COVERED CALIFORNIA

Covered California Plan Options

Participant Guide

Version 3.0

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1 Course Objectives

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2 Health Insurance Options Through Covered California

Covered California Certified Health Plans

Covered California is a one-stop, convenient marketplace for Californians to get health insurance. Whether consumers qualify for a health plan through Covered California or may be eligible for Medi-Cal, they can apply through CoveredCA.com. Covered California health plans are provided by private health insurance companies that are certified by Covered California. All health insurance companies offering coverage through Covered California are required to accept all applicants during approved enrollment times regardless of their health status or other factors (age, gender, race, national origin, tobacco use etc.).

The law implementing the Affordable Care Act authorized Covered California to establish and use a competitive process to select participating health insurance companies. Covered California sets minimum requirements for participating health insurance companies, as well as standards and criteria that ensure selected health insurance plan provide health care coverage choice that offer the best possible combination of choice, value, quality and service. To meet the Covered California certification criteria, health insurance companies must:

- Provide the ten essential health benefits
- Follow established limits on cost-sharing (such as deductibles, copays and out-of-pocket maximum amounts)
- Offer benefit or plan designs to all that do not discriminate against consumers because of age, present or predicted disability, degree of medical dependency, life expectancy or other health conditions
- Meet network adequacy requirements, including Medi-Cal non-profit providers who serve predominately low-income, medically underserved individuals
- Comply with premium rating rules and requirements
- Be accredited by an approved accrediting entity and submit quality measures
- Meet other requirements as set by Covered California

To be a Covered California health plan, the health insurance company must also be licensed, solvent and in good standing with the state. In California, health plans may either be licensed as health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 administered by the Department of Managed Health Care (DMHC), or possess a Certificate of Authority as an insurer from the California Department of Insurance (CDI).

How Health Insurance Companies are Held Accountable

Covered California ensures high quality care by selecting health insurance companies that provide consumers with high quality coverage to get the care they need, when they need it. Covered California has worked hard with health insurance companies and regulators to offer consumers access to quality care and will continue to regularly monitor all plans on a regular basis to ensure adequate networks are in place.

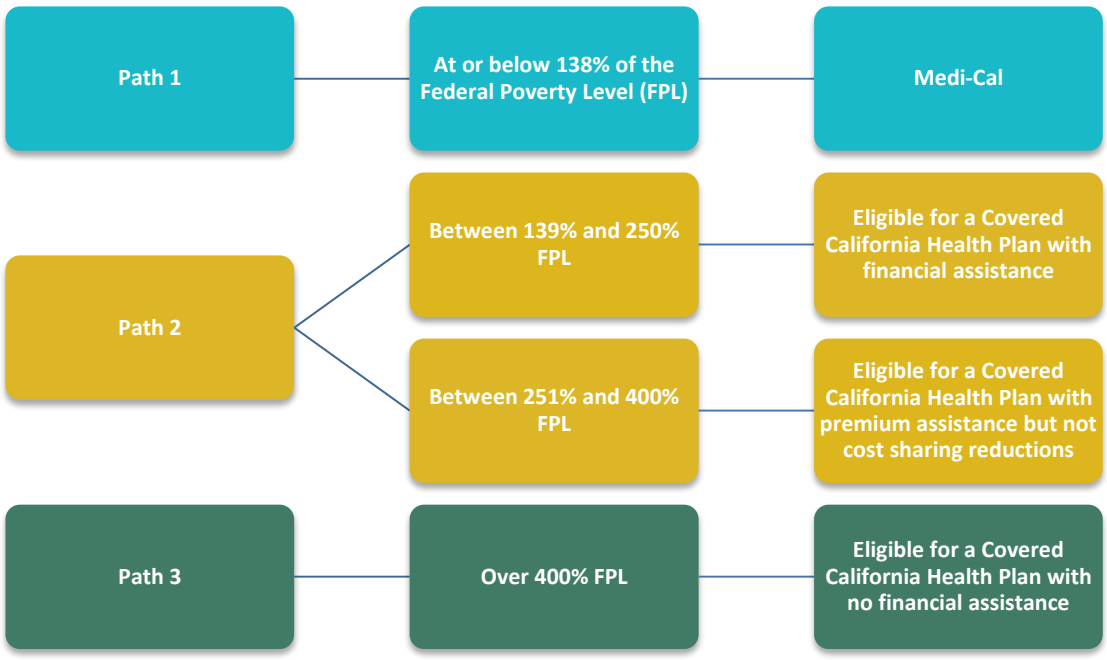
If consumers experience challenges accessing providers in their plan's networks, Covered California has and will continue to help consumers navigate the process with their health plans and with state agencies to resolve their individual cases. Covered California, along with health insurance companies and regulators, work to resolve consumer network access challenges.

Additionally, Covered California will continue to refer consumers to the Health Consumer Alliance (HCA), an independent legal assistance organization that is supported by Covered California, to assist consumers and help monitor patterns or problems.

Beyond these efforts, Covered California is building stronger partnerships with its health insurance plans to ensure the most updated information is available about providers in each network. Furthermore, Covered California is coordinating directly and regularly with regulators to ensure network adequacy rules are met. Covered California is also creating an infrastructure to evaluate networks and consumers' access to services in each network.

Three Consumer Paths to Health Insurance

There are three paths to health care coverage through Covered California, each of which results in different health plan options for individuals. The paths are:



Covered California is the only place eligible individuals in California have access to Path 2 and thus can receive financial assistance and reduce the overall cost to the consumer of their health insurance. The Eligibility for Individuals and Families course discusses in more detail the various ways consumers apply and qualify for these paths.

