2.0 Assister Job Skills

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

- Assister roles and responsibilities
- Customer service guidelines
- Customer service best practices
- Consumer accommodations when providing customer service

2.1 Assister Roles and Responsibilities

No matter what state they live in, consumers are able to get in-person help as they apply for and choose new coverage options in the Marketplace.

The different Assister roles include the following:

- **Navigators:** Navigators are present in the Federally-facilitated Marketplace, State Partnership Marketplaces, and State-based Marketplaces. They are funded through state and federal grant programs.
- **Non-Navigator assistance personnel:** Non-Navigator assistance personnel (also known as in-person assistance personnel) perform generally the same functions as Navigators, but are funded through separate grants or contracts administered by a state or the federal government.
- **Certified application counselors (CACs):** The Federally-facilitated Marketplace designated organizations to certify application counselors who perform many of the same functions as Navigators and non-Navigator assistance personnel, including educating consumers and helping them complete an application for coverage. These organizations include community health centers or other health care providers, hospitals, or social service agencies. A State-based Marketplace may choose to certify application counselors directly, rather than designate organizations to do so. CACs and the organizations they serve don't receive federal grant money through the Marketplace. These counselors and organizations may, however, receive federal funding through other grant programs or Medicaid to help support their consumer assistance and enrollment activities.

Additional details on the duties of Navigators, non-Navigator assistance personnel, and CACs can be found in CMS regulations at 45 CFR Sections 155.210, 155.215 and 155.225. Each state might have additional requirements for Assisters. Because the Marketplace Background Guide is focused on federal requirements for Assisters in states served by the Federally-facilitated Marketplace or a State Partnership Marketplace, it does not address additional requirements that may be in place for Assisters in specific states. Nor does it address requirements that State-based Marketplaces might expect their Assisters to meet.

2.1.1 Navigator and Non-Navigator Assistance Personnel Responsibilities

To assist consumers through the eligibility and enrollment process, Navigators are required to perform the following activities:

- Maintain expertise in eligibility, enrollment, and program specifications, and conduct public education activities to raise awareness about the Marketplace.
- Provide information and services in a fair, accurate, and impartial manner, which includes: providing information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including qualified health plans (QHPs); [1] and helping consumers make informed decisions during the health coverage selection process. Such information must include other health programs, such as Medicaid and the Children's Health Insurance Program (CHIP).
- Provide information to consumers about the full range of QHP options and insurance affordability programs[2] for which they are eligible.
- Facilitate selection of a QHP.
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the PHS Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage.
- Consistent with the requirements set forth in 45 CFR 155.215, provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Marketplace, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act.
- Comply fully with the conflict-of-interest and training standards set forth in 45 CFR 155.215.

Non-Navigator assistance personnel generally perform similar functions as Navigators, but they are not required to perform all of the functions listed above. At a minimum, non-Navigator assistance personnel in the Federally-facilitated Marketplace and State Partnership Marketplaces must provide information and services in a fair, accurate, and impartial manner (as described above); must provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible; must comply with the standards set forth in 45 CFR 155.215 regarding accessibility for persons with disabilities and persons with limited English proficiency; and must comply fully with the conflict-of-interest and training standards set forth in 45 CFR 155.215.

Navigators and non-Navigator assistance personnel are prohibited from:

- Being a health insurance issuer or issuer of stop loss insurance.
- Being a subsidiary of a health insurance issuer or issuer of stop loss insurance.
- Being an association that includes members of, or lobbies on behalf of, the insurance industry
- Receiving any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or a non-QHP.
- Charging applicants for application or other assistance related to the Exchange.

[1] Qualified health plans, or QHPs, are health insurance plans that are certified by the Marketplace.
[2] Additional information on insurance affordability programs can be found in Section 4.0 of this Guide.

- Steering individuals to particular QHPs offered in the Exchange or plans outside of the Exchange

Training and other requirements for Navigators and non-Navigator assistance personnel are set forth at 45 CFR 155.210 and 155.215. Information on implementation of these requirements for 2014-2015 is provided in the *Guidance Regarding Training, Certification, and Recertification for Navigator Grantees, Certified Application Counselors, and Non-Navigator Assistance Personnel in the Federally-facilitated Marketplaces* bulletin released August 15, 2014, which can be found here. Additionally, training materials for all Assisters for 2014-2015 are hosted on the Medicare Learning Network (MLN).

2.1.2 Certified Application Counselor Responsibilities

To assist consumers, CACs are expected to perform the following activities:

- Provide information to individuals and employees about the full range of QHP options and insurance affordability programs for which they are eligible, which includes: providing information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process.
- Assist individuals and employees to apply for coverage in a QHP through the Marketplace and for insurance affordability programs.
- Help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs.

Training and other requirements for CACs in states with a Federally-facilitated Marketplace or a State Partnership Marketplace is provided at 45 CFR 155.225. Information on implementation of these requirements for 2014-2015 is provided in the *Guidance Regarding Training, Certification, and Recertification for Navigator Grantees, Certified Application Counselors, and Non-Navigator Assistance Personnel in the Federally-facilitated Marketplaces* bulletin released August 15, 2014, which can be found here. Additionally, training materials for all Assisters for 2014-2015 is hosted on the Medicare Learning Network (MLN).

2.2 Customer Service Guidelines & Best Practices

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

- Making consumers feel welcome, important, heard, and respected by listening and responding to their requests.
- Communicating in a way that supports consumers' understanding and displays sensitivity to their needs.
- Assisting consumers in a culturally-sensitive manner, using language translation services as appropriate or required.
- Responding appropriately to consumers' needs and accommodation requests in a timely manner.

3.0 General Consumer Education

Before making any health coverage decisions, individuals, families, and small employers who are interested in getting health care coverage through the Marketplace may need help to understand the basics of:

- Health insurance and health coverage
- The Affordable Care Act
- The Marketplace
- Eligibility and enrollment through the Marketplace

Assess a consumer's baseline knowledge of health coverage options and understanding of how the Affordable Care Act impacts them. Use this section of the Guide to review various topics with consumers as you assist them with eligibility decisions and enrollment activities.

