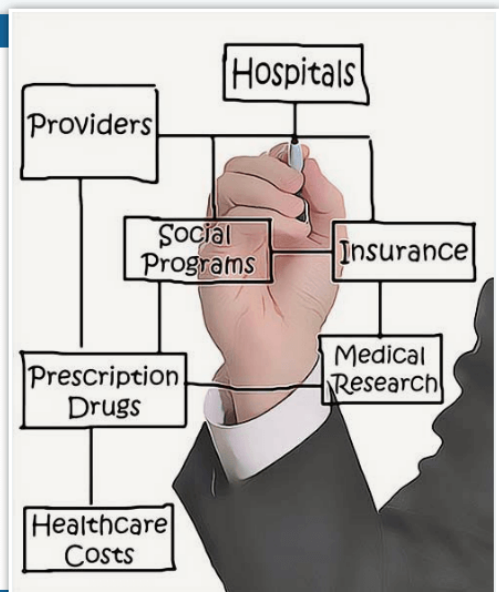
Pre-existing Conditions

Pre-existing conditions are medical conditions (e.g., asthma, back pain, diabetes, or cancer) that consumers had before the date their current health coverage became effective.

How Does Health Insurance Work?

Health insurance companies often contract with certain hospitals, doctors, pharmacies, and other health care providers to deliver medical services for an agreed-upon rate. These providers are known as a health insurance company's provider network. Health insurance companies create various provider networks to develop different health plan options for plan members to choose from.

Before they enroll, it's important for consumers to carefully review provider networks to make sure the doctors they want to visit and the pharmacies they want to use participate in their desired health plans. It is strongly recommended that consumers contact their doctors and pharmacies directly to confirm that they are participating in the plan the consumer has chosen.



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Knowledge Check

Which of the following is **NOT** a reason why health coverage is important?

Select the **correct answer** and then select **Check Your Answer**.

- ☐ A. Health coverage often gives consumers access to preventive health care services to help them stay healthy.
- ☐ B. Health coverage helps consumers pay for health care services if they become sick or injured.
- ☐ C. Without health coverage, costs for health services can be extremely high and may result in serious financial hardship.
- ☒ D. Helping consumers identify and enroll in health insurance plans through the Marketplaces increases the number of consumers enrolled in Medicaid, CHIP, or Medicare.

✓ Check Your Answer

HEALTH INSURANCE

NAME

GROUP

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Correct!

Health coverage often gives consumers access to preventive health care services to help them stay healthy, helps consumers pay for health care services if they become sick or injured, and prevents financial hardship that can occur when consumers don't have health insurance and must pay higher costs for health services.

Which of the following is **NOT** a reason why health coverage is important?

- A.** Health coverage often gives consumers access to preventive health care services to help them stay healthy.
- B.** Health coverage helps consumers pay for health care services if they become sick or injured.
- C.** Without health coverage, costs for health services can be extremely high and may result in serious financial hardship.
- D.** Helping consumers identify and enroll in health insurance plans through the Marketplaces increases the number of consumers enrolled in Medicaid, CHIP, or Medicare.

The correct answer is D. Health coverage often gives consumers access to preventive health care services to help them stay healthy, helps consumers pay for health care services if they become sick or injured, and prevents financial hardship that can occur when consumers don't have health insurance and must pay higher costs for health services.

Key Points



- Consumers purchase health insurance or enroll in other health coverage to help pay for medical care and avoid serious financial hardship.
- Health insurance companies often contract with groups of hospitals, doctors, pharmacies, and other health care providers (known as provider networks) to provide health care services for an agreed-upon rate.

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Common Health Coverage Terms

Introduction

To help consumers make health coverage decisions, it's important to understand and be able to describe these health coverage terms.