3 Health Plan Options through Covered California

Health Plans Selected for 2015

Covered California has selected 10 health insurance companies to be in the state health exchange in 2015. All 10 health insurance companies were in the exchange for 2014 and submitted bids to return to the exchange for 2015 coverage. The portfolio reflects a wide mix of large nonprofit and commercial leaders in the individual health insurance market, along with Medi-Cal and regional plans. Covered California selected the following health insurance companies for the 2015 exchange:

- Anthem Blue Cross of California
- Blue Shield of California
- Chinese Community Health Plan
- Health Net
- Kaiser Permanente
- L.A. Care Health Plan
- Molina Healthcare
- Sharp Health Plan
- Valley Health Plan
- Western Health Advantage

Types of Plans Offered

Plans for Individuals and Families

Covered California offers health plans with four major metal tiers: Bronze, Silver, Gold, and Platinum. Each Covered California health plan must cover minimum essential coverage, but they differ in the share of costs covered. There are variety of factors that contribute to health plan costs which will be explained in greater detail later in this course.

Minimum coverage plans

Marketplaces also must make available minimum coverage plans, also referred to as catastrophic coverage plans, to people under 30, as well as to individuals who are exempt from the mandate to purchase coverage because they have an affordability or hardship exemption. A minimum coverage plan covers minimum essential coverage, but only after out-of-pocket cost sharing reaches a high deductible that will match the level of the Affordable Care Act's required out-of-pocket maximum. In 2015, that is $6,350 for self-only coverage and $12,700 for family coverage.

Pediatric dental plans

Under the essential health benefit requirements, health insurance companies must provide pediatric services, including oral and vision care. Below is a list of the pediatric dental coverage included with Covered California's health insurance plans:

Health Insurance Plan Selected	Pediatric Dental Coverage Embedded into Health Insurance Plan
Anthem Blue Cross of California	Anthem Blue Cross
Blue Shield of California	Blue Shield of California
Chinese Community Health Plan	Delta Dental of California
Health Net	Dental Benefit Providers
Kaiser Permanente	Delta Dental of California
L.A. Care Health Plan	Liberty Dental Plan
Molina Healthcare	California Dental Network
Sharp Health Plan	Access Dental Plan
Valley Health Plan	Liberty Dental Plan
Western Health Advantage	Premier Access

Family Dental Plans

Family dental plans are optional plans that provide both adult dental coverage and children's dental coverage at an additional cost. While the plans are primarily intended to offer dental coverage for adults, some consumers may also be drawn to family dental plans if a provider they prefer for their child is not offered in their embedded children's dental coverage. There is no financial assistance available for the purchase of Family Dental Plans and financial assistance cannot be applied to the purchase of family dental plans. The optional stand-alone family dental plans, which offer coverage for adults, will not be available at the beginning of open enrollment, which starts November 15, but are planned to be added in early 2015. Family dental plans are offered from the companies listed below:

- Access Dental Plan
- Anthem Blue Cross
- Blue Shield of California
- Delta Dental of California
- Dental Health Services
- Premier Access

Further information about Children's Dental Plans Rates are available online at:
http://www.coveredca.com/PDFs/CC_Childrens_dental_plan_rates.pdf

Overview of Premium Rates and Health Plan Costs

Covered California health insurance companies develop premium rates as prescribed by the Affordable Care Act and California law. It is important for consumers to understand that the cost of health insurance is made up of the monthly premium payments and the costs due when covered services are used, which is referred to as out-of-pocket costs.

Premium Development

The premium is the amount paid to the health insurance company for coverage. Under the Affordable Care Act and California law, health insurance companies are only permitted to vary premiums for particular health plans based on the following factors:

- **Age:** Health insurance companies may charge higher premiums to people who are older and low premiums for younger people. They may charge all consumers ages 0 to 20 years of age the same rate based on age, while consumers ages 21 and above will experience increases in premiums related to their age, up to age 64.
- **Geographic pricing regions:** There are 19 different pricing regions in California. This means health plan prices will vary by geography. For example, a 21 year old consumer who lives in Sacramento will likely have a different rate than a 21 year old consumer who lives in San Francisco, since Sacramento is in pricing region 3 and San Francisco is in pricing region 4.
- **Family composition** (for example, an individual versus a family): Each family member will be charged a premium based on their age. However, health insurance companies can charge for only three children under 21 in a family. For example, in a family of six, the rate would be the member rate + spouse rate + Child 1 rate + Child 2 rate + Child 3 rate. Child 4 would enjoy the same coverage as the other 3 children, but at no additional expense to the family. All children age 21 and older are charged premiums based on their ages and are not subject to the 3 child under 21 maximum.

Out-of-Pocket Costs

Out-of-pocket costs, also called cost-sharing, refers to the amount the consumer pays for covered services at the time they use them. Out-of-pocket costs typically include:

- Coinsurance
- Co-payments, or similar charges
- Deductibles

Out-of-pocket costs generally do not include:

- Monthly premiums
- Balance billing amounts for out-of-network doctors and hospitals
- The cost of non-covered services or not medically necessary services

Consumers can use CoveredCA.com Shop and Compare Tool to estimate how much they will pay out-of-pocket for the health plans they are interested in.

Annual Premium Rate Increases

In talking with consumers about health plans, it is also important to know that consumers can expect their rates to increase with their age and due to other factors such as medical inflation. However, Covered California health plan rates cannot change more than once a year. It is also important to emphasize that the rates for 2015 are fixed and will not change.

Each year, Covered California negotiates with health insurance companies to keep rate increases low and the choices for consumers robust. For 2015, the vast majority of Covered California consumers will see low increases in their health insurance premiums and many consumers will see no increase or even a decrease. Utilize the following talking points when discussing 2015 rate increases with consumers:

- Health care is regional, it's local and it's personal. This means that the cost and options for each consumer in California are different.
- The statewide weighted average increase came in at 4.2% with some plans offering weighted average rates that are 8.5% lower than current pricing.
- Covered California's team of negotiators actively engaged in vigorous back-and-forth with insurance companies to keep increases at a minimum and maintain high quality by delivering networks of doctors and hospitals that meet consumers' needs and give them meaningful choice when shopping for the plan that is the best fit.