3.1 Health Insurance Overview

This section provides general information on health coverage that consumers can purchase both through and outside of the Marketplace. Although the terms "health insurance and "health coverage" are often used interchangeably, they have two distinct meanings.

Health insurance is a contract between a consumer and a health insurance company. In exchange for a fee (usually a monthly payment) called a premium, the health insurance company agrees to pay part, or all (in some cases), of the consumer's health care costs.

Health coverage is defined as a set of benefits consumers are entitled to when enrolled in a health coverage program. Consumers may obtain health coverage from sources outside the Marketplace, including Medicaid; the Children's Health Insurance Program (CHIP); Medicare; veteran's health benefits or TRICARE; or employer-sponsored plans, or other private health insurance options, including grandfathered health plans.

Grandfathered health plans are coverage provided by a group health plan or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010. Grandfathered plans are exempt from many Affordable Care Act requirements. Plans or policies will lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers or fail to meet other requirements, including providing required disclosure of their grandfathered status to consumers.

3.1.1 Health Insurance Costs

Consumers are required to pay their health insurance company for:

- **Premiums:** The amount consumers and/or their employers pay for health coverage on a monthly, quarterly, or yearly basis. The amount paid varies depending on many factors, including the health care services covered and the health insurance company. Generally speaking, the lower the monthly premium, the higher a consumer's expected out-of-pocket costs for services received will be.

Consumers are required to pay out-of-pocket costs for health services for:

- **Deductibles:** The amount consumers owe for health care services before the health insurance company begins to pay. For example, if the deductible is $1,000, consumers will spend $1,000 of their own money on health care services before the insurance company starts to pay for services. The deductible may not apply to all services. Some plans also have separate deductibles for medical benefits and prescriptions. Premiums, copayments, and coinsurance may not count towards the deductible.
- **Copayments:** A fixed amount (e.g., $15) consumers pay for covered health care services, usually when consumers receive the services. The amount can vary by the type of covered health care service (e.g., primary care physician [PCP] visit $20, specialist visit $30, generic prescription drug $10, emergency room visit $125). As previously stated, copayments do not count towards the deductible, but they do count towards the plan's maximum out of pocket spending.
- **Coinsurance:** The share of the costs of a covered health care service, calculated as a percent (e.g., 20%) of the allowed amount for the service. Consumers pay coinsurance, plus any deductibles owed. For example, if the health insurance company's or plan's allowed amount for an office visit is $100 and the consumer has met the deductible, the consumer's coinsurance payment of 20% would be $20. The health insurance company pays the rest of the allowed amount.

There is a limit to how much consumers must pay out-of-pocket, which is referred to as maximum out of pocket spending. The out-of-pocket maximum is the amount consumers pay during a policy period (usually one year) before their health insurance companies or plans pay 100% for covered health services. This limit includes deductibles, coinsurance, and copayments, but does not have to count premiums or spending for services that are not covered or are non-essential.

Health care costs paid by the health insurance company might vary depending on the coverage offered, but must include coverage for:

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

Tip: Check to Confirm a Consumer's Desired Provider is in their Plan's Network

If consumers want to use a particular doctor or health care facility, they should ensure that any plans they are considering include these providers in the plans' provider networks.

Health insurance companies may control health care costs by limiting consumers' coverage to include only services rendered by certain facilities, providers, and suppliers, otherwise known as a network. Assisters should be familiar with the different types of plans and help a consumer determine which plan most effectively meets the wants and needs of the consumer. Typically, there is a trade-off between the monthly cost of a plan and its other features, such as access to providers. Some types of plans allow consumers to see almost

any doctor or health care facility. Others limit choices to a network of doctors and facilities, or require consumers to pay more if they use providers outside the network.

3.1.2 Types of Health Insurance Plans

There are different types of health insurance plans that meet different needs. Different plan types provide different levels of coverage for care you get inside and outside of the plan's network of doctors, hospitals, pharmacies, and other medical service providers. The types of plans that consumers might encounter in the Marketplace include:

- **Health Maintenance Organization (HMO):** Limits coverage to care from in-network doctors who work for or contract with the HMO. An HMO generally will not cover out-of-network care, except in an emergency. An HMO may require consumers to live or work in its service area to be eligible for coverage. In exchange for limited access to providers, premiums are typically lower for an HMO than for other types of plans.
- **Point of Service (POS):** Allows consumers to pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. With this type of plan, consumers may go to out-of-network providers at a higher cost. POS plans may also require consumers to get a referral from their primary care doctor to see a specialist.
- **Preferred Provider Organization (PPO):** Contracts with health care providers, such as hospitals and doctors, to create a network of participating providers. Consumers pay less if they use providers that participate in the plan's network. Consumers can visit doctors, hospitals, and providers outside the network at an additional cost. Referrals are often not needed to see specialists. In exchange for access to a wider range of providers, premiums are generally higher for a PPO than for a health maintenance organization (HMO).
- **High Deductible Health Plan (HDHP):** Features higher deductibles than traditional insurance plans, in exchange for lower monthly premiums. HDHPs can be combined with a health savings account (HSA), which is a medical savings account available to consumers enrolled in an HDHP, or a flexible spending account (FSA), which is set up through an employer to pay for many out-of-pocket medical expenses with tax-free dollars. HSAs and FSAs let consumers pay for qualified out-of-pocket medical expenses on a pre-tax basis. The money that is contributed to an HSA or FSA is not subject to federal income tax at the time of deposit, but must be used to pay for qualified medical expenses. Consumers use the money in their HSAs to help meet the deductible before the HDHP kicks in. Funds contributed to an HSA roll over from year to year if consumers don't spend them, but FSA funds generally don't carry over from year to year. HDHPs may not be appropriate for consumers with chronic or serious health conditions that require multiple specialist visits and procedures. It's important that you remind consumers to consider these financial factors before deciding on health coverage.
- **Catastrophic Health Plan:** Provides coverage of the essential health benefits, but only provides certain limited coverage until the out-of-pocket maximum is met. This type of coverage is designed to protect consumers from very high medical costs resulting from an emergency or catastrophic medical condition. The premium a consumer pays for a catastrophic health plan is generally lower than the premium for other plan types.