Provider networks

Describe health insurance provider networks



Coverage costs

List the general types of costs associated with health coverage



Formularies

Define prescription drug formularies (drug lists) and tiered formularies

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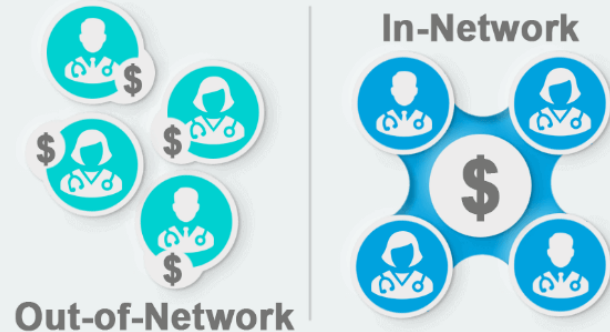
Define prescription drug formularies (drug lists) and tiered formularies

Provider Networks

Remember, nearly all health insurance companies use provider networks to manage the costs of providing care to consumers. A **network** is a list of doctors and hospitals that consumers generally must use to get coverage or lower out-of-pocket costs.

- Some health plans, like Health Maintenance Organizations (HMOs), will only pay for services performed by providers within their network (also known as in-network providers).
- Other plans, like Preferred Provider Organizations (PPOs), may pay for services by any provider, even providers who aren't in-network. It's often more expensive for consumers to go to doctors who aren't in their health plans' networks (that is, out-of-network providers).*
- Some plans require consumers to choose an in-network primary care provider. A primary care provider is usually a doctor who directly provides or coordinates a range of health care services for a patient. Primary care providers may be responsible for coordinating care and making referrals to specialists. Costs charged for services provided by a primary care doctor, including copayments, are usually lower than those for specialists regardless of whether the specialist is in network or out of network.

*Note: You'll learn more about the different types of health insurance and other health coverage plans later in this course.



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*Note: You'll learn more about the different types of health insurance and other health coverage plans later in this course.

Costs Associated With Health Insurance

When consumers have health insurance, their cost of care is split with the insurance company based on the plan they selected. Understanding terms related to health insurance helps consumers choose the coverage that meets their needs and fits their budget. You can help them understand these terms.

Select each term to learn more about the costs associated with health insurance:

 Premium	Copayment (sometimes called a "copay")	Deductible	Coinsurance	Out-of-Pocket Costs
<p>Premium</p> <p>A premium is the amount that must be paid to a health insurance company for a health insurance plan. Consumers and/or their employers usually pay it monthly.</p>				

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Premium

A premium is the amount that must be paid to a health insurance company for a health insurance plan. Consumers and/or their employers usually pay it monthly.

Copayment (sometimes called a "copay")

A copayment is a fixed amount (e.g., \$15) consumers pay to health care providers for a covered health care service, usually at the time of service. The amount can vary by the type of covered service, like visiting a doctor, filling a prescription, or going to the emergency room. Copayments are generally lower for services delivered by primary care doctors and higher for services delivered by specialists. Remember that copayments for in-network providers are typically lower than copayments for out-of-network providers. Copayments are also typically lower for generic prescription drugs than for brand-name prescription drugs.

Deductible

A deductible is the amount consumers must pay out of pocket for health care services before their health insurance plans begin to pay. Premiums don't count toward the deductible. For example, if a consumer's deductible is \$1,000, the plan won't pay anything until the consumer has paid \$1,000 for covered health care services. However, some health care services aren't subject to the deductible and may be covered by health insurance plans even if consumers haven't met the deductible. The deductible may not apply to all services.

Coinsurance

Coinsurance is a consumer's share of the cost of a covered health care service calculated as a percentage (e.g., 20 percent) of the amount allowed by the health plan for that service. Consumers pay coinsurance plus any deductibles they owe. For example, if a health insurance plan's allowed amount for an office visit is \$100 and a consumer has met the deductible, the consumer pays coinsurance of 20 percent, or \$20. The health insurance plan pays the remaining 80 percent, or \$80. Some plans may require both a copayment and coinsurance for particular types of services.

Out-of-Pocket Costs

Out-of-pocket costs are consumers' expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services. Consumers pay out-of-pocket costs in addition to their monthly premiums. Some consumers may be eligible for savings on out-of-pocket costs, called cost-sharing reductions (CSRs), based on their household incomes and sizes. CSRs will be reviewed later in the training.