At the end of the year, health insurance companies must prove to their regulators that they have spent at least 80 percent of premiums collected on clinical health care services and quality improvement activities. If they do not spend at least 80 percent they must send refunds to consumers or employers. This minimal loss ratio rule helps keep premiums affordable.

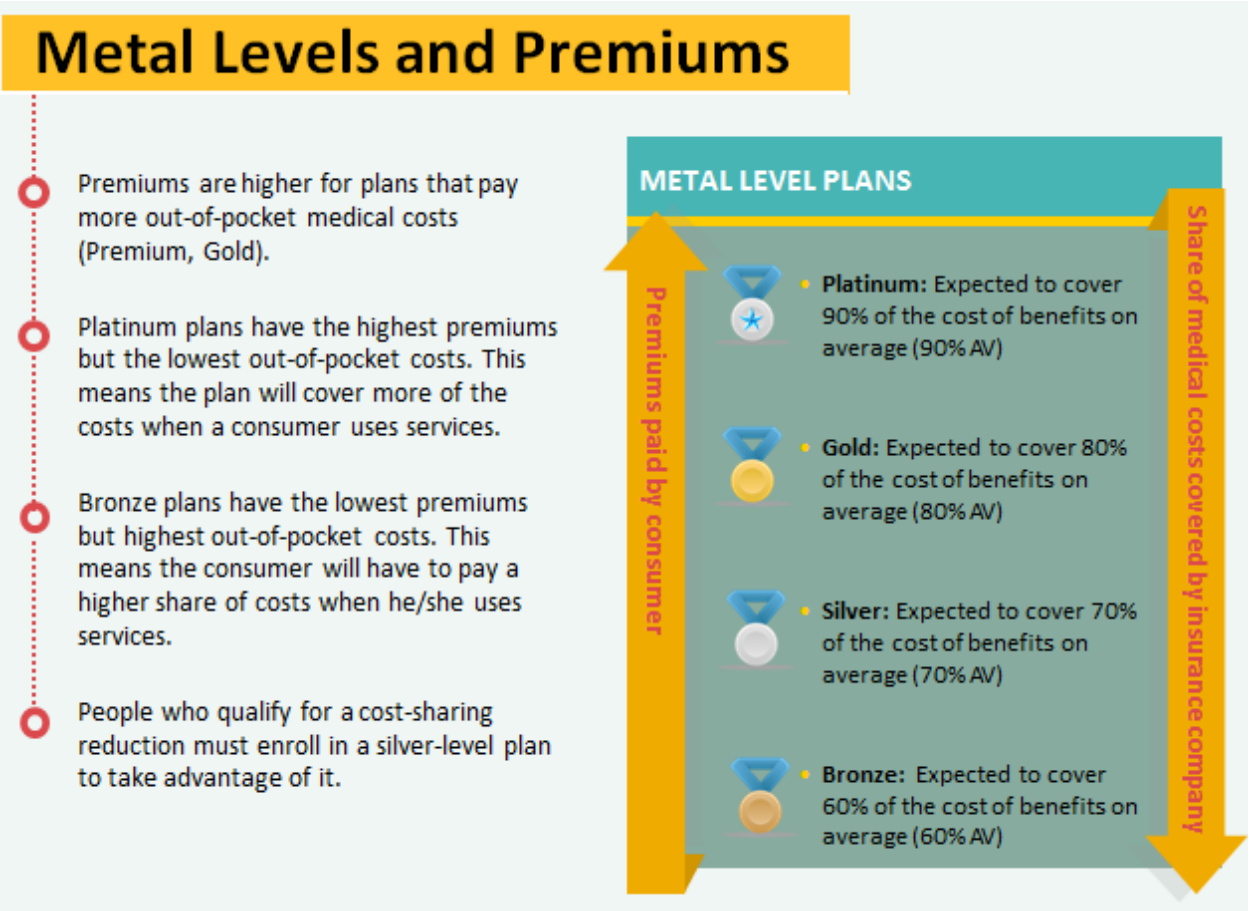
UNDERSTANDING METAL TIERS AND ACTUARIAL VALUE

Covered California health plans are sold in four levels of coverage: Bronze, Silver, Gold and Platinum. A health plan's actuarial value is the percentage of total average benefit costs that a health insurance company covers. Beginning in 2014, all health plans in the market are described by the metal tier corresponding to their actuarial value. The higher the metal value, the higher the percentage of health care expenses paid for by the health insurance company.

Plans in higher metal categories (platinum is the highest) have higher monthly premiums, but when the consumer needs medical care, they will pay less out-of-pocket. Alternatively, consumers who choose a lower metal tier will pay a lower monthly premium, but will pay more out-of-pocket for medical care when they need it. All Covered California health plans offer the same standard benefits. The differences in each metal tier is not in the health benefits provided, but can be found in the up-front monthly premium costs vs. out-of-pocket costs for medical care. Costs are standard in each health plan across metal tiers. For example, the co-pay for prescription medication on a gold-level plan with Kaiser Permanente is the same co-pay as a gold-level plan with Anthem Blue Cross.

For the platinum tier plans, over the period of a single plan year, the health plan will cover on average, 90 percent of the out-of-pocket costs for medical care on behalf of an individual (also known as an actuarial value of 90). For instance, out-of-pocket costs will be lower, so an average a primary care visit co-payment in a platinum-level plan is $20. For a silver-level plan, on average over the period of a single plan year, the health plan will cover 70 percent of the out-of-pocket costs on behalf of the consumer (also known as an actuarial value of 70). For instance, out-of-pocket costs will be higher, so an average primary care visit co-payment in a silver-level plan is $45.

The chart below provides an overview of the percentage of costs paid by the health plan and by the consumer by each metal tier:



Help the consumer understand the level of coverage that best meets both their health needs and budget. Both of these factors are important and should be considered in the decision of a metal tier and health plan. When the consumer is ready to enroll, it is important to help them understand the pros and cons of selecting health plans within each metal tier. Consumers should use the Shop and Compare Tool to review plan options and estimated out-of-pocket costs.