3.1.3 The Affordable Care Act

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

- Prohibiting health insurance companies from charging consumers higher premiums based on health status or gender for non-grandfathered plans in the individual and small group markets.
- Requiring plans that offer dependent coverage of children to allow most child dependents to remain on their parent's health plan until the age of 26.
- Prohibiting health insurance companies from denying or preventing them from enrolling in coverage for consumers who have pre-existing conditions (i.e., health problems consumers have before the day that new health coverage starts).
- Eliminating annual and lifetime dollar limits on coverage of essential health benefits from health plans (some health plans placed a cap or limit on the dollar amount of health care costs for which the plan would pay each year or over the consumer's lifetime).

The Affordable Care Act's key provisions establish:

- Medicaid Expansion
- The Health Insurance Marketplace
- Individual Shared Responsibility Payment
- Employer Shared Responsibility Payment

3.1.3.1 Medicaid Expansion

Medicaid is a state-administered health coverage program for low-income families and children; pregnant women; the elderly; people with disabilities; and, in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets broad guidelines for the program. States have flexibility in designing their programs within these broad federal guidelines, so Medicaid programs may vary state by state and may have a different name in each state.

The Affordable Care Act allows states new opportunities to expand their Medicaid programs to allow more people to be eligible to receive Medicaid and introduced several changes to the Medicaid program. Under the Affordable Care Act, states can expand Medicaid coverage to individuals over the age of 19 and under the age of 65 who have household incomes below 133% of the federal poverty level (FPL). In states that have implemented this provision, non-disabled, childless adults may be eligible for Medicaid if their income is below 133% of the FPL. For example, in a state that's expanded Medicaid, consumers may qualify if they make up to $15,521 a year for one person ($31,720 for a family of four). See Exhibit 1 for income limits for different family sizes.

Please note that consumers applying for Medicaid are also required to meet other non-financial requirements, like being a resident of the state in which they are applying. The only way to know for sure whether someone will be eligible for Medicaid is to complete and submit an application. More information on Medicaid and CHIP can be found in Section 4.1.1.

Exhibit 1 – Medicaid Eligibility Based on Household Size and Income

Number of people in your household						
Medicaid coverage	**1**	**2**	**3**	**4**	**5**	**6**
If your state **is** expanding Medicaid in 2014: You may qualify for **Medicaid coverage** if your yearly income is below…	$15,521	$20,921	$26,321	$31,720	$37,120	$42,520
If your state **isn't** expanding Medicaid: **You may not qualify for any Marketplace savings programs** if your yearly income is below…	$11,670	$15,730	$19.790	$23,850	$27,910	$31,970

3.1.3.2 Health Insurance Marketplace

The Marketplace, also called "Affordable Insurance Exchange" in the Affordable Care Act, allows eligible consumers to shop for, compare, and purchase health coverage for themselves, their dependents, or employees. Through tools and resources available at HealthCare.gov (https://www.HealthCare.gov/), consumers can learn about the health insurance options available to them. The Marketplace application can help consumers obtain a determination as to whether they qualify for:

- **Private health insurance:** These are qualified health plans (QHPs) that cover essential health benefits, including preventive care, and cannot exclude coverage based on pre-existing conditions.
- **Premium tax credits and cost-sharing reductions that lower costs based on factors including family size and household income:** Consumers can preview and sign up for qualified health plans available in their area with prices that reflect lower premiums based on factors, including household income and family size. Many people who apply for QHP coverage will qualify for lower premiums.
- **Medicaid and CHIP:** These programs cover millions of families with limited incomes. If it looks like a consumer will qualify for Medicaid or CHIP, CMS shares information with the consumer's state agency and the state agency will contact the consumer.

The Marketplace creates a centralized and transparent place consumers can go to shop for and compare health coverage options based on price, network, and other features before they enroll in a plan. There are two ways to obtain health coverage through the Marketplace:

- **Individual Marketplace:** The Individual Marketplace is for qualified individuals and families to enroll in health coverage and choose plans that best fit their budgets and needs. Self-employed consumers whose businesses have no employees or who employ only their

spouses also may be eligible to purchase coverage for themselves and their families through the Individual Marketplace.

- **SHOP Marketplace:** The SHOP Marketplace helps eligible small employers provide health insurance to their employees. The Federally-facilitated SHOP Marketplace (FF-SHOP) is currently open to employers with one to 50 full-time equivalent (FTE) employees and who also meet other eligibility requirements. Participating employers determine how much of the premium cost they will cover for their employees. Beginning in 2016, the SHOP Marketplace will be open to employers with up to 100 FTE employees. Unlike consumers who obtain coverage through the Individual Marketplace, consumers who enroll in coverage through the SHOP Marketplace will not qualify for Marketplace programs to lower their costs (e.g., premium tax credits, cost-sharing reductions) unless they decline the SHOP Marketplace coverage, apply for and are eligible for coverage in the Individual Marketplace, and the SHOP Marketplace coverage offer is not considered to be affordable. More information about the SHOP Marketplace is included in a forthcoming publication on the FF-SHOP.

3.1.3.3 Qualified Health Plans

Under the Affordable Care Act, an insurance plan is referred to as a QHP when it's certified by the Marketplace and provides essential health benefits, follows established limits on cost-sharing (e.g., deductibles, copayments, coinsurance, out-of-pocket maximum amounts), and meets other requirements. A QHP will have a certification by each Marketplace in which it is sold.

3.1.3.4 Essential Health Benefits

The Affordable Care Act requires all non-grandfathered small group and individual health insurance plans, both inside and outside of the Marketplace, to cover a comprehensive package of items and services, known as the essential health benefits (EHB). This comprehensive package includes, at a minimum, the 10 EHB described in Exhibit 2. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.