The amount paid is limited by an out-of-pocket maximum. After the out-of-pocket maximum is reached, the insurance company must pay for all covered essential health benefits (EHB) without imposing out-of-pocket costs. This limit includes deductibles, copayments, coinsurance, and any other amount that may be required to pay for EHB. This limit doesn't include premiums, extra amounts consumers pay for out-of-network cost sharing, or the cost of benefits that aren't considered covered.

Additional Costs Associated With Health Insurance

Here are a few more terms about the costs of insurance that you can explain to consumers.

Claim

A claim is a request for payment that consumers or health care providers submit to a health insurance company for items or services they think are covered.

Allowed Amount

An allowed amount is the maximum amount allowed to be paid for a covered health service by a health insurance company. This may also be called an "eligible expense," "payment allowance," or "negotiated rate." If providers charge more than the allowed amount, consumers may have to pay the difference.

Balance Billing

Balance billing happens when providers bill consumers for the difference between the provider's charge and the amount allowed by the health plans. For example, if a provider charges \$100 and the allowed amount is \$70, the provider may bill the consumer for the remaining \$30. Some providers may not balance-bill consumers for covered services. This typically happens when providers have a contract with consumers' health insurance companies to provide services at a discount, also known as a preferred provider or network agreement. It's important for consumers to understand their plan's provider network and that they may have to pay more to see certain providers if they are outside of the plan's provider network.

Note: As of January 1, 2022, the No Surprises Act requires health plans and issuers to limit cost sharing to in-network cost-sharing amounts and prohibits out-of-network providers, facilities, or providers of air ambulance services from billing individuals more than the applicable cost-sharing amounts in three main scenarios:

- A person gets covered emergency services from an out-of-network provider or out-of-network emergency facility;
- A person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network health care facility; or
- A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

Here are a few more terms about the costs of insurance that you can explain to consumers.

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- A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

Knowledge Check

Common Health Coverage Terms Knowledge Check

Text Only



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Helen is a 46-year-old mother of three children. Her husband's health insurance plan has a \$1,000 deductible for the family each calendar year. Helen's 8-year-old son requires a medical procedure that will cost \$1,500. The family already paid \$750 toward the deductible this year.

Assuming that the service is covered by the health insurance plan, there are no copayments or coinsurance, and balance billing doesn't apply, what will Helen pay for her son's medical procedure?

Select **the correct answer** and then select **Check Your Answer**.

- ☐ A. \$250
- ☐ B. \$500
- ☐ C. \$1,000
- ☐ D. \$1,500

✓ Check Your Answer



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- A. \$250
- B. \$500
- C. \$1,000
- D. \$1,500

The correct answer is A. Helen's cost for her son's medical procedure will be \$250 since this is the remaining balance on the \$1,000 annual deductible before the health insurance plan will pay any expenses for covered health care services.

Formulary or Drug List



Health plans use the term formulary, or drug list, to describe the list of prescription drugs that they cover. When helping consumers compare plans through the Marketplaces, it's a good idea to advise them to make sure that any drug(s) they're currently taking are listed on a plan's drug formulary before enrolling in that plan.

A formulary typically includes details about the copayment consumers pay for each type of covered drug. You'll learn more about the FFM tools available to compare plans to better assist consumers later in this training.

Some plans, however, use coinsurance for prescription drugs instead of copayments. As you've learned, coinsurance requires consumers to pay a percentage of the total cost of a procedure or drug instead of a set amount. For brand-name drugs, this can be very costly.

For example, a consumer who owes 20 percent coinsurance for a \$1,000 drug would pay \$200. That same drug under a plan that charges copayments might cost only \$40.

As a best practice, encourage consumers to consider what types of drugs they currently take when choosing a plan. Plans that charge copayments for prescription drugs may be more affordable for certain consumers than plans that charge coinsurance for prescription drugs.

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As a best practice, encourage consumers to consider what types of drugs they currently take when choosing a plan. Plans that charge copayments for prescription drugs may be more affordable for certain consumers than plans that charge coinsurance for prescription drugs.