Overview of Covered Services

Covered services are also known as medical benefits. They are the set of medical services, such as physician visits, hospitalizations and prescription drugs, covered by the health plan.

All Covered California health plans cover the same, standard benefit packages across the metal tiers. Health insurance plans must follow the standard benefit designs. With standardized benefits, consumers can accurately compare health insurance plans, because the benefits are the same for all plans offered in the Covered California marketplace. Additionally, standardizing benefits ensure that the selected health insurance plans define what the consumers get and limit the consumer's out-or-pocket costs by type of service. The chart below shows the categories and coverage options for consumers not eligible for financial assistance. When the chart below shows a dollar amount, the member will need to pay that amount as a copayment whenever the member receives that service. When the chart has a percentage, the member pays that percentage of the allowed amount as coinsurance for the covered benefit. After the maximum out-of-pocket amount is paid by the consumer, the plan would now pay for 100 percent of any covered service after that point in time. The following table demonstrated the covered services standard benefit design by metal tier:

2015 STANDARD BENEFIT DESIGNS BY METAL TIER				
Coverage Category	**Bronze**	**Silver**	**Gold**	**Platinum**
	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Preventive Care Copay*	No cost	No cost	No cost	No cost
Primary Care Visit Copay	$60 for 3 visits	$45	$30	$20
Specialty Care Visit Copay	$70	$65	$50	$40
Urgent Care Visit Copay	$120	$90	$60	$40
Emergency Room Copay	$300	$250	$250	$150
Lab Testing Copay	30%	$45	$30	$20
X-Ray Copay	30%	$65	$50	$40
Generic Medicine Copay	$15 or less	$15 or less	$15 or less	$5 or less
Annual Out-of-Pocket Maximum Individual and Family	$6,250 individual and $12,500 family	$6,250 individual and $12,500 family	$6,250 individual and $12,500 family	$4,000 individual and $8,000 family

*In most situations, this is true for one visit per year

4 Determining Eligibility for Financial Assistance

Consumers who are eligible for financial assistance pay less for health insurance when they buy a Covered California health plan. The amount they pay is determined by income and household size, for example the lower the household income, the larger the amount of financial assistance.

Good to know

Covered California health plan premiums are so low in some areas, that a consumer may not receive financial assistance because the overall cost of insurance is below the affordability threshold. For example, a consumer at 322 percent of the FPL purchases a health plan that is $175/month ($2,100/year). The premium payment is 5 percent of the consumer's annual income $37,578) and thus is below the 8 percent affordability limit set by the Affordable Care Act. They would not be eligible to be receive premium assistance.

Determining Income Eligibility for Premium Assistance

Premium assistance offers eligible individuals a tax credit to help pay for the cost of enrolling in a Covered California health plan. To qualify for premium assistance, consumers must generally have income between 138 percent and 400 percent of the FPL and meet a set of non-financial criteria, including a requirement that they are not offered other affordable health insurance options.

Determining eligibility for premium assistance is based on the following three-step process:

1. Identify the members of the consumer's family who are considered part of the tax household for MAGI calculation purposes.
    - Married couples must file a joint tax return to be eligible for premium assistance.
    - Consumers seeking premium assistance must agree to file taxes or be claimed as a tax dependent during the benefit (current coverage) year.
2. Add the income of relevant household members (tax filer and tax dependents).
3. Compare total household income to the FPL for the number of people in the household.
    - To be eligible for premium assistance, the total household income must be between 138 percent and 400 percent of the FPL.
    - Lawfully present individuals with incomes below 138 percent of the FPL are eligible for premium assistance if they are not eligible for Medi-Cal.

How Premium Assistance May Be Applied

Consumers who are eligible for premium assistance can choose among three options for applying their premium assistance amount:

- Take the premium assistance in advance to lower the cost of monthly premiums. The monthly amount will be sent directly to the health insurance company to pay the premium.
- Use some of the premium assistance in advance and receive the balance in the form of a credit when filing taxes.
- Apply the entire premium assistance amount as a tax credit when filing taxes for the benefit year.

The following examples show how two of the options for applying premium assistance would work.

Example 1: Receiving Premium Assistance in Advance

Sam enrolled in a Covered California health plan with a January 1, 2014 effective date. His annual premium total is $2,880 (or $240/month) and he qualifies for $700 of premium assistance. Sam decided to apply his full $700 in premium assistance immediately. Covered California notified Sam's health insurance company, and they applied the premium assistance amount as a credit to Sam's premium bills throughout the benefit year, making the annual premium amount of $2,180 (or 181/month).

If Sam's income increases in 2014 and he is entitled to $500 in premium assistance for the year rather than the $700 he was originally eligible for, he will be responsible for paying back the $200 difference at tax time. However, if Sam has a pay cut in 2014, he may be entitled to a tax credit at the end of the year for any increase in premium assistance he is eligible for.

Example 2: Changing Premium Assistance Received Based on Possible Income Changes

Greta enrolled in the same Covered California health plan as Sam and was also eligible for $700 in premium assistance. She decided to use only $300 of her premium assistance immediately because she was unsure if her income would change.

Later, when Greta was confident there would be no changes to her income, she decided to increase the amount of premium assistance applied in advance by $200. When Greta files her taxes for 2014, she will report on her return the $500 premium assistance she took in advance. But she will also receive a $200 tax credit for her unused premium assistance.

By doing this, she avoided a situation where she would have to pay back in taxes any premium assistance she may not have been entitled to if her income had increased. It is recommended for consumers to choose this method of premium assistance to avoid owing money when filing taxes if their income has changed.

Income changes during the year can affect premium assistance:

- If income increases, premium assistance may decrease.
- If income decreases, premium assistance may increase.

A consumer should immediately report income changes of 10 percent or more (increase or decrease) by using the Report a Change feature on CoveredCA.com, seeking assistance by a certified in-person representative or by contacting the Covered California Service Center at 1-800-300-1506.

