



Wisconsin Office of the
COMMISSIONER
OF INSURANCE

Affordable Care Act for Navigators & CACs

Our Mission

The mission of the Office of the Commissioner of Insurance is to **protect and educate Wisconsin consumers by maintaining and promoting a strong insurance industry.**



Key Navigator Information

- Navigators are licensed by OCI under Ch. 628 subchapter V Wisconsin Statutes and ss. Ins 6.91 to 6.99 Wis. Admin. Code.
<https://oci.wi.gov/Pages/Agents/NavigatorLicense.aspx>
- Complete federal training for navigators and assisters -
<https://marketplace.cms.gov/>.
- Upon successful passage of the navigator examination, individual navigators are required to submit Wisconsin Navigator application and fingerprints.



Key Certified Application Counselor Information

- CACs are regulated by OCI under Ch. 628 subchapter V Wisconsin Statutes and ss. Ins 6.91 to 6.99 Wis. Admin. Code.
<https://oci.wi.gov/Pages/Agents/NavigatorLicense.aspx>
- CACs are not licensed by OCI. Complete prelicensing training, pass the navigator examination, and complete the federal training -
<https://marketplace.cms.gov/>.
- The navigator or assister organization the CAC work with shall submit the registration form to OCI. The individual CAC does not submit anything to OCI and does not need to be fingerprinted. The certification form that the CAC receives is provided by the CAC organization.





Wisconsin Office of the **COMMISSIONER OF INSURANCE**



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Navigator License and Certified Application Counselor Registration

Last Updated: February 19, 2021

Individual Navigators



Navigator Entities



Navigator Licensing Requirements

- 18 years of age
- Resident of Wisconsin
- Completion of pre-licensing training
- Completion of federal training requirements
- Pass the written examination
- Fingerprinting and background check
- Affiliated with a navigator entity



Polling Slide #1

- Which of the following is NOT a Navigator Licensing requirement:
 - A. Be fingerprinted and receive a background check
 - B. Be appointed with an insurance company
 - C. Be a resident of Wisconsin
 - D. Be affiliated with a navigator entity



Licensed Agents as Navigators

- Currently licensed insurance agents with accident and health lines of authority may apply to work as a navigator.
- Licensed agents cannot have active appointments with health insurers
- Licensed agents cannot receive commission from the health insurance company.



Initial Application Requirements -Navigators

- <https://oci.wi.gov/Pages/Agents/NavigatorLicense.aspx>
- Initial Application Requirements for Navigators:
 1. Complete 16 hours of accident and health prelicensing. Courses are available on the OCI website.
 2. Complete federally mandated training required under the federal health care exchange.
 3. Schedule and pass a navigator exam through the PSI website at home.psiexams.com. Exam fee is \$75.
 4. Submit fingerprinting through www.fieldprintwisconsin.com. Use Fieldprint code FPWIOCIINSURANCE.
 5. Submit Individual Navigator Application.



Navigator License Renewal

Requirements for Renewing Your Navigator License

1. Complete 8 hours of accident-and-health-specific continuing education. Eligible conference sessions will count toward CE credit.
 2. Complete any federally mandated training required under the federal health care exchange and provide evidence of training to OCI.
 3. Must be affiliated with a Navigator Business Entity.
 4. Submit your renewal application online at www.nipr.com.
 5. Renewal fee is \$35.00 + NIPR processing fee.
- Supporting documentation and inquiries can be sent to email to ociagentlicensing@wisconsin.gov.
 - Additional guidance can be found at <https://oci.wi.gov/Pages/Agents/NavigatorLicense.aspx>.



Initial Application Requirements - Assistors

- <https://oci.wi.gov/Pages/Agents/NavigatorLicense.aspx>
- **Registration Requirements for CACs:**
 1. Complete 16-hour prelicensing training requirement which can be in accident and health or navigator-specific training. Courses that are available on the OCI website. CACs should retain a copy of the documentation demonstrating successful completion of the prelicensing requirement for their own records.
 2. Complete any federally mandated training required under the federal health care exchange for CACs.
 3. Schedule and pass a navigator exam through the PSI website at home.psiexams.com. Exam fee of \$75.
 4. Provide evidence of certification with an organization (entity) designated by the federal exchange as a CAC organization.
 5. Organization CAC is affiliated with will notify OCI with your name.
 6. Certified application counselors must be registered with OCI by contacting ocialdocuments@wisconsin.gov.



