



Revisiting the Affordable Care Act

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OVERVIEW

- U.S. Department of Labor
- Internal Revenue Service
- Covered California
- Questions

DISCLAIMER

The information provided in this presentation is intended only as a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was presented. We encourage audience members to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them.

UPCOMING WEBINAR

1095 Training and Open Enrollment Update

Thursday, January 28, 2016

10:00 am – 11:00 am

- Learn about 2016 updates to the IRS 1095 Forms, consumer APTC reporting and reconciliation processes, and how you can help.
- Open Enrollment update and other announcements



THE AFFORDABLE CARE ACT: MARKET REFORM PROVISIONS FOR EMPLOYER-BASED HEALTH PLANS

Cristina Collazo, Senior Benefits Advisor
U.S. Department of Labor



BACKGROUND

From young adults starting out in the workforce to workers nearing retirement, the Affordable Care Act (ACA) adds important protections related to employer-based group health plan coverage.



OVERVIEW

Provisions regarding:

- Dependent coverage to age 26
- Lifetime and annual limits
- Preexisting condition exclusions
- Internal claims and appeals and External Review
- Preventive services
- Patient protections
- Wellness Programs
- 90-day waiting period



YOUNG ADULTS AND DEPENDENT COVERAGE

- Young adults under age 26 can generally stay on their parent's health coverage if the plan allows for dependent coverage.

Who can qualify?

- Generally includes a child even if the child:
 - does not live with their parent,
 - is not a dependent on their parent's tax returns,
 - is not a student, or
 - is married.



LIFETIME AND ANNUAL LIMITS

- In the past, some people with cancer or other chronic illnesses ran out of insurance coverage because their health care expenses reached a dollar limit imposed by their plan or insurance company.
- Now, a group health plan or insurer can not establish lifetime or annual limits on the dollar value of essential health benefits for any individual.



PREEXISTING CONDITION EXCLUSIONS

- Plans can not limit or deny benefits or deny coverage due to a preexisting condition.
- This is true even if you've been turned down or refused coverage due to a pre-existing condition in the past.



SUMMARY OF BENEFITS AND COVERAGE (SBC) AND UNIFORM GLOSSARY

Plans are required to provide:

- A summary of benefits and coverage (SBC). This is an easy-to-understand summary about your health plan coverage to help you better understand the benefits available and to help you evaluate your health coverage choices.
- A uniform glossary of terms commonly used in health insurance coverage, such as deductible and copayment.



CLAIMS AND APPEALS

- There are new rights and protections related to internal appeal processes for individuals. Internal appeals refers to when you are asking your health plan to reconsider its decision to deny payment for a service or treatment.
- If your plan denies your claim, the plan must provide a notice describing why the claim was denied and your appeal rights.
- If your plan still denies payment after considering your appeal, you now have the right to external review. For self-insured health plans you will generally have an independent review organization decide the outcome of your external appeal.



PREVENTIVE SERVICES

- You can receive certain recommended preventive services, without having to pay a copayment or deductible (or other cost-sharing).
- Some examples of the preventive services that you can get without cost sharing (may depend upon your age) include:
 - Blood pressure, diabetes and cholesterol tests
 - Many cancer screenings
 - Regular well-baby and well-child visits
 - Routine vaccinations
 - Flu and pneumonia shots
 - Well-woman visits
 - Gestational diabetes screening
 - Domestic and interpersonal violence screening and counseling
 - Breastfeeding support, supplies and counseling
- A full list of preventive services can be found at:
<http://www.Healthcare.Gov/center/regulations/prevention.html>



PATIENT PROTECTIONS

Designation of Primary Care Provider

A plan or issuer that requires participants or beneficiaries to designate a primary care provider must permit the participant or beneficiary to designate any participating primary care provider who is available to accept the participant. With respect to a child, the plan or issuer must allow the designation of a pediatrician as a child's primary care provider, if the provider participates in the network of the plan or issuer.

Obstetrical and Gynecological Care

A plan providing OB/GYN care that requires the designation of a participating primary care provider:

- may not require authorization or referral for a female participant who seeks coverage for OB/GYN care provided by a participating OB/GYN specialist.