Note: The adjustment for premium assistance is made under the Adjust button on the selected health plan. Premium assistance can be adjusted at any time throughout the year.

How Premium Assistance Makes Coverage More Affordable

The following table provides examples of how premium assistance makes health insurance coverage more affordable for low-income and middle-income consumers. Since the following are only examples, actual costs and the amount of premium assistance will vary depending on a consumer's specific situation.

Consumer's Situation	Annual Health Care Premium Cost	Premium Assistance	Premium after Assistance
Joan: • **A 40-year-old single mother** • **Has three children** • **Earns $35,000/year**	$12,336	Joan qualifies for $10,908 in premium assistance	Joan pays $1,428 per year after applying the premium assistance. Monthly payment: $119
Henry and June: • **Married** • **Have two children** • **Earn $50,000/year jointly**	$12,336	Henry and June qualify for $8,892 in premium assistance	Henry and June pay $3,444 per year after applying premium assistance. Monthly payment: $287

Consumer's Situation	Annual Health Care Premium Cost	Premium Assistance	Premium after Assistance
Tory: • **22 years of age and unmarried** • **Earns $18,000/year** • **Her parents do NOT claim her as a dependent on their tax return**	$3,408	Tory qualifies for $2,607 in premium assistance	Tory's annual premium is $801, or $67/month
Jacob: • **24 years of age and a college student** • **Has a part-time job with annual income of $12,000** • **His parents claim him as a dependent on their tax return**	Because Jacob's parents claim him as a dependent, the family's annual health insurance premium will be determined by his parents' household income. Jacob can obtain coverage as a dependent on his parents' plan until their 26th birthday.		
Dustin and Blair: • **Same-sex couple living together** • **Both are 40 years old** • **File separate tax returns; neither can claim the other as a dependent** • **Dustin earns $50,000 year, and Blair earns $30,000 year** • **Must complete two separate applications**	Dustin and Blair each have an annual health insurance premium of $3,500	Dustin's income makes him ineligible for premium assistance. Blair qualifies for $1,020 in annual premium assistance	Dustin's annual premium is $3,500, or $294/month. Blair's premium assistance reduces his annual premium to $2,480, or $207/month.

Because of their income, Joan and Tory may also be eligible for cost-sharing reductions (CSRs) to help lower their out-of-pocket expenses when they receive health care services (i.e., reduced copayments, deductibles).

Premium Assistance Reconciliation

In January, consumers who receive premium assistance through Covered California will get a new tax form 1095 from the IRS, which they'll need to file their tax return. Form 1095 will show the amount of premium assistance the consumer received during the year.

Remember that the amount of premium assistance received is based on the consumer's reported income and tax household size.

This is why the consumer should report any changes to income and tax household size during the year, since changes may raise or lower their premium assistance and impact their taxes.

At tax time, any difference in reported income or household size is reconciled by the IRS. If income was higher than expected, the consumer may have to pay back assistance they received to pay premiums during the year. On the other hand, if they earned less than expected, or their household size grew, they might receive a larger credit on their taxes.

For more on how premium assistance reconciliation works, see: http://www.irs.gov/uac/The-Premium-Tax-Credit

Minimum Essential Coverage and Affordability

Some consumers are not eligible for financial assistance if they have access to other health coverage that is both affordable and meets minimum essential coverage (MEC) requirements.

For health coverage to be considered affordable, the cost is determined by the amount the consumer pays for self-only coverage, regardless of the insurance status of other family members—the cost to add dependents, spouse, children, etc. to the health plan.

Coverage is deemed affordable if the following two conditions are met:

1. The individual's contribution for self-only health insurance (annual premium amount) is no greater than 9.5 percent of the tax household MAGI income.
2. The healthcare plan pays at least 60 percent of the total allowed costs for benefits it provides, and the individual pays no more than 40 percent, on average.

Affordability Example 1:

Maria has a MAGI of $47,000, and her employer offers her and her family healthcare coverage. Her employer-sponsored plan requires her to contribute $6,000 annually to cover herself and her husband Jorge. $6,000 is equal to 12.8% of Maria's MAGI; however, her employer-sponsored plan requires her to contribute only $2,400 for self-only coverage. Since the $2,400 required contribution for self-only coverage does not exceed 9.5% of MAGI ($2,400 is 5.1% of Maria's MAGI), the employer's plan is considered affordable for both Maria and Jorge (even though the cost of covering both individuals is 12.8% of their MAGI).

Because Maria and Jorge are considered eligible for MEC through Maria's employer-sponsored plan, neither Maria nor Jorge is eligible for premium assistance if they were to apply for a Covered California health plan.

Cost-Sharing Reductions with Enhanced Silver Plans

After payment of premium and plan enrollment, cost-sharing reductions (CSRs) help consumers with their out-of-pocket costs like deductibles, coinsurance and co-payments. Important things to remember about CSRs:

- Only available to people who enroll in a silver plan which are referred to as enhanced silver plans when they include CSRs.
- There are three levels of savings available to people who qualify for CSRs.
- The level of savings (or tier) for which a family qualifies is based on the family's income.
- The health insurance company provide the extra help with out-of-pocket costs by offering a silver plan with higher actuarial value.

- The higher the actuarial value, the lower the deductibles, coinsurance or copayments, or both.