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

Exhibit 2 – Essential Health Benefits

Essential Health Benefit	Description
Ambulatory patient services	Care provided without admission to a hospital – for example, at a clinic, physician's office, or same-day surgery center
Emergency services	Care provided for conditions that, if not immediately treated, could place the health of the individual in serious jeopardy, lead to serious impairment of bodily functions, serious dysfunction of any organ or body part, or death
Hospitalization	Care provided to you as an inpatient in a hospital, such as room and board, care from doctors and nurses, and tests and drugs administered during your stay
Maternity and newborn care	Care provided to women during pregnancy, childbirth, and after childbirth

Essential Health Benefit	Description
Mental health and substance abuse disorder services, including behavioral health treatment	Care to evaluate, diagnose, and treat mental health and substance abuse issues (including counseling and psychotherapy)
Prescription drugs	Drugs prescribed to treat a temporary condition, like an infection or other physical or mental illness, or an ongoing physical or mental condition requiring treatment, like depression, high cholesterol, or high blood pressure
Rehabilitative and habilitative services and devices	Services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills
Laboratory services	Testing of blood, tissues, etc., from a patient to help diagnose a medical condition and monitor the effectiveness of treatment
Preventive and wellness services and chronic disease management	Preventive or wellness services including routine physicals, screenings, and immunizations; chronic disease management as an integrated approach to managing an ongoing condition, like asthma or diabetes
Pediatric services, including oral and vision care	Physician and other health care services provided to children

3.1.3.5 Health Plan Categories

To assist consumers and employers with selecting health coverage options, the Affordable Care Act defines five categories of health plans. These categories indicate the estimated percentage of a consumer's health care costs that a plan will cover. This estimate takes into account the plans' monthly premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums. While these metal "tiers" can help consumers determine which type of plan may be right for them based on their anticipated health care needs, it is important to remember that the actual percentage a consumer will pay in total or per service will depend on the services the consumer uses during the year, and may not precisely reflect the estimate reflected by their plan's category.

For example, for plans in the Bronze category, if a consumer's medical treatment costs $100, the Bronze plan covers approximately 60%, or $60, of that cost (assuming that the consumer has met their deductibles and does not have any copays). The consumer is then responsible for $40 in out-of-pocket expenses for that treatment. The five health plan categories are:

- **Bronze Health Plans:** Insurance company pays approximately 60% of covered medical expenses. The consumer pays approximately 40%.
- **Silver Health Plans:** Insurance company pays approximately 70% of covered medical expenses. The consumer pays approximately 30%.
- **Gold Health Plans:** Insurance company pays approximately 80% of covered medical expenses. The consumer pays approximately 20%.
- **Platinum Health Plans:** Insurance company pays approximately 90% of covered medical expenses. The consumer pays approximately 10%.
- **Catastrophic Health Plans:** Health plans that meet all of the QHP requirements, but cover only three primary care visits each year until consumers meet plan deductibles. To qualify, consumers must be under 30 years of age or receive a hardship exemption.

3.1.3.6 Individual Shared Responsibility Payment

The Affordable Care Act requires applicable taxpayers to take responsibility for their own health coverage by maintaining minimum essential coverage (MEC) or making a shared responsibility payment. If consumers do not maintain MEC beginning January 1, 2014, they may have to make an individual shared responsibility payment through their annual federal income tax returns. Consumers can apply for certain exemptions from the shared responsibility payment, either through the Marketplace or through the tax filing process.

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

- Enrolling in any Marketplace plan
- Maintaining an existing insurance plan that meets the MEC definition
- Enrolling in an employer-sponsored plan (including COBRA), with or without "grandfathered" status and retiree health plans
- Enrolling in a public health care program, such as Medicare (Parts A and C), Medicaid, CHIP, or TRICARE (for current service members and military retirees, their families, and survivors)
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before December 31, 2014
- Other health plans designated as MEC by the Secretary of Health and Human Services

Some benefits, such as dental coverage, workers' compensation, or disability insurance, do not satisfy the requirement to maintain MEC for consumers.

3.1.3.7 Exemptions

If individuals don't maintain minimum essential coverage, they must qualify for an exemption to avoid paying the shared responsibility payment. To qualify for an exemption, a consumer has to meet one of the following conditions:

- Member of a recognized religion that is opposed to accepting health insurance benefits, including Social Security and Medicare
- Not lawfully present in the United States (U.S.)
- Member of a federally recognized tribe or eligible for services through an Indian Health Services provider
- Member of a recognized health care sharing ministry
- Have a short coverage gap (lacked minimum essential coverage for fewer than three consecutive months during the year)
- The premium for the lowest-priced Bronze plan available in the Marketplace (after any applicable advance payments of the premium tax credit [APTC] has been applied) would cost more than 8% of household income
- Currently incarcerated, and not awaiting the disposition of charges
- Under a hardship that prevents them from obtaining health coverage, including cancellation of the consumer's current plan by the health insurance company and other available coverage is unaffordable
- Have household income that is below the threshold required for filing an annual tax return

Consumers may seek an exemption either through the Marketplace or by claiming an exemption during the tax filing process on their federal income tax return, depending on the exemption category. Although consumers may submit applications for more than one exemption, only one exemption is required to excuse consumers from the obligation to purchase health coverage or pay a fee. Appendix A: Exemptions Information, lists the exemptions that consumers may apply for through the Marketplace and/or through the tax filing process.

3.1.3.8 Employer Shared Responsibility Payment

The Affordable Care Act establishes that certain employers must offer health coverage to their full-time employees or a shared responsibility payment may apply.

For 2015 and after, employers employing at least a certain number of employees (generally 50 full-time employees or a combination of full-time and part-time employees that is equivalent to 50 full-time employees) will be subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (added to the Code by the Affordable Care Act). As defined by the statute, a full-time employee is an individual employed on average at least 30 hours of service per week. An employer that meets the 50 full-time employee threshold is referred to as an applicable large employer.

Under the Employer Shared Responsibility provisions, if these employers do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees (and their dependents), the employer may be subject to an Employer Shared Responsibility payment if at least one of its full-time employees receives a premium tax credit for purchasing individual coverage on one of the Individual Marketplaces.

4.0 Individual Marketplace Education

This section contains important information you can use to educate consumers who want to explore health coverage options and know if they are eligible to sign up for an Individual Marketplace QHP and if they will qualify for financial assistance.