Tiers are groups of drugs that have a different cost for each group. A drug in a lower tier will cost less than a drug in a higher tier. Each plan can divide its tiers in different ways. In general, a tiered formulary encourages consumers to select lower-cost drugs, like generic (non-brand-name) drugs.

Here's an example of a three-tiered formulary approach:

- The first tier includes generic drugs with the lowest cost to consumers (e.g., a \$10 copayment).
- The second tier includes preferred brand-name drugs with a higher cost to consumers (e.g., a \$25 copayment).
- The third tier includes non-preferred brand-name drugs with the highest cost to consumers (e.g., a \$40 copayment).

If a plan uses tiers, its formulary will list which drugs are included in each tier.



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If a plan uses tiers, its formulary will list which drugs are included in each tier.

Key Points



- Health insurance companies often contract with a network of health care providers to provide care to consumers. Plans may differ based on provider networks, how much consumers are responsible for paying, and the benefits they offer.
- Health insurance companies use deductibles, copayments, and coinsurance to share health care costs with consumers.
- A formulary, or drug list, describes the list of prescription drugs covered by a health insurance plan and includes details about the copayments or coinsurance required for each type of drug.

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Summary of Benefits and Coverage

Introduction

Under the law, health insurance companies and group health plans (i.e., health plans provided by employers, also known as employer-sponsored coverage) are required to give consumers an easy-to-understand summary of health plan benefits and coverage. This is called a Summary of Benefits and Coverage (SBC).



Purpose

State the purpose of an SBC



Obtain an SBC

Describe how to obtain an SBC



Content

Describe the information provided in an SBC, including the Uniform Glossary of Terms

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Content

Describe the information provided in an SBC, including the Uniform Glossary of Terms

Purpose of the SBC

The SBC helps consumers understand their health care costs under a specific plan in plain language.

SBCs make it easier for consumers to compare different coverage options by summarizing key features of health plans, including:

- Covered benefits
- Cost-sharing provisions
- Coverage limitations and exceptions

Insurance companies can't set limits on what they will pay in a year for EHB while a consumer is enrolled in a particular health insurance plan.

For more information on SBCs, visit [HealthCare.gov/health-care-law-protections/summary-of-benefits-and-coverage/](https://www.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/).

Important Questions	Answers
What is the overall deductible?	\$500 / individual or \$1,000 / family
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage and \$300 for occupational therapy services. There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	For network providers \$2,500 individual / \$5,000 family; for out-of-network providers \$4,000 individual / \$8,000 family
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.

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Ways to Obtain an SBC

Health insurers and group health plans must provide an SBC:

- When consumers enroll in coverage for the first time
- At the beginning of each new plan year
- Within seven business days after a consumer requests a copy

Insurers may provide SBCs in person, by mail, or by email (if consumers consent to receive their SBCs electronically).

If an SBC is posted on the Internet, consumers must be notified about where the SBC is posted and that the SBC is available in paper form free of charge upon request. The electronic version must be in a format that is readily accessible.

Before receiving an application, an insurer can comply with the requirement to provide an SBC by providing the required information to the Department of Health and Human Services (HHS) for posting online.

Note: for Medicaid recipients, the Managed Care plan (also known as Managed Care Entities or Managed Care Organizations) will send each member a handbook that outlines covered services and benefits.



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Under the ACA, insurance companies and group health plans are required to describe their plans using a uniform glossary of commonly used terms, like **deductible** and **copayment**. HHS and the Department of Labor (DOL) also post the glossary at [HealthCare.gov](https://www.healthcare.gov) and at [DOL.gov](https://www.dol.gov).

Additional resources are available to help consumers understand and use an SBC, including:

- [Regulations & Guidance](#)
- [Fact Sheets & FAQs](#)
- [Letters & News Releases](#)
- [Other Resources](#)

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance," or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (Refer to Balance Billing)

Appeal

A request for your health insurer or plan to review a decision or a grievance again.

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 the covered services.