Determining Eligibility for Cost Sharing Reductions

Consumers with income up to 250 percent of FPL receive both premium assistance and CSRs. With the addition of CSRs the percentage of expenses covered by the health plan goes up. In essence, the consumer could receive the same level of coverage as a platinum or gold tier health plan without the cost of higher monthly premiums. There are three enhanced-silver plans that offer levels of CSRs based on the household income. The following chart shows the income ranges for and cost of benefits for each enhanced-silver level health plan:

2015 STANDARD BENEFIT DESIGNS BY INCOME

Coverage Category	Enhanced Silver 94	Enhanced Silver 87	Enhanced Silver 73
Eligibility Based on Income and Premium Assistance	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost
Single Income Ranges	**up to $17,235 (≤150% FPL)**	**$17,236 to $22,980 (>150% to ≤200% FPL)**	**$22,981 to $28,725 (>200% to ≤250% FPL)**
Annual Wellness Exam	$0	$0	$0
Primary Care Vist	$3	$15	$40
Specialist Visit	$5	$20	$50
Laboratory Tests	$3	$15	$40
X-Rays and Diagnostics	$5	$20	$50
Imaging	10%	15%	30%
Generic Drugs	$3	$5	$15 or less
Annual Out-of-Pocket Maximum Individual and Family	$2,250 individual and $4,500 family	$2,250 individual and $4,500 family	$5,200 individual and $10,400 family

UNDERSTANDING MONTHLY PREMIUMS AND OUT-OF-POCKET COSTS

It may be a difficult decision for consumers to decide between a health plan with higher monthly premiums and lower out-of-pocket costs, or vice versa. The following example helps demonstrate how to help consumers find the best fit health plan:

Jane is eligible for an enhanced silver 94 health plan because her income qualifies her for the highest level enhanced-silver plan. Her premium assistance is $906 a year. Jane's eligibility for CSRs lowers her out-of-pockets costs for medical care when she uses it.

It is important that Jane understands her cost trade-offs. If she chooses one of the enhanced silver plans, she may pay a higher monthly premium then if she selected a bronze plan, but her out-of-pocket costs will be a lot lower with an enhanced silver plan when she needs medical care.

Lower monthly premiums usually translate to higher out-of-pocket costs. With a bronze plan, Jane is taking on much greater financial risk in the event of an accident or when she seeks medical care, and is foregoing the CSRs she is eligible for. On average, Jane will pay about six times as much in out-of-pocket medical expenses for medical expenses she incurs if she enrolls in a bronze plan instead of one of the enhanced silver plans.

In talking with consumers, be sure to take the time to help them understand the value of health insurance and the cost trade-offs between monthly premiums and out-of-pocket costs. **Note:** You are encouraged to recommend metal tiers that best fits the consumer's needs, however you cannot recommend a specific health plan (e.g. Anthem Blue Cross)

To consider total costs, consumers should evaluate:

- The frequency with which they used covered benefits (e.g. how often they need to see a doctor, do they have routine appointments)
- Their ability to pay a monthly premium versus out-of-pocket costs
- The level of financial risk they are willing to take on if an accident, or sudden illness or injury occurs

5 PREMIUM PAYMENT FUNCTIONALITY

It is important to note that in order for coverage to start, the premium payment must be received in full by the health insurance company that the consumer selects. The ten Covered California health insurance companies offer a comprehensive menu of payment alternatives. All payments should be made payable directly to the selected health insurance company. Covered California will not accept forms of payment made payable to Covered California. All billing questions should be directed to the consumer's specific health insurance company and not to Covered California.

Covered California health plans accept payments via:

- Personal check
- Money order
- Re-loadable credit, debit and prepaid cards (contains Visa, MasterCard or American Express Symbol)
- Some Covered California health plans are planning to include other payment options including the ability for enrollees to make payments with cash, delivered in-person to a designated payment facility, or Electronic Funds Transfer (EFT)/Automated

- Clearing House (ACH) transactions.

The table below shows Covered California's health insurance companies payment options.

		Cash	Personal Check	Cashier Check	Money Order	Credit Card	Debit Card	EFT/ACH	Wire Transfer
1.	Anthem Blue Cross		Yes	Yes	Yes	V, MC	Yes	Yes	
2.	Blue Shield of CA*		Yes	Yes	Yes	V, MC	Yes	Yes	
3.	Chinese Community HP	Yes	Yes	Yes	Yes	V, MC	Yes	Yes	
4.	Health Net of CA		Yes	Yes	Yes	V, MC	Yes	Yes	
5.	Kaiser Permanente		Yes	Yes	Yes	V, MC, AMEX, D	Yes	Yes	
6.	L.A. Care Health Plan	Yes	Yes	Yes	Yes	V, MC, D	Yes		
7.	Molina Healthcare		Yes	Yes	Yes	V, MC, D	Yes		
8.	Sharp Health Plan	Yes	Yes	Yes	Yes	V, MC	Yes		
9.	Valley Health Plan	Yes	Yes	Yes	Yes	V, MC, AMEX	Yes	Yes	Yes
10.	Western Health Advantage	Yes	Yes	Yes	Yes	V, MC, D	Yes	Yes	Yes

*V = Visa, MC = Master Card, AMEX = American Express, D = Discover Card
** EFT = Electronic Funds Transfer, ACH = Automated Clearing House

The health insurance company will send the consumer a bill two weeks after they receive the Covered California application. The payment due date will be printed on the bill. Consumers should send the payment to the health insurance company before the deadline. If a consumer choses to pay their bill by mail, the in insurance company must receive the payment before the due date printed on the bill.

UNBANKED CONSUMERS PREMIUM PAYMENT FUNCTIONALITY

Covered California appreciates that not all consumers have bank accounts or revolving lines of credit (such as a credit card). In order to facilitate both initial premium and on-going monthly premium payments, unbanked consumers may make payments directly to their selected health insurance company by:

- Cash payments will be accepted at designated payment offices (cash should not be mailed)
- Money orders payable to the health plan may be mailed or delivered in person to designated payment offices
- Re-loadable credit, debit and prepaid cards (contains Visa, MasterCard or American Express Symbol)

NON-PAYMENT OF PREMIUMS

In the case of termination due to non-payment of premiums, the health insurance company will send the consumer a notice of delinquency. A grace period of three consecutive months will be

provided if an enrollee receiving the advance premium assistance has previously paid at least one month's premium during the benefit year. If an enrollee receiving financial assistance exhausts the three-month grace period without paying all outstanding premium balances, coverage will be terminated. In addition, the premium assistance paid to the Covered California health insurance company on behalf of the consumer will be returned for the second and third months of the grace period.