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

- Live in a state served by the Marketplace in which they are applying
- Are a U.S. citizen, national, or lawfully present
- Are not currently incarcerated (unless pending disposition of charges)

4.1 Eligibility Requirements for Insurance Affordability Programs

If consumers are interested in programs to help lower their costs, the Marketplace determines consumers' eligibility to purchase a QHP through the Marketplace and determines or assesses consumers' eligibility for:

- Medicaid
- CHIP
- Advanced payment of the premium tax credit (APTC)
- Cost-sharing Reductions (CSRs)

4.1.1 Eligibility for Medicaid and CHIP

4.1.1.1 Medicaid

Medicaid is a health coverage program for low-income families; children; pregnant women; the elderly; individuals with disabilities; and, depending on the state, other adults. Medicaid pays for the medical costs of individuals who have limited incomes and meet other state-specific requirements. Under the Affordable Care Act, some states have expanded their Medicaid programs to cover a greater number of people, including non-disabled, childless adults with incomes below 133% of the federal poverty level (FPL).

Some states have not expanded their Medicaid programs to cover additional population groups. In these states, the income limits to be eligible for Medicaid for adults are more restrictive than those states that expanded Medicaid. Individuals who are determined ineligible for Medicaid solely because their states have not expanded Medicaid under the Affordable Care Act are eligible for exemptions from the individual shared responsibility payment. These individuals should submit the notice of denial of eligibility for Medicaid with their exemption form.

Lawfully residing immigrants who wish to enroll in Medicaid are subject to additional requirements related to their immigration status. For example, lawfully residing immigrants who are lawfully present in the U.S. may be subject to a five-year waiting period before they can be eligible for Medicaid, assuming they meet all other eligibility requirements.

To determine most consumers' eligibility for Medicaid and CHIP, modified adjusted gross income (MAGI) is used. MAGI, which is calculated on a monthly basis for Medicaid and CHIP,

is the adjusted gross income (AGI) on consumers' federal income tax returns, plus any excluded foreign income, nontaxable Social Security benefits (including tier 1 railroad retirement benefits), and tax-exempt interest received or accrued during the taxable year. MAGI does not include Supplemental Security Income (SSI).

4.1.1.2 CHIP

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

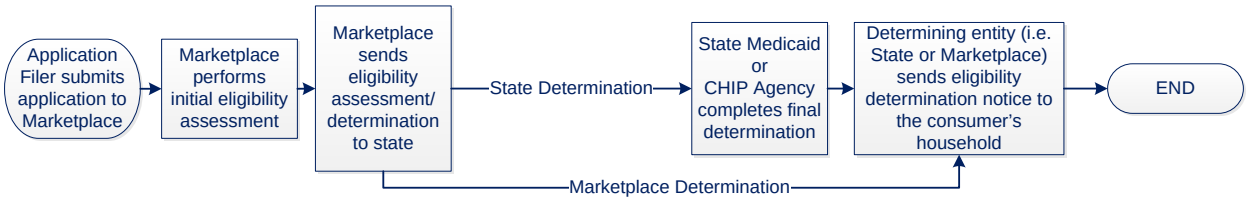
4.1.1.3 Medicaid and CHIP Eligibility Determination Process

Some states allow the Marketplace to determine consumers' eligibility for Medicaid and CHIP, while others only allow the Marketplace to assess consumers' eligibility for these programs. Depending on the state in which consumers live, consumers will receive one of the following results related to their Medicaid/CHIP eligibility determination or assessment:

- **Assessed as Potentially Eligible:** The Marketplace makes an initial decision that consumers are *potentially* eligible for Medicaid or CHIP. The Marketplace will then transfer these consumers' information to their state Medicaid or CHIP agencies for a *final* determination of eligibility. Once final determinations of eligibility have been made, their state agencies will send these consumers eligibility determination notices.
- **Determined Eligible:** The Marketplace makes final determinations of consumers' eligibility for Medicaid or CHIP. The Marketplace then transfers the determination information for these consumers to their state Medicaid or CHIP agencies. Consumers will receive eligibility determination notices from the Marketplace, but their state Medicaid or CHIP agencies will follow up with eligible consumers about how to access their benefits.

Exhibit 3 illustrates the Medicaid or CHIP eligibility determination process.

Exhibit 3 – Medicaid or CHIP Eligibility Determination Process



4.1.2 Eligibility for the Premium Tax Credit and Cost-Sharing Reductions

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

- **Premium Tax Credit (or Advance Payments of the Premium Tax Credit (APTC) if the consumer chooses to use to lower their monthly premium):** The premium tax credit is a refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the Marketplace. Eligible consumers can choose to have the credit paid in advance (APTC) to their insurance company to lower their monthly premium or they can claim all of the credit when they file their tax return for the year. Family size, household income, and the cost of the second lowest cost Silver plan available determine premium tax credit eligibility. Consumers' household incomes must fall between 100% and 400% of the FPL to be eligible for a premium tax credit.[4]

  Advance payments of the premium tax credit are reconciled during the annual tax filing process. That means, if a consumer's household income increases over the course of the year, the consumer may be required to repay the excess APTC when filing the federal income tax return. Conversely, if a consumer's household income decreases, he or she may be eligible for a larger premium tax credit in the form of a refund when filing taxes. The Marketplace will provide documentation to tax filers and to the Internal Revenue Service (IRS) to support this process. If consumers request the APTC, they must file annual federal income tax returns. If consumers are married, they must file joint tax returns with their spouses to be eligible for premium tax credits for that year.(Note: Certain victims of domestic abuse and spousal abandonment [5]are able to claims the premium tax credit using the Married Filing Separately filing status. Taxpayers may claim this relief from the joint filing requirements for no more than three consecutive years.)