Note: As of January 1, 2022, the No Surprises Act requires health plans and issuers to limit cost sharing to in-network cost-sharing amounts and prohibits out-of-network providers, facilities, or providers of air ambulance services from billing individuals more than the applicable cost-sharing amounts in three main scenarios:

- A person gets covered emergency services from an out-of-network provider or out-of-network emergency facility;
- A person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network health care facility; or
- A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

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- A person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network health care facility; or

- A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

Knowledge Check

Summary of Benefits and Coverage Knowledge Check

Text Only



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Which of the following statements are true about an SBC?

Select **all that apply** and then select **Check Your Answer**.

- ☐ A. An SBC contains a consumer's estimated costs for three medical scenarios: having a baby, managing type 2 diabetes, and emergency room treatment for a simple fracture.
- ☐ B. Health insurers and group health plans must provide an SBC within seven business days after a consumer requests a copy.
- ☐ C. An SBC summarizes key features of health plans, including covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
- ☐ D. An SBC must always be provided in a paper format that is mailed to the consumer for a small fee.

✓ Check Your Answer



Which of the following statements are true about an SBC?

- A.** An SBC contains a consumer's estimated costs for three medical scenarios: having a baby, managing type 2 diabetes, and emergency room treatment for a simple fracture.
- B.** Health insurers and group health plans must provide an SBC within seven business days after a consumer requests a copy.
- C.** An SBC summarizes key features of health plans, including covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
- D.** An SBC must always be provided in a paper format that is mailed to the consumer for a small fee.

The correct answers are A, B, and C. An SBC must summarize key features of a health plan, including covered benefits, cost-sharing provisions, and coverage limitations and exceptions. It must include a beneficiary's estimated costs for three medical scenarios: having a baby, managing type 2 diabetes, and emergency room treatment for a simple fracture. A health insurer or group health plan must provide an SBC within seven business days after a consumer requests a copy. Finally, insurers may provide SBCs in person, by mail, by email (if consumers consent to receive their SBCs electronically), or may also post SBCs online, provided applicable requirements are met.

Key Points



- Consumers must be provided an SBC detailing simple and consistent information about their coverage and benefits.
- An SBC must contain examples of consumer costs for specific scenarios as well as cost-sharing limits and contact information.
- The Uniform Glossary of Terms provides definitions for key terms used in an SBC.

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Types of Health Coverage

Introduction

Health coverage is available from a variety of sources. Some consumers purchase health insurance through the Marketplaces or directly from a health insurance company, while others get health insurance through their jobs or meet eligibility requirements to participate in government health coverage programs.

You must provide fair, accurate, and impartial information to consumers about the full range of coverage options for which they are eligible through the FFMs. You can help consumers determine which of these coverage options may be the most suitable. This training will provide you with the skills to explain:



Coverage Options available through the FFMs

State the types of private and public coverage options that might be available to consumers through the FFMs, including Marketplace plans, Medicaid, and CHIP



Managed Care Plans

Describe the types and features of managed care plans



Coverage Options & Features

Describe the types and features of private insurance plans and public programs

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Managed Care Plans

Describe the types and features of managed care plans

Coverage Options & Features

Describe the types and features of private insurance plans and public programs

Private Health Coverage Options

Health insurance is available from a variety of sources, including private organizations.

Select each program title to learn more about different ways to get privately run health insurance.

**Health Insurance through the Marketplaces**

Health Insurance Outside the Marketplaces

Employer-based Insurance

COBRA

Coverage Under a Parent's Plan

Health Insurance through the Marketplaces

Qualified consumers can enroll in individual market coverage through the Marketplaces during the Open Enrollment Period (OEP). For Plan Year 2023, the individual market OEP for Marketplace plans will begin on November 1, 2022 and end on January 15, 2023. The insurance plans offered in the Marketplaces are called qualified health plans (QHPs). The Marketplaces certify each QHP sold in a state. QHPs, among other things, must provide a comprehensive benefits package and EHB and follow limits on cost sharing.

Generally, during the individual market OEP, if consumers enroll between November 1 and December 15, their coverage starts on January 1. In addition to enrolling during the OEP, consumers may enroll in individual market coverage through the Marketplaces if they qualify for a Special Enrollment Period (SEP).

