

Coverage to Care Assistance



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Course Introduction

Welcome



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

Can you answer these questions?

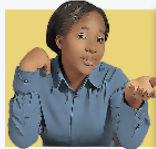
- How can I help consumers learn about their coverage costs?
- How can I help consumers confirm they are enrolled in health coverage?
- How can I help consumers understand how to identify in-network providers and how to make and prepare for an appointment with a provider?

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Disclaimers



Before we begin, you need to be aware of these training disclaimers. Select each menu item below to read each disclaimer.

Disclaimers



Assister Training Content



Coronavirus



Remote Application Assistance



FFM Navigator Duties



Section 1557 of the Affordable Care Act

Section 1557 of the Affordable Care Act:

As of May 10, 2021, the Department of Health and Human Services (HHS) will interpret and enforce Section 1557's prohibition on discrimination on the basis of sex to include: (1) discrimination on the basis of sexual orientation; and (2) discrimination on the basis of gender identity, consistent with Title IX of the Education Amendments of 1972 and the Supreme Court's decision in *Bostock v. Clayton County, GA* (140 S.Ct 1731 (2020)).

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Assister Training Content:

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

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

Coronavirus (COVID-19):

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

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

Remote Application Assistance:

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

Certified application counselors in FFM 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://www.marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf).

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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Definitions

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

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

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

Reminder: Tax or Legal Advice

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

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

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Course Goal

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



Goal:

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



Topics:

The topics in this course include:

- Resources available to consumers to obtain information about their plans
- Techniques for explaining information like costs of coverage and services available under a plan
- Protections available for all consumers, including new rights and protections made available by the No Surprises Act
- How to help consumers make premium payments, make an appointment, and report a life change

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From Coverage to Care (C2C)

Introduction

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



Coverage to Care Purpose

State the purpose of the From Coverage to Care initiative



Plan Details

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



First Month's Premium

Describe options for making the first month's premium payment

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First Month's Premium

Describe options for making the first month's premium payment

From Coverage to Care Initiative

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

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

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

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

Select each item to learn about the information presented to consumers.

Confirm Your Coverage

Know Where to Go for Answers

Find a Provider

Make an Appointment

Fill Your Prescriptions

Know Where to Go for Answers

Once consumers have enrolled in a health plan, they should receive a health insurance card with a member service number in the mail. Starting in 2022, new pricing information will appear on any physical or electronic plan or insurance identification (ID) card provided to patients that includes:

- Applicable deductibles.
- Applicable out-of-pocket maximum limits.
- A telephone number and website for consumer assistance.

Consumers can contact their health plan to see what services are covered and what their costs will be. Additional information may be provided on a health plan's website that can be accessed through a Quick Response code (QR code) on a physical ID card or through a hyperlink on a digital ID card. Many health insurance companies' websites allow consumers to:

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

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

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Confirm Your Coverage

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

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Find a Provider

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

Make an Appointment

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

Fill Your Prescriptions

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

Knowledge Check

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

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

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

✓ Check Your Answer



Correct!

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

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

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

Important plan information includes:

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

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

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

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Paying Premiums



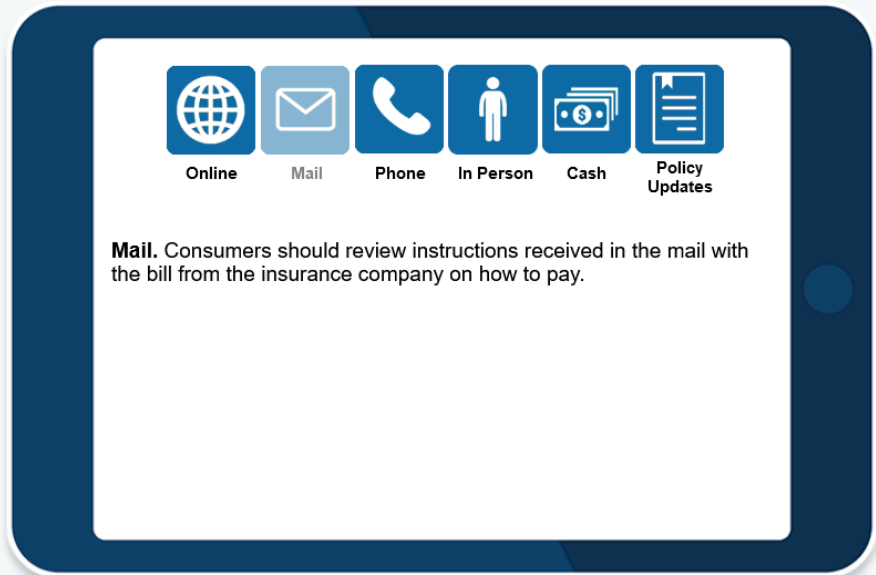
Some consumers who have Medicaid may need to pay a nominal premium.

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

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

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

Select each option for more information.



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

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

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

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

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

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

Policy Updates

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

Key Points



- C2C can make the health care system easier to navigate for consumers and provides education and tools to better understand health coverage options.

- Consumers should check with their insurance company to know the type of premium payment accepted.

- It is important for consumers to know when their premium due date is so they make their payments on time.

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Coverage to Care Assistance

Introduction

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



Consumer Protections

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



Plan Services

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



Resources

Identify resources available to consumers to obtain information about their coverage



Plan Costs

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

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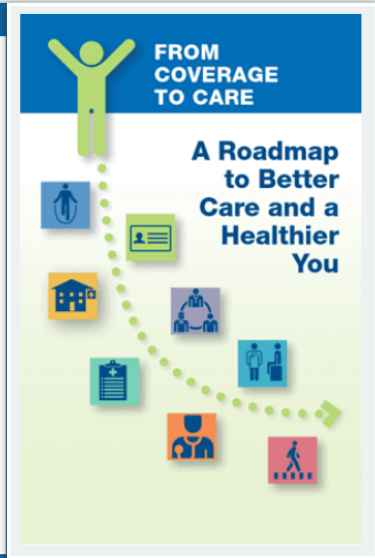
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Know Where to Go for Answers

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

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

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



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Summary of Benefits and Coverage



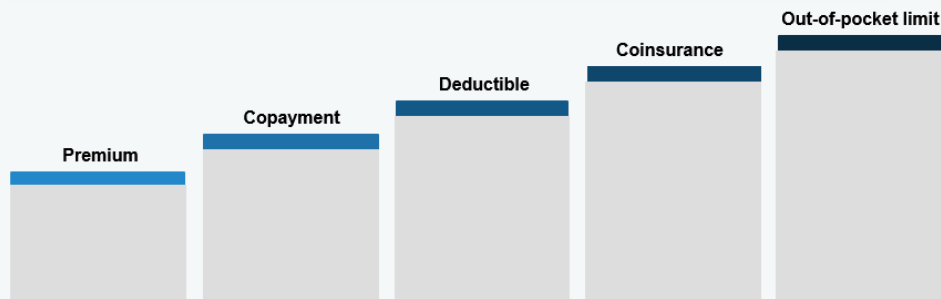
Because consumers have the right to an easy-to-understand summary about a health plan's benefits and coverage, insurance companies and job-based health plans must provide consumers with:

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

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

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

Select **Premium** to continue.



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Coach speaking to Lori

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

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

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

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

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

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

Key Tips:

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

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

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

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

Key Tip

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

Out-of-pocket limit

The maximum out-of-pocket limit for any 2023 Marketplace plan is \$9,100 for an individual and \$18,200 for a family. Keep in mind that this doesn't include monthly premium amounts. To find out if a consumer may qualify for savings on additional costs, use [the Savings Estimator Tool](#).

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

Insurance Card Information

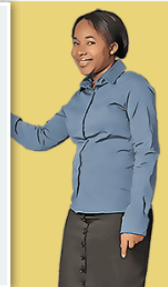
Many consumers receive a health insurance card or other document as proof of coverage after they enroll. Both a health insurance card and SBC include key health plan information and contact information. Let's review an example of how you could explain this to Lori.