- **Cost -sharing Reductions (CSRs):** A program that lowers consumers' out-of-pocket costs for health benefits (e.g., deductibles, copayments, and coinsurance) received through QHPs purchased through the Marketplace. Consumers must be eligible for APTCs to be eligible for CSRs. There are different variations of CSRs based on projected annual household income and family size. Each health insurance company provides different level of cost-sharing reductions for different essential health benefits, based on its specific health plan design. Consumers who are eligible for CSRs can review the cost-sharing reductions when they compare their available health plan options on the Marketplace. In general, to be eligible for CSRs, consumers must have household incomes less than or equal to 250% of the FPL, receive or be eligible to receive the APTC, and enroll in Silver-level plans through the Marketplace. American Indians/Alaska Natives with household incomes up to 300% of the

[4] Lawfully present individuals who are subject to the five-year waiting period to enroll in Medicaid are eligible, even if their income is below 100% FPL.

[5] Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or other family member living in the household may constitute abuse of the victim.

A taxpayer is a victim of spousal abandonment for a taxable year if, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence.

FPL are eligible to enroll in plans with zero cost-sharing or limited cost-sharing plan at any metal levels and do not have to be eligible for APTCs.

When determining eligibility for APTCs and CSRs, remind consumers to report all forms of household income (except for Supplemental Social Income) and any changes in their household income to the Marketplace. Consumers are prohibited from falsifying their household income information. To help consumers understand the difference between the PTC, APTC and CSRs, review Exhibit 4 with them and explain that they may be eligible to receive both options to lower their health insurance costs.

Exhibit 4 – Advance Payments of the Premium Tax Credit vs. Cost-Sharing Reductions

APTC	Cost-Sharing Reductions
• Consumers can use their APTCs to lower their monthly premiums. • The Marketplace determines eligibility for the APTC and the amount allowed. • Any premium tax credit paid on an advance basis is reconciled at the end of the year, so consumers could be required to return excess APTCs (if their household incomes go up) or receive refunds (if their household incomes go down). • Consumers can adjust the amount of their APTCs (up to the maximum allowed) at the time of plan selection. • To receive a premium tax credit, consumers must file annual tax returns at the end of the year.	• CSRs limit consumers' out-of-pocket costs (i.e., deductibles, coinsurance, and copayments). • The Marketplace determines eligibility for CSRs. • In general, consumers found eligible for CSRs must enroll in plans with a Silver level of coverage. • American Indians/Alaska Natives with household incomes up to 300% FPL are eligible to enroll in plans with zero cost-sharing.

4.2 ENROLLMENT

Once consumers are determined eligible to purchase QHPs through the Marketplace, they can see what help they're eligible for in lowering their costs if they applied for insurance affordability programs, select plans, and make premium payments directly to their selected health insurance companies. Consumers who are eligible for Medicaid or CHIP can complete the enrollment process for Medicaid or CHIP through their state agencies.

4.2.1 Open Enrollment Period

Consumers in the Individual Marketplace may enroll in QHPs during the annual Open Enrollment period. The Open Enrollment period for 2015 coverage is November 15, 2014, to February 15, 2015.

- If consumers have not enrolled in coverage by February 15, 2015, they generally cannot buy Marketplace health coverage for 2015 until the next Open Enrollment period for coverage for the following year (unless they are eligible for a special enrollment period, as discussed below).

- If consumers are enrolled in a 2014 Marketplace plan, their benefit year ends December 31, 2014. To continue health coverage in 2015, they can renew their current health plan (if it remains available) or choose a new health plan through the Marketplace during the 2015 Open Enrollment period.
- Consumers have to enroll in a plan by December 15, 2014 to ensure coverage by January 1, 2015, so they do not have a gap in coverage.
- If consumers do not enroll in coverage by February 15, 2015, do not otherwise have health coverage that qualifies as minimum essential coverage, and are not exempt from the individual responsibility payment, they may have to pay a fee that increases every year.
- In 2015, consumers who do not maintain minimum essential coverage or receive an exemption will be responsible for a yearly fee of 2% of their annual income or fixed fee for each uninsured adult and child ($325 per adult; $162.50 per child). Consumers will pay the higher of the two fees as part of their annual federal income taxes.

Consumers who have coverage for only part of the year will only be responsible for paying a portion of the annual fee. The exact amount will be calculated based on the number of months that consumers don't have health coverage. Consumers will not be responsible for paying a fee if they are uninsured for fewer than three consecutive months in a given calendar year.

4.2.2 Special Enrollment Periods

After the annual Open Enrollment period ends, consumers can enroll in QHPs through the Marketplace only if they experience a qualifying circumstance. The Marketplace will consider consumers' circumstances and determine whether consumers are eligible for special enrollment periods.

Examples of circumstances that may qualify consumers for special enrollment periods include:

- Marriage
- Having a baby, adopting a child, or placing a child for adoption or foster care.
- Moving residences, gaining citizenship, or leaving incarceration.
- Losing certain other health coverage—due to losing job-based coverage, the end of an individual policy plan year in 2014, COBRA expiration, aging off a parent's plan, losing eligibility for Medicaid or CHIP, and similar circumstances.
  - It is important to note that voluntarily ending coverage or losing coverage other than the specified types does not qualify a consumer for a special enrollment period.
- For people already enrolled in Marketplace coverage, having a change in household income or family size that makes them newly eligible or ineligible for premium tax credits or a change in eligibility for CSRs.
- People who are American Indians, Alaska Natives, or who are members of federally recognized Indian tribes and Alaska Native Corporation shareholders can sign up for or change plans once per month throughout the year.

Consumers who believe they've experienced qualifying circumstances can report these changes in one of two ways:

- **Online:** Consumers should log into their Marketplace accounts, select their applications, and then select "Report a life change" from the menu on the left.
- **By Phone:** Contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Consumers will then receive eligibility determination notices that state if they qualify for special enrollment periods. If consumers are eligible for special enrollment periods, in most cases, they have 60 days from the associated qualifying circumstances to apply for health coverage through the Marketplace.

4.2.3 Enrollment Process

You will help consumers complete some, or all, of the following steps so that they can obtain health coverage through the Marketplace for which they're eligible.

