2019 HEALTH INSURANCE MARKETPLACE TRAINING

OPEN ENROLLMENT 6
Morgantown - October 16
Charleston – October 18
Contacts

Insurance Companies
Care Source
Highmark WV

Marketplace Plans

Short-Term Limited Duration

Resources
Contacts

WV Offices of the Insurance Commissioner

www.wvinsurance.gov
Divisions: Health Policy & Consumers
Contains assisters, agents, ACA information useful links
Assister’s Standard Operating Procedures Manual

Ellen Potter, Director, Health Policy
Ellen.J.Potter@wv.gov
304-558-6279 ext. 1120

Joylynn Fix, Life & Health, Policy and Rate Analyst Supervisor
Joylynn.Fix@wv.gov
304-558-6279 ext. 1170

Consumer Services
Consumer.service@wv.gov
1-888-879-9842
Dena Wildman

MarketPlace Health Insurance Companies

CareSource WV

Customer Service  Direct Enrollment  Claims
855-202-0622  844-539-1733  855-202-1091

If you need additional help after working with customer service, you may email:
Tiffany Jones
Tiffany.Jones@caresource.com
304-400-2015 -Cell/Office
Kathy Oplinger
Kathy.Oplinger@CareSource.com
937-531-3120 - Office
937-487-0148 - Cell

Highmark WV

On-Exchange Member Services
888-601-2109

If you need additional help after working with member services, you may email:
Connie Sams
Connie.Sams@Highmark.com
304-424-7770 – Office

MarketPlace Call Center

Health Insurance Marketplace

West Virginia 2019
CARESOURCE
OUR VISION

Transforming lives through innovative health and life services.

It’s not just about making a change.
It’s about making a difference.
OUR MISSION

To make a lasting difference in our members’ lives by improving their health and well-being.

ABOUT US

A nonprofit health plan and national leader in Managed Care

29-year history of serving varied populations across multiple states and insurance products

Currently serving nearly 2 million members* in Georgia, Kentucky, Ohio, Indiana and West Virginia

*Based on members enrolled in all CareSource product lines across all service areas as of August 15, 2018.
CareSource is and will always be members first

Over 90% of the revenue that comes into our organization goes right back out to our members.

Our profits go back to the people we serve.
Real Insurance

All Essential Health Benefits covered

Coverage for pre-existing conditions

No annual or lifetime coverage limits for most benefits

Preventive Services covered at no cost
CARESOURCE COVERAGE AREA:
West Virginia

Member Services
1-800-202-0622
TTY 1-800-982-8771 or 711
www.CareSource.com/marketplace
Coverage area subject to change
It is easy to underestimate how much medical care can cost:

- A broken leg can cost up to $7,500 to treat.
- The average cost of a 3-day hospital stay is around $30,000.
- Comprehensive cancer care can cost hundreds of thousands of dollars.

*Having health coverage can help protect you from high, unexpected costs like these.*

Sources: healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/
ESSENTIAL HEALTH BENEFITS
Marketplace plans cover all of the following services:

• Prescription drugs
• Preventive and wellness services and chronic disease management
• Emergency services
• Hospitalization
• Pediatric services, including dental and vision care (plus orthodontia)
• Birth control coverage
• Pregnancy, maternity, and newborn care
• Breastfeeding coverage
• Ambulatory patient services
• Mental health and substance use disorder services, including behavioral health treatment
• Rehabilitative and habilitative services and devices
• Laboratory services
Over 75% of CareSource Marketplace members qualify for subsidies that help bring down the total cost of a Marketplace insurance plan.*

**COST SHARING REDUCTION (CSR)**
A discount that lowers the amount owed for any deductible, copayments and coinsurance. CSR only apply to Silver plans, so if you qualify for a CSR, you must enroll in a Silver plan to get it.

**ADVANCE PREMIUM TAX CREDIT (APTC)**
Tax credit taken in advance, in whole or in part, to lower monthly premium payments. This can be used no matter what plan you enroll in.

*Based on CareSource Marketplace membership as of 8/19/2018. Eligibility for subsidies is determined by the Health Insurance Marketplace, not CareSource.
2019 OPEN ENROLLMENT

November 1 – December 15, 2018
For a January 1 effective date, Enrollees must make their first premium payment to activate their coverage.

After December 15, 2018, you can only enroll if you qualify for a Health Insurance Marketplace “Special Enrollment Period” (SEP) due to a qualifying life event.

How to Enroll:
• Visit: Enroll.CareSource.com
• Call: 1-844-539-1733
SPECIAL ENROLLMENT PERIOD

Available year-round for people who qualify.

*After December 15, 2018 you can only enroll if you have a qualifying life event.

Examples of the most common qualifying life events include:
1. Getting married
2. Having a baby
3. Moving outside your insurer’s coverage area
4. Divorce
5. Leaving incarceration
6. Adopting a child or placing a child for adoption or foster care
7. Loss of minimum essential coverage

*Federal and state laws limit enrollment into CareSource plans to designated time periods within a calendar year (“open enrollment”), unless you qualify for a special enrollment period. The 2019 plan year open enrollment period for all CareSource plans will end December 15th, 2018. CareSource does not determine whether you will qualify for a special enrollment period. Please contact the Health Insurance Marketplace for greater detail on special enrollment periods.
Choose the plan that fits your budget – low premium, low deductible or balance premium and deductible with the Standard plan. Plus, Silver plans are subsidy-eligible (CSR) for those who qualify.

<table>
<thead>
<tr>
<th></th>
<th>Low Premium</th>
<th>Standard</th>
<th>Low Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$6,400</td>
<td>$5,700</td>
<td>$4,400</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$7,900</td>
<td>$7,700</td>
<td>$7,500</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>15%*</td>
<td>20%*</td>
<td>30%*</td>
</tr>
<tr>
<td><strong>Primary Care or Retail Clinic Visit</strong></td>
<td>$25</td>
<td>$15</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>$50</td>
<td>$40</td>
<td>$60</td>
</tr>
<tr>
<td><strong>Urgent Care Visit</strong></td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td>$500*</td>
<td>$500*</td>
<td>$500*</td>
</tr>
<tr>
<td><strong>Generic Prescription Drug Coverage (Retail/90-day Mail)†</strong></td>
<td>$20 / $50</td>
<td>$15 / $37.50</td>
<td>$10 / $25</td>
</tr>
<tr>
<td><strong>Pediatric Dental &amp; Vision Services</strong></td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

In the chart above, amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance.

All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply.

*After deductible.

†Applicable only to drugs in the generic tier on the formulary
CSR SILVER PLANS

These values apply only to Silver members who receive a CSR.

<table>
<thead>
<tr>
<th></th>
<th>CSR Level 1</th>
<th>CSR Level 2</th>
<th>CSR Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low Premium</td>
<td>Standard</td>
<td>Low Premium</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$5,300</td>
<td>$4,900</td>
<td>$4,300</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$6,300</td>
<td>$6,100</td>
<td>$6,100</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>15%*</td>
<td>20%*</td>
<td>30%*</td>
</tr>
<tr>
<td><strong>Primary Care or Retail Clinic Visit</strong></td>
<td>$15</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>$40</td>
<td>$40</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Urgent Care Visit</strong></td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td>$400 *</td>
<td>$400 *</td>
<td>$400 *</td>
</tr>
<tr>
<td><strong>Generic Prescription Drug Coverage (Retail/90-day Mail)</strong>†</td>
<td>$20 / $50</td>
<td>$15 / $37.50</td>
<td>$10 / $25</td>
</tr>
<tr>
<td><strong>Pediatric Dental &amp; Vision Services</strong></td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

In the chart above, amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance. All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply. CSR eligibility is determined by the Health Insurance Marketplace, not by CareSource.

*After deductible. †Applicable only to drugs in the generic tier on the formulary
BRONZE PLANS  
LOWEST PREMIUMS, HIGHEST OUT-OF-POCKET COSTS

Generally a good choice if you do not expect to have a lot of doctor appointments, need many prescription medicines, or require other routine health services. The HSA-eligible plan is a High Deductible Health Plan (HDHP), where benefit amounts are paid only after meeting the deductible (except preventive care). HSAs are a tax-free way to save for health care costs.¹

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Bronze HSA-Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$7,400</td>
<td>$5,200</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$7,900</td>
<td>$6,650</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Primary Care or Retail Clinic Visit</td>
<td>$35</td>
<td>50%*</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Generic Prescription Drug Coverage (Retail/90-day Mail)†</td>
<td>$30 / $75</td>
<td>50%* / 50%*</td>
</tr>
<tr>
<td>Pediatric Dental &amp; Vision Services</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

In the chart above, amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance.

All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply. *After deductible.

†Applicable only to drugs in the generic tier on the formulary.
GOLD PLAN
HIGHER PREMIUMS, LOWER OUT OF POCKET COSTS

Typically a good choice if you expect to have a lot of doctor appointments, need many prescription medicines, or need other health services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Gold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$2,000</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$6,500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20%*</td>
</tr>
<tr>
<td>Primary Care or Retail Clinic Visit</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$35</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$75</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>20%*</td>
</tr>
<tr>
<td>Generic Prescription Drug Coverage (Retail/90-day Mail)†</td>
<td>$10 / $25</td>
</tr>
<tr>
<td>Pediatric Dental &amp; Vision Services</td>
<td>Included</td>
</tr>
</tbody>
</table>

In the chart above, amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance.

All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply.

*After deductible.

†Applicable only to drugs in the generic tier on the formulary.
The importance of good vision care is easy to see – even at an early age.

- Almost 80% of parents express concern over the possible harm being done to their children’s eyes by digital devices¹
- About 5% of pre-school aged children have an eye problem that could result in permanent vision loss if left untreated²
- About 80% of learning in a child’s first years is visual³

With the CareSource Pediatric vision benefit, kids can learn, grow and succeed through healthy eye care habits. We even provide coverage for replacement eyewear if it’s medically necessary.

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>In-Network Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam with Dilation as Necessary</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Contact Lens Fit &amp; Follow-up</strong></td>
<td></td>
</tr>
<tr>
<td>Standard contact lens</td>
<td>Up to $40 copay</td>
</tr>
<tr>
<td>Premium contact lens</td>
<td>10% off retail price</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
</tr>
<tr>
<td>Any available frame at a provider location</td>
<td>100% coverage for provider designated frames</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Progressive</td>
<td>$0 copay</td>
</tr>
<tr>
<td>See fixed premium progressive price list</td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses (includes materials only for one of the options below)</strong></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>100% coverage for provider designated contact lenses</td>
</tr>
<tr>
<td>Extended Wear Disposables</td>
<td>Up to 6-month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses</td>
</tr>
<tr>
<td>Daily Wear / Disposable</td>
<td>Up to 3-month supply of daily disposable, single vision spherical contact lenses</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td>Once every calendar year</td>
</tr>
<tr>
<td>Lenses or contact lenses</td>
<td>Once every calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>Once every calendar year</td>
</tr>
<tr>
<td><strong>Replacement Glasses</strong></td>
<td>If medically necessary, 1 replacement for glasses as outlined above</td>
</tr>
</tbody>
</table>

Additional savings...

40% off additional pair discount*

20% off non-prescription sunglasses*

20% off any remaining frame balance*

*These discounts are offered at in-network providers only. Discounts are not funded by CareSource.

²Prevent Blindness America
³Problems & Conditions.

www.checkyearly.com

**See benefit summary details for full list of vision care services**
NEW for 2019! our CareSource Marketplace hearing aid discount provides you with high-quality hearing aids and local professional care at a reduced cost. Hearing aids can be very expensive, with an average retail price of over $2,300 each. The program, offered exclusively through TruHearing, can save you 30-60% off of retail.