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

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

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



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Lori

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Coach

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

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


Insurance Card Front and Back



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

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

Continue

	INSURANCE COMPANY NAME	PPO
YOUR NAME	<i>Hospital admissions require prior approval</i>	
Member ID: 54321-123-321		
PCP: \$40/50% COINSURANCE	OOP Max:	
SPC: \$60/50% COINSURANCE	\$5400 / \$10800	
HO: \$300	Effective Date:	
ER: \$600	01-01-2014	

MEMBER	For hospital approvals call: 1-234-222-4398	For customer service call: 1-234-567-8910
	Deductible / Co-insurance: In-network \$2900 / 30%	
	Send Medical Claims to: Insurance Company Name PO Box 123 City, USA 12345	
	WWW.INSURANCECOMPANY.COM	

Coach

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

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

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

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

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

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

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

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

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

The back of your card has other information like your plan's deductible and coinsurance amounts. Lori, your particular plan has a deductible of \$2,900 and then requires you to pay about 30 percent coinsurance for covered in-network services. You'll pay more for out-of-network services. This means you must generally pay for the first \$2,900 of your medical bills every year before your insurance company starts covering the majority

of your health care costs. But remember, certain preventive services are covered in full by your insurance company with no coinsurance, even before you meet your deductible.

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

Beginning with Plan Year 2023, all insurance ID cards must also provide out-of-pocket maximum limits.

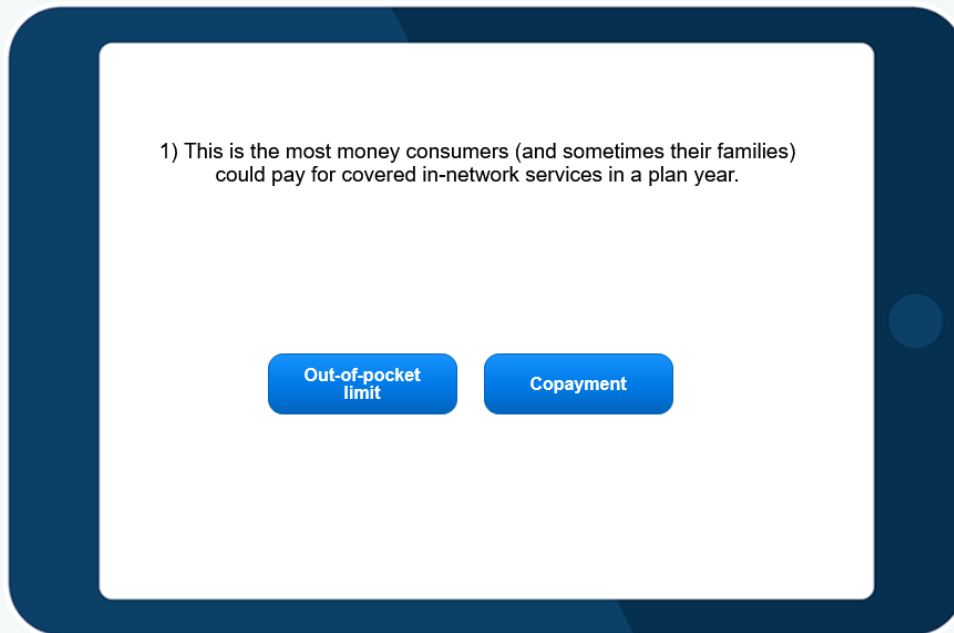
You'll also find a telephone number and website where you can get help and access additional applicable deductibles and maximum out-of-pocket limits. On physical ID cards, there may also be a QR code you can scan to access the website.

Key Tip:

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

Knowledge Check

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



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

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

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

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

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

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

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

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

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

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

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

Finding a Provider



Lori, remember that it's important to select a primary care provider in your plan's network. Your primary care provider will form a relationship with you, learn about your personal and family medical history, work with you to get your recommended health screenings, and help you manage any chronic conditions. To get started, you can schedule a well checkup with your primary care provider. Your provider can work with you during the rest of the year to schedule routine checkups, preventive care, or visits when you are sick and it's not an emergency. Remember, you might pay more if you visit a provider who is out of network. Select [this link](#) for information on who qualifies as a primary care provider. You should know about this important [policy update](#).

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



Coach

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

Lori

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

*Primary Care Provider

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

Policy Updates

Beginning January 1, 2022, plans and issuers must take certain steps to ensure that provider directory information given to consumers, whether posted online, provided electronically, or by phone, is accurate. This includes the name, address, specialty, telephone number, and digital contact information of each in-network health care provider or facility.

Under the No Surprises Act, if a person receives items or services from an out-of-network provider or facility that would have been covered if provided by an in-network provider, and the individual received incorrect information from their plan or issuers regarding whether that provider or facility was in network with regard to those items or services, their plan or issuer must:

- Limit billed cost-sharing amounts to in-network amounts that would apply had items or services been furnished by an in-network provider.

- Apply the deductible or out-of-pocket maximum, if any, as if the provider or health care facility were in network.

The provider or health care facility must not bill an individual more than their in-network cost sharing.

The No Surprises Act also protects certain consumers when their treating provider's network status changes or ends with the plan or issuer. These consumers are notified of the termination of the provider's or facility's in-network status and the right to elect to continue transitional care and provided the opportunity to request transitional care from their plan or issuer. This is called continuity of care. Continuing care patients are given a 90-day transitional period during which:

- Health plans and issuers must provide the patient benefits with respect to the course of treatment furnished by the provider or facility relating to the patient's status as a continuing care patient under the same terms and conditions that would have applied had the provider's or facility's in-network status not changed.
- The treating provider or facility must accept cost sharing and payment from plans and issuers under this continuing care as payment in full.

A patient is considered a "continuing care patient", with respect to a provider or facility, if at least one of these applies. They are:

- Undergoing treatment from the provider or facility for a serious and complex condition. A **serious complex condition** is defined as:
 - In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
 - In the case of a chronic illness or condition, a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.
- Undergoing a course of institutional or inpatient care from the provider or facility.
- Scheduled to undergo non-elective surgery from the provider or facility, including post-operative care related to the surgery.
- Pregnant and undergoing treatment for pregnancy from the provider or facility.
- Terminally ill and receiving treatment for such illness from the provider or facility.

Costs of In-network Versus Out-of-network

While discussing provider networks with the Gomez family, you told them that consumers might pay more if they visit a provider who is out of network. How much more? Select each type of medical service for an example*.

Medical Service	Routine Dr. Visit	Skin Graft	Spinal Surgery	Skin Lesion Removal
In-Network	\$25	\$1,781	\$5,893	\$690
Out-of-Network				

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

Note: As of January 1, 2022, the No Surprises Act generally requires health plans and issuers to limit cost-sharing amounts to those that would apply in network 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.

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

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

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

Routine Dr. Visit

In-network – \$25

Out-of-network – \$30

Skin Graft

In-network – \$1,781

Out-of-network – \$105,500

Spinal Surgery

In-network – \$5,893

Out-of-network – \$115,625

Skin Lesion Removal

In-network – \$690

Out-of-network – \$18,275

Remember, it's important for consumers to use providers that are in network to limit cost sharing. Note: As of January 1, 2022, the No Surprises Act generally requires health plans and issuers to limit cost-sharing amounts to those that would apply in network 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.

Consumer protections under the No Surprises Act and implementing regulations are discussed further in module 4.