PATIENT PROTECTIONS

Emergency Services

- A group health plan or issuer that provides benefits with respect to services in an emergency department of a hospital, must cover emergency services:
 - Without the need for preauthorization (even if provided out-of-network);
 - Without regard to whether the provider of the emergency services is a participating network provider with respect to the services;
 - If the emergency services are provided out-of-network, by complying with special cost-sharing
 - Without regard to any other term or condition of the coverage, other than the exclusion of or coordination of benefits; an affiliation or waiting period; or applicable cost sharing.



WELLNESS PROGRAMS

- A wellness program is a program intended to improve health and fitness that is commonly offered through employer health plans.
- More employers are establishing wellness programs that encourage employees to work out, stop smoking, and generally adopt healthier lifestyles.
- Check with your plan and see if they offer a wellness program.



90-DAY WAITING PERIOD

- In general, the ACA prohibits the application of any waiting period that exceeds 90 days
- A ***waiting period*** is the period that must pass before an employee or dependent is eligible to enroll (becomes covered) under the terms of the group health plan.
- There are special rules related to certain hourly workers.



QUESTIONS?

Contact the U.S. Department of Labor

- Website: dol.gov/ebsa
- Dedicated ACA web page: dol.gov/ebsa/healthreform/
- To submit a question, contact us electronically at askebsa.dol.gov or call **1-866-444-3272**
- Please subscribe to our dedicated health reform website: dol.gov/ebsa/healthreform/ for notice of the latest updates

Reporting Health Insurance Coverage for Individuals and Families:

Individual Shared Responsibility Provision



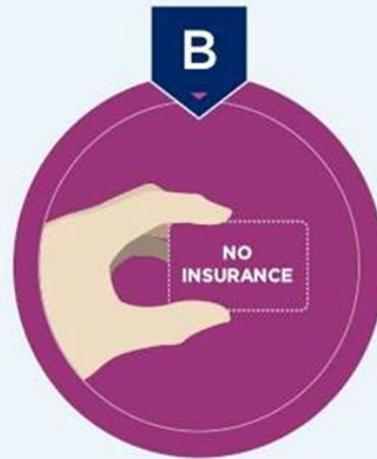
Vivienne Antal
Sr. Stakeholder Liaison

1/20/2016

Individual Shared Responsibility



**Report
Health
Care Coverage**



**Claim
Exemption
from Coverage**



**Make
Shared
Responsibility
Payment**

Reporting Coverage

	56	Subtract line 55 from line 47. If line 55 is more than line 47, enter -0-			
	57	Self-employment tax. Attach Schedule SE			
Other Taxes	58	Unreported social security and Medicare tax from Form: a <input type="checkbox"/> 4137 b <input type="checkbox"/> 8919			
	59	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required			
	60a	Household employment taxes from Schedule H			
	60b	First-time homebuyer credit repayment. Attach Form 5405 if required			
	61	Health care: individual responsibility (see instructions) Full-year coverage <input checked="" type="checkbox"/>			
	62	Taxes from: a <input type="checkbox"/> Form 8959 b <input type="checkbox"/> Form 8960 c <input type="checkbox"/> Instructions; enter code(s)			
	63	Add lines 56 through 62. This is your total tax			
Payments	64	Federal income tax withheld from Forms W-2 and 1099	64		

- Check box and leave entry space blank if everyone on the return had coverage for the full year

Minimum Essential Coverage

MEC coverage is:

- Offered by an employer, COBRA and retiree coverage
- Purchased through private insurance or Health Insurance Marketplace
- Provided by government-sponsored programs, including veteran's coverage, most Medicare and Medicaid

Information Statements

- Marketplace - Form 1095-A, - *Health Insurance Marketplace Statement*
- Insurers - Form 1095-B, *Health Coverage*
- Large Employers – Form 1095-C, *Employer-Provided Health Insurance Coverage and Offer*

Form 1095-A

Form **1095-A**

Department of the Treasury
Internal Revenue Service

Health Insurance Marketplace Statement

► Information about Form 1095-A and its separate instructions
is at www.irs.gov/form1095a.