**2019 Hearing Aid Discount Examples**

<table>
<thead>
<tr>
<th>Product</th>
<th>Retail</th>
<th>TruHearing Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starkey Muse iQ i1600</td>
<td>$2,180</td>
<td>$1,275</td>
</tr>
<tr>
<td>Resound LiNX 3D 7</td>
<td>$2,475</td>
<td>$1,595</td>
</tr>
<tr>
<td>Signia Nx 7</td>
<td>$3,125</td>
<td>$2,095</td>
</tr>
</tbody>
</table>

Call (866) 202-2459 to schedule an appointment. KY members dial (866) 202-2667.
PHARMACY COVERAGE

NETWORK PHARMACIES
Our network includes many major pharmacies, including those listed below, and many smaller pharmacies. Over 67,000 pharmacies in network nationally.
In order to have your prescriptions covered by CareSource, you must get them filled at a pharmacy in our network.

• Costco
• CVS
• Discount Drug Mart
• Kmart
• Kroger
• Meijer
• Rite Aid
• Sam’s Club
• Target
• Walmart
CareSource Marketplace members have access to MYidealDOCTOR™, a telemedicine company reinventing the way health care is delivered, bringing physician care to you in the comfort of your own home.

Can’t wait for your family doctor? MYidealDOCTOR can be consulted to treat many common conditions:
- Colds/flu/cough
- Congestion/sinus infection
- Allergies
- Pink eye
- Rashes
- And more
DENTAL AND VISION COVERAGE

...and so much more!
Picking a dental and vision plan gives you & the adults on your plan several extra benefits:

- Preventive dental services copays as low as $0
- Coverage for vision exams, frames, lenses and more
- Access to EyeMed Provider network and benefits
- $0 fitness center access or choice of two home fitness kits
ACTIVE&FIT® PROGRAM*

• No extra cost – all Active&Fit benefits are included with your Dental & Vision plan. No monthly gym fee, no contracts!
• Access to a network of fitness centers for the benefit year – including select LA Fitness®, Snap Fitness™, Anytime Fitness®, Planet Fitness® centers – plus more!
• Multi-fitness center access. Members may register for and use more than one fitness center in a given month.
• The option to receive up to 2 home fitness kits (20 to choose from) to work out at home
• The Active&Fit Connected!™ tool, a fun and easy way to track your exercise at a fitness center or through a wearable fitness device or app**
• An online newsletter 4 times a year
• Other web tools like a fitness center search, online classes, and more!

The Active&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit, Active&Fit Connected!, and the Active&Fit logo are federally registered trademarks of ASH.

* Limitations and Exclusions apply to the Active and Fit Program. Full details are available in the applicable 2019 CareSource Marketplace plan Evidence of Coverage or by calling CareSource.

** Purchase of a wearable fitness device or app is not included.
CareSource has partnered with EyeMed Vision Care to bring you a vision benefit solution that offers more...

- Access to the biggest network with the most choice – including hundreds of independent providers, and truly in-network access to popular national retailers as well as regional favorites
- Service that is always open to new patients and without an appointment
- Locations with extended evening and weekend hours in convenient locations
- Online solutions that allow seniors and their caregivers to evaluate options at home and reduce stress at the provider office
- Benefit options that offer more flexibility, choice and savings

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>In-Network Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam with Dilation as Necessary</strong></td>
<td>$40-$65 Copay or 40% Coinsurance'</td>
</tr>
<tr>
<td><strong>Frame, Lenses &amp; Options Package</strong></td>
<td>$250 allowance for frame, lens and lens options, 20% off balance over $250</td>
</tr>
<tr>
<td>Any frame, lens and lens options available at provider location.</td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses (includes materials only for one of the options below)</strong></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$0 copay; $250 allowance, 15% off balance over $250</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 copay; $250 allowance, plus balance over $250</td>
</tr>
<tr>
<td><strong>Laser Vision Correction</strong></td>
<td>15% off retail price or 5% off promotional price</td>
</tr>
<tr>
<td>LASIK or PRK from U.S. Laser Network</td>
<td></td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td>Once every calendar year</td>
</tr>
<tr>
<td>Frame &amp; Lenses or Contact Lenses</td>
<td>Once every calendar year</td>
</tr>
</tbody>
</table>

*These discounts are offered at in-network providers only. Discounts are not funded by CareSource.
†Extra Discounts may be available for those that qualify for a CSR. Coinsurance applies after deductible.
HOW TO ENROLL

• Visit Enroll.CareSource.com
  Anonymously shop for plans, compare benefits, premiums, and cost-sharing amounts. Then, enroll in the plan that suits your healthcare needs and budget best!

• Prefer to talk to someone? Our staff will be happy to help you! Just call toll-free 1-844-539-1733 (TTY: 711)

Open enrollment begins on November 1, 2018.
Health Savings Accounts (HSAs) are a tax advantaged health care account that you own. HSA contributions are subject to limits established by the Internal Revenue Service (IRS). The funds you contribute, but do not use, roll over year to year. Please consult your tax advisor for guidance and review IRS Publication 969 at www.irs.gov.

CareSource is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

All covered health care services must be received by in-network providers, except as otherwise required by applicable law, and subject to policy limitations and exceptions. Benefits, premiums, deductibles and copays may vary based on individual circumstances and plan selection. For complete details of coverage, limitations and exclusions, please review the CareSource Marketplace 2018 Evidence of Coverage and Schedule of Benefits documents at CareSource.com/marketplace.

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-202-0622 or TTY: 711.

如果您或者您在帮助的人对 CareSource 存有疑问，您有权 免费获得以您的语言提供的帮助和信息。如果您需要与一位翻译交谈，请致电 1-800-202-0622 or TTY: 711.
REAL HEALTH INSURANCE
2019 West Virginia

CareSource
GET REAL INSURANCE

There’s a lot of noise around health insurance these days. It can be difficult to know what’s true about your coverage and what really matters. But at CareSource, we’ve seen it all. We’ve been around since 1989, and we’re currently providing health coverage to nearly 2 million members**. We’ve been helping Marketplace insurance shoppers in West Virginia since 2016 and we never quit. CareSource coverage is here when you need it.
SHOPPING FOR A PLAN?

Here are some basics you should know if you’re shopping for an individual or family health insurance plan. Health Insurance Marketplace-qualified plans, like the ones CareSource offers, are the only plans that are guaranteed to provide all the Essential Health Benefits required by the Affordable Care Act. These benefits include:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory patient services</td>
<td>(outpatient care you get without being admitted to a hospital)</td>
</tr>
<tr>
<td>Emergency services</td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td>(like surgery and overnight stays)</td>
</tr>
<tr>
<td>Pregnancy, maternity, and newborn care</td>
<td>(both before and after birth)</td>
</tr>
<tr>
<td>Mental health and substance use disorder services, including behavioral health treatment</td>
<td>(this includes counseling and psychotherapy)</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative and habilitative services and devices</td>
<td>(services and devices to help people with injuries, disabilities or chronic conditions gain or recover mental and physical skills)</td>
</tr>
<tr>
<td>Laboratory services</td>
<td></td>
</tr>
<tr>
<td>Preventive and wellness services and chronic disease management</td>
<td></td>
</tr>
<tr>
<td>Pediatric services, including dental and vision care</td>
<td>(but adult dental and vision coverage aren’t classified as essential health benefits)</td>
</tr>
<tr>
<td>Birth control coverage</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding coverage</td>
<td></td>
</tr>
</tbody>
</table>
Marketplace-qualified plans have no limits on pre-existing conditions and no lifetime coverage caps.\["\]

This is real health insurance. Individual and family health plans that aren’t Marketplace-qualified may not provide coverage for all of these items, so to make sure you’re getting coverage for all services, purchase a Marketplace-qualified health plan.

CareSource’s Marketplace-qualified Dental & Vision plans cover more than the essential health benefits, including adult dental, adult vision and a fitness program with access to multiple fitness centers or home fitness kits.
Discounts

Marketplace plans are also the only plans that qualify for government-sponsored funds that help bring down the overall cost of the plan. APTC and CSR are calculated by the Health Insurance Marketplace when you submit your household size and income information during the shopping and enrollment process at enroll.CareSource.com. If you qualify, it can save you money each time you get medical services. So consider the total cost of your medical care when you pick a plan. Your total costs include your monthly premium and the payments you make when you get care. There are two ways the funds are distributed:

**Advance Premium Tax Credit (APTC)**
Tax credit taken in advance, in whole or in part, to lower monthly premium payments. This can be used no matter what plan you enroll in.

**Cost-Sharing Reduction (CSR)**
CSRs are discounts or “extra savings” that lower the amount you have to pay for deductibles, copayments and coinsurance. CSRs only apply to Silver plans, so if you qualify for a CSR, you must enroll in a Silver plan to get it.*
Coverage Area

In order to purchase a CareSource Marketplace plan, you must live in one of the counties in our coverage area. We cover 35 counties in West Virginia. See our coverage map to find out if we’re in your county:
CareSource has three different Silver plans to choose from so you can pick the plan that fits your budget – Low Premium, Low Deductible or balance premiums and deductibles with the Standard plan. These are the only plans that offer CSRs in addition to premium tax credits. If you qualify for a CSR, the cost of most benefits listed below will be reduced. See our Benefits Guide for more detail.

<table>
<thead>
<tr>
<th>SILVER LOW PREMIUM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$6,400</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$7,900</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>15% *</td>
</tr>
<tr>
<td><strong>Primary Care or Retail Clinic Visit</strong></td>
<td>$25</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>$50</td>
</tr>
<tr>
<td><strong>Urgent Care Visit</strong></td>
<td>$75</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td>$500*</td>
</tr>
<tr>
<td><strong>Generic Prescription Drug Coverage</strong> (Retail/90-day Mail) ‡</td>
<td>$20 / $50</td>
</tr>
</tbody>
</table>

*After deductible.

In the chart above, amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance. All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply. All Silver levels are based upon eligibility for Cost Sharing Reductions as determined by the Health Insurance Marketplace at healthcare.gov.
### SILVER STANDARD
- **Deductible:** $5,700
- **Out-of-Pocket Maximum:** $7,700
- **Coinsurance:** 20%*
- **Primary Care or Retail Clinic Visit:** $15
- **Specialist Visit:** $40
- **Urgent Care Visit:** $75
- **Emergency Room Visit:** $500*
- **Generic Prescription Drug Coverage:** $15 / $37.50

### SILVER LOW DEDUCTIBLE
- **Deductible:** $4,400
- **Out-of-Pocket Maximum:** $7,500
- **Coinsurance:** 30%*
- **Primary Care or Retail Clinic Visit:** $10
- **Specialist Visit:** $60
- **Urgent Care Visit:** $75
- **Emergency Room Visit:** $500*
- **Generic Prescription Drug Coverage:** $10 / $25

*After deductible.

Copays (except for Deductible, Out-of-Pocket Maximum).

Amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance.

All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply. All Silver levels are based upon eligibility for Cost Sharing Reductions as determined by the Health Insurance Marketplace at healthcare.gov.
Generally a good choice if you do not expect to have a lot of doctor appointments, don’t need many prescription medications or need other health services. Plus, the Health Savings Account (HSA)-eligible plan provides a tax-free way to save for healthcare costs. It can be used in conjunction with an HSA from the bank of your choice.

<table>
<thead>
<tr>
<th></th>
<th>BRONZE</th>
<th>BRONZE HSA-ELIGIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$7,400</td>
<td>$5,200</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$7,900</td>
<td>$6,650</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Primary Care or Retail Clinic Visit</strong></td>
<td>$35</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Urgent Care Visit</strong></td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td>40%*</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Generic Prescription Drug Coverage (Retail/90-day Mail)</strong>‡</td>
<td>$30 / $75</td>
<td>50%* / 50%*</td>
</tr>
</tbody>
</table>

*After deductible.

In the chart above, amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance.

All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply.
This may be a good choice for you if you expect to have a lot of doctor appointments, need many prescription medications or need other health services. Gold plans have:

<table>
<thead>
<tr>
<th>CARESOURCE GOLD PLANS</th>
<th>COPAY ($) OR COINSURANCE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$2,000</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$6,500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20%*</td>
</tr>
<tr>
<td>Primary Care or Retail Clinic Visit</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$35</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$75</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>20%*</td>
</tr>
<tr>
<td>Generic Prescription Drug Coverage (Retail/90-day Mail) ‡</td>
<td>$10 / $25</td>
</tr>
</tbody>
</table>

*After deductible.