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



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

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

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

[Continue](#)

Common Medial Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization required. Failure to preauthorize may result in claim denial.
	Rehabilitation services	30% coinsurance	50% coinsurance	
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	
	Durable medical equipment	30% coinsurance	50% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
If your child needs dental or eye care	Hospice service	30% coinsurance	50% coinsurance	Preauthorization required. Failure to preauthorize may result in claim denial.
	Eye exam	\$35 copay/visit	Covered	One visit per year. Reimbursed up to \$30 out-of-network. See benefit booklet for network details.
	Glasses	20% coinsurance	Covered	One pair of glasses per year. Reimbursed up to \$45 out-of-network. See benefit booklet for network details.
	Dental check-up	Not Charge	Not Covered	---none---

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

Note: These amounts may vary with different plans.

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

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

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

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

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

Encouraging Consumers to Advocate for Themselves

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

Continue

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

Lori

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

Coach

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

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

Visit the C2C [Roadmap](#) resource provided earlier in this module to get more information about finding the right provider.

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

All health plans offered inside the Marketplaces and many health plans offered outside the Marketplaces must cover a certain set of preventive services without requiring consumers to pay copayments or coinsurance, as long as the services are delivered by a doctor or other provider in their plan's network. This is true even if they haven't met their annual deductible.

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

Select each for examples of preventive services.



Preventive services for all adults include:

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

For a complete list, visit [HealthCare.gov/preventive-care-adults/](https://www.healthcare.gov/preventive-care-adults/).

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- Flu shot and other immunizations and vaccines
- Obesity screening and counseling
- Tobacco use screening

For a complete list, visit [HealthCare.gov/preventive-care-adults/](https://www.healthcare.gov/preventive-care-adults/).

Preventive services for women include:

- Cervical cancer screening
- Domestic and interpersonal violence screening and counseling
- Prenatal screening, including gestational diabetes screening, preeclampsia prevention and screening, and Rh incompatibility screening
- Urinary tract or other infection screening
- Well-woman visits

For a complete list, visit [HealthCare.gov/preventive-care-women/](https://www.healthcare.gov/preventive-care-women/).

Preventive services for children include:

- Autism screening
- Behavioral assessments
- Flu shot and other immunizations and vaccines
- Height, weight, and body mass index (BMI) measurements
- Obesity screening and counseling
- Vision screening
- Well-baby and well-child visits

For a complete list, visit [HealthCare.gov/preventive-care-children/](https://www.healthcare.gov/preventive-care-children/).

Making an Appointment

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

When making an appointment, consumers should:

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

For their first appointment, consumers should:

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

After each appointment, consumers should:

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



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

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For their first appointment, consumers should:

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- Bring a list of any medicines, vitamins, or herbs that they take.
- Prepare a list of questions to ask the doctor and bring it with them to their appointment so they don't forget.

After each appointment, consumers should:

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

Filling Prescriptions

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

Select this link for [tips to help consumers find out if their prescriptions are covered by their new plan](#).

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

[More information about SBCs and drug coverage](#).

The screenshot shows the HealthCare.gov website. The header includes the logo and navigation links: 'Get Coverage', 'Keep or Update Your Plan', and 'See Topics'. The main content area is titled 'Using your health insurance coverage' and features a large heading 'Getting prescription medications'. Below this heading is a list of links: 'Common coverage questions', 'Getting prescription medications', 'Getting regular medical care', 'Getting emergency care', 'Using coverage and improving your health', and 'Appealing an insurance company decision'. On the right side, there is a section titled 'Does my new insurance...' with a list of bullet points: 'Visit your insurer's website', 'See your Summary of Benefits and Coverage (SBC)', 'Call your insurer directly', and 'Review any coverage information'.

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

Select this link for [tips to help consumers find out if their prescriptions are covered by their new plan](#).

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

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

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

Formulary Drug Tiers

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

Select each Tier to learn more.

Tier 1

\$



Tier 2

\$\$



Tier 3

\$\$



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

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

Tier 1:

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

Tier 2:

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

Tier 3:

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

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

Costs of In-network Versus Out-of-network



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

Continue

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay /office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	None
	Specialist visit	\$50 copay /visit	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$10 copay /test	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$50 copay /test	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs (Tier 1)	\$10 copay /prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	\$30 copay /prescription (retail & mail order)	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance	
	Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100/day copay	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia.

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

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

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

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

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

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

Primary Care Versus the Emergency Department

	Primary Care Provider	Emergency Department
<p>Some other services listed on a plan's SBC include primary care and emergency care. Remember, primary care is preventive care or care received when it's not an emergency. Primary care providers generally form an important relationship with a consumer; become familiar with the consumer's medical history; and work with the consumer to provide preventive services or manage chronic conditions. However, a consumer gets emergency care when he or she needs immediate medical assistance in a life-threatening situation.</p> <p>View the table for key differences between these two services. Select the table to enlarge.</p>	You'll pay your primary care copay , if you have one. This may cost you between \$0 and \$50.	You'll likely pay a copay, co-insurance, and have to meet your deductible before your health plan pays for your costs, especially if it's not an emergency. Your copay may be between \$50 and \$150.
	You go when you feel sick and when you feel well .	You should only go when you're injured or very sick .
	You call ahead to make an appointment.	You show up when you need to and wait until they can get to you.
	You may have a short wait to be called after you arrive but you will generally be seen around your appointment time .	You may wait for several hours before you're seen if it's not an emergency.
	You'll usually see the same provider each time .	You'll see the provider who is working that day .
	Your provider will usually have access to your health record.	The provider who sees you probably won't have access to your health records.
	Your provider works with you to monitor your chronic conditions and helps you improve your overall health.	The provider may not know what chronic conditions you have .
	Your provider will check other areas of your health , not just the problem that brought you in that day.	The provider will only check the urgent problem you came in to treat but might not ask about other concerns.
	If you need to see other providers or manage your care, your provider can help you make a plan , get your medicines, and schedule your recommended follow-up visits or find specialists.	When your visit is over you will be discharged with instructions to follow up with your primary care provider and/or specialist. There may not be any follow-up support.
	In some areas, you may be able to go to an Urgent Care Center . If Urgent Care is available in your area, call your health plan before you go to find out how much you will have to pay.	

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

[Select this link to access the table for key differences between these two services.](#)

Knowledge Check

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

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

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

Check Your Answer



Correct!

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

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

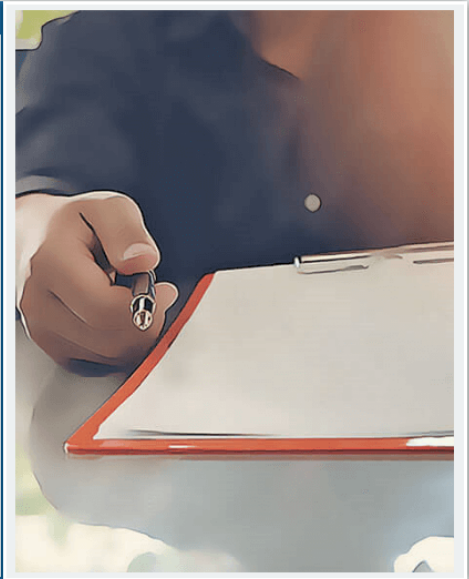
- A. Well-woman visits
- B. Cholesterol screening
- C. X-ray services
- D. Flu shots and other immunizations and vaccines

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

Personally Identifiable Information

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

For more information, refer to the [CMS model consent form](#) for FFM Navigators and CMS guidance available at [Marketplace.cms.gov/technical-assistance-resources/draft-authorization-form-navigators.pdf](https://www.cms.gov/technical-assistance-resources/draft-authorization-form-navigators.pdf) and refer to the *Privacy, Security, and Fraud Prevention Standards* course.



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Nondiscrimination Protections



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

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

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

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

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

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Key Points



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

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Consumer Protections in the No Surprises Act

Introduction

In this module, you'll learn about new rights and protections for consumers implemented by the No Surprises Act to end surprise medical bills, help consumers better understand costs before getting care, and remove them from payment disagreements between their health care providers, health care facilities, and health plans.