Job-based coverage can be made available by eligible small employers through the Small Business Health Options Program (SHOP) Marketplaces. If so, an employer will generally set the enrollment period for their employees, but SEPs may also be available depending upon employees' individual circumstances. The SHOP Marketplaces are covered in more detail in other courses.

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Health Insurance through the Marketplaces

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Health Insurance Outside the Marketplaces

Consumers can also get individual market coverage directly through a health insurance company that sells insurance outside of the Marketplaces. Health insurance companies are required to accept enrollments for coverage outside the Marketplaces during the individual market OEP and certain other SEPs. Coverage becomes effective based on the date a plan was selected, along the same timelines that apply in the Marketplaces. However, if consumers purchase health insurance in the individual market outside of the Marketplaces, they won't benefit from Marketplace programs to help lower their costs, even if their income is low.

Note: Plans offered outside the Marketplaces may not be required to meet all of the same standards as QHPs.

Employer-based Insurance

Consumers who are currently employed may be able to purchase employer-sponsored or job-based insurance through their employers. If consumers lose or quit their jobs, they often may:

- Extend their job-based health insurance coverage through a program called Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.
- Be eligible for an SEP to purchase an individual market QHP through the Marketplaces or to purchase coverage outside the Marketplaces.
- Be eligible for Medicaid/CHIP.

COBRA

Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage lets most consumers continue with their existing job-based health insurance coverage for a limited period of time, typically at a higher cost than when they were employed, as employers aren't required to pay any portion of the premiums. Typically, consumers have 60 days from their last day of health coverage or when they received the election notice to enroll in COBRA coverage. Additional information is available in the Advanced Marketplace Issues and Technical Support course.

Instead of choosing COBRA continuation coverage, qualified consumers who lose job-based health insurance coverage generally may enroll in individual market coverage, either through the Marketplaces or outside the Marketplaces.

Policy Updates

As mentioned above, typically, consumers have until the later of 60 days after losing eligibility for their employer's group health coverage or 60 days after receiving their COBRA election notice to elect COBRA continuation coverage. However, due to the COVID-19 Public Health Emergency, these deadlines have been temporarily extended. Instead of employees being required to elect COBRA coverage within 60 days of losing group health coverage, plans are now required to "disregard" the period between March 1, 2020, and 60 days after the end of the COVID-19 Public Health Emergency. Therefore, employees who have experienced a COBRA continuation coverage qualifying event have until the earlier of one year from the date they were first eligible for relief or 60 days after the announced end of the COVID-19 Public Health Emergency, which is ongoing.

Coverage Under a Parent's Plan


In all states, young adults are eligible to enroll in or remain on health coverage under their parents' health plans until they turn 26 if those plans cover dependent children.

Health Insurance in the Private Market

Consumers who get privately run health insurance generally choose between a few common types of managed care plans. These plans give consumers different levels of access to providers.

Plans like a fee-for-service (FFS) plan (also called an indemnity plan) provide alternatives to managed care.

Select each type of plan to learn more.

 HMO	PPO	POS	EPO	FFS Plan	HDHP	Catastrophic Health Plan
<h3>HMO</h3> <p>A Health Maintenance Organization (HMO) is a type of health insurance plan that usually limits coverage to care from in-network doctors who work for or contract with the HMO. HMO plans usually require consumers to get a referral from their primary care doctor to visit a specialist, and they generally won't cover out-of-network care except in an emergency. In exchange for the limited access to providers, premiums are typically lower in an HMO than in other types of plans.</p>						

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PPO

A PPO (Preferred Provider Organization) is a type of health plan that contracts with health care providers like hospitals and doctors to create a network of participating providers. Consumers pay less if they use providers that belong to the plan's network (e.g., in-network providers). Consumers can visit doctors, hospitals, and providers outside of the network (e.g., out-of-network providers) at an additional cost. Referrals aren't needed to visit specialists. In exchange for greater access to providers, premiums are generally higher in a PPO than in an HMO.

POS

A POS (Point of Service) plan is a type of plan in which consumers pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. With this type of plan, a consumer may go to out-of-network providers at a higher cost. Unlike PPO plans, POS plans generally require consumers to get a referral from their primary care doctor to visit a specialist.