In the chart above, amounts using a dollar sign ($) refer to copays (except for Deductible, Out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance.

All services (except ER and Urgent Care) must be received by in-network providers in order for the cost shares listed to apply.
ENHANCED BENEFITS PACKAGE

Our Enhanced Benefits packages add Dental and Vision benefits to our Gold, Silver and Bronze† plans for adults over the age of 19. If you choose a Dental & Vision plan, you pay one premium for health, dental and vision coverage. Plus, CareSource Dental & Vision plans include the FREE Active&Fit® fitness program which gives you access to multiple fitness centers and gyms – without a long-term contract – or two home fitness kits every benefit year.
FIRST STEPS:

To make your application process as smooth as possible, you’ll need to collect the following information for each family member you are enrolling:

<table>
<thead>
<tr>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security number or document number for legal immigrants</td>
</tr>
<tr>
<td>Employer and income information, for example, wage and tax statements from pay stubs or W-2 forms</td>
</tr>
<tr>
<td>If currently covered by health insurance, the policy number</td>
</tr>
<tr>
<td>If eligible for employer health insurance coverage (even if the coverage is through another person like a spouse or parent), information about the employer’s health insurance plan</td>
</tr>
</tbody>
</table>

HOW TO ENROLL:

Head to enroll.CareSource.com to find out if you qualify for CSRs or APTCs, shop and compare plans, and enroll in the plan that best fits your needs!

You can also visit CareSource.com to view current plan documents and see what medications are covered in our drug formulary.

Or find CareSource in-network doctors and hospitals at https://findadoctor.caresource.com.
QUESTIONS?
CALL US AT
1-844-539-1733
(TTY: 1-800-982-8771 or 711)
**Based on members enrolled in all CareSource product lines across all service areas as of August 15, 2018.
†Excluding HSA-Eligible plan.
‡Applicable only to drugs in the generic tier on the formulary.
#CSRs also applicable on Limited and Zero plans, available only to members of federally recognized tribes and ANCSA corporation shareholders.
‖Lifetime coverage limit applies to pediatric orthodontia.
The Active&Fit program is provided by American Specialty Health Fitness (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas.

At CareSource, your privacy matters to us. Learn more about our Privacy Practices at CareSource.com.

This is a solicitation for health insurance. CareSource Marketplace plans have exclusions, limitations, reductions and terms under which the policy may be continued in force or discontinued. Premiums, deductibles, coinsurance and copays may vary based upon individual circumstances and plan selection. Benefits and costs vary based upon plan selection. Not all plans and products offered by CareSource cover the same services and benefits. Covered services and benefits may vary for each plan. For costs and complete details of coverage, please review CareSource’s 2019 Evidence of Coverages and Schedules of Benefits documents at CareSource.com/marketplace.

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status or public assistance status.

If you, or someone you’re helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-202-0622 (TTY: 1-800-982-8771 or 711).

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-855-202-0622 (TTY: 1-800-982-8771 or 711).

如果您或者您在帮助的人对 CareSource 存有疑问，您有权 免费获得以您的语言提供的帮 助和信息。如果您需要与一位翻译交谈，请致电 1-855-202-0622 (TTY: 1-800-982-8771 or 711).

CareSource is a Qualified Health Plan issuer in the

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WV-EXCM-0446a
WVOIC Approved xx/xx/2018
Aggregate list of services not available in Kanawha County other than at CAMC

There may be some clinical areas with CAMC which have not yet reported on their respective areas, so it is possible that other services may need to be added. After December 31, 2018, the services below require prior authorization. The length of the prior authorization (per visit or during a time span) is dependent on the service rendered.

CAMC Only Services:

Epilepsy Monitoring Unit (EMU)

Trauma (Level 1)

Kidney/Renal Transplant

L 3 & 4 NICU

L1 PIC

Primary Stroke/Endovascular for Stroke (Thomas does offer a limited level of cva cases)

Bariatric

Peripheral Vascular Surgery

Neurosurgery

Vascular Neurosurgery, including aneurysms, coiling and AVM's

Traumatic Orthopedic Procedures

Traumatic Hand Surgery

High Risk OB

Higher end Cardiovascular,

Cardiology Services and Surgeries, including:

EP, TAVAR, IMPPELLA, MITRAL CLIPS, FLAPS

Hemophilia

Trauma for Oral Maxilla Facial and Craniofacial Injuries/Fractures

Full Service Oncology, including Radiation Oncology

HIV/AIDS and other Infectious Disease

MRI services outside the hours of operation for the Thomas O/P imaging center.
Highmark Blue Cross Blue Shield
West Virginia

2019 Individual Product
Potential Direct Pay Members for On or Off the marketplace - Telesales 877-959-2562

- Not yet enrolled, inquiries regarding new coverage for On the Health Insurance Marketplace (exchange)
- Not Medicare eligible

Hours of operation during the 2019 OEP will be as follows:
- November 1, 2018 through December 15, 2018
- Monday through Friday - 8:00 am to 8:00 pm EST
- Saturday and Sunday – 9:00 am to 2:00 pm EST

Member calling about any benefit/claims/billing for a current product or one that was already purchased.
- On Exchange – 888-601-2109
- Off Exchange - 888-809-9121
2019 Highmark West Virginia - Important Information to Note

**Highmark Cannot -**
- Make address changes where a zip code is changed
- Plan changes
- Adding or Removing a Dependent
- Cancel policy
- Answer APTC questions

**Highmark Can -**
- Make an address change where zip code is not changed
- Add a correspondence address
- Answer Billing (not APTC amount discrepancies), benefit, and claim questions
Highmark WV Hospital & Physician Network

WV Hospital Network
100%

Nationwide Hospital Network
96%

WV Physician Network
96%

Nationwide Physician Network
93%
Glossary

- **Coinsurance** - The part of a medical bill that you pay after reaching your deductible.
- **Copayments or Copays** - Fixed, upfront dollar amounts that you pay each time you receive certain health care services.
- **Deductible** - The dollar amount you must pay each benefit period (calendar year January 1st through December 31st) for your health care expenses before your plan begins to pay.
- **Formulary** - A list of prescription drugs that are covered by your health insurance plan.
- **In-network providers** - Health care providers who have an agreement with the health plan pertaining to payment as a network participant.
- **Out of network providers** - Health care providers who do not have an agreement with the plan.
- **Out-of-pocket maximum** - The highest amount you will need to pay each benefit period (calendar year January 1st through December 31st) before your plan pays at 100%.
- **Premium** - The amount you pay each month for your health insurance.
Questions?
Open Enrollment 6

Medical Plans

Information provided is current as of today. Please join the OIC listserv to keep up to date on federal and state updates.
Objectives

• Upon completion of this module, participants will be able to:
  • Help consumers compare health plans based on cost, provider network, and availability of services
  • Educate consumers to select the right plan for their circumstances
  • Inform consumers how to pay for their plans, including application of any available tax subsidies or cost sharing reductions
Comparing Plans

- Healthcare.gov allows consumers to compare plans so you get an ESTIMATE of what premiums you’d pay and what benefits and protections you’d get before you enroll.
Factors to Consider when Selecting a Plan

- Cost *(premium, copay, deductible, out-of-pocket max)*
- Expected Number of Doctor Visits
- Benefits and Prescriptions Offered
- Provider Network
Marketplace Plans Offered in WV

CareSource
Health Care with Heart

HIGHMARK
West Virginia

35 Counties
Statewide
## Essential Health Benefits

<table>
<thead>
<tr>
<th>Ambulatory patient services</th>
<th>Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Rehabilitative and habilitative services and devices</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Laboratory services</td>
</tr>
<tr>
<td>Maternity and newborn care</td>
<td>Preventive and wellness services and chronic disease management</td>
</tr>
<tr>
<td>Mental health and substance use disorder services, including behavioral health treatment</td>
<td>Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)</td>
</tr>
</tbody>
</table>
Preventive Coverage

• The US Preventive Services Task Force is tasked with grading preventive medical services
• A or B graded services must be covered with no cost sharing as a part of the ACA
• See the complete list
Legislative Update

- SB 242 – Lyme Disease Treatment
- SB 273 – Opioid Reduction
- SB 299 – Medical Foods
- SB 401 – Substance Abuse Disorders
## Health Plans on the FFE: Metal Tiers

<table>
<thead>
<tr>
<th></th>
<th>Gold</th>
<th>Silver</th>
<th>Bronze</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Cost</td>
<td>$$$</td>
<td>$$</td>
<td>$</td>
</tr>
<tr>
<td>Cost When You Get Care</td>
<td>$$</td>
<td>$$$</td>
<td>$$$$</td>
</tr>
<tr>
<td>Good Option If You...</td>
<td>want to pay higher monthly premiums while keeping your out-of-pocket costs low</td>
<td>need to balance your monthly premium with your out-of-pocket costs premium</td>
<td>don't plan to need a lot of health care services</td>
</tr>
</tbody>
</table>
Network

WE'RE HERE FOR YOU
Meet your Highmark healthcare team.

SWITCHING DOCTORS IS AS EASY AS 1-2-3
An in-network doctor close to home can save you time and money.
Make a switch today!

#LIVINGPROOF
Read stories about how members like you live healthier lives with Highmark's help.

NEED A DOCTOR NOW?
See a doctor anytime and anywhere.
Network
Network
Highmark

- My Blue Access Plans
- Catastrophic
  - Major Events
- NO out of network benefits
- Rx restructure
- Hospital Tiering
Highmark

• Prescription Restructure
  – Rx changes with the plans
  – Pay attention to the copays with each plan
  – Same formulary for all plans
    • Essential
    • Closed
Highmark West Virginia

My Blue Access WV EPO Gold 1000

- $1000/$2000 Deductible
- $7000/$14,000 OOP Max
- 20% Co-Insurance
- $0 (Visits 1-2), then $20 Primary/$45 Specialist
- Deductible, $500 Copay**, then 100% ER
- Rx $5/$30/35%/50% ($250 min and $1000 max)

**ER Copay waived if admitted.

Points of Interest...
- $25 Lab Copay
- $50 Standard Imaging Copay
- $15 Telemed Copay
Highmark West Virginia

My Blue Access WV EPO Silver 0
• $0/$0
• $7800/$15,600 OOP Max
• 40% Co-Insurance
• $40 Primary/$90 Specialist
• $1400 Copay**, then 100% ER
• Rx$5/$30/35%/50% ($250 min and $1000 max)

Points of Interest...
• $45 Lab Copay
• $90 Standard Imaging Copay
• $20 Telemed Copay

**ER Copay waived if admitted.
Highmark West Virginia

My Blue Access EPO Silver 2400
- $2400/$4800 Deductible
- $7800/$15,600 OOP Max
- 30% Co-Insurance
- $0 (Visits 1-2) then $40 Primary/$90 Specialist
- Deductible, then $750 copay**
- Rx $5/$30/35%/50% ($250 min and $1000 max)

Points of Interest...
- $55 Lab Copay
- $95 Standard Imaging Copay
- $20 Telemed Copay

**ER Copay waived if admitted.
Highmark West Virginia

My Blue Access WV EPO 4450  HSA

• $4450/$8900
• $6650/$13,300 OOP Max
• 10% Co-Insurance
• Deductible, 10% Primary/ Deductible, 10% Specialist
• Deductible, then 10% ER
• Rx Deductible, 10%
Highmark West Virginia

My Blue Access WV EPO Bronze 7900

- $7900/$15,800 Deductible
- $7900/$15,800 OOP Max
- 0% Co-Insurance
- $100 Primary/ $140 Specialist
- Deductible then 30% ER (all hospital tiers)
- Rx Deductible

Points of Interest...
- $0 Copay Visits 1-2 Outpatient Mental Health or Substance Abuse Treatment

BRONZE
Highmark West Virginia

Major Events Catastrophic Plan

- $7,900/$15,800 Deductible
- $7,900/$15,800 OOP Max
- 100% Co-Insurance
- 3 PCP Visits no cost sharing
# CareSource

## Expanded Availability in 2019

- Barbour
- Boone
- Brooke
- Cabell
- Calhoun
- Clay
- Doddridge
- Fayette
- Gilmer
- Hancock
- Harrison
- Jackson
- Kanawha
- Lincoln
- Logan
- Marion
- Marshall
- Mason
- McDowell
- Mingo
- Monongalia
- Ohio
- Pleasants
- Preston
- Putnam
- Raleigh
- Ritchie
- Roane
- Taylor
- Tyler
- Wayne
- Wetzel
- Wirt
- Wood
- Wyoming
CareSource

Gold

• $2000/$4000 Deductible
• $6500/$13000 OOP Max
• 20% Co-Insurance
• $0 Primary/$35 Specialist
• Deductible, then 20% ER
• Rx $10/$50/$200/40%/40%
  • Tier 4 and 5 capped at $300 per script

**ER Copay waived if admitted.**

Points of Interest...