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Beginning January 1, 2022, the NSA implements several consumer protections, including:

- Preventing surprise medical bills
- Tools to understand consumer costs in advance
- A process that takes consumers out of the middle of a payment dispute between providers/facilities and health plans
- A payment dispute resolution process for uninsured (or self-pay) individuals
- Expanded rights to external review
- New requirements to include deductibles and out-of-pocket maximums on insurance ID cards, as well as a phone number and website where consumers can get more information
- New requirements to improve the accuracy of provider directories
- Ensuring continuity of care when a provider's network status changes

The rules require certain health care providers and facilities to make publicly available, post on a public website, and provide to individuals a one-page notice about:

- The requirements and prohibitions that apply to the provider or facility.
- Any applicable state balance billing limitations or prohibitions.
- How to contact appropriate state and federal agencies if someone believes the provider or facility has violated the rules.

These protections don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Service, Veterans Affairs health care, or TRICARE, since each of these programs already has other protections against high medical bills.

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Definitions

Here are some important terms related to No Surprises Act consumer protections.

Select each term in the image for definitions.

[Surprise Billing](#)

[Balance Billing](#)

[Good Faith Estimate](#)

[Self-pay Individual](#)

Surprise Billing

Surprise billing happens when people unknowingly get care from providers or facilities that is outside of their health plan's network for both emergency and non-emergency care.

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Surprise Billing

Surprise billing happens when people unknowingly get care from providers or facilities that is outside of their health plan's network for both emergency and non-emergency care.

Balance Billing

Balance billing is when a provider or facility bills a consumer for the balance remaining on the bill that the plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. This happens most often when a consumer visits an out-of-network provider or out-of-network facility. These balance bill costs are separate from what the consumer pays out of pocket for out-of-network services according to the consumer's health plan coverage. An in-network provider generally may not balance bill the consumer for covered services.

Good Faith Estimate

A good faith estimate is an estimate of expected charges that a provider or facility must provide after an item or service is scheduled but before an uninsured or self-pay consumer gets an item or service, or upon request.

Self-pay Individual

A consumer is generally considered a self-pay individual if they do not plan to use their insurance to pay for a medical item or service.

Consumers With Health Insurance: Billing

Surprise bills and balance bills affect many Americans, particularly when people with health coverage unknowingly get medical care from a provider or facility outside their health plan's network. This can be very common in emergency situations, when people usually go (or are taken) to the nearest emergency department without considering their health plan's network.

It can also happen when people with health coverage get care from an out-of-network provider at an in-network facility.

The No Surprises Act protects people covered under group and individual health plans from surprise medical bills when they get most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers.

These new rules:

- Ban surprise bills for certain emergency services, even if consumers get them out of network and without prior authorization.
- Ban out-of-network cost sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. Consumers can't be charged more than in-network cost sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Ban out-of-network charges for air ambulance services.
- Require that health care providers and facilities give consumers an easy-to-understand notice explaining the applicable billing protections, who to contact if they have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., consumers must receive notice of and consent to being balance billed by an out-of-network provider).

These surprise billing protections apply to consumers who get their coverage through their employer (including a federal, state, or local government employer), a multi-employer plan, or through the FFM or a State-based Marketplace, or who purchase individual health insurance coverage directly through a health insurance plan.

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Consumers With Health Insurance: Notice and Consent Form

Under the No Surprises Act, certain [post-stabilization services](#) are considered emergency services, and prohibitions on balance billing generally apply. Post-stabilization services are covered services that are provided after the individual is stabilized, as part of an outpatient observation, or an inpatient or outpatient stay related to the emergency visit (regardless of the department of the hospital). In limited circumstances, however, an out-of-network provider or emergency facility can use the No Surprises Act's notice and consent exceptions to obtain voluntary consent from an individual to waive the balance billing protections for post-stabilization services.

Consumers also can't be balanced billed for [ancillary services](#) (such services are always subject to balance billing prohibitions). Ancillary services are defined by the No Surprises Act as:

- Emergency medicine, anesthesiology, pathology, radiology, neonatology items or services provided by physician or non-physician practitioner;
- Items or services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

However, consumers may be asked to sign a notice and consent form if they schedule certain non-ancillary, non-emergency services furnished in an in-network facility and all of the following are true:

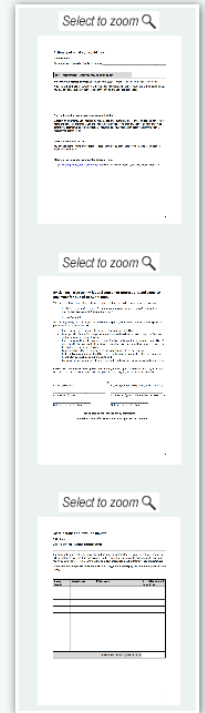
- The items or services do not meet the definition of ancillary services, including that another in-network provider can deliver the items or services at the in-network health care facility; AND
- The provider gives written notice and gets written consent from the individual to waive the balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements.

The notice and consent form:

- Informs consumers about their protections from unexpected medical bills;
- Gives consumers the option to give up those protections and pay more for out-of-network care; and
- Provides an estimate of what their out-of-network care might cost.

Consumers aren't required to sign the form. If they don't sign, they may have to reschedule their care with a provider in their health plan's network.

You can view a sample notice and consent form at [CMS.gov/files/document/notice-and-consent-form-example.pdf](https://www.cms.gov/files/document/notice-and-consent-form-example.pdf).



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Consumers With Health Insurance: Out-of-network Payments

The new rules take consumers with job-based or individual health plans out of the middle of certain out-of-network payment disagreements and provide a process for providers, facilities, provider of air ambulance services, and health plans to negotiate those payments.

The amount a consumer must pay is determined by state All-Payer Model Agreement, state law, or the lesser of the amount the provider or facility charged and the qualifying payment amount, which is generally the average in-network rate for the same or similar items or services for the health plan.

Any additional amount to be paid by the health plan to the provider is determined by an All-Payer Model Agreement, state law or negotiated between the health plan and the provider, first through a 30-business-day open negotiation period, then, if the parties fail to determine an amount, through a new federal independent dispute resolution (IDR) process. The consumer is not involved in this process.

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Consumers With Health Insurance: External Review Process

If a plan or issuer denies payment of a health care item/service, and upholds this decision after its internal review process, the consumer may be eligible for a second review (known as external review) by an independent third-party reviewer.

The external review process allows individuals with non-grandfathered group or individual health coverage to appeal certain decisions by their plan, like their plan's denial of a payment for a health care item/service due to:

- An item/service not being covered,
- Restrictions on coverage, or
- The item/service not being considered medically necessary by the health plan.

Expansion of External Reviews to Include No Surprises Act (NSA) Compliance Matters (New):

Effective January 1, 2022, the NSA and implementing regulations expanded the types of adverse determinations eligible for external review related to a health plan or issuer's compliance with NSA protections like:

- Patient cost-sharing and surprise billing for emergency services;
- Patient cost-sharing and surprise billing protections related to care provided by nonparticipating providers at participating facilities;
- Whether patients are in a condition to get notice and provide informed consent to waive NSA protections; and
- Whether a claim for care received is coded correctly and accurately reflects the treatments received and the associated NSA protections related to patient cost-sharing and surprise billing.

Section 110 of the NSA and implementing regulations extend these protections to grandfathered plans to make external review available to individuals enrolled in grandfathered health plans or coverage.

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Consumers Without Health Insurance or Self-pay Consumers

The No Surprises Act requires that health care providers and facilities give uninsured or self-pay individuals a "good faith estimate" for the cost of their health care when scheduling the item or service or upon request.

If, after receiving the items or services, the uninsured (or self-pay) individual is billed for an amount at least \$400 above the good faith estimate, the individual may be eligible to dispute the bill through the patient-provider dispute resolution (PPDR) process by submitting a request to HHS and paying a small administrative fee (\$25 in 2022).