VOID

CORRECTED

OMB No. 1545-2232

2015

Part I Recipient Information

1 Marketplace identifier	2 Marketplace-assigned policy number	3 Policy issuer's name	
4 Recipient's name		5 Recipient's SSN	6 Recipient's date of birth
7 Recipient's spouse's name		8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth
10 Policy start date	11 Policy termination date	12 Street address (including apartment no.)	
13 City or town	14 State or province	15 Country and ZIP or foreign postal code	

Part II Covered Individuals

A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
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Form 1095-B

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

VOID

CORRECTED

560115

OMB No. 1545-2252

2015

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Marketplace Identifier, if applicable	

Part II Employer Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage																			
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec								



Form 1095-C

Form 1095-C
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

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600116

OMB No. 1545-2251

CORRECTED

2015

Part I Employee

Applicable Large Employer Member (Employer)

1 Name of employee		2 Social security number (SSN)		7 Name of employer			8 Employer identification number (EIN)		
3 Street address (including apartment no.)				9 Street address (including room or suite no.)			10 Contact telephone number		
4 City or town	5 State or province	6 Country and ZIP or foreign postal code		11 City or town	12 State or province	13 Country and ZIP or foreign postal code			

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage												
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Form 8965

Health Coverage Exemptions

Form 8965 Department of the Treasury Internal Revenue Service	Health Coverage Exemptions ▶ Attach to Form 1040, Form 1040A, or Form 1040EZ. ▶ Information about Form 8965 and its separate instructions is at www.irs.gov/form8965 .		OMB No. 1545-0074
			2015 Attachment Sequence No. 75
Name as shown on return		Your social security number	
Complete this form if you have a Marketplace-granted coverage exemption or you are claiming a coverage exemption on your return.			
Part I Marketplace-Granted Coverage Exemptions for Individuals. If you and/or a member of your tax household have an exemption granted by the Marketplace, complete Part I.			
	(a) Name of Individual	(b) SSN	(c) Exemption Certificate Number
1			

Submit Form 8965 with federal tax return to claim coverage exemptions granted by either the Health Insurance Marketplace or IRS



Making an Individual Shared Responsibility Payment

Taxpayers calculate Shared Responsibility Payment if **everyone on the return does not have:**

- Minimum Essential Coverage for every month of the year, **or**
- Exemption for months without Minimum Essential Coverage

How is the 2015 Payment Calculated?

- For the year, based on the greater of the calculated:
 - percentage of income (2%) or
 - flat dollar amount (\$325 per adult)
 - Limited to maximum of \$975 per household
- Prorated for months without coverage/exemption
- Cannot exceed the national average premium for bronze level health plans

Common Errors

- Eligible for coverage exemption but did not claim
 - Income below filing threshold
 - Not lawfully present
 - Coverage gaps
- Miscalculated Shared Responsibility Payment
- Shared Responsibility Payments on dependent returns

2015: What You Need to Know

- Forms 1095-A, B and C
- Apply for Marketplace exemptions early
- Individual Shared Responsibility Payments amounts increase
- 2016 Marketplace enrollment
 - Nov 1, 2015 to January 31, 2016
 - Special Enrollment Periods

Resources

The screenshot shows the IRS website's 'Affordable Care Act Tax Provisions' page. The header includes the IRS logo, a search bar, and navigation tabs for Filing, Payments, Refunds, Credits & Deductions, News & Events, Forms & Pubs, Help & Resources, and for Tax Pros. The main heading is 'Affordable Care Act Tax Provisions'. Below this, there is a list of 'Affordable Care Act Topics' including Individuals and Families, Employers, Tax Professionals, What's Trending, News, Health Care Tax Tips, Questions and Answers, List of Tax Provisions, Legal Guidance and Other Resources, and Affordable Care Act Tax Provisions Home. A central section titled 'Affordable Care Act (ACA) Tax Provisions' contains a paragraph explaining the ACA's comprehensive health insurance reforms and includes a link to 'Find out what to do if you got a letter from the IRS asking for more information about your premium tax credit and a copy of your 1095-A'. There are also sections for 'Individuals & Families' and 'Employers', each with a 'Learn more...' button. A 'Forms and Publications' section lists Form 8965, Form 8962, and Publication 5187.