EPO

An Exclusive Provider Organization (EPO) is a managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency). Services received outside the network must generally be paid for by the consumer.

FFS Plan

A Fee-for-Service (FFS) plan lets consumers choose their own providers, and the health insurance company reimburses providers for a portion of the total cost of each service that consumers use.

HDHP

A High Deductible Health Plan (HDHP) is a type of health plan that features higher deductibles than traditional insurance plans in exchange for lower monthly premiums. HDHPs can be combined with a health savings account (HSA) or a flexible spending account (FSA). HSAs and FSAs let a consumer pay for qualified out-of-pocket medical expenses on a pretax basis. The money that's contributed to an HSA or an FSA isn't subject to federal income tax at the time of deposit but must be used to pay for qualified medical expenses. A consumer uses the money in the HSA to help meet the deductible before the HDHP begins to pay for services. Funds contributed to an HSA roll over year to year if a consumer doesn't spend them, but FSA funds don't carry over from year to year. In other words, any FSA funds that consumers don't spend by the end of the plan year can't be used for expenses in the next year. HDHPs may not be appropriate for consumers with chronic or serious health conditions that require multiple specialist visits and procedures. It's important that you remind consumers to consider these financial factors before deciding on a plan. However, keep in mind that you shouldn't provide tax advice in your role as an assister.

Catastrophic Health Plan

A Catastrophic health plan is designed to provide emergency services to protect consumers from unexpected medical costs, but it has limits on coverage of regular doctor visits. Generally, people under 30 years of age before the beginning of the plan year or people age 30 and older with hardship exemptions or affordability exemptions may buy a Catastrophic health plan. The premium amount a consumer pays each month for a Catastrophic health plan is generally lower than other types of plans, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally much higher.

Knowledge Check

Types of Health Coverage Knowledge Check

Text Only



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Juan, a 50-year-old construction supervisor, is very particular about the doctors he visits for his back problem. He asks you which plans give him the option to visit out-of-network providers and which plans will pay for at least a portion of the health care costs.

Which of the following types of health insurance plans should you tell him would give him access to those features?

Select **all that apply** and then select **Check Your Answer**.

- ☒ A. Preferred-Provider Organization
- ☒ B. Point of Service
- ☐ C. Health Maintenance Organization
- ☐ D. Exclusive Provider Organization

Check Your Answer



Correct!

Both PPO and POS plans could allow consumers to visit out-of-network providers and will pay for a portion of those health care costs for covered benefits.

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Which of the following types of health insurance plans should you tell him would give him access to those features?

- A. Preferred-Provider Organization
- B. Point of Service
- C. Health Maintenance Organization
- D. Exclusive Provider Organization

The correct answers are A and B. PPO and POS plans could allow consumers to visit out-of-network providers and will pay for a portion of those health care costs for covered benefits.

Public Health Coverage Options

When consumers apply for coverage through the Marketplaces with subsidies, their applications will be reviewed to determine if they're eligible for public health coverage through Medicaid and CHIP. It's important for you to understand how these government-operated health coverage programs work so you can help consumers identify the type of coverage that is right for them. For the same reason, it's also important for you to have at least a basic knowledge of other government-operated health programs that might be available to consumers.

Note: Like private health insurance, some public programs, like Medicaid or CHIP, may have small premiums and/or copayments for consumers to pay to participate in the program. These cost-sharing amounts may be different depending on the types of public health programs offered in each state.

Select each program title below to learn more about the different government-operated public health coverage programs.

Medicaid	CHIP	Medicare	TRICARE	VA Health Benefits	Peace Corps
Medicaid A state-administered health coverage program for low-income families and children, pregnant individuals, older adults, people with disabilities, and in many states, other adults. The Federal Government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid varies state by state and may have a different name in your state.					

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Medicaid

A state-administered health coverage program for low-income families and children, pregnant individuals, older adults, people with disabilities, and in many states, other adults. The Federal Government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid varies state by state and may have a different name in your state.

CHIP

CHIP is a program jointly funded by the federal and state governments that provides health coverage to uninsured low-income children and, in some states, pregnant individuals in families with income too high to qualify for Medicaid but who can't afford private health insurance.