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Consumers Without Health Insurance or Self-pay Consumers: Good Faith Estimates

The good faith estimate will generally include:

- A list of items and services that the scheduling provider or facility reasonably expects to provide the consumer for that period of care.
- Beginning in 2023, a list of items and services and their associated costs that can be reasonably expected to be given to the consumer by another provider or facility involved in the consumer's care (a co-provider or co-facility).
- Applicable diagnosis codes and service codes.
- Expected charges or costs associated with each item or service from each provider and facility.
- Information on how to dispute the bill if it is at least \$400 higher for any provider or facility than the good faith estimate the consumer received from that provider or facility.

An example good faith estimate is available at [CMS.gov/files/document/good-faith-estimate-example.pdf](https://www.cms.gov/files/document/good-faith-estimate-example.pdf).



The estimate should be based on information known at the time the estimate was created and does not include any unknown or unexpected costs that may arise during the course of treatment. For example, an individual could be charged more if complications or special circumstances occur.

Consumers should find information about the availability of good faith estimates on their provider or facility's website and in the provider or facility's office or on-site where consumers might schedule items or services or have questions about their costs. If consumers have questions about the cost of items or services, their provider or facility must inform them in writing or orally about requesting a good faith estimate. All of this information must also be available in accessible formats and languages.

If a consumer schedules an item or service at least three business days before the date they will receive the item or service, they must be given a good faith estimate no later than one business day after scheduling. If a consumer schedules the item or service at least 10 business days before the date they will receive it or requests cost information about an item or service without scheduling the item or service, the provider or facility must give them a good faith estimate no later than three business days after scheduling or requesting.

The good faith estimate will generally include:

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The Patient-Provider Dispute Resolution (PPDR) Process

The PPDR process is set up for:

- People without health insurance.
- People with health insurance who get an item or service that isn't covered by their plan or coverage.
- People with health insurance who don't plan to use their plan or coverage to pay for a portion or all of the costs of the item or service.

Note: Providers and facilities are not required to provide good faith estimates to enrollees in federal health care programs (like Medicaid, Medicare, or TRICARE), as there are other surprise billing protections under these programs.

When a consumer's billed charges for any provider or facility are at least \$400 more than the good faith estimate for that provider or facility, the items or services may be eligible for payment determination by an independent party called a selected dispute resolution (SDR) entity through the PPDR process.

As each good faith estimate could potentially contain expected charges from multiple providers and facilities, eligibility for the PPDR process is determined separately for each specific provider or facility listed on the good faith estimate.

In 2022, items or services that are to be provided by a co-provider or co-facility (rather than the provider or facility the consumer scheduled items or services with or requested a good faith estimate from) that don't appear on the good faith estimate with expected charges are not eligible for PPDR.

Beginning in 2023, estimates from co-providers and co-facilities must be included in the good faith estimate from the main provider or facility.

Eligibility for PPDR is determined separately for each unique provider or facility listed on the good faith estimate.

- For each provider or facility, the total expected charges for each item or service should be added up.
- This total amount is then compared with the total of all billed charges for the provider or facility, including billed charges for items and services that were furnished but not included in the good faith estimate, to determine eligibility for PPDR.

The PPDR process is set up for:

- People without health insurance.
- People with health insurance who get an item or service that isn't covered by their plan or coverage.
- People with health insurance who don't plan to use their plan or coverage to pay for a portion or all of the costs of the item or service.

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PPDR Process Eligibility

Eligibility for PPDR is determined separately for each unique provider or facility listed on the good faith estimate.

- For each provider or facility, the total expected charges for each item or service should be added up.
- This total amount is then compared with the total of all billed charges for the provider or facility, including billed charges for items and services that were furnished but not included in the good faith estimate, to determine eligibility for PPDR.

Provider	Item or Service	Expected Charge
Provider A	Item 1	\$300
Provider A	Item 2	\$1275
Provider A	Item 3	\$550
Total Expected Charges from Provider A		\$2125
Provider B	Item 1	\$500
Total Expected Charges from Provider B		\$500

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- This total amount is then compared with the total of all billed charges for the provider or facility, including billed charges for items and services that were furnished but not included in the good faith estimate, to determine eligibility for PPDR.

Initiating the PPDR Process

To start the PPDR process, a consumer must submit an initiation notice either electronically or postmarked within 120 calendar days of getting the initial bill containing charges for the items or services that are substantially in excess of the expected charges in the good faith estimate.

The consumer, or the consumer's authorized representative, can start the PPDR process by submitting an initiation notice to HHS:

- Through the online federal Independent Dispute Resolution (IDR) portal,
- By fax, or
- By mail.

[Online Federal IDR Portal](#)

[By Fax](#)

[By Mail](#)

The initiation notice must include:

- Information sufficient to identify the items or services under dispute, including the date of service or date the item was provided, and a description of the item or service.
- A copy of the bill for the items and services under dispute (the copy can be a photocopy or an electronic image, like a photo taken with the consumer's phone, so long as the document is readable).
- A copy of the good faith estimate for the items and services under dispute (the copy can be a photocopy or an electronic image, like a photo taken with the consumer's phone, so long as the document is readable).
- The consumer's contact information, including name, email address, phone number, and mailing address and the contact information (name, email address, phone number, and mailing address) of the provider or facility.
- The state where the consumer received the items or services in the dispute.
- The consumer's communication preference: email, paper mail, or phone.

The consumer, as the uninsured or self-pay individual, will need to pay a \$25 (for 2022) administrative fee to initiate the PPDR process. If the SDR entity decides that the consumer should pay anything less than the billed charge, the \$25 administrative fee will be subtracted from the final amount the SDR entity determines the consumer must pay the provider or facility. If the SDR entity decides that the billed charge from the provider or facility is the appropriate amount, the consumer must pay the full billed charge, and the \$25 administrative fee will not be subtracted from the consumer's bill.

For more information, direct consumers to [CMS.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured](https://www.cms.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured).

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The consumer, or the consumer's authorized representative, can start the PPDR process by submitting an initiation notice to HHS:

- Through the online federal Independent Dispute Resolution (IDR) portal,
- By fax, or
- By mail.

Online Federal IDR Portal

HHS strongly recommends that consumers submit the initiation notice through the online federal IDR portal to help ensure efficient processing.

By Fax

Consumers may fax the initiation form using the fax number on the form.

By Mail

Consumers can find a copy of the initiation notice at [CMS.gov/files/document/billing-dispute-initiation-form.pdf](https://www.cms.gov/files/document/billing-dispute-initiation-form.pdf) for download, and consumers can mail their initiation notices to:

C2C Innovative Solutions Inc.
Patient-Provider Dispute Resolution
P.O. Box 45105
Jacksonville, FL 32232-5105

The initiation notice must include:

- Information sufficient to identify the items or services under dispute, including the date of service or date the item was provided, and a description of the item or service.
- A copy of the bill for the items and services under dispute (the copy can be a photocopy or an

electronic image, like a photo taken with the consumer's phone, so long as the document is readable).

- A copy of the good faith estimate for the items and services under dispute (the copy can be a photocopy or an electronic image, like a photo taken with the consumer's phone, so long as the document is readable).
- The consumer's contact information, including name, email address, phone number, and mailing address and the contact information (name, email address, phone number, and mailing address) of the provider or facility.
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- The consumer's communication preference: email, paper mail, or phone.

The consumer, as the uninsured or self-pay individual, will need to pay a \$25 (for 2022) administrative fee to initiate the PPDR process. If the SDR entity decides that the consumer should pay anything less than the billed charge, the \$25 administrative fee will be subtracted from the final amount the SDR entity determines the consumer must pay the provider or facility. If the SDR entity decides that the billed charge from the provider or facility is the appropriate amount, the consumer must pay the full billed charge, and the \$25 administrative fee will not be subtracted from the consumer's bill.