Certified Application Counselors

- Complete pre-licensing training
- Complete any mandatory federal training
- Pass the navigator examination
- Be affiliated with, or supervised by, a registered Nonnavigator Assister Entity. This entity is responsible to register the individual CAC with the OCI.
- CACs do not receive a license or certificate from OCI.
- Complete 8 credits of continuing education training each year



Navigator and CAC Permitted Practices

- Public education
- Distribute fair and impartial information
- Plans available on and off the exchange
- Facilitate enrollment in a QHP
- Describe the features and benefits of plans
- Provide information about provider networks, metal tiers
- Referrals to appropriate state/federal agency



Navigator Prohibited Practices

- Cannot receive compensation from an insurer
- Provide information about plans off exchange
- Recommend one plan over another
- Engage in deceptive acts or unfair methods of competition
- Disclose personally identifiable information, health information and financial information.



Navigator Examination

- Total of 35 questions:
 - 10% Affordable Care Act (4 items)
 - 15% Basic Health insurance concepts (5 items)
 - 10% Health insurance exchange under the ACA (5 items)
 - 10% Navigators and Non-navigator (3 items)
 - 5% Brokers, Agents and Producers (3 items)
 - 15% Public Assistance Programs (3 items)
 - 15% Wisconsin Insurance Statutes, Rules and Regulations Common to Life, Disability (A&H), Property & Casualty Insurance (5 items)
 - 20% Wisconsin Insurance Statutes, Rules and Regulations pertinent to Disability (A&H insurance) (7 items)



Navigator and CAC FAQ's

- Examination - Register online through our website at home.psiexams.com
- Fee is \$75.00
- Examination – Bring pre-licensing course certificate
 - 800 733-9267
 - CE@psionline.com
- OCI Agent Licensing Questions
 - 800 236-8517 or 608 266-8699
 - ociagentlicensing@wisconsin.gov



2024 Open Enrollment Timeframe

- Open enrollment is the annual timeframe during which consumers can purchase individual health insurance plans, either on or off the federal Exchange
- November 1, 2023 through January 15, 2024
- Plans sold during open enrollment period would have an effective date of January 1 of the follow year if purchased before December 15, 2023
- Plans sold after December 15, 2023 will have an effective date of February 1, 2024
- Outside the Open Enrollment Period, a person generally can enroll in a health insurance plan only if s/he qualifies for a Special Enrollment Period (SEP)



Open Enrollment: SEPs

- Special Enrollment Periods (SEPs) are available for individuals to enroll outside of the open enrollment period
 - Examples:
 - Loss of coverage thru loss of employment or divorce/legal separation
 - Change in residence
 - No longer eligible for Medicaid
 - Newly obtained citizenship
 - Life event
 - Birth, marriage, adoption or child placed in foster care



2024 Open Enrollment: Plan Options

- WI has a very competitive individual health insurance market with 14 insurers offering plans on Exchange in 2023.
- On Exchange issuers must offer their plans off Exchange as well, so those same insurers plus 1 additional are offering plans available in the individual market off Exchange
- OCI has an interactive map on its Web site, including names and contact information for insurers offering coverage throughout the state:
 - <https://oci.wi.gov/Pages/Consumers/FindHealthInsurer.aspx>



Polling Slide #2

- Special Enrollment Periods are available for individuals when they:
 - A. Are no longer eligible for Medicaid
 - B. Receive a promotion at work
 - C. Find an insurance plan that they like better
 - D. Want to change their primary care doctor



Insurance Contracts

- Laws apply to policies sold in Wisconsin
- Notice to agent is notice to insurer
- Insurer bound by acts of the agent within scope of apparent authority
Representations – oral and written statements by applicant
- Privacy protections
- Right to file a complaint with Commissioner of Insurance



Insurance Contracts cont.