Medicare

Medicare is the federal health coverage program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Medicare beneficiaries pay a premium or qualify for benefits coverage based on payment of payroll taxes.

TRICARE

TRICARE is the Department of Defense's health care program available to eligible members and their families of the eight United States (U.S.) uniformed services: the Army, Navy, Air Force, Marine Corps, Space Force, Coast Guard, Commissioned Corps of the Public Health Service, and the National Oceanic and Atmospheric

Administration.

VA Health Benefits

The VA provides coverage for eligible veterans who served in the U.S military. The VA administers a variety of benefits and services that provide financial and other forms of assistance to service members, veterans, and their dependents and survivors.

Peace Corps

The Peace Corps provides volunteers with comprehensive health and dental insurance during their Peace Corps service.

Knowledge Check

Types of Health Coverage Knowledge Check

Text Only



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Which of the following coverage programs would allow consumers to continue to purchase their existing job-based health insurance coverage if they lost their job?

Select **the correct answer** and then select **Check Your Answer**.

- ☐ A. TRICARE
- ☐ B. Medicare
- ☒ C. Consolidated Omnibus Budget Reconciliation Act (COBRA)
- ☐ D. CHIP

✓ Check Your Answer



Correct!

COBRA lets consumers continue to purchase their same job-based health insurance if they lose or quit their jobs.

Which of the following coverage programs would allow consumers to continue to purchase their existing job-based health insurance coverage if they lost their job?

- A. TRICARE
- B. Medicare
- C. Consolidated Omnibus Budget Reconciliation Act (COBRA)
- D. CHIP

The correct answer is C. COBRA lets consumers continue to purchase their same job-based health insurance if they lose or quit their jobs.

Key Points



- It's important for assisters to know about the different types of private and public coverage that might be available to consumers and to be able to explain the coverage options that might be available to consumers through the FFMs.
- Managed care is a way insurance companies manage cost, quality, and access to health care services.
- The most common types of health insurance plans consumers should know about include PPOs, POS plans, HMOs, HDHPs, and Catastrophic health plans.

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- Managed care is a way insurance companies manage cost, quality, and access to health care services.
- The most common types of health insurance plans consumers should know about include PPOs, POS plans, HMOs, HDHPs, and Catastrophic health plans.

Conclusion


Conclusion
Conclusion

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Congratulations! You learned about the purpose of health coverage and how health coverage works. You can now describe various types of private and public health coverage options that might be available to consumers, including Marketplace plans, Medicaid, CHIP, and Medicare.

You've finished the learning portion of this course. Select the link to take the [Health Coverage Basics](#) exam, or you can close the course and return to the exam later.

Congratulations! You learned about the purpose of health coverage and how health coverage works. You can now describe various types of private and public health coverage options that might be available to consumers, including Marketplace plans, Medicaid, CHIP, and Medicare.

You've successfully completed the learning portion of this course.

Select the link to take the [Health Coverage Basics exam](#) or you can close the course and return to the exam later.

Resources:

More About COBRA: Additional information for consumers who have coverage through COBRA.

[HealthCare.gov/what-if-i-currently-have-cobra-coverage/](https://www.healthcare.gov/what-if-i-currently-have-cobra-coverage/)

HealthCare.gov Glossary: An index to reference key terms about health coverage.

[HealthCare.gov/glossary/](https://www.healthcare.gov/glossary/)

Summary of Benefits and Coverage: An example of a SBC and a Uniform Glossary of Terms

[CMS.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html)

Federal Poverty Guidelines 2022: Official HHS guidance on FPL levels for 2022.

[ASPE.hhs.gov/poverty-guidelines](https://aspe.hhs.gov/poverty-guidelines)

State Medicaid & CHIP Profiles, including each state's Medicaid eligibility criteria.

[Medicaid.gov/medicaid/by-state/by-state.html](https://www.medicaid.gov/medicaid/by-state/by-state.html)

No Surprises Act: Consumer Webpage

[CMS.gov/nosurprises/consumers](https://www.cms.gov/nosurprises/consumers)