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During the PPDR Process



Select each step to review the process that occurs after a consumer submits the initiation notice and pays the fee.

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Step 1 HHS will select an SDR entity to conduct the payment determination.					

While the PPDR process is pending, the provider or facility must not move the bill for the disputed item or service into collection or threaten to do so. If the bill has already moved into collection, the provider or facility must cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the PPDR process has concluded. Lastly, the provider or facility must not take or threaten to take any retaliatory action against the consumer for utilizing the PPDR process to seek resolution for a disputed item or service.

Select each step to review the process that occurs after a consumer submits the initiation notice and pays the fee.

Step 1

HHS will select an SDR entity to conduct the payment determination.

Step 2

The SDR entity will notify the consumer and the provider or facility by electronic or paper mail that the initiation request has been received and is under review.

Step 3

The SDR entity will review the initiation notice to ensure that the items or services in dispute meet the eligibility criteria for the PPDR process and that the initiation notice contains all the required information.

- The SDR entity will also notify the consumer in cases where the initiation notice is determined to be incomplete or the item or service is determined ineligible for dispute resolution.
- In these cases, the consumer will be provided 21 calendar days to submit any missing information or provide more information to demonstrate that the item or service is eligible for the PPDR process.

Step 4

Once the SDR entity has determined that an item or service is eligible for dispute resolution, the SDR entity must notify both parties (the consumer and the consumer's provider or facility) and request the provider or facility provide certain information within 10 business days through the online federal IDR portal.

Step 5

The SDR entity will review the billed charges to see if the items and services were included on the good faith estimate, as well as all documentation submitted by the uninsured (or self-pay) individual or their authorized representative and all documentation submitted by the provider or facility.

Step 6

No later than 30 business days after receipt of the information from the provider, the SDR entity must make a determination regarding the amount the consumer must pay:

- The good faith estimate,
- The billed amount, or
- An amount between the good faith estimate and the billed amount.

This amount is based on whether the provider or facility has provided credible information to demonstrate that the difference between the billed charge and the expected charge for the item or service in the good faith estimate:

- Reflects the costs of a medically necessary item or service, and
- Is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.

While the PPDR process is pending, the provider or facility must not move the bill for the disputed item or service into collection or threaten to do so. If the bill has already moved into collection, the provider or facility must cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the PPDR process has concluded. Lastly, the provider or facility must not take or threaten to take any retaliatory action against the consumer for utilizing the PPDR process to seek resolution for a disputed item or service.

PPDR Process Outcomes

Here are some examples of PPDR process outcomes.

[Scenario 1: The billed charge is equal to or less than the expected charge in the good faith estimate](#)

[Scenario 2: The billed item or service is substantially in excess of the good faith estimate](#)

[Scenario 3: The billed charge is higher than the good faith estimate due to unforeseen circumstances](#)

[Scenario 4: Billed items or services are not listed on the good faith estimate](#)

Scenario 4: Billed items or services are not listed on the good faith estimate

If the SDR entity determines the provider or facility did not provide credible information that demonstrates that the difference between the billed charge for the new item or service, and the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances, then the SDR entity must determine that amount to be paid for the new item or service to be equal to \$0.

If the SDR entity determines that a provider or facility has provided credible information that the billed charge for an item or service not listed on the good faith estimate is based on unforeseen circumstances, then the SDR entity must determine the charge to be paid by the uninsured (or self-pay) individual for the new item or service as the lesser of:

- The billed charge, or
- The median payment amount paid by a plan or issuers for the same or similar service by a same or similar provider in the geographic area where the services were provided that is reflected in an independent database.

Here are some examples of PPDR process outcomes.

Scenario 1: The billed charge is equal to or less than the expected charge in the good faith estimate

The SDR entity would determine that the billed amount is not substantially in excess of the good faith estimate and in this case is not eligible for the PPDR process. The SDR entity would inform the consumer or their authorized representative that the case is ineligible for review via this dispute resolution process. For example:

Billed charge = \$500

Expected charge (i.e., the good faith estimate) = \$975

Scenario 2: The billed item or service is substantially in excess of the good faith estimate

The SDR entity determines the provider or facility has not provided credible information that the difference between the billed charge and the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances. Therefore, the SDR entity must determine the amount to be paid by the consumer for the item or service to be equal to the good faith estimate amount. For example:

Billed charge = \$875

Expected charge = \$450

Payment amount = \$450

Scenario 3: The billed charge is higher than the good faith estimate due to unforeseen circumstances

The SDR entity determines that the provider or facility has provided credible information that the difference between the billed charge and the good faith estimate reflects the cost of a medically necessary item or service and is based on unforeseen circumstances. Therefore, the SDR entity must select as the amount to be paid by the consumer the lesser of:

- The billed charge, or
- The median payment amount paid by a plan or issuers for the same or similar service by a same or similar provider in the geographic area where the services were provided that is reflected in an independent database.

For example:

Bill charge = \$900

Expected charge = \$450

Median rate reflected in an independent database = \$2,000

Payment amount = \$900

Scenario 4: Billed items or services are not listed on the good faith estimate

If the SDR entity determines the provider or facility did not provide credible information that demonstrates that the difference between the billed charge for the new item or service, and the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances, then the SDR entity must determine that amount to be paid for the new item or service to be equal to \$0.

If the SDR entity determines that a provider or facility has provided credible information that the billed charge for an item or service not listed on the good faith estimate is based on unforeseen circumstances, then the SDR entity must determine the charge to be paid by the uninsured (or self-pay) individual for the new item or service as the lesser of:

- The billed charge, or
- The median payment amount paid by a plan or issuers for the same or similar service by a same or similar provider in the geographic area where the services were provided that is reflected in an independent database.

Settling Disputes During the PPDR Process

Consumers can settle payment disputes with providers and facilities during the PPDR process by settling on a payment amount.

At any point after the PPDR process has been initiated but before a determination is made by the SDR entity, the parties can settle the payment amount through either an offer of financial assistance or an offer to accept a lower amount, or the consumer agrees to pay the billed charges in full.

In the event that the parties agree to settle on a payment amount, the provider or facility should notify the SDR entity through the federal IDR portal, electronically, or in paper form as soon as possible, but no later than three business days after the date of the agreement. The settlement notice must document that the provider or facility has applied a reduction to the consumer's settlement amount that is equal to at least half of the administrative fee (\$12.50).

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Consumer Help With the PPDR Process

Consumers can use authorized representatives to help them with the PPDR process.

- Authorized representatives, on a consumer's behalf, will be allowed to submit initiation notices, upload documents, receive notices from HHS and the SDR entity, upload additional supporting documentation, and view the SDR entity's payment determination.
- Authorized representatives from state Consumer Assistance Programs (CAPs), personal attorneys, or legal aid organizations may also be resources for helping consumers with the PPDR process.
- Consumers cannot use as authorized representatives providers directly represented in the good faith estimate, providers associated with such providers or facilities, or non-clinical staff associated with such providers or facilities.

Consumers can also contact the No Surprises Help Desk at 1-800-985-3059 from 8am – 8pm EST, 7 days a week.

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No Surprises Act Help and Resources for Consumers

The No Surprises Help Desk

Consumers who have questions about the No Surprises rules or believe the rules aren't being followed may contact the No Surprises Help Desk either by phone or online.

By phone: Consumers can call 1-800-985-3059 from 8am – 8pm EST, seven days a week, to submit questions or complaints. TTY users can also call 1-800-985-3059.

Online: Consumers may also submit complaints online at [CMS.gov/nosurprises/consumers/complaints-about-medical-billing](https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing). Consumers may be asked to provide supporting documentation like medical bills and their Explanation of Benefits.

- The Help Desk will send a confirmation email when they receive the complaint to notify the consumer of next steps and let them know if any additional information is needed.
- To check on the status of a complaint or find out what documentation is needed, consumers can contact the No Surprises Help Desk at 1-800-985-3059. TTY users can also call 1-800-985-3059.