• No charge PT/OT/Speech
CareSource

Gold Enhanced

- $2000/$4000 Deductible
- $6500/$13000 OOP Max
- 20% Co-Insurance
- $0 Primary/$35 Specialist
- Deductible, then 20% ER
- Rx $10/$50/$200/40%/40%
  - Tier 4 and 5 capped at $300 per script
- **ER Copay waived if admitted.**

- $50 Copay for Adult Vision Exam
- $250 limit for glasses/contacts
- $35 copay Preventive Dental
- 40% Major Services

- $2000/$4000 Deductible
- $6500/$13000 OOP Max
- 20% Co-Insurance
- $0 Primary/$35 Specialist
- Deductible, then 20% ER
- Rx $10/$50/$200/40%/40%
  - Tier 4 and 5 capped at $300 per script
- **ER Copay waived if admitted.**
CareSource

Standard Silver

- $5,700/$11,400 Deductible
- $7,700/$15,400 OOP Max
- 20% Co-Insurance
- $15 Primary/$40 Specialist
- $500 Copay**, then Deductible ER
- Rx $15/$45/20%/20%/50%

**ER Copay waived if admitted.

Points of Interest...

- $15 copay for PT/OT/Speech
CareSource

Standards Silver Enhanced

- $5,700/$11,400 Deductible
- $7,700/$15,400 OOP Max
- 20% Co-Insurance
- $15 Primary/$40 Specialist
- $500 Copay**, then Deductible
- Rx $15/$45/20%/20%/50%
- $50 Copay for Adult Vision Exam
- $250 limit for glasses/contacts
- $0 copay Preventive Dental
- 25% Major Services

**ER Copay waived if admitted.
CareSource

Low Deductible Silver

- $4400/$8800 Deductible
- $7500/$15,000 OOP Max
- 30% Co-Insurance
- $10 Primary/$60 Specialist
- Deductible, then $500 Copay** ER
- Rx $10/$60/30%/30%/50%

**ER Copay waived if admitted.

Points of Interest...

- $10 copay for PT/OT/Speech
CareSource

Low Deductible Silver Enhanced

- $4400/$8800 Deductible
- $7500/$15,000 OOP Max
- 30% Co-Insurance
- $10 Primary/$60 Specialist
- Deductible, then $500 Copay** ER
- Rx $10/$60/30%/30%/50%

- $65 Copay for Adult Vision Exam
- $250 limit for glasses/contacts
- $30 copay Preventive Dental
- 25% Major Services

**ER Copay waived if admitted.
CareSource

Silver Low Premium

• $6400/$12,800 Deductible
• $7900/$15,800 OOP Max
• 15% Co-Insurance
• $25 Primary/$50 Specialist
• Deductible, then $500 Copay** ER
• Rx $20/$50/15%/15%/50%

Points of Interest...
• $25 copay for PT/OT/Speech

**ER Copay waived if admitted.
CareSource

Silver Low Premium Enhanced

• $6400/$12,800 Deductible
• $7900/$15,800 OOP Max
• 15% Co-Insurance
• $25 Primary/$50 Specialist
• Deductible, then $500 Copay** ER
• Rx $20/$50/15%/15%/50%

• $40 Copay for Adult Vision Exam
• $250 limit for glasses/contacts
• $0 copay Preventive Dental
• 15% Major Services

**ER Copay waived if admitted.
CareSource

Bronze

• $7400/$14,800 Deductible
• $7900/$15,800 OOP Max
• 40% Co-Insurance
• $35 Primary/Deductible, then 40%
• Deductible, then 40% ER
• Rx $30/40%/40%/40%/50%
CareSource

**Bronze Enhanced**

- $7400/$14,800 Deductible
- $7900/$15,800 OOP Max
- 40% Co-Insurance
- $35 Primary/Deductible, then 40%
- Deductible, then 40% ER
- Rx $30/40%/40%/40%/40%/50%

- Deductible, 40% ($250 Limit)
- $20 Copay Preventive Dental
- 40% Major Services
Summary of Benefits and Coverage

- Federally mandated layout
- Limited to the information provided
- Available on Healthcare.gov or on the Company webpage
Summary of Benefits

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately, in your coverage, or to get a copy of the complete terms of coverage, please and www.highmarkbcbs.com or call 1-988-383-9121. For other questions or comments about your coverage, see the Glossary. You can view the Glossary at www.HealthCare.gov or call 1-877-833-8980 or visit www.HighmarkBCBS.com for more information.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0 individual/$0 family network</td>
<td>See the Common Medical Expenses chart below for your costs for services the plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>This plan covers some items and services even if you haven’t met the deductible amount. But co-payments or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.HealthCare.gov/preventive-care/">https://www.HealthCare.gov/preventive-care/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$7,600 individual/$15,600 family network</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in the plan, they have to meet their own out-of-pocket limits and the overall family out-of-pocket limit has been reached.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billed charges, and health care that this plan doesn’t cover</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. Her a list of network providers, see <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> or call 1-877-409-9121.</td>
<td>The plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s usual charge and what your plan pays (balance billing). To ensure your network provider might use an out-of-network provider for some services, call your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s Eye exam</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s Glasses</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s Dental checkup</td>
<td>No charge</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**

- Abortion, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the woman in danger unless an abortion is performed.
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months in-network prenatal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
</tr>
<tr>
<td>■ Specialist copayment</td>
<td>■ Specialist copayment</td>
<td>■ Specialist copayment</td>
</tr>
<tr>
<td>■ Hospital (facility) copayment</td>
<td>■ Hospital (facility) copayment</td>
<td>■ Hospital (facility) copayment</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>$90</td>
<td>$90</td>
<td>$90</td>
</tr>
<tr>
<td>$3,900</td>
<td>$3,900</td>
<td>$3,900</td>
</tr>
<tr>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>In this example, Peg would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$12,800</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td></td>
<td>Deductibles</td>
</tr>
<tr>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions | $0 |

The total Peg would pay is: $5,100

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>In this example, Joe would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7,400</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td></td>
<td>Deductibles</td>
</tr>
<tr>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions | $0 |

The total Joe would pay is: $1,800

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>In this example, Mia would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,900</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td></td>
<td>Deductibles</td>
</tr>
<tr>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions | $0 |

The total Mia would pay is: $1,100

The plan would be responsible for the other costs of these EXAMPLE covered services.
Key Marketplace Dates for 2019

- Open Enrollment Begins – November 1, 2018
- Coverage Begins – January 1, 2019 (If enrolled before December 15)
- Open Enrollment Ends – December 15, 2018
How Would the Consumer like to Enroll?

Online at healthcare.gov

By phone
1-800-318-2596

By mail to
Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001
Enroll by completing the following sections:

On healthcare.gov...

- Set discount usage by applying tax credit, if applicable
- Answer questions about the household
- Select a health insurance plan
- Review and confirm health insurance plan
Questions?
SHORT-TERM LIMITED DURATION PLANS

West Virginia Offices of the Insurance Commissioner

SHORT-TERM LIMITED DURATION

A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.
STLD plan can have the following:

- Lifetime maximum limit
  - Total claims dollars spent
  - Max out benefits for one condition
- Limited number of visits
- Medically underwritten

STLD plan can have the following:

- No coverage for preexisting conditions
  - Potential for lengthy limitations
- Limited mental health/substance abuse coverage
- No therapy, rehabilitive or habilitative services
  - Other than chronic pain
STLD plan can exclude the following:

- Prescription drug coverage
- Preventative coverage
- Maternity coverage
- Essential Health Benefits

STLD plans in West Virginia

WV follows the federal rule:

- Policies can be written for one year
- Policies can provide two renewals
- Disclosure language must be displayed as required
Education is Key

• Explain differences between STLD and an ACA plan
• Informational brochure on OIC website
Understanding Special Enrollment Periods

A Special Enrollment Period may let you enroll in health coverage outside of the annual Open Enrollment Period if you experience certain situations, or during Open Enrollment for an earlier coverage start date. You may qualify for a Special Enrollment Period through the Health Insurance Marketplace in these situations:
### Situation Details

#### 1. Loss of qualifying health coverage
You may qualify for a Special Enrollment Period if you (or anyone in your household) lost qualifying health coverage (or “minimum essential coverage”). Some examples of qualifying coverage include:

- Coverage through a job, or through another person's job. This also applies if you’re now eligible for help paying for Marketplace coverage because your employer stops offering coverage or the coverage is no longer considered qualifying coverage.
- Medicaid or Children’s Health Insurance Program (CHIP) coverage (including pregnancy-related coverage and medically needy coverage).
- Medicare.
- Individual or group health plan coverage that ends during the year.
- Coverage under your parent’s health plan (if you’re on it). If you turn 26 and lose coverage, you can qualify for this Special Enrollment Period.

**Note:** This Special Enrollment Period doesn't include loss of coverage because you didn't pay your premiums or if your coverage was taken away because of fraud or intentional misrepresentation.

#### More information

**Available in advance:**
You may report a loss of qualifying health coverage up to 60 days before the loss of coverage.

**Special Enrollment Period confirmation:**
If you’re enrolling in Marketplace coverage for the first time, you may need to submit documents to confirm that you qualify for this Special Enrollment Period.

---

#### 2. Change in household size
You may qualify for a Special Enrollment Period if you (or anyone in your household):

- Got married
- Had a baby, adopted a child, or placed a child for foster care
- Gained or became a dependent due to a child support or other court order

**Note:** If you gained or became a dependent due to marriage, then at least one spouse must have also had qualifying health coverage for one or more days in the 60 days prior to the marriage. This doesn’t apply if the spouse was living in a foreign country or a U.S. territory for one or more days in the 60 days prior to the marriage; or is a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation; or lived for one or more days during the 60 days before their move or during their most recent enrollment period in a service area where they couldn’t get qualifying health coverage through the Marketplace.

#### More information

**Special Enrollment Period confirmation:**
If you’re enrolling in Marketplace coverage for the first time, you may need to submit documents to prove you qualify for a Special Enrollment Period due to a marriage or due to an adoption, foster care placement, or child support or other court order.
### Situation Details

#### 3. Change in primary place of living

You may qualify for a Special Enrollment Period if you (or anyone in your household) have a change in your primary place of living and gain access to new Marketplace health plans as a result. Household moves that qualify you for a Special Enrollment Period include:

- Moving to a new home in a new ZIP code or county
- Moving to the U.S. from a foreign country or U.S. territory
- A student moving to or from the place he or she attends school
- A seasonal worker moving to or from the place he or she lives and works
- Moving to or from a shelter or other transitional housing

**Note:** You qualify only if you had qualifying health coverage for one or more days in the 60 days prior to your move. This doesn't apply if you were living in a foreign country or a U.S. territory for one or more days in the 60 days prior to the move, or if you're a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation, or lived for one or more days during the 60 days before your move or during your most recent enrollment period in a service area where you couldn't get qualifying health coverage through the Marketplace. Moving only for medical treatment or staying somewhere for vacation doesn't qualify you for a Special Enrollment Period.

#### More information

**Special Enrollment Period confirmation:**

If you're enrolling in Marketplace coverage for the first time, you may need to submit documents to confirm that you qualify for this Special Enrollment Period due to a change in primary place of living.