Good to Know

In the case of an involuntary termination, for a consumer receiving financial assistance the last day of coverage shall be the last day of the first month of the three-month grace period.

6 Medi-Cal Coverage

What Medi-Cal Covers

Medi-Cal pays for a variety of medical, mental health, vision and dental services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes. Consumers can enroll in Medi-Cal at any point throughout the year, there are no enrollment periods for Medi-Cal.

Medi-Cal coverage for adults includes medical services, pharmacy and vision services, as well as durable medical equipment. The following table lists these services:

Medical	Pharmacy and Vision	Durable Medical Equipment
Clinic services Drug and alcohol treatment Inpatient/outpatient services Long-term care Mental health Physician-administered drugs Physician services Podiatry services	Prescription drug coverage Eye exams and tests	Wheelchairs Wheelchair repair Hearing aids Batteries for hearing aids or pacemakers, or both
Acupuncture	Audiology and hearing aids	Chiropractic
Medical transportation	Orthotics and prosthetics	Therapies: occupational, physical and speech

For children and young adults until their twenty-first birthday, there is no charge for the following:

Medical	Pharmacy	Dental and Vision
Physician, medical and surgical services Preventive health care exams Immunizations	Prescription drug coverage	Vision benefits, including an eye exam and eyeglasses every 24 months

Medical	Pharmacy	Dental and Vision
Well-child services Medically necessary hospitalization Inpatient and outpatient services Family planning services Laboratory and x-ray services Mental health services Occupational, physical and speech therapies		Dental benefits, including preventive and diagnostic services

ADMINISTRATION OF MEDI-CAL BENEFITS

Medi-Cal administers benefits in two ways. The first, under Medi-Cal Fee-For-Service (FFS) or "Regular Medi-Cal" a consumer can access benefits with any FFS Medi-Cal provider (i.e. doctors, clinics, hospitals or pharmacies). For the most part, FFS Medi-Cal beneficiaries will be consumers enrolled in a temporary form of Medi-Cal coverage. If and when the consumer is determined eligible for a Medi-Cal program through a formal application they may be transitioned into Managed Care. Others who can chose to participate in FFS Medi-Cal are children in a foster care or adoption aid program and consumers with a share of cost.

Medi-Cal also administered benefits under a Managed Care system where a consumer accesses care through a Medi-Cal health plan network (i.e. health plan network doctors, clinics, hospitals and pharmacies) and will chose a primary care physician. Medi-Cal beneficiaries are assigned to or can chose from Medi-Cal health plans near their residence. Consumers that enroll in Managed Care are consumers who are aged, blind or disabled, receiving Supplemental Security Income (SSI), State Supplementary Payments (SSP) or CalWORKS benefits, and those that are Medi-Cal only with no share of cost (i.e. children, pregnant women, parents and adults). For more information on Medi-Cal Managed Care please visit: http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.

HOW MEDI-CAL ELIGIBILITY AFFECTS ELIGIBILITY FOR PREMIUM ASSISTANCE

People who are eligible for Medi-Cal are not eligible for a Covered California health plan with premium assistance. However, when the online application determines that an applicant is not eligible for expanded Medi-Cal, or at any point during the application process, the applicant can choose to request a full Medi-Cal determination by the California Department of Health Care Services.

While that is happening, the consumer can enroll temporarily in a Covered California health plan and use any premium assistance and CSRs if their attested information qualifies them. It is important to know that if it turns out the consumer is not eligible for premium assistance/CSRs they must re-pay the premium assistance received up to a certain dollar amount.

If the Department of Health Care Services determines that the applicant is eligible for any Medi-Cal program, then they would dis-enroll from the Covered California health plan and enroll in Medi-Cal.

MEDI-CAL SHARE OF COST

In rare instances, Medi-Cal consumers must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called share of cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible.[i] The SOC amount depends upon a consumer or family's monthly income:

- The SOC is determined first by subtracting certain exemptions and deductions from a consumer's or a family's gross monthly income
- And then subtracting an additional amount for living expenses called maintenance need.
- The remaining amount is the SOC. County social service departments calculate the SOC amounts

When a Medi-Cal beneficiary uses medical services and would like Medi-Cal to pay for them:

- The SOC amount must first be met in that month before Medi-Cal will pay for the service(s)
- A SOC is required only in those months in which services are used

The Medi-Cal member needs to keep their permanent Benefits Identification Card (BIC) in case medical services are needed in the future.

MEDI-CAL HEALTH PLAN SELECTION

Most individuals who qualify for Medi-Cal will need to enroll with a health insurance company to receive benefits. Health insurance companies contract with Medi-Cal to provide services to Medi-Cal consumers.

Medi-Cal health plans are available to individuals based on their county of residence. The counties listed below require Medi-Cal individuals to enroll in a plan while individuals who live in other counties may choose to enroll either in a health plan or remain in fee-for-service Medi-Cal.

Counties requiring enrollment into a health plan are:

Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquín, Santa Clara, Stanislaus, Tulare

For more information on how to enroll with a health plan or change a health plan go to, http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Choice_Enrollment_Form.aspx or call Medi-Cal Health Care Options at 1-800-430-4263.

"REGULAR" OR FEE-FOR-SERVICE MEDI-CAL (FFS)

FFS is beneficiary driven; they go to the doctor when they want to and only access the services they believe they need. Some beneficiaries like this flexibility but it leaves a gap in preventive care and services may only be sought once a condition has developed and extensive treatment is needed.

- Automatically assigned to some persons with disabilities. Former foster youth and Native Americans can choose regular Medi-Cal

- Consumers find their own doctors and hospitals
- County hospitals and health systems, community clinics and health centers provide quality care to Medi-Cal beneficiaries
- FFS was the most common type of Medi-Cal delivery system; as recently as 2010 the majority of Medi-Cal beneficiaries were in FFS. If a consumer has been in Medi-Cal before, there is a good chance that they were in FFS
- The FFS delivery system is statewide, and beneficiaries can access any provider in the state who accepts Medi-Cal FFS

Managed Care Medi-Cal

In managed care, coordination of services is done through a Primary Care Provider, which every member has either by choice or assignment. This allows for more preventative care and less duplication of services. Managed care members can only see network providers; getting services from out-of-network providers must be approved by the plan or it will not be covered by the plan.