Select each item for more information on what the No Surprises Act Help Desk can and can't help consumers with.

[What the Help Desk CAN Do](#)

[What the Help Desk CAN'T Do](#)

If consumers still need help with their health insurance and have a problem or question, they can contact their state CAP. These programs help consumers experiencing problems with their health insurance or seeking to learn about health coverage options.

Consumers can also visit these websites for more information:

- [PPDR guidance for consumers](#)
- [PPDR fee guidance](#)
- [CMS.gov/nosurprises](https://www.cms.gov/nosurprises)

The No Surprises Help Desk

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- To check on the status of a complaint or find out what documentation is needed, consumers can contact the No Surprises Help Desk at 1-800-985-3059. TTY users can also call 1-800-985-3059.

What the Help Desk CAN Do

- Review the complaint to make sure the insurance company, medical provider, or health care facility followed surprise billing rules.
- Investigate and enforce federal laws and policies under their jurisdiction.
- Try to find patterns of problems that may need further review.
- Help consumers understand what documentation they need to submit or what next steps they should take.
- Help answer questions or direct consumers to others who can.

What the Help Desk CAN'T Do

- Require medical providers or health care facilities to adjust their charges.
- Act as a lawyer or give legal advice.
- Make medical judgements or determine if further treatment is necessary.
- Determine the value of a claim or the amount owed to consumers.

- Address issues we can't legally enforce.

If consumers still need help with their health insurance and have a problem or question, they can contact their state CAP. These programs help consumers experiencing problems with their health insurance or seeking to learn about health coverage options.

Consumers can also visit these websites for more information:

- [PPDR guidance for consumers](#)
- [PPDR fee guidance](#)
- [CMS.gov/nosurprises](#)

Key Points



- The No Surprises Act provides new consumer protections when seeking and receiving care, including for consumers with group health plan or group or individual health insurance coverage, consumers without coverage, and consumers either with or without coverage who are self-pay.

- These protections include prohibitions against surprise billing and balance billing, requirements to provide good faith estimates and advanced explanations of benefit so consumers know their costs before receiving care, an expanded external review process, a dispute process for out-of-network providers or facilities and plans or issuers that removes the consumer from the dispute process, and a dispute process for consumers without health insurance or self-pay consumers.

- Health insurance issuers are also required to include additional information on insurance ID cards, maintain up-to-date provider directories, and ensure continuity of care when a provider's network status changes.

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- Health insurance issuers are also required to include additional information on insurance ID cards, maintain up-to-date provider directories, and ensure continuity of care when a provider's network status changes.

Coverage Costs and a Life Change

Introduction

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



Costs of Coverage

Describe techniques for explaining the costs of coverage to a consumer



Report a Life Change

Describe techniques for demonstrating how to report a life change to a consumer

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

Costs of Coverage

Describe techniques for explaining the costs of coverage to a consumer

Report a Life Change

Describe techniques for demonstrating how to report a life change to a consumer

Introduction



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

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



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

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



Okay, can you explain what my costs would be?

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



Lori

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

Coach

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

Lori

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Lori

Okay, can you explain what my costs would be?

Coach

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

Covering the Costs



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

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



Okay, that's helpful to know.



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

Coach

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

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

Lori

Okay, that's helpful to know.

Coach

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

Additional Costs



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



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

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

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

$$0.30 * \$20,000 = \$6,000$$

Select [this link for calculation tips](#).

Lori:

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

Coach:

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

$$0.30 \text{ times } \$20,000 = \$6,000$$

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

Calculation Tips

50 percent = 0.50

30 percent = 0.30

15 percent = 0.15

5 percent = 0.05*

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

Maximum Cost With Insurance



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

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

Key Tip:

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

\$2,655.60

+

\$5,400

=

\$8,055.60

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

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

Key Tip:

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

Knowledge Check

Consumers may have questions about the total cost of their health care during a plan year. Tony does not qualify for financial assistance through a Marketplace but has enrolled in a Silver plan. If Tony's plan will cover 70 percent (on average) of his medical expenses, which of the following statements about his costs are true?

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

- A. Tony is responsible for paying 30 percent of his deductible.
- B. Once Tony has met his deductible, his health insurance company will begin to pay 70 percent (on average) of his covered, in-network medical costs.
- C. The most that Tony will pay during the plan year for covered essential health benefits provided in network is the cost of his monthly premiums plus his out-of-pocket limit.
- D. Tony's health insurance company will only pay for preventive care services after he meets his deductible.

Check Your Answer



Correct!

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

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

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

- A. Tony is responsible for paying 30 percent of his deductible.
- B. Once Tony has met his deductible, his health insurance company will begin to pay 70 percent (on average) of his covered, in-network medical costs.
- C. The most that Tony will pay during the plan year for covered essential health benefits provided in network is the cost of his monthly premiums plus his out-of-pocket limit.
- D. Tony's health insurance company will only pay for preventive care services after he meets his deductible.

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

The Gomez Family Addition



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

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

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Report a Life Change





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

TRY IT YOURSELF!

Select **My Applications & Coverage**.

Lori  |  Logout [Español](#)

-  My Applications & Coverage
-  My Profile

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

Report a Life Change (cont'd)



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

TRY IT YOURSELF!

Select **2023 Delaware application for Individual and Family Coverage**.

MY APPLICATIONS & COVERAGE

MY PROFILE

MESSAGES (1)

Lori, what would you like to do?

Get coverage for:

Select Year

Select State

APPLY OR RENEW

Don't see your state? Visit the website of your state-based Marketplace, or call the Marketplace Call Center at 1-800-318-2596 (TTY:1-855-889-4325). [Find your State's website.](#)

Your existing applications:

[2023 Delaware application for Individual & Family Coverage](#)

Status: **In progress**
ID#: 4388176565

REMOVE

Need to find your application? Take the next steps here if you applied with a paper application or the Marketplace Call Center, or you were referred by your appropriate state agency. [Find my application.](#)

If you were referred here by your state agency and something's changed since you applied, like your income or family size, select "APPLY OR RENEW."

If you think you may be exempt from the requirement to enroll in coverage, [get more information and download applications here.](#)

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

Report a Life Change (cont'd)



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

TRY IT YOURSELF!

Select **Report a life change**.

- My plans & programs
- My plan profile
- Eligibility & appeals
- Applications details
- **Report a life change**
- Communication preferences
- Exemptions
- Tax forms

APPLICATION STATUS

View eligibility results

Your application has been processed and your eligibility results are ready for your review.

VIEW RESULTS

Need to remove your application?

Only remove your application as a last resort. If you're having problems with your application, log out and try again later.

Important: If you enrolled in coverage with this application, we don't recommend you remove it. Removing your application won't terminate your coverage, and means you won't be able to get an electronic 1095-A tax form. [Learn more before removing this application.](#)

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

Report a Life Change (cont'd)



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

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

TRY IT YOURSELF!

Select **Report a life change**.

- My plans & programs
- My plan profile
- Eligibility & appeals
- Applications details
- **Report a life change**
- Communication preferences
- Exemptions
- Tax forms

Report a life change

Some changes may qualify you or your dependents for a Special Enrollment Period.

What kind of changes should I report?

Your household's income and size affect the program you qualify for, including help with costs. As soon as you have a change, report it here.

Important: If you're enrolled in Delaware Medicaid or Delaware Healthy Children Program (CHIP) coverage, be sure to report life changes to your state Medicaid or CHIP agency before you report these changes to the Marketplace.