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#### 4. Change in eligibility for Marketplace coverage or help paying for coverage

You may qualify for a Special Enrollment Period if you (or anyone in your household):

- Are enrolled in Marketplace coverage and report a change that makes you:
  - Newly eligible for help paying for coverage.
  - Newly ineligible for help paying for coverage.
  - Eligible for a different amount of help paying for out-of-pocket costs, like copayments.
- Become newly eligible for Marketplace coverage because you've become a citizen, national, or lawfully present individual.
- Become newly eligible for Marketplace coverage after being released from incarceration (detention, jail, or prison).
- Gain or maintain status as a member of a federally recognized tribe or an Alaska Native Claim Settlement Act (ANCSA) Corporation shareholder (a status that lets you change plans once per month, and lets your dependents enroll in or change plans with you).
- Become newly eligible for help paying for Marketplace coverage because you moved to a different state and you were previously both of these:
  - Ineligible for Medicaid coverage because you lived in a state that hasn't expanded Medicaid.
  - Ineligible for help paying for coverage because your household income was below 100% of the Federal Poverty Level (FPL).
<table>
<thead>
<tr>
<th>Situation</th>
<th>Details</th>
</tr>
</thead>
</table>
| **5. Enrollment or plan error** | You may qualify for a Special Enrollment Period if you (or anyone in your household):  
- Weren't enrolled in a plan or were enrolled in the wrong plan because of:  
  - Misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity to help you enroll (like an insurance company, Navigator, certified application counselor, agent or broker).  
  - A technical error or other Marketplace-related enrollment delay.  
  - Wrong plan data (like benefit or cost-sharing information) displayed on HealthCare.gov at the time that you chose your health plan.  
- Can prove your Marketplace plan violated a material provision of its contract. |
| **6. Other situations** | You may qualify for a Special Enrollment Period if you (or anyone in your household):  
- Applied for Medicaid or Children's Health Insurance Program (CHIP) coverage during the Marketplace Open Enrollment Period, or after a qualifying event, and your state Medicaid or CHIP agency determined you (or anyone in your household) weren't eligible after Open Enrollment ended, or more than 60 days had passed since your qualifying event.  
- Are a victim of domestic abuse or spousal abandonment and want to enroll yourself and any dependents in a health plan separate from your abuser or abandoner.  
- Submitted documents requested by the Marketplace to confirm your eligibility, but your coverage had already ended.  
- Are under 100% of the Federal Poverty Level (FPL), submitted documents to prove that you have an eligible immigration status, and didn't enroll in coverage while you waited for your documents to be reviewed.  
- Are an AmeriCorps service member starting or ending AmeriCorps service.  
- Can show you had an exceptional circumstance that kept you from enrolling in coverage, like being incapacitated or a victim of a natural disaster during an Open Enrollment Period or another Special Enrollment Period qualifying event. |

**More information**

**Special Enrollment Period confirmation:**  
If you're enrolling in Marketplace coverage for the first time, you may need to submit documents to confirm that you qualify for a Special Enrollment Period due to a denial of Medicaid or CHIP coverage.
**What if I think I qualify for a Special Enrollment Period?**

Visit HealthCare.gov/screener/ and answer a few questions to find out if you qualify for a Special Enrollment Period to enroll in or change plans. You’ll also find out if you’re eligible for coverage through Medicaid or the Children’s Health Insurance Program (CHIP) when you apply. We’ll tell you when your coverage will start and your next steps.

You can also call the Marketplace Call Center at 1-800-318-2596 to enroll by phone (TTY users can call 1-855-889-4325). Be sure to tell the representative you think you qualify for a Special Enrollment Period. They’ll verify whether you do.

**Important:** When you apply, you must attest that the information you provide on the application is true, including the facts that qualify you for a Special Enrollment Period.

**Note:** If you’re applying for health coverage in a state running its own Marketplace, your state may have Special Enrollment Periods other than those listed here. Visit HealthCare.gov to find your state’s Marketplace.

**What if the Marketplace needs documents to confirm my Special Enrollment Period?**

When you apply for Marketplace coverage and qualify for a Special Enrollment Period, if you’re newly enrolling in Marketplace coverage, you may be asked to provide documents to confirm the events that make you eligible. You must either upload your documents online or mail in copies of the documents (don’t send originals) before you can make your first payment and start using your coverage.

After you submit your application, you’ll learn if you have to provide documents. Details and instructions appear on your eligibility results screen and in a notice you can download or get in the mail.

It’s best to pick a plan first and submit your documents afterwards. After you pick a plan, you have 30 days to send the documents.

Your coverage start date is based on when you pick a plan. But you can’t use your coverage until your Special Enrollment Period eligibility is confirmed and you make your first premium payment.

If your eligibility results don’t say you need to provide documents, you don’t have to. Simply pick a plan and enroll. For more information, visit https://www.HealthCare.gov/coverage-outside-open-enrollment/confirm-special-enrollment-period/.

You have the right to get Marketplace information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users can call 1-855-889-4325.

Paid for by the Department of Health & Human Services.
Health coverage exemptions: Forms & how to apply

Hardship exemptions, forms & how to apply

Hardships are financial situations and other circumstances that keep you from getting health insurance. If you qualify for a hardship exemption, you don’t have to pay a fee for the months you were uncovered.

2018 hardship exemptions

- Starting with plan year 2018 (for which you’ll file taxes in April 2019), you don’t have to fill out an application to get a hardship exemption. You can claim the exemption, without having to submit documentation about the hardship, on your 2018 federal tax return.

- If you’d prefer to complete an application and submit documentation for a 2018 hardship exemption (or are applying for a 2016 or 2017 hardship exemption), you may follow the instructions below.

Need a 2018 hardship exemption form?

Get instructions for downloading the hardship exemption form (/exemption-form-instructions/), and a link to the form itself.
2019 Hardship Exemptions

- Starting with the 2019 plan year (for which you'll file taxes in April 2020), the penalty no longer applies. (The fee is sometimes called the “Shared Responsibility Payment” or “mandate.”) If you don't have coverage during 2019, you don't need an exemption in order to avoid the penalty.

- If you are 30 or older and want to buy a Catastrophic health plan, you must apply for a hardship exemption to qualify. Learn about hardship exemptions and Catastrophic plans for 2019. (/choose-a-plan/catastrophic-health-plans/)

Hardship exemptions

Following are all hardship exemptions, with links to details, forms, and instructions.

1. You were homeless (/exemptions-tool/#/results/2018/details/homeless)

2. You were evicted or were facing eviction or foreclosure (/exemptions-tool/#/results/2018/details/eviction)

3. You received a shut-off notice from a utility company (/exemptions-tool/#/results/2018/details/utilities-shut-off)


6. You experienced a fire, flood, or other natural or human-caused disaster (/exemptions-tool/#/results/2018/details/disaster) that caused substantial damage to your property


8. You had medical expenses you couldn’t pay (/exemptions-tool/#/results/2018/details/owe-medical-expenses) that resulted in substantial debt

9. You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member (/exemptions-tool/#/results/2018/details/care-for-family)
10. You claim a child as a tax dependent who’s been denied coverage for Medicaid and CHIP (/exemptions-tool/#/results/2018/details/medicaid-chip-denied) for 2017, and another person is required by court order to give medical support to the child. In this case you don’t have to pay the penalty for the child.

11. As a result of an eligibility appeals decision (/exemptions-tool/#/results/2018/details/eligible-based-on-appeal), you’re eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren’t enrolled in a QHP through the Marketplace in 2017.

12. You were determined ineligible for Medicaid because your state didn’t expand eligibility for Medicaid in 2018 (/exemptions-tool/#/results/2018/details/secretary-hardship) under the Affordable Care Act.

13. The exemption for "grandfathered" individual insurance plans is no longer available for 2017 and later.

14. You had another hardship. If you experienced another hardship obtaining health insurance, use this form to describe your hardship and apply for an exemption (/exemption-form-instructions/).
Tips for Assisters: Helping Consumers Understand Grace Periods and Termination due to Non-Payment of Premiums

June 2018

This assister tip sheet provides in-depth guidance on grace periods, premium payments, and termination of coverage in the individual Federally-facilitated Marketplaces and State-based Marketplaces that use the federal eligibility and enrollment platform.

Grace Period Facts

If consumers do not pay their monthly premium payments in full, or within the tolerance of an applicable premium payment threshold by the deadline, their health insurance company (or “issuer”) may terminate their qualified health plan (QHP) coverage. But before an insurance company can end consumers’ coverage, they have a short period of time to pay called a "grace period."

- Consumers who receive advance payments of the premium tax credit (APTC) have a grace period of three consecutive months.¹ Issuers must pay all appropriate claims for services rendered to consumers during the first month of a grace period and may pend claims for services rendered to consumers during the second and third months.

- Consumers who do not receive APTC have a grace period determined by state rules.² Assisters should help consumers who do not receive APTC contact their State Department of Insurance (DOI) for more information on grace periods in their state.
Helping Consumers Enroll in a New QHP after Their QHP coverage is terminated for Non-Payment of Premiums

Open Enrollment

During Open Enrollment, consumers whose previous QHP coverage was terminated for nonpayment of premiums will still be able to receive an eligibility determination and, if eligible, enroll in a QHP for plan year 2019. Consumers can enroll in the same QHP they had in 2018 for plan year 2019 if it is still available. However, any issuers in the same organization may apply payments for the new enrollment to past due premiums applicable in the previous 12 months if the issuer has properly adopted such a policy and notified consumers of the policy. In such cases, the consumer would need to pay all past due premiums under the policy, and pay the binder payment for the new enrollment before the new enrollment could be effectuated.

Auto Re-enrollment

Auto Re-enrollment is the process the individual Federally-facilitated Marketplaces and State-based Marketplaces using the federal eligibility and enrollment platform use to ensure that current consumers who do not make an active plan selection by December 15 can have coverage on January 1 of the following plan year. If current consumers do not make an active plan selection by December 15, 2018 these Marketplaces will:

1. Determine 2019 eligibility, and
2. Re-enroll eligible consumers effective January 1, 2019 in a QHP under a hierarchy designed to ensure the same or similar QHP coverage with any financial assistance they qualify for.

Consumers who are auto re-enrolled receive an eligibility determination notification from the Marketplace and enrollment materials from the issuer after December 15. Consumers may actively select a plan to replace the auto-enrollment plan until the end of Open Enrollment, or under a special enrollment period, if they qualify for one. For example, a consumer can select a new QHP on December 15 with an effective date of January 1.

Consumers who are not enrolled in Marketplace coverage in mid-December 2018 are not eligible for auto re-enrollment.

Special Enrollment Periods (SEPs)

If a consumer claims loss of minimum essential coverage (MEC) as their SEP qualifying event, and that loss was the result of non-payment of premiums, then the consumer is not eligible for the loss of MEC SEP. If an issuer terminates a consumer’s coverage for nonpayment of
premiums, the consumer is also not eligible for an SEP for loss of minimum essential coverage (MEC) due to this termination from coverage. However, the consumer may qualify for an SEP for other reasons.

Scenario #1: A Consumer Who is Not Receiving APTC

John does not receive APTC. He enrolls in a QHP, and has paid all his premiums in full since January. John fails to pay his July premium—due July 1. Since John does not receive APTC, his state’s grace period requirements apply. In John’s state, the grace period for consumers who do not receive APTC is one month; therefore, John’s grace period starts July 1 and ends July 31.

John makes no further premium payments and, complying with state law, John’s issuer terminates his coverage with an effective date of July 31. John later qualifies for an SEP and is determined eligible for Marketplace coverage. On August 13, John selects a QHP with a different issuer that is not part of the same organization as his prior issuer, with an effective date of September 1. John makes the September binder payment by the due date in the new issuer’s enrollment materials.

John’s issuer may not:

- Apply the September 1 payment toward the debt that resulted in termination in July; or,
- Refuse to confirm the new enrollment on the basis of non-payment.

The issuer may not reject the enrollment based on non-payment, and must communicate the enrollment confirmation transaction to the Marketplace.