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

4.2.4 Enrolling With Electronic Application vs. Paper Application

Once consumers create their online accounts, they can begin filling out eligibility applications online. The electronic application available online will allow consumers to make real-time updates to their eligibility applications. Assisters should be ready to help consumers complete and submit applications in either the electronic or paper form. Exhibit 5 details the additional benefits of using electronic applications as opposed to paper applications. The Marketplace encourages the use of electronic applications when at all possible as the electronic application allows for "near real-time" verification of a consumer's information to facilitate a quicker eligibility determination notification and plan selection and enrollment process.

insurance companies or to learn more about other methods of submitting premium payments. Consumers have the option to pay immediately or request bills to be sent. Health insurance companies must accept various forms of payment from consumers including:

- Paper checks
- Cashier's checks
- Money orders
- Electronic fund transfers
- General purpose pre-paid debit cards
- Credit cards

Consumers should make sure they understand their health insurance companies' specific payment requirements and deadlines to ensure they follow the companies' payment policies.

4.3.2 Cancellation and Termination of Coverage

Cancellation of Coverage

Cancellation is a specific type of termination action that ends a qualified individual's enrollment on the date coverage became effective, resulting in coverage never having been effective with the QHP. Cancellation of health coverage can happen when consumers choose to end coverage before coverage has been effectuated. Coverage has been effectuated once premium payments have been made and the effective date of coverage has passed. Coverage can also be cancelled in certain other circumstances, such as where consumers commit fraud.

If consumers wish to cancel their coverage *before* their plans' effective dates of coverage, they may do so through their Marketplace accounts. Cancelling coverage after a plan's effective date of coverage is only possible in situations where the insurance company has allowed for premium payment after the effective date of coverage. If the coverage effective date has passed and the premium has been paid, cancellation is not an option; consumers may prospectively terminate coverage instead (as discussed below).

Consumers may choose to cancel coverage for any reason, including:

- Consumers who no longer want or need coverage through the Marketplace.
- Consumers wish to cancel current coverage and select different, available QHPs. (Note that consumers may cancel their chosen QHPs and re-enroll in different, available QHPs as many times as they choose during an Open Enrollment period or special enrollment period.)

Health insurance companies offering QHPs through the Marketplace may also cancel coverage if consumers fail to pay their first month's premiums by the specified deadline. After selecting QHPs, consumers should consult their insurance companies' websites to learn about company-specific payment requirements and deadlines to ensure the consumers follow their companies' payment policies.

Termination of Coverage

A termination is an action taken after a coverage effective date that ends an enrollee's coverage through the Marketplace for a date after the original coverage effective date, resulting in a period

during which the individual was covered by the health insurance company Termination of health coverage can occur when consumers choose to end coverage after coverage has been effectuated. Coverage has been effectuated once premium payments have been made and the effective date of coverage has passed.

If consumers wish to terminate their coverage, they may do so through their Marketplace accounts. Consumers can select the desired end date for their coverage, generally with a minimum of 14 days between submission of a termination request and termination of coverage. Consumers should be aware that their termination of coverage will result in termination of coverage for all enrollees in an enrollment group (e.g., family) and for all plans in which members of that enrollment group are enrolled (e.g., QHP, qualified dental plan). If a consumer wants to remove only one or more family member from coverage, the consumer must do so through reporting a life change in their application. The life change option then allows the consumer to designate which family member no longer needs coverage.

Consumers may choose to terminate coverage for any reason. For instance, a consumer may begin a new job which provides minimum essential coverage and no longer needs to buy an individual Marketplace plan, or is newly eligible for Medicare, or the consumer is newly qualifies for QHP coverage. Health insurance companies offering QHPs through the Marketplace may also terminate coverage due to consumer fraud or a consumer's failure to make their premium payments.

Grace Period

If consumers don't pay the monthly premium payments for their QHPs in full, their health insurance companies could terminate the plan coverage, as provided under state law. However, the Marketplace has rules in place that give consumers with outstanding premiums a short period of time to pay before their insurance companies can terminate QHP coverage. This short period of time is called a "grace period" and its duration varies, depending on whether consumers are receiving APTCs or not.

Under the rules, QHP issuers must:

- Provide consumers who receive APTCs and who have previously paid at least one full month's premium during the benefit year a three-month grace period, per 45 CFR 156.270(d)
- Grant consumers who do not receive APTCs a grace period in accordance with state rules, per 45 CFR 155.430(d)(5). Assisters and consumers may want to contact their State DOIs for more information on grace periods based on state rules.

4.4 Eligibility Appeals

The Marketplace allows consumers to request an appeal of the following:

- Eligibility or redetermination of eligibility to purchase a Marketplace QHP
- Eligibility for a special enrollment period (SEP)
- Eligibility or redetermination of eligibility for advance payments of the premium tax credit or cost-sharing reductions, or the amount of advance payments of the premium tax credit or cost-sharing reductions for which consumers are deemed eligible

- Eligibility for an exemption from the individual shared responsibility payment
- Eligibility for Medicaid or CHIP[6]
- Marketplace, Medicaid or CHIP applications that have not been acted on with reasonable promptness

Consumers should be aware that they may be granted eligibility while an appeal is in process, as long as they meet certain qualifications specified by the Marketplace or their state Medicaid or CHIP agencies. Consumers can accept or waive these benefits while the appeal is pending. If consumers accept the benefits during the appeals process, they may need to repay the benefits if the appeal decision states that they were not eligible for the benefits they accepted.

Consumers who were determined eligible by the Marketplace to enroll in a QHP and are appealing their eligibility for advance payments of the premium tax credit and/or cost-sharing reductions may enroll in a QHP to get coverage even while their appeal is pending. If on appeal, it is found that the contested eligibility determination was incorrect, consumers will have the option to have their eligibility for advance payments of the premium tax credit and/or cost-sharing reductions implemented retroactively.

When consumers have their eligibility redetermined by the Marketplace, they may accept eligibility pending appeal. This would allow them to remain eligible for enrollment in a QHP or eligible for advance payments of the premium tax credit and cost-sharing reductions at the level of eligibility in effect prior to the redetermination. However, if they do not prevail in their appeal, they may be required to repay the benefits they received while their appeal was underway.