- Notice of claim
- Prompt settlement of claims
- Effect of a mistake in an insurance contract
- Unfair claim settlement practices
- Right to Return policy
- Grace periods
- Grievances
 - Internal Grievance procedure
 - Independent review



Health Insurance

- Principles of insurance
 - Definition of risk
 - Pooling concept
 - Types of insurance companies
- Contract law
 - Elements of a contract
 - Unique aspects of health insurance contracts



BREAK



Mandated Benefits 1 of 2

- Disabled children
- Home health care
- Skilled nursing care
- Kidney disease and transplants
- Coverage for newborns
- Adopted children
- Coverage for grandchildren
- Diabetic supplies and equipment
- Maternity benefits
- Mammograms
- Drugs for Treatment of HIV



Mandated Benefits 2 of 2

- Hearing aids and cochlear implants
- Contraceptives and services
- Cancer clinical trials
- Dependents (children)
- Mental Health (group contracts)
- Lead Poisoning Screening
- Temporomandibular joint disorders (TMJ)
- Breast reconstruction
- Anesthesia for dental care
- Immunizations for children
- Autism spectrum disorders
- Student on medical leave



Contingent Mandated Benefits

- Prescription Eye Drops
- Oral or injected chemotherapy
- Colorectal cancer screening
- Nurse practitioners
- Optometrists
- Chiropractic benefits
- COVID 19 testing



Marketing Practices

- Advertising rules
 - Advertisements must be truthful and not misleading
 - No disparaging statements
- Unfair marketing practices
 - Unfair inducements
 - Unfair discrimination
 - Misrepresentation
 - Unfair restraint of competition
 - Extra charges (if not disclosed and agreed)
 - Undue influence
 - Unfair use of official position
- Home solicitation and sales



Polling Slide #3

- The following are examples for Unfair Marketing Practices:
- A. Misrepresentation
- B. Unfair Inducements
- C. Undue Influence
- D. All of the above



Marketing Methods and Practices

- Insurer/agent are responsible for the suitability of sale
- Agents are appointed by an insurer to represent the insurer in sales and marketing. As a result of appointment, the insurer is bound by the acts of its agents.
- Agent compensation. Typically, commission fees are paid by the insurer.



Short-term Limited Duration (STLD)

- A type of health insurance coverage that was originally designed to fill temporary gaps in coverage that occur when a person transitions from one plan to another.
- Not Qualified Health Plan under the ACA
- Do not qualify for ACA subsidies
- Loss of a STLD plan does not trigger a SEP on the ACA marketplace

- Application fees when solicited by associations
- Limited authority over out-of-state Association plans



Healthcare Sharing Ministries (HCSMs)

- By definition, HCSMs are **not insurance**
- There are specific requirements charitable & religious associations must comply with. (Wisconsin Statute § 600.01 (b) 9.)
- Organizations meeting all the requirements are exempt from the requirements set forth in the insurance statutes and regulations.
- States potentially have regulatory authority if it is determined that the organization is not exempt – i.e. if it is doing the business of insurance



Federal Health Insurance Exchanges

- The ACA was based upon a premise that states would create a state-based exchange and the federal exchange would be the fall back. For many reasons, including IT costs and short time frame to set up an Exchange only a few states initially set up a state-based exchange.
- Private exchange is not the same thing as the state-based, partnership or federal exchange. Private exchange is an exchange set up by an employer for employees to select health and other benefits typically funded by the employer or self-funded employer plan.



Qualified Health Plans for the ACA

- Qualified Health Plans (QHPs) are insurance plans:
 - Certified by the Federal Health Insurance Marketplace
 - Provides essential health benefits
 - Follows established cost-sharing limits
 - Meets requirements of the ACA.
- QHPs that offer coverage on the federal exchange must also offer the product off the exchange.



Minimum Essential Coverage for the ACA

- Minimum Essential Coverage (MEC)
 - Under the ACA, individuals are to maintain at least MEC = Individual Mandate.
 - Any insurance plan that complies with the ACA requirements qualifies as a plan meeting the MEC.



Essential Health Benefits (EHBs)

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorders services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral and vision care



Assistance within the ACA

- Advance Premium Tax Credits (APTC)
- Cost sharing reduction
- American Indians and Alaska Natives



How to Navigate Selecting Health Insurance

Individual Federal Marketplace Plans

Start by creating an account at <http://www.Healthcare.gov> . Once your family information and current and estimated financial information are in the system, it will help guide you through the next steps.