Scenario #2: A Consumer Receiving APTC

Dawn receives APTC, enrolls in a QHP, and has paid all her premiums in full since January 2018. Dawn fails to pay her August premium—due August 1. Dawn enters a three-month grace period on August 1 and it expires on October 31.

If Dawn does not pay all outstanding premiums by October 31, Dawn’s issuer terminates her QHP coverage with an effective date of August 31—the end of the first month of her grace period.

Since Dawn is not enrolled in Marketplace coverage in mid-December 2018, she is not eligible for auto-re-enrollment. During Open Enrollment, Dawn updates her application at HealthCare.gov for the upcoming plan year and is determined eligible for coverage with APTC. Dawn selects the same QHP she had in 2018 for coverage starting January 1, 2019 and pays her binder payment premium by the due date. The issuer, which has properly adopted and
implemented a policy of applying payments to past due premiums, applies the binder payment to previous debt and requests full payment of Dawn’s past debt and the 2019 binder payment before the issuer effectuates Dawn’s enrollment in 2019 coverage.

**Grace Periods Spanning Two Plan Years**

Some consumers may experience a grace period for non-payment of premiums that spans two plan years. These are consumers who:

- Receive APTC; and
- Fail to pay premiums due at the beginning of November or December.

**Auto-reenrollment**

Consumers with grace periods extending beyond the 2018 plan year may still be eligible for auto-re-enrollment. If a consumer is auto-re-enrolled, the issuer may not reject the enrollment based on non-payment of premiums.

**Termination Date**

If a consumer is auto-re-enrolled but does not pay all outstanding premiums by the end of the three-month grace period, the issuer must terminate the consumer’s coverage retroactively to the last day of the first month of the grace period. If the consumer’s 2019 coverage is considered a renewal of the 2018 coverage (i.e., a re-enrollment that would not require a binder payment to be effectuated), this termination also ends coverage for the 2019 plan year.

If a consumer is re-enrolling, either through auto-re-enrollment or active plan selection in a plan for 2019 coverage that is not considered a renewal of the 2018 coverage (i.e., a re-enrollment that would require a binder payment to be effectuated, such as an alternate enrollment or an active enrollment in a product different than the issuer’s renewal product) and does not pay all outstanding premiums by the end of the three-month grace period, the termination will retroactively apply to end the 2018 coverage (November 30 or December 31, depending on when the enrollee entered APTC Grace), but the 2019 coverage will generally remain in place, which may result in a gap in coverage. If the consumer pays the binder payment on the new coverage (and any applicable past due premium from the last twelve months if the new coverage’s issuer has adopted the optional payment policy) and the new coverage is effectuated, but then the consumer does not meet subsequent premium payment obligations, the new plan year’s coverage would be subject to its own grace period.

**Scenario #3: A Consumer in a Grace Period during Auto-Re-enrollment**
James receives APTC, enrolls in a QHP, and pays all his premiums in full through November 2018. Then, James fails to pay the December premium by the due date—December 1, 2018. James enters a three-month grace period that will end on the last day of February 2019. James does not actively select a plan for plan year 2019, and the Marketplace sends an auto-re-enrollment transaction to the issuer that would renew James’ 2018 coverage in the same plan for 2019 plan year coverage. The issuer may not reject the enrollment based on non-payment of premiums.

James’ coverage continues into 2019 and the existing grace period continues, meaning he must pay all outstanding premiums by Feb. 28. However, since James does not pay all outstanding premiums by Feb. 28, the issuer retroactively terminates his coverage effective Dec. 31, 2018.

James is no longer covered for plan year 2019. Since Open Enrollment has ended, James cannot enroll in the 2019 coverage unless he qualifies for an SEP.

**Grace Periods Ending December 31, 2018 (the End of Plan Year 2018)**

Consumers who are enrolled in a QHP for plan year 2018 with a grace period ending December 31, 2018 may make a premium payment intended for January 2019 coverage rather than for 2018 coverage with outstanding premiums. In this situation, the Marketplace needs to determine:

- If the consumer is enrolling in new coverage (see Scenario #1 above); or
- If the consumer is attempting to renew the current coverage (see Scenarios #2 and #3).

Determination depends on whether the consumer took action to update his/her application, was determined eligible, and actively selected a QHP for 2019 coverage.

**Enrolling in New Coverage during Open Enrollment**

Consumers with grace periods expiring at the end of the plan year and who actively complete a plan selection for 2019 coverage during Open Enrollment may enroll in 2019 coverage in certain scenarios, if otherwise eligible. If the enrollee actively enrolls in a policy requiring binder payment, the Marketplace considers this a new enrollment, and the new coverage takes effect if a consumer pays the January 2019 premium (and any applicable past due premium) by the due date. However, if the active selection does not require binder, the issuer will cancel the enrollment as the enrollee’s selection is considered merely an update to a continuous enrollment that is terminated.
Auto-re-enrollment

Consumers whose grace period expires on December 31 may be auto re-enrolled in 2019 coverage if 1) they don’t actively select a new QHP during Open Enrollment; and, 2) their 2018 QHP issuer will offer a QHP through the Marketplace for plan year 2019. If the consumer does not pay all outstanding premiums by December 31, the issuer may reject the auto-renewal.

Scenario #4: Consumer Updates Application

Monica does not receive APTC. She enrolls in a QHP and pays all her premiums in full through November 2018. Monica fails to pay her November 2018 premium—due November 1. Her issuer has adopted the payment policy to condition new enrollment on payment of recent past due premium. In Monica’s state, the grace period for consumers who do not receive APTC is one month. Monica enters the grace period on November 1 and it expires on November 30. If Monica fails to pay the outstanding amount by the end of state grace, Monica’s issuer may terminate her coverage effective November 30.

During Open Enrollment on December 10, 2018, Monica updates her application at HealthCare.gov for the upcoming plan year. She is determined eligible for coverage and selects a different QHP offered by the same 2018 issuer with coverage starting January 1, 2019. She pays the first month’s premium and any outstanding payment from the 2018 enrollment by the due date—January 1. The issuer effectuates Monica’s coverage and sends the Marketplace a confirmation transaction.

Scenario #5: Consumer Auto-Re-enrolled

Consider the same facts from Scenario #4, except Monica does not return to HealthCare.gov to select a new plan for 2019. Since Monica is still covered when the Marketplace sends auto-renewals and the same QHP is offered for the upcoming year, the Marketplace sends an auto-re-enrollment transaction to Monica’s issuer. Since Monica did not any more premium payments, the issuer rejects this renewal since Monica did not pay all her outstanding premium payments by December 31.

Scenario #6: Gap in Coverage

Donna receives APTC, enrolls in a QHP, and pays all her premiums in full from January 2018 to September 2018. Then, Donna fails to pay her October premium—due October 1. Donna enters a three-month grace period on October 1 and it expires December 31.

During Open Enrollment on December 10, Donna updates her application for the upcoming plan year at Healthcare.gov and is determined eligible for coverage. Donna selects a new plan with coverage offered by an unrelated issuer starting January 1, 2019 and pays her first month’s
premium by the due date.

Because Donna selected a different plan for plan year 2019, the issuer may not apply the January 2019 premium payment to the December 2018 nonpayment (and would not be aware of the nonpayment). The issuer must accept the enrollment and apply the premium payment to January. The issuer sends the Marketplace a confirmation transaction. Since Donna did not pay all outstanding amounts due for the grace period ending December 31, 2018, her coverage during the prior year is terminated with a retroactive effective date of October 31, 2018. This leaves Donna with a gap in coverage for November and December and new coverage from January 1, 2019 forward.

This document is only a summary of applicable requirements and does not itself create any legal rights or obligations.

This was produced and disseminated at U.S. taxpayer expense. This is merely a summary of law and policy, does not create any legal rights or obligations, and applicable legal requirements are fully stated in the relevant statues and regulations.

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i 45 C.F.R. § 156.270(d); § 155.430(d)(4).

ii 45 C.F.R. § 155.430(d)(5).
Health Insurance Glossary

A

Accountable Care Organization (ACO): An Accountable Care Organization is a group of Doctors, hospitals and other healthcare providers who work together to provide you with coordinated care.

Actuarial Justification: The demonstration by an insurance company that the premiums collected are reasonable, given the benefits provided under the plan, or that the distribution of premiums among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. The ACA requires health insurance companies to publicly disclose the actuarial justifications behind unreasonable premium increases.

Actuarial Value: The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits after paying your premium. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Advanced Premium Tax Credits (APTC): A tax credit that can reduce what you pay for insurance. When you apply for coverage in the Health Insurance Marketplace, you estimate your expected income. If your estimate falls in the range to save, you can use an advance payment of the premium tax credit to lower your monthly insurance bill. If at the end of the year you’ve taken more premium tax credit in advance than you’re due based on your final income, you’ll have to pay back the excess when you file your federal tax return. If you’ve taken less than you qualify for, you’ll get the difference back. If you’re concerned about having to pay back any excess tax credits, you may choose to not take them in advance, and take them instead when you file your federal tax return.

Adverse Benefit Determination: A plan’s decision to deny a claim, in whole or in part, based on medical judgment or rescission.

Affordable Care Act (ACA): Also known as the Patient Protection and Affordable Care Act is the federal healthcare reform legislation signed by President Obama in March 2010. The ACA is also known as “Obamacare.”
Agent: An agent is a person or business who can help you apply and enroll you in health insurance. An agent may also be called a producer. An agent can make specific recommendations about which plan you should enroll in. Agents typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer’s plans. Some agents may only be able to sell plans from specific health insurers.

Allowable Charge: The maximum dollar amount that your health insurance company will pay a health care provider for a benefit (i.e. healthcare service) covered by your health insurance plan.

Annual Limit: The maximum dollar amount that a health insurance company will pay for a particular benefit over the course of a plan year. Health insurance companies are prohibited from placing annual limits on essential health benefits.

Appeal: To ask that a health plan reconsider its decision to deny payment for a treatment or service.

Association Health Plans (AHPs): Under the Department of Labor’s (DOL) rule, are group health plans that employer groups and associations offer to provide health coverage for employees. To be recognized as an association, a form M-1 must be approved by the DOL.

Balance Billing: When you receive services from a healthcare provider that does not participate in your health insurance plan’s network, the provider may bill you for the difference between the dollar amount charged to your health insurance company and the dollar amount your health insurance company actually paid (the allowable charge) for the services.

Benefit Year: A year of benefits coverage under a health insurance plan. The benefit year for individual plans bought inside or outside the Marketplace begins January 1 of each year and ends December 31 of the same year.

Brand Name (Drugs): A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Catastrophic Health Plan: A health plan that meets all the requirements applicable to other Qualified Health Plans (QHPs) but that doesn’t cover any benefits other than 3 primary care visits per year before the plan’s deductible is met. The premium amount you pay each month for a catastrophic health plan is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old OR get a "hardship exemption" from the Marketplace (based on a determination by the Marketplace that you’re unable to afford health coverage).
Center for Consumer Information and Insurance Oversight (CCIIO): An organization that oversees the implementation of the parts of the Affordable Care Act related to private insurance.

Centers for Disease Control and Prevention (CDC): The nation’s health protection agency.

Centers for Medicare and Medicaid Services (CMS): A federal agency that administers Medicare, and, in partnership with the state, Medical Assistance and the Children’s Health Insurance Program.

Certified Application Counselor: An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers.

Children’s Health Insurance Program (CHIP): The Children’s Health Insurance Program provides coverage to eligible children and teens up to age 19. Like Medical Assistance, it is jointly funded and administered by the states and the federal government.

Claim: A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

Co-Op Plan: A health insurance plan sold by member-owned and operated nonprofit organizations through exchanges. The ACA provides grants and loans to help Co-Op plans enter the marketplace. There are no Co-Op plans operating in West Virginia.

Co-insurance: The percentage of a health insurance company’s allowable charge the patient is financially responsible for under the health insurance plan’s terms. For example: If the allowable charge for a service is $200 and your health insurance plan has a 10% co-insurance, the health insurance company will pay $180 and you will be responsible to pay $20.

Community Health Center (CHC): A community-based organization that serves populations with limited access to healthcare.