The screenshot shows the HealthCare.gov website. The header includes the HealthCare.gov logo, navigation tabs for Individuals & Families and Small Businesses, and a 'Log In' button. Below the header, there are links for 'Get Coverage', 'Change or Update Your Plan', and 'Get Answers'. A search bar is also present. The main banner features the text 'You can still get 2015 health coverage' and a sub-headline: 'You can enroll if you have certain life changes — like getting married, having a baby, losing other coverage, or moving — or if you qualify for Medicaid or CHIP'. A green button says 'SEE IF YOU CAN GET COVERAGE'. Below the banner, there is a 'Want a quick overview first?' section with four columns: 'TAX QUESTIONS?' with a 'GET TOOLS & ANSWERS' button, 'COVERAGE TO CARE' with a 'SEE ROADMAP' button, 'APPEAL A DECISION' with a 'GO' button, and 'CONTACT US' with a 'GO' button.

- [IRS.gov/TaxPros](https://www.irs.gov/TaxPros)
- [IRS.gov/DraftForms](https://www.irs.gov/DraftForms)
- [IRS.gov/Form8965](https://www.irs.gov/Form8965) (links to Form and its instructions)



THE AFFORDABLE CARE ACT (ACA) INDIVIDUAL MANDATE

THE AFFORDABLE CARE ACT (ACA) INDIVIDUAL MANDATE

Since implementation of the ACA in 2014, you and your family must:

- Have health insurance coverage throughout the year

OR

- Qualify for an exemption from coverage

OR

- Make a payment on your federal income tax return

MINIMUM ESSENTIAL COVERAGE (MEC)

If you are covered by any of the following health plans, you're considered covered under the Affordable Care Act (ACA) and don't have to pay a penalty:

- Any Covered California Plan, or any individual insurance plan you already have
- Any employer plan (including COBRA policy)
- Retiree health plans
- Most Medicare coverage
- Medi-Cal (excluding Share of Cost and other limited-scope Medi-Cal programs)
- Medi-Cal Kids (formerly Healthy Families)
- TRICARE (for current service members and military retirees, their families, and survivors)
- Veterans health care programs (including the Veterans Health Care Program, VA Civilian Health and Medical Program (CHAMPVA), and Spina Bifida Health Care Benefits Program)
- Peace Corps Volunteer plans
- Self-funded health coverage offered to students by universities for plan or policy years that began on or before Dec. 31, 2014

MINIMUM ESSENTIAL COVERAGE (MEC)

Some products that help pay for medical services DO NOT qualify as MEC. If you only have this type of product or coverage, you may have to pay the tax penalty. These include:

- Coverage only for vision care or dental care
- Workers' compensation
- Coverage only for a specific disease or condition
- Plans that offer only discounts on medical services

INDIVIDUAL SHARED RESPONSIBILITY PAYMENT – “TAX PENALTY”

The Tax Penalty for not having Minimum Essential Coverage (MEC) is calculated in one of 2 ways.

- 1) Pay either a percentage of your household income; OR
- 1) A flat fee

*Whichever is greater

Penalty for Tax Year 2015

Per Adult	\$325
Per Child (under age 18)	\$162.50
Family Maximum (Using the above method)	\$975
Or a % of yearly household income above the tax filing threshold	2%

INDIVIDUAL SHARED RESPONSIBILITY PAYMENT – “TAX PENALTY”

TAX YEAR	2015	2016
Per Adult	\$325.00	\$695
Per Child (under age 18)	\$162.50	\$347.50
Family Maximum (using the above method)	\$975.00	\$2,085
Or a % of household income above the tax filing threshold	2%	2.5%