[Learn more about reporting these changes, including what to do if someone on your application has Marketplace coverage](#)

Examples of changes to report:

- Someone's enrolled in Medicaid or CHIP at the same time they're enrolled in a Marketplace plan.
- Someone's enrolled in Medicare at the same time they're enrolled in a Marketplace plan.
- Your household income goes up or down, like from a job or benefits
- Your household size changes because of things like marriage, divorce, a new baby, or someone moving out
- Someone needs new coverage
- Someone is getting new coverage, like from a job
- Your citizenship or immigration status is changing, like a visa expired and isn't renewed
- You want to change your preference on how we send information to you
- Your tax filing status changes

Important: Check your income information frequently. Your eligibility for help with costs is based on factors including your household income. Accurate information will help you get the right amount of help and avoid differences when you file your federal income tax return.

After you report a change:

- You'll get new Eligibility Results that will explain if you're eligible for a Special Enrollment Period to enroll or change plans.
- You'll find out if you qualify for a different amount of help paying costs.
- You can check your enrollment details before we send your updates to your plan or your state.

REPORT A LIFE CHANGE

This page contains a lot of information about reporting a life change and some examples of changes to report. Once you have reviewed this information, select the **Report a life change** button.

Report a Life Change (cont'd)



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

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

TRY IT YOURSELF!

Select **Continue**.

Have you had any changes like these?

- You had family changes, like a new baby or a divorce
- You lost your job, got a new job, or your income changed
- You or one of your dependents turned 26
- You moved to a different state

Important: Check your income information frequently. Your eligibility for help with costs is based on factors including your household income. Accurate information will help you get the right amount of help and avoid differences when you file your federal income tax return.

Choose an option below to continue

- Report a change in my household's income, size, address, or other information
- Change the way we send information to you, like by email or paper copies
- Report a move to a new state

CANCEL

CONTINUE

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

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

Savings Setup Page



On the "Savings setup" page, indicate whether you would like your application set up to check your household's eligibility for savings. You can select "Help me decide" to answer questions to determine if your household is likely to qualify for savings.

On the "Decide if you'd like to check for savings" page, indicate how many people you will report on your tax return, including yourself. Then indicate your estimated household income range for 2023.

TRY IT YOURSELF!

Select **Continue** to proceed to the application so Lori can review and update her information.

[← Back](#) | **1 Set up** - [2 Household](#) - [3 Coverage & changes](#) - [4 Review & submit](#)

Savings setup

Your application is set up to check your household's eligibility for savings. You can continue, or change your answer below.

[Learn more about the types of savings we can check for.](#)

Check for all savings options. (Recommended)

You'll see your results after you fill out and submit your application. If you're eligible to enroll, you can apply these savings to the plan you select.

Continue without checking for savings options.

You'll still fill out and submit your application. If you're eligible to enroll, you'll pay the full price of your health insurance premiums on the plan you select.

Help me decide.

You'll answer a couple of questions to see if your household is likely to qualify for savings.

Continue

Application ID: 4388176565

On the "Savings setup" page, indicate whether you would like your application set up to check your household's eligibility for savings. You can select "Help me decide" to answer questions to determine if your household is likely to qualify for savings.

On the "Decide if you'd like to check for savings" page, indicate how many people you will report on your tax return, including yourself. Then indicate your estimated household income range for 2023.

Add a Child



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

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

TRY IT YOURSELF!

Select **Save & continue**.

HealthCare.gov

[Back](#) | [Set up](#) | [Household](#) | [Coverage & changes](#) | [Review & submit](#)

Add a person who needs health coverage

First name

Middle name
Optional

Last name

Suffix
Optional

Date of birth
For example: 3/4/2018
Month Day Year
 / /

Sex
 Female
 Male

How is Marie related to Lori?
Marie is Lori's...

How is Marie related to John?
Marie is John's...

Save & continue

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

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

Updating Family and Household Information



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

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

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

APPLICATION STATUS

View eligibility results

Your application has been processed and your eligibility results are ready for your review.

VIEW RESULTS

Eligibility results

Results based on your application (ID 4388121912) submitted on 05/19/2022. Follow these steps below to complete your enrollment. [Learn more about your eligibility results](#)

Eligibility overview

Lori Gomez

John Gomez

Marie M. Gomez

Eligible

To buy a Marketplace plan

For a premium tax credit of up to \$1996 each month for your tax household

Your eligibility is temporary: By August 17, you must submit documents to confirm some information. See your eligibility notice for details and deadlines.

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

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

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

Eligibility Results



Finally, Lori should select **Continue to Enrollment** to choose a plan. If the Gomez family remains eligible for APTC, Lori should set the amount she'd like to use. She should also report whether anyone in the household uses tobacco before viewing available plans and prices.

Remember, Lori can use Marketplace tools to get an estimate of her family's yearly costs based on whether she thinks the family will use high, medium, or low amounts of health care. She can also find out if available plans cover her family's doctors, hospitals, and prescription drugs.

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

Select this link for [additional reminders](#) you can share with Lori.

Eligibility overview

Lori Gomez

John Gomez

Marie M. Gomez

Eligible

To buy a Marketplace plan

For a premium tax credit of up to \$1996 each month for your tax household

Your eligibility is temporary: By August 17, you must submit documents to confirm some information. See your eligibility notice for details and deadlines.

Required action: View your eligibility notice

Your eligibility notice explains your options for coverage, costs, deadlines and next steps. If you're eligible for coverage through a Marketplace plan, you can enroll after you view your notice.

You're eligible for a Special Enrollment Period. You must pick a plan by June 27. If you don't, you may not be able to enroll until the next yearly Open Enrollment Period.

[VIEW ELIGIBILITY NOTICE \(PDF\)](#)

Continue to enrollment

You've submitted your application and viewed your results. Next, you'll choose a plan.

You must pick a plan by June 27 to enroll through this Special Enrollment Period.

[CONTINUE TO ENROLLMENT](#)

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

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

Additional Information for Lori

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

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

Key Points



- When consumers experience a life change, they should report it using their Marketplace account at HealthCare.gov.

- After consumers add new information to their Marketplace account, consumers should review and update their entire application.

- The Marketplaces will provide an eligibility notice containing information about an SEP, if appropriate.

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

Conclusion



Good work! You should now have a good understanding of Coverage to Care and how to help consumers report a life change. Even if consumers keep their Marketplace plan from one year to the next, it's important to point out that certain aspects of the plan like copayments, coinsurance, and provider networks may change. As you meet with consumers who are re-enrolling in plans, be sure to review this information with them and be sure they understand the basic aspects of their plan. This will ensure that consumers continue to select plans that meet their needs and help them continue to access the coverage each year.

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

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

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

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

Resources

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

From Coverage to Care: Main Page

[Go.cms.gov/c2c](https://www.cms.gov/c2c)

From Coverage to Care: Resources and Tools

[CMS.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumer-resources](https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumer-resources)

From Coverage to Care: Enrollment Toolkit: The Enrollment Toolkit is for community partners, assisters, and other people who help consumers enroll in coverage or change plans.

[CMS.gov/About-CMS/Agency-Information/OMH/Downloads/C2C-Enrollment-Toolkit-2016-small-508.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/C2C-Enrollment-Toolkit-2016-small-508.pdf)

Getting Coverage: How to get coverage through a Health Insurance Marketplace^{®1}.

[HealthCare.gov/apply-and-enroll/how-to-apply/](https://www.healthcare.gov/apply-and-enroll/how-to-apply/)

How much will health insurance cost? Health Insurance Marketplace Calculator.

[KFF.org/interactive/subsidy-calculator/](https://www.kff.org/interactive/subsidy-calculator/)

What plans are available in my area?

[HealthCare.gov/see-plans/](https://www.healthcare.gov/see-plans/)

Value of Prevention: How can we help you?

[HealthCare.gov/using-marketplace-coverage](https://www.healthcare.gov/using-marketplace-coverage) **See which preventive services you may need:**

[Healthfinder.gov/](https://www.healthfinder.gov/)

Finding a Provider

Reviews and ratings of local providers

[Healthgrades.com/](https://www.healthgrades.com/)

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

No Surprises Act: Consumer Webpage

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

¹ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.