- You may be found eligible for Medicaid, there will be a link provided or a phone number to contact so the Department of Health Services can assist you with signing up.
- You may be found to be eligible for the Marketplace with cost-sharing reduction for a silver level health insurance product with a reduce premium. Silver plans near where you live will be presented on the website for you to review and select a plan that works best for you.
- Federal Marketplace is **ONLY** place you can qualify for Advance Premium Tax Credits (APTC).



How to Navigate Selecting Health Insurance

- You may be found to be eligible for the Marketplace with Advance Premium Tax Credits. This credit can be taken in advance of filing taxes to help reduce your monthly premium. The amount of assistance is calculated based upon the second lowest cost silver level plan near where you live, but you may apply that credit to bronze, silver, gold or platinum level plans.
- You may be found to be eligible for the Marketplace but with no additional financial assistance. You can select from any metal level plan that meets your family's needs. You might also consider pricing options for insurance through licensed insurer in Wisconsin outside of the federal marketplace.



How to Navigate Selecting Health Insurance

- An insurance policy is a contract. The insurance company agrees to provide health coverage in exchange for a premium and identified out of pocket costs.
- Some terms frequently found in policies are important to understand. Knowing these terms and how they work and affect the premium is valuable to ensure the plan chosen is affordable and meets the anticipated and unanticipated needs of the individual or family.



How to Navigate Selecting Health Insurance

- **Cost sharing.** Cost sharing mainly includes three different terms: coinsurance, copayments, and deductibles.
 - **Coinsurance** is the percent of a billed service that you will be responsible to pay. For instance, a 10% coinsurance for durable medical equipment like an orthopedic boot, means that you will be responsible for 10% of what the orthopedic boot is billed to your insurance company.
 - **Copayment** is a set or flat fee that you are required to pay. For instance, each time you take your child to the pediatrician there is a \$10.00 copayment that is frequently collected when you check in for your appointment.
 - **Deductibles** are fixed dollars amounts that you must pay before your insurance policy will begin to pay for covered services. You will need to read the policy or Summary of Benefit and Coverage to understand what payments count towards meeting your deductible. Sometimes copayments do not accumulate towards your deductible and sometimes they will.



How to Navigate Selecting Health Insurance

Cost Sharing

- The more you are able to pay from your own financial resources before your insurer is responsible to pay, typically lowers your premium.
- However, you need to be sure you understand exactly how much you will need to pay out of your own pocket or “out of pocket” and decide that in combination of the premium and cost sharing which policy is most affordable to you or your family.
- There will be a maximum out of pocket dollar amount identified in your policy.
- Once you have met your maximum the insurance plan should pay all costs of your care. However, it is important to know if copayments are counted in that amount or not. If not included, you may continue to pay a fee for a visit to your doctor even after the maximum has been met.
- This is important to know so you can determine before you buy your coverage how much money you will have to spend in addition to what the insurance policy will cover for you.
- You will also want to understand whether there is a single deductible for all care and prescriptions or if there is a medical deductible and a separate pharmacy benefit deductible. Knowing this can avoid surprises when you are planning which policy to purchase.





The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined terms](#), see the Glossary. You can view the Glossary at [www.\[insert\].com](#) or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 / individual or \$1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage and \$300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For network providers , \$2,500 individual / \$5,000 family; for out-of-network providers , \$4,000 individual / \$8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

How to Navigate Selecting Health Insurance

Network.

Many insurers have preferred network of providers. Using these “preferred providers” typically lowers the level of cost sharing you are required to pay. Some insurers use a very narrow network of providers, frequently referred to as Exclusive Provider Organizations or EPOs. These products tend to be more affordable but also have the most restrictions on what providers you may see for care. Some health maintenance organizations or HMOs may also have a “closed” group or panel of providers. EPOs and HMOs will not provide insurance coverage if you end up visiting a provider that is not in their identified network.



How to Navigate Selecting Health Insurance

Covered items

- Insurers offering qualified health plans provide the most comprehensive coverage for you. This means once your cost sharing is met, you will have the broadest coverage in the event that you or someone in your family becomes ill.
- Qualified Health Plans or QHPs are compliant with the Federal Patient Protection and Affordable Care Act. These plans cover essential health benefits like preventive care visits with no cost sharing.
- They will include prescription drug coverage either directly or through a third-party sometimes a Pharmacy Benefit Manager or PBM. This is one area that you may find that the benefits provided under the policy are only covered when you visit preferred pharmacies or use mail order delivery.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	\$30 copay /visit	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 copay /office visit and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits/year
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 visits/calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.