Community Rating: A way of pricing insurance in which every enrollee pays the same premium, regardless of health status, age or other factors. The ACA requires modified community rating, where an enrollee’s premium may be adjusted based family size, geography, age and tobacco use.

Consolidated Omnibus Budget Reconciliation Act (COBRA): Passed in Congress in 1986, COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporarily continue their health coverage at group rates. The law generally covers health plans maintained by private employers with 20 or more employees, employee organizations or state or local governments. (For smaller employers, see “Mini-COBRA”.)

Conversion: The ability to switch coverage. For example, the ability to switch from job-based coverage to individual coverage when the group continuation coverage through COBRA, PA Mini-COBRA or group coverage ends.
Coordination of Benefits (COB): A way insurers use to figure out which company pays first and for which charges when 2 or more health insurance plans are responsible for paying the same medical claim.

Co-payment: The flat-dollar amount a patient must pay when visiting a doctor or other healthcare provider. The co-payment is a pre-determined fee under the health insurance plan’s terms and does not change based on the allowable charge.

Cost-Sharing: The portion of charges for a healthcare service that a patient is responsible to pay. Common forms of cost-sharing include deductibles, co-insurance and co-payments. The total dollar amount of cost-sharing allowed over the course of a plan year is called the out-of-pocket maximum.

Cost-Sharing Reduction: A discount received through the Marketplace that lowers the amount you must pay out-of-pocket for deductibles, co-insurance, and co-payments. You also have a lower out-of-pocket maximum. You can get these savings if your income is below a certain level, and only if you choose a health plan from the Silver plan category through the Marketplace.

Current Procedural Terminology Codes (CPT Codes): CPT codes are numbers assigned to a medical, surgical or diagnostic service a health practitioner provides. These codes are used by insurers to determine how much to pay a provider for medical services.

D

Deductible: A dollar amount that a patient must pay for healthcare services each plan year before the insurance company will begin paying claims. Some services, like preventive services, are not subject to the deductible and will be covered whenever you need them.

Department of Health and Human Services (HHS): The United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those least able to help themselves.

Dependent Coverage: Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

E

Employee Benefits Security Administration (EBSA): An organization within the federal Department of Labor that assures the security of the retirement, health and other workplace related benefits of America’s workers and their families.

Employee Retirement Income Security Act of 1974 (ERISA): ERISA is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering healthcare benefits that employers fund directly, rather than through insurance, which are called employee welfare benefit plans.
**Essential Health Benefits (EHBs):** Ten categories of benefits, including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services. Health insurance plans sold after 2014 are required to provide the essential health benefits and will have restrictions on the amount of cost-sharing that patients must pay for these services.

**Exchange:** The online store, also called the Marketplace, where individuals and small employers may buy health insurance plans sold by insurance companies. You can get to the exchange by going to [www.healthcare.gov](http://www.healthcare.gov).

**Exemption:** Under the individual mandate, most people who do not have health insurance have to pay a penalty each year. However, some people are eligible for exemptions, which allow them to not pay a penalty even if they do not have health insurance. Exemptions are granted based on certain hardships, membership in some groups, and other circumstances.

**Explanation of Benefits (EOB):** A document sent to you by your health insurance company that gives you information about how an insurance claim from a healthcare provider for services provided to you was processed and what portion was paid by the health insurance company on your behalf. The EOB will also explain what dollar amount a healthcare provider may charge you if you are responsible for any cost-sharing under the health insurance plan.

**External Review:** An independent review of a health plan’s Adverse Benefit Determination.

**Federal Poverty Level (FPL):** A federal estimate of the point below which a household has income insufficient to meet minimal basic needs. Tax credits received through the Marketplace are based on how your income compares to the FPL. Individuals and families with incomes up to four times (400%) of the FPL are eligible for subsidies through the Marketplace.

**Federally Qualified Health Center (FQHC):** A community-based organization that provides comprehensive primary care and preventive care to people regardless of their ability to pay or health insurance status.

**Fee-for-Service (FFS):** A type of health insurance plan in which the policyholder or beneficiary may see any provider, pay directly for a service, and submit a claim to the insurance company, and, if the service is covered in the policy, receive reimbursement for some or all of their payment.

**First Dollar Coverage:** Coverage for expenses beginning with the first dollar charged for healthcare - without a deductible having to be paid first.

**Flexible Spending Account (FSA):** An account set up through your employer to pay for eligible medical expenses with tax-free dollars. There is usually a maximum amount you can contribute, and any amount not used will be lost, so plan carefully.

**Formulary:** The list of prescription drugs covered in full or in part by a health plan.
**Fully Insured:** A plan is fully insured when all covered benefits will be paid under a contract of insurance that transfers the risk to an insurance company.

**G**

**Generic Drugs:** A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

**Grandfathered Plan:** A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by the ACA if no significant changes have been made to the benefits covered by the plan. New employees and family members may be added to existing group plans that are grandfathered, but grandfathered plans are no longer sold to new customers.

**Group Health Plan:** An employee benefit plan established or maintained by an employer or by an employee organization (such as a union), that provides medical care for participants or their dependents. A group health plan may be fully or partially insured or may be fully or partially paid for directly by the employer or employee organization.

**Guaranteed Issue:** A requirement that health insurance companies sell a health insurance plan to any person who requests coverage. All health insurance is now sold on a guaranteed-issue basis.

**Guaranteed Renewability:** A requirement that health insurance companies renew coverage under a health plan except for failure to pay premiums or fraud. Federal law requires that all health insurance be guaranteed renewable.

**H**

**Health Maintenance Organization (HMO):** A type of managed care organization (health plan) that provides healthcare coverage through a network of hospitals, doctors and other healthcare providers. Typically, the HMO only pays for care that is provided by an in-network provider.

**Health Savings Account (HSA):** A type of medical savings account that allows an individual to save money on a tax-preferred basis to be used for future qualified medical and retiree health expenses. In order to be eligible to use a HSA individuals need to be covered by a qualified high-deductible health plan (HDHP).

**High-Deductible Health Plan (HDHP):** A type of health insurance plan that typically requires greater out-of-pocket spending than traditional health insurance plans, although premiums may be lower. HDHPs are often paired with an HSA or other medical savings account that allows money to be deposited into a separate account on a tax-preferred basis to help pay for the higher out-of-pocket spending.

**Home and Community-Based Services:** A program that provides services and support to people with intellectual and developmental disabilities who are living with their family, in their own home or in other community settings, such as small group homes.
I

In-Network Provider:  A healthcare provider (such as a hospital or doctor) that is contracted to be part of a health plan’s network. You will pay less out-of-pocket if you see an in-network provider than if you see an out-of-network provider.

Independent Review Organization (IRO): An independent third-party organization contracted to conduct an external review of health appeals.

Individual Mandate: Under the ACA, the individual mandate is a requirement that everyone have health insurance coverage. The ACA requires that everyone who can purchase health insurance for less than eight percent of their household income do so or pay a tax penalty.

Individual Market: The market for health insurance coverage offered to individuals not in a group health plan.

Internal Appeal or Review: A review of a health plan’s determination that a requested or provided healthcare service or treatment is not or was not medically necessary. All plans are required to conduct an internal review upon the request of the patient or the patient’s representative.

L

Large Group Health Plan: In general, a group health plan that covers employees of an employer that has 51 or more employees.

Limited Benefit Plan: A type of health plan that provides coverage for only certain specified healthcare services or treatments or provides coverage for healthcare services or treatments for a certain dollar amount during a specified period. Limited benefit plans are not considered minimum essential coverage, so individuals with only these plans may be subject to the individual mandate penalty.

Long-Term Care Insurance: Insurance used to pay for services that assist an individual who is no longer able to adequately or safely perform activities of daily living for an extended period of time due to age or disability.

M

Mandated Benefit: A requirement in state or federal law that all health insurance plans provide coverage for a specific healthcare service.

Marketplace: The online store, also called the exchange, where individuals may buy health insurance plans sold by insurance companies. West Virginia uses the federal Marketplace, at www.healthcare.gov.

Medicaid: Medicaid is a joint state and federal program that provides healthcare coverage to eligible individuals.
**Medical Loss Ratio (MLR):** The percentage of health insurance premiums that are spent by an insurance company on healthcare services. Large group plans are required to spend 85 percent of premiums on clinical services and other activities devoted to the quality of care for enrollees. Small group and individual market plans must devote 80 percent of premiums to these purposes.

**Medical Underwriting:** The process an insurance plan uses to determine your health status when you are applying for insurance to decide whether or not to offer you coverage, how much to charge you for coverage and if there will be exclusions or limits. Under the ACA, health insurers may no longer deny you coverage and can only vary how much you pay by your age, where you live, and how many people will be covered by your plan. But, other types of insurance like long-term care may still use medical underwriting practices.

**Medically Necessary or Medical Necessity:** Generally speaking, services or supplies your health care provider determines are needed for prevention, diagnosis or treatment of a patient’s illness or injury or other medical condition that meet generally accepted medical standards and are clinically appropriate for the patient. Your health plan may have a more specific definition.

**Medicare:** A federal program that provides healthcare coverage for all eligible individuals age 65 or older, or individuals under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B) and prescription drugs (Medicare Part D). Together, Medicare Parts A and B are known as original Medicare. Benefits can also be provided through a Medicare Advantage Plan (Medicare Part C).

**Medicare Advantage:** Also known as Medicare Part C, this option provides Medicare beneficiaries with most or all their Medicare benefits through a managed care plan from a health insurance company. Health insurance companies contract with the federal government and are required to offer at least the same benefits as original Medicare but may follow different rules and offer additional benefits.

**Medicare Part D:** A program that helps pay for prescription drugs for people with Medicare. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

**Medigap (Medicare Supplement) plan:** A private insurance plan that can be purchased by someone who has Medicare to “fill in the gaps” and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original Medicare (Parts A and B).

**Minimum Essential Coverage (MEC):** Any insurance that meets the Affordable Care Act requirement for having health coverage. If you have MEC you don’t have to pay the tax penalty for being uninsured. Examples include: Health Insurance Marketplace plans; most individual plans bought outside the Marketplace; job-based insurance, including SHOP plans; Medicare; Medicaid; CHIP; TRICARE; and certain other coverage.
National Association of Insurance Commissioners (NAIC): The U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and the five U.S. territories.

National Committee for Quality Assurance (NCQA): A private, not-for-profit organization dedicated to improving healthcare quality.

National Institutes of Health (NIH): The nation’s medical resource agency.

Navigator: An individual or organization that is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. Getting your health care services in-network means you will be subject to the lowest cost-sharing available under your plan.

Network Adequacy: For plans that use networks, the term for evaluating whether a plan has an adequate number and distribution of healthcare providers required to operate a health plan.

Non-Grandfathered Plans: Health plans that started after the ACA was signed into law or plans that existed before the law was signed that have made significant changes that reduced benefits and/or raised costs.

Obamacare: An informal name sometimes used to refer to the health coverage plans available through the Health Insurance Marketplace. Obamacare is often another term for the Affordable Care Act.

Open Enrollment Period (OEP): A specified period during the year when individuals may enroll in a health insurance plan. In certain situations, such as a birth, death or divorce in a family, individuals may be allowed to enroll in a plan during a special enrollment period, which takes place outside of the open enrollment period.

Out-of-Network Provider: A healthcare provider (such as a hospital or doctor) that is not part of your health plan’s network. Depending on the health insurance plan, you may be required to pay the total charge for the healthcare service or you may be required to pay a higher portion of the charge when you seek care from an out-of-network provider.

Out-of-Pocket Costs: Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, co-insurance, and co-payments for covered services plus all costs for services that aren't covered.

Out-of-Pocket Maximum: The total dollar amount of cost-sharing that a patient is responsible for paying under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out-of-network healthcare providers or services that are not covered by the plan. The ACA defines limits on the total dollar amount of cost-sharing that a health insurance company may charge individuals and families, and these amounts may be adjusted annually.
**Patient Protection and Affordable Care Act (PPACA):** See Affordable Care Act.