- Most consumers assigned to Managed Care
- Consumers choose doctors and hospitals from their plan's provider network
- In some areas, consumers must also pick a medical group (Independent Physicians' Association – IPA) within a Managed Care plan
- Since Medi-Cal managed care began expanding in 2010, enrollment into managed care plans now outnumbers FFS enrollment

*__For additional information refer to the Advanced Study Course on Medi-Cal.__

7 The Annual Renewal Process

Each year, consumers who enroll in a Covered California health plan will receive an open enrollment notification. The notification will advise consumers on the necessary steps for renewal including submission of documentation, if necessary. After initial enrollment with Covered California, there may be occasions when consumers need to reconsider their health insurance company choice.

Reporting Changes

Consumers are required to report any changes in eligibility criteria to Covered California.

Examples of changes that should be reported include, but are not limited to:	
• Add a household member (birth, adoption, marriage, etc.)	• Change in income (employment)
• Remove a household member	• Change in income (self-employment)
• Change in incarceration status	• Change in income (other)
• Change in health coverage	• Change in income (income tax deductions)
• Change in citizenship/immigration status	• Change in all income type and deductions
• Change in household contact information	• Tax information change
• Change in name	• Miscellaneous information change

Changes should be reported within 30 days of the event. Consumers can report these changes at CoveredCA.com or by calling the Covered California Service Center. Consumers may also work with Certified Enrollment Counselors and Certified Insurance Agents to make changes.

Reporting income and tax household composition changes is the most important to report because any change in income or household composition may result in a change in the amount of premium assistance or CSRs a consumer may receive. Notifying Covered California of these changes has the following benefits:

- Consumers are informed and educated about any potential changes in their eligibility for premium assistance or CSRs as a result of a change in income
- Consumers can adjust how much of their premium assistance they take in advance, which will help minimize repayment at tax time of excess premium assistance taken during the benefit year
- Consumers' ability to obtain more affordable coverage may increase if income decreases

Upon receiving notification, Covered California will conduct a redetermination and verify the new information received. Covered California will then notify the consumer regarding the redetermination outcome.

Consumers have a right to appeal redetermination decisions, and should contact the Covered California Service Center for additional information on the appeal process.

Annual Eligibility Redetermination

A consumer's eligibility for a Covered California health plan as well as Medi-Cal will be reviewed annually. Covered California must have an active authorization from the enrollee to obtain updated tax information to perform the redetermination. Covered California will send a notification to the consumer based on updated data used in the redetermination and stating the projected eligibility determination for the following year. Prior to redetermination, Covered California sends this notice which includes:

- Any updated income and family size information

- Any updated tax information
- Any other information used to re-determine eligibility
- Projected eligibility for the following year as well as any changes in:
    - Advanced Premium Tax Credit (APTC)
    - Cost-sharing reductions (CSR)
    - Eligibility for Covered California or Medi-Cal

If the consumer still qualifies for coverage, new coverage will start on the first day of the coverage year. Individuals in a Covered California health plan will remain in their same plan unless they cancel coverage to select a new plan. Consumers have a right to appeal redetermination decisions and should contact the Covered California Service Center for additional information on the appeal process.

DISENROLLMENT FROM A COVERED CALIFORNIA HEALTH PLAN

Termination from coverage can be either voluntary or involuntary:

- Voluntary termination occurs when the consumer elects to discontinue coverage
- Involuntary termination occurs when Covered California or the health plan initiates termination

If a consumer's coverage in a Covered California health plan is terminated for any reason, the consumer will receive a notice of termination of coverage that describes the reason, as well as information about how to appeal the termination. This notification will be sent at least 30 days prior to the last day of coverage.

For voluntary disenrollment the termination date will occur 14 days after the termination is requested by the enrollee if not given reasonable notice. If reasonable notice is provided, the termination date will be the date the enrollee specifies.

Voluntary Disenrollment

Consumers can voluntarily dis-enroll from a Covered California health plan in the following circumstances:

- The consumer obtains other coverage that meets the minimum essential coverage requirement (i.e. government-sponsored plans or employer-sponsored plans)
- The consumer changes from one Covered California health plan to another during open enrollment or during the special enrollment period. Consumers may not change plans outside of open enrollment unless they meet criteria defined for the special enrollment period

Consumers wishing to dis-enroll should contact Covered California or their health insurance company. Consumers should not dis-enroll until new coverage is active, as gaps in coverage may lead to unplanned medical expenses.

Involuntary Disenrollment

Involuntary disenrollment can be initiated under the following circumstances:

- The consumer is no longer eligible for coverage under Covered California (i.e. deceased or moved out of the service area for Covered California)
- The consumer did not pay their premiums. It is important for consumers to remain current with their monthly premium payments
- The consumer commits fraud and coverage is rescinded by the health insurance company
- The Covered California health plan is terminated or is decertified

8 ACTIVITIES

Check your knowledge of health care fundamentals and plan options available through Covered California. The answers follow the activities.

Activity 1

Answer true or false for each statement.		
	True	**False**
1. Evaluating quality was a key criterion against which Covered California evaluated all health insurance companies before certifying them as Covered California health plans.		
2. A Bronze plan is a good choice for people who want low out-of-pocket costs for the services they use.		
3. Consumers who are income eligible may use cost-sharing reductions in any metal tier health plan.		
4. Changes to a consumer's circumstances must be reported within 30 days.		
5. Premium assistance may increase and decrease throughout the year, even if the consumer's income stays the same.		

9 Activity Answers

Lesson Activity 1

1. True
2. False
3. False
4. True
5. False

10 Endnotes

[1] Share of cost per www.medi-cal.ca.gov