4.5 RE-ENROLLMENT

Consumers in the Federally-facilitated Marketplace will receive notices from the Marketplace before the start of Open Enrollment which will explain the renewal and reenrollment process and the process to ensure consumers confirm if they qualify for additional financial assistance and confirm their plan selection. Consumers will also receive notices from their insurance company about their 2015 plan, their new 2015 premium, and the amount they may save on their monthly bill with an APTC.

As part of the renewal process in the Federally-facilitated Marketplace, generally, if consumers do nothing, they will be auto-enrolled in the same plan with the same APTC and other financial assistance, if applicable, as the 2014 plan year. However, consumers are strongly encouraged to return to the Marketplace to update their information to make sure they are getting all the financial assistance they qualify for, and to shop for or confirm the plan that best suits their

[6] Alabama, Arkansas, Idaho, Louisiana, Montana, New Jersey, Tennessee, and Wyoming have delegated authority to the Marketplace to make Medicaid eligibility determinations and conduct Medicaid appeals for populations whose income is determined using modified adjusted gross income (MAGI). For all Medicaid appeals in these states, consumers have the right to submit their Medicaid appeal to: (1) the Marketplace Appeals Entity, if they originally submitted their application to the Marketplace; or (2) their state Medicaid agency. Appeals submitted to the state Medicaid agency will be heard by a hearings officer in the state. Appeals submitted to the Marketplace will be coordinated with any related appeals of advance payments of premium tax credits or cost-sharing reductions.

needs. If consumers do not come back to the Marketplace to update their information, the Marketplace will not recalculate the financial assistance available to the consumer for the next year. Consumers whose 2013 tax return indicates that they had very high income, or who did not give the Marketplace permission to check updated tax information for annual eligibility redetermination purposes will get auto-enrolled without financial assistance if they do not return to the Marketplace.

Appendix A: Exemptions Information

Exhibit 10 outlines the different types of exemptions. As an Assister, you can use this chart to help consumers identify which exemptions to apply for, what documentation is needed for exemption applications, which exemption application form should be used for submission, and how to claim their exemptions depending on the exemption type.

Exhibit 10 – Exemptions Information

Type of Exemption: Membership in a health care sharing ministry			
When to Use This Exemption	**Information Consumers Need When Applying for Exemption**	**Link to Exemption Application**	**How to Claim Exemption**
Use this exemption application if consumers and/or anyone in their tax households is/was a member of a health care sharing ministry that's recognized by the Marketplace. A health care sharing ministry is an organization whose members share a common set of ethical and religious beliefs and share medical expenses among themselves in accordance with these beliefs.	• Name and address of the health care sharing ministry of which they are a member • SSNs, if consumers have them • Information about people in their tax household	Application for Exemption from the Shared Responsibility Payment for Members of a Health Care Sharing Ministry	Marketplace exemption application or claim on federal tax return

Exhibit 10 – Exemptions Information (continued)

Type of Exemption:	Membership in a federally recognized Indian tribe or eligibility for services through an Indian health care provider

When to Use This Exemption	Information Consumers Need When Applying for Exemption	Link to Exemption Application	How to Claim Exemption
Use this exemption application if consumers and/or anyone in their tax household is: • A member of a federally recognized Indian tribe; or • Eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations.	• Documents showing membership in a federally recognized Indian tribe or eligibility for services from the Indian Health Service, a tribal health care provider, or an urban Indian health care provider • SSNs, if they have them • Information about people in their tax household	Application for Exemption for American Indians and Alaska Natives and Other Individuals who are Eligible to Receive Services from an Indian Health Care Provider	Marketplace exemption application or claim on tax return

Type of Exemption:	Incarceration

When to Use This Exemption	Information Consumers Need When Applying for Exemption	Link to Exemption Application	How to Claim Exemption
Use this exemption application if a consumer and/or anyone in their tax household is/was incarcerated (detained or jailed), other than being held pending disposition of charges.	• Documents showing the name and address of the facility where the consumer was incarcerated, and the time periods of incarceration • SSNs, if they have them • Information about people in their tax household	Application for Exemption from the Shared Responsibility Payment for Individuals who are Incarcerated (Detained or Jailed)	Marketplace exemption application or claim on tax return

Exhibit 10 – Exemptions Information (continued)

Type of Exemption: Coverage being unaffordable			
When to Use This Exemption	**Information Consumers Need When Applying for Exemption**	**Link to Exemption Application**	**How to Claim Exemption**
Use this exemption application if a consumer's required contribution for coverage exceeds 8% percent of the individual's household income.	• SSNs, if they have them • Employer and income information for everyone in their family • Information about any job-related health insurance available to their family • Proof of yearly income for 2014 (examples of documents are found in the exemption application)	Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in a State with a Federally Facilitated Marketplace	Marketplace exemption application or claim on tax return

Type of Exemption: Membership in a recognized religious sect whose members object to insurance			
When to Use This Exemption	**Information Consumers Need When Applying for Exemption**	**Link to Exemption Application**	**How to Claim Exemption**
Use this exemption application if consumers and/or anyone in their tax household is/was a member of an approved religious sect or division described in section 1402(g)(1) of the Internal Revenue Code, and an adherent of established tenets or teachings of such sect or division.	• Name and address of their religious sect • SSNs, if they have them • Copy of an approved IRS Form 4029 (Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits), if they have one	Application for Exemption from the Shared Responsibility Payment for Members of Recognized Religious Sects or Divisions	Marketplace exemption application

Exhibit 10 – Exemptions Information (continued)

Type of Exemption: Hardship exemption			
When to Use This Exemption	**Information Consumers Need When Applying for Exemption**	**Link to Exemption Application**	**How to Claim Exemption**
Use this exemption application if consumers and/or anyone in their tax household have experienced a hardship There are multiple types of categories of hardship exemptions. Eligibility will depend on particular facts and circumstances for each hardship category, with respect to the capability to obtain coverage under a qualified health plan.	• SSNs, if they have them • Information about people in their tax household • Documents that support their claim of hardship (see page 1 of the hardship exemption application). * Note: If consumers can't obtain documents to support hardship, call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.	Application for Exemption from the Shared Responsibility Payment for Individuals who Experience Hardships	Marketplace exemption application

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For detailed definitions of these Marketplace terms and others, see the Glossary on HealthCare.gov.