**Point of Service Plan (POS):** A health insurance plan that combines features of both an HMO and a PPO. A POS plan is similar to an HMO because typically requires you to identify a primary care physician and requires you to obtain a referral to see a specialist. A POS plan is also similar to a PPO plan, as a POS plan typically pays for out-of-network care, though a POS plan typically requires a primary care physician’s referral to obtain out-of-network care.

**Pre-Existing Condition:** The period of time that an individual receives no benefits for an illness or medical condition that occurred before an insurance plan took effect. Pre-existing condition exclusions are no longer allowed in health insurance, but may be found in other types of policies, such as long-term care insurance or disability insurance.

**Preferred Provider Organization (PPO):** A type of managed care organization that provides coverage through a network of providers. Typically, a PPO will provide coverage for services that are provided by an out-of-network healthcare provider but will require you to pay higher costs for services provided out-of-network.

**Premium:** A recurring fee a health insurance company charges for your health insurance coverage, typically charged monthly. The amount of premium the health insurance company charges depends on your health insurance plan’s type and level of coverage. The portion of premium you pay depends on whether part of the premium is paid by your employer, whether you qualify for tax credit and cost-sharing subsidies, and other factors.

**Premium Tax Credit:** A tax credit that can help you afford health coverage through the Marketplace. If you qualify for the premium tax credit based on your income, you can lower your monthly premium payment. If you take more advance payments of the tax credit than you qualify for based on your final yearly income, you must repay the difference when you file your federal income tax return. If the amount of advance payments you take is less than the tax credit you qualify for based on your final income, you’ll get the difference as a refund when you file your taxes. If you’re concerned about having to pay back any excess tax credits, you may choose to not take them in advance, and take them instead when you file your federal tax return.

**Preventive Benefits:** Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. Insurance companies are required to provide coverage for preventive benefits without deductibles, co-payments, co-insurance or any other cost-sharing.

**Primary Care Physician (PCP):** A primary doctor who gives general medical care and provides referrals to see a specialist.

**Prior Authorization:** Approval from a health plan that may be required before you get a service or fill a prescription for the service or prescription to be covered by your plan.
**Producer:** A health insurance producer is also known as either an agent. A producer is a person or business who can help you apply and enroll you in health insurance. They can make specific recommendations about which plan you should enroll in. Producers who are agents typically get payments or commissions from health insurers for enrolling a consumer into an issuer’s plans. Some producers may only be able to sell plans from specific health insurers.

**Qualified Health Plan:** A health insurance plan that is sold on the Marketplace and meets all the standards required by the Marketplace.

**Rate Review:** The review by insurance regulators of proposed premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims likely to be made in the coming year, that they are not unreasonably high in relation to the benefits being provided, and that they are not unfairly discriminatory to any individual or group of individuals.

**Referral:** A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor.

**Re-insurance:** Insurance that is purchased by insurance companies from other insurance companies to limit the total loss the company would experience in the case of a disaster or unexpectedly high claims. The ACA created a temporary reinsurance program to stabilize the individual markets in each state for the first three years of coverage under the ACA, because many new customers have been getting coverage for the first time and it is a challenge for insurance companies to know how to price coverage without knowing how much health care the new customers likely will need, even though the companies are required to issue insurance to anyone willing to purchase it, regardless of their health status.

**Rescission:** Rescission is the retroactive cancellation of a health insurance policy. Rescission is prohibited except in cases of fraud or intentional misrepresentation of a relevant fact.

**Rider:** An amendment to an insurance policy.

**Risk Adjustment:** A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for this risk by other plans that enroll a disproportionate number of healthy individuals. Risk adjustment is required under the ACA for all non-grandfathered health insurance plans.

**Second Lowest Cost Silver Plan (SLCSP):** The second lowest monthly premium for a Marketplace health plan in the Silver category in a given area is used by the IRS to calculate premium tax credits.
**Self-Funded or Self-Insured:** A plan is self-funded when the employer assumes the financial risk for providing healthcare benefits to the employees. Self-funded plans are regulated by the federal government, not a state.

**Short Term Limited Duration (STLD) Plan** – A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

**Skilled Nursing Facility (SNF):** A facility that provides short- or long-term medical treatment, nursing, rehabilitation and other health services to patients.

**Small Group Market:** The market for health insurance coverage offered to small businesses that employ up to 50 individuals.

**Solvency:** The ability of a health insurance plan to meet all its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan’s financial situation becomes hazardous.

**Special Enrollment Period:** A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.

**State Health Insurance Assistance Program (SHIP):** A free health benefits counseling service for Medicare beneficiaries and their families or caregivers.

**Summary of Benefits and Coverage (SBC):** An easy-to-read summary that lets you make apples-to- apples comparisons of costs and coverage between health plans. All plans are required to make SBCs available to consumers and they can be helpful tools if you are shopping for coverage.

**T**

**Temporary Assistance for Needy Families (TANF):** A federal program to help move recipients into work and turn welfare into a program of temporary assistance.

**TRICARE:** A health care program for active-duty and retired uniformed services members and their families.

**U**

**United States Department of Labor (DOL):** The Department of Labor (DOL) supports job seekers, wage earners, and retirees by improving their working conditions, helping them find work and protecting their retirement and healthcare benefits.

**United States Public Health Service (USPHS):** A federal organization that protects our nation’s public health.

**Urgent Care Claim:** A claim you may make for expedited review of your denied claim. You may make this claim if a medical provider determines withholding care will endanger your life or cause you prolonged or severe pain.
**Usual, Customary and Reasonable Charge (UCR):** The cost associated with a healthcare service that is consistent with the going rate for identical or similar services within a particular geographic area. Reimbursement for out-of-network providers is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

**W**

**Waiting Period:** A period of time that an individual must wait, either after becoming employed or submitting an application for a health insurance plan, before coverage becomes effective and claims may be paid. Premiums are not collected during this period.

**Wellness Program:** A program intended to improve and promote health that is usually offered through the work place, although insurance plans sometimes offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventive health screenings.

**West Virginia Offices of the Insurance Commissioner (WVOIC):** The government agency in West Virginia that regulates the business of insurance.
Health Insurance Shopping Tool

There is more to shopping for health insurance than just finding the lowest premium. What you pay each month for health insurance (the premium) is important, but it's also important to understand what the policy will cover.

A policy with a lower monthly premium seems like a better deal. But, a lower monthly premium could also mean you'll have less coverage -- or that you'll pay more out-of-pocket for your health care, maybe when you least expect it.

This three-part tool will help you compare health insurance policies and find the policy that best meets your needs.

Part 1: Identify your current health care needs - doctors, services, and prescription drugs. Keep these in mind as you compare health insurance policies.

Part 2: Compare health insurance policies. One of these might be your current health insurance policy.

Part 3: Compare the costs. Think about the out-of-pocket costs you may have to pay when you need care as well as the monthly premiums.

<table>
<thead>
<tr>
<th>Part 1 - Information that is important to me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will this health insurance cover? (Check or circle one)</td>
</tr>
<tr>
<td>Just me</td>
</tr>
<tr>
<td>A list of my health conditions (and those of family members the policy will cover). <strong>These are called pre-existing conditions.</strong></td>
</tr>
</tbody>
</table>

List the health care services or prescription drugs regularly used or needed.

Do you or your family have a doctor(s) you regularly see? Do you have a hospital that you prefer to use?

Doctor(s): ________________________________________________________________
Hospital: ________________________________________________________________
### Part 2 - Comparing health insurance policies

Ask these questions when you're talking to an insurance company, your agent or navigator. Or, jot this information down as you're reviewing policy information, like a Summary of Benefits and Coverage document (SBC).

<table>
<thead>
<tr>
<th>Name of Plan</th>
<th>Policy 1:</th>
<th>Policy 2:</th>
<th>Policy 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Insurance Company</td>
<td>Covered?</td>
<td>Out-of-pocket cost/Limits on services</td>
<td>Covered?</td>
</tr>
<tr>
<td>How long does coverage last?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Does this policy cover pre-existing conditions? (see your list above)</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Is there a waiting period for any health condition - or, how long before coverage starts?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>If I develop a health condition, can this policy be cancelled or not renewed, even if I've paid my premiums?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Will my doctor or hospital directly bill the insurance company? Or do I have to pay up front and get reimbursed?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Does the policy require that I use a specific network of doctors or hospitals?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Are my doctor and hospital in this plan’s network?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Is there a point where I no longer have to pay anything out-of-pocket for health care (an annual maximum out-of-pocket)?</td>
<td>Covered?</td>
<td>Out-of-pocket cost/Limits on services</td>
<td>Covered?</td>
</tr>
<tr>
<td>Maximum:</td>
<td>yes/no</td>
<td>Maximum:</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

### What does this policy cover?

Ask if these services are covered AND what you'll pay out-of-pocket. The out-of-pocket amounts you'll pay will be either co-pays (a dollar amount) or a coinsurance amount (a percentage of the cost, after the deductible is met). Some policies may also limit the number of covered visits or limit how much will be paid for each type of visit. So make sure you also ask about any limits.

<table>
<thead>
<tr>
<th>Policy 1:</th>
<th>Policy 2:</th>
<th>Policy 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered?</td>
<td>Out-of-pocket cost/Limits on services</td>
<td>Covered?</td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Preventive Care (physicals and wellness visits, immunizations)</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Service</td>
<td>Policy 1:</td>
<td>Policy 2:</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Covered?</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Out-of-pocket cost/Limits on services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Hospital Emergency Room Care                | yes/no   | yes/no   | yes/no   |
| Hospital Inpatient Care                     | yes/no   | yes/no   | yes/no   |
| Outpatient Services                         | yes/no   | yes/no   | yes/no   |
| Laboratory Services                         | yes/no   | yes/no   | yes/no   |
| Maternity Care                              | yes/no   | yes/no   | yes/no   |
| Mental Health and Substance Use Disorder - Inpatient | yes/no   | yes/no   | yes/no   |
| Mental Health and Substance Use Disorder - Outpatient | yes/no   | yes/no   | yes/no   |
| Chiropractic, Physical, Occupational or Speech Therapy | yes/no   | yes/no   | yes/no   |

**Prescription drugs**

<table>
<thead>
<tr>
<th>Does this policy cover prescription drugs?</th>
<th>yes/no</th>
<th>yes/no</th>
<th>yes/no</th>
</tr>
</thead>
</table>

| Does this policy cover the drugs I use and are there any limits or requirements for approval before I fill a prescription? | yes/no   | yes/no   | yes/no   |

| What will I have to pay out-of-pocket for prescription drugs? (Hint: You may have to pay different amounts (like a co-pay) for different types of drugs.) | $         | $         | $         |

<p>| Example: Generics                          | $         | $         | $         |
| Brand Name                                 | $         | $         | $         |
| Mail Order                                 | $         | $         | $         |
| Specialty Drugs                            | $         | $         | $         |
| Other: ____________________________________ | $         | $         | $         |</p>
<table>
<thead>
<tr>
<th><strong>Deductible</strong></th>
<th><strong>Policy 1:</strong></th>
<th><strong>Policy 2:</strong></th>
<th><strong>Policy 3:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Separate deductible for certain services (for example, drugs)...

<table>
<thead>
<tr>
<th><strong>Does this policy have any limits on the coverage?</strong></th>
<th><strong>Policy 1:</strong></th>
<th><strong>Policy 2:</strong></th>
<th><strong>Policy 3:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual limit on coverage; I pay all costs after this amount each year</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Lifetime limit on coverage; I pay all costs after this amount</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Premium information</strong></th>
<th><strong>Policy 1:</strong></th>
<th><strong>Policy 2:</strong></th>
<th><strong>Policy 3:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>How much will I pay for coverage each month?</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Are there any other fees like application or membership fees?</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Will I pay more because I have a pre-existing condition?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Will I receive financial help with the out-of-pocket costs?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Am I eligible for any premium subsidies with this policy?</td>
<td>yes/no</td>
<td>yes/no</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

Click here for a list of local help by county.
You may also contact the West Virginia Offices of the Insurance Commissioner's Consumer Service Division at 888-879-9842.