How to Navigate Selecting Health Insurance

Limitations and Exclusions.

- Limitations in policies identify items that **may be** covered but only if conditions are met. **For instance, maternity coverage is provided, however, some plans might not provide coverage for delivery of your baby if you travel away from your home during the last 2 to 3 months of your pregnancy.** Read the limitations carefully.
- Exclusions are items or services that the plan **will not** cover, period. This may include specific types of treatment or therapies that the insurer has determined not to be effective. Knowing the exclusions will help you avoid paying a high medical bill or help you select a different insurance product that might provide coverage for a particular service you are seeking.



Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Hearing aids
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinekehgo shika a'ohwol ninisingo, kwijigo holne' [insert telephone number].]

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

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

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

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

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$800
Copayments	\$900
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

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

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$200
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact [insert].

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

Polling Slide #4

- Which of the following should be considered when selecting a health insurance plan?
 - A. Premium
 - B. Cost-sharing
 - C. Network and coverage
 - D. All of the above



Consumer Assister Tips

Provide a refresher on premiums, cost-sharing, differences in benefits and provider networks...individuals may not be familiar with these terms

Recommend that your client review provider directories or use search tools on the Marketplace to verify that any providers they rely on are in-network

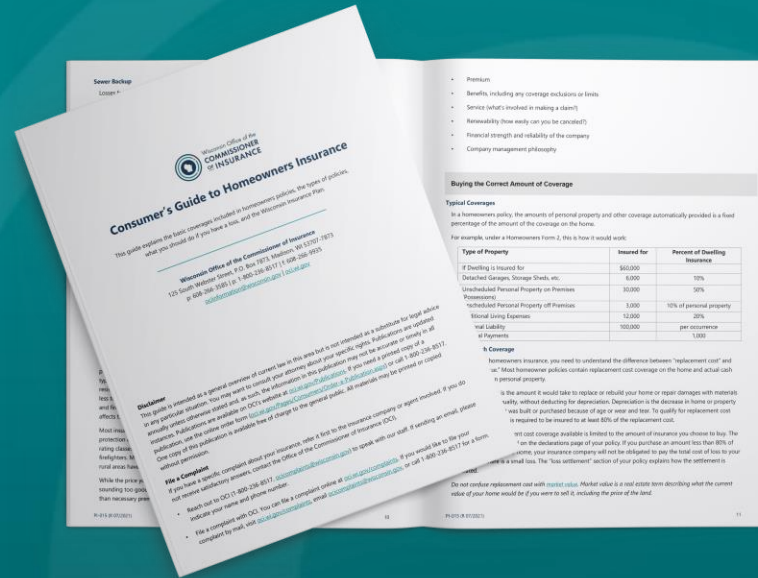
Help your client understand that they can report issues with getting medical appointments (i.e. providers aren't accepting new patients, or the client is experiencing long wait times)



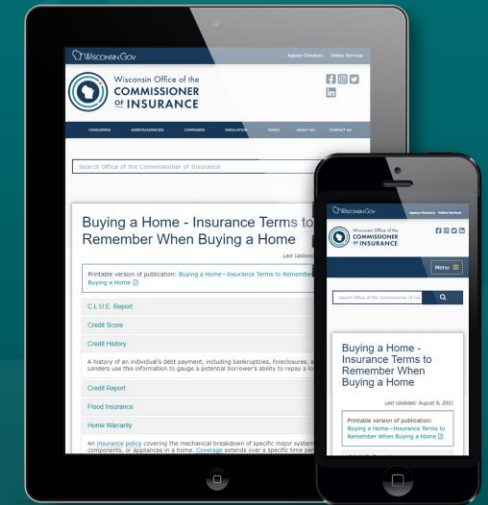
OCI Resources

- Policy form checklists
- Bulletins
- Publications
- WisCovered.com
- Wisconsin Insurance Report

<https://oci.wi.gov/Pages/Agents/NavigatorLicense.aspx>



Printable Consumer Guides and FAQ Sheets



Easy to Read Webpages