*Note: After 2016, the penalty is adjusted for inflation

EXEMPTIONS FROM THE INDIVIDUAL MANDATE

Under some circumstances, you won't have to make the payment even if you don't have MEC. This is called an "exemption." You may qualify for an "exemption" if any of the following apply to you:

- You're uninsured for less than 3 months of the year
- The lowest-priced coverage available to you (premium for the lowest cost Bronze plan) would cost more than 8.13% of your household income
- You don't have to file a tax return because your income is too low (under the tax filing thresholds)
- You're a member of a federally recognized tribe or eligible for services through an Indian Health Services provider
- You're a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- You're a member of a recognized health care sharing ministry
- You're incarcerated (either detained or jailed and not being held pending disposition of charges)
- You're not lawfully present in the U.S.
- You qualify for a hardship exemption

EXEMPTIONS FROM THE INDIVIDUAL MANDATE

You can get more information about qualifying exemptions and how to apply for an exemption by visiting:

www.healthcare.gov

Note: If the consumer claims an exemption on their federal tax filings, they are required to complete IRS Form 8965 – Health Coverage Exemptions.

ADVANCED PREMIUM TAX CREDIT (APTC)

Covered California uses the following information to calculate APTC:

- The individual's or family's tax household gross annual income or Modified Adjusted Gross Income (MAGI)
- Tax household size (of those individuals for whom the tax filer properly claims a deduction for a personal exemption for the taxable year, including the tax filer him/herself, his/her spouse and/or children, and his/her relative as applicable)
- Coverage family size (of those members of the tax filer's family who are seeking enrollment in a Covered California plan and are not eligible for employer-sponsored coverage or any government-sponsored program, such as Medi-Cal or Medicare)
- The Second Lowest Cost Silver Plan in the individual or family's zip code

ADVANCED PREMIUM TAX CREDIT (APTC) RECONCILIATION



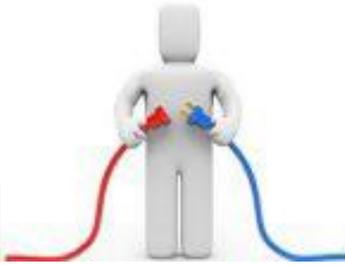
Covered California Plan enrollees already meet the Affordable Care Act Mandate to have Minimum Essential Coverage because all plans offered through Covered California meet the MEC standard, even enrollees in the Bronze and Catastrophic Plans.

APTC Reconciliation is the means by which Covered California Plan enrollees and the IRS will determine whether the amount of APTC, or premium assistance, paid to Covered California Health Insurance Companies on their behalf was accurate.

ADVANCED PREMIUM TAX CREDIT (APTC) RECONCILIATION

Consumers need help making the connection between:

Premium Tax Credits



Filing Their Taxes

Many consumers are unaware that they must reconcile their Advance Premium Tax Credit by filing their taxes.

PREMIUM TAX CREDIT PROCESS

Covered California Eligibility & Enrollment Process: Covered California will oversee the enrollment of eligible consumers into Qualified Health Plans (QHPs) and determine the amount of premium tax credit applied. The tax credits will be paid to Health Insurance Companies on the consumers behalf.

1095-A Process: At the end of the plan year, Covered California provides consumers with a Form 1095-A which provides information about the consumer's enrollment and APTC.

Federal Income Tax Filing Process: Consumers use the information provided on Form 1095-A to file their federal income tax return with the IRS, reconcile any APTC applied, and/or claim premium tax credit. The information provided in the Form 1095-A is also sent to the IRS.

APTC Reconciliation Process: The IRS determines the actual APTC based off the consumers household MAGI for the tax year versus and compares it to what was reported via the tax filing process. Consumers will use Form 8962 or 8965 for exemptions when they file their taxes.

WHAT CONSUMERS WILL RECEIVE

By January 31, 2016, Covered California will mail an envelope which includes:

- Cover letter
- Form 1095-A instructions
- Form 1095-A
 - A separate Form 1095-A will be generated for each policy in which members of the household enrolled.
 - Each member of a tax household who is on the same policy will be listed together on one Form 1095-A.
 - Households of more than five enrolled members will receive an additional Form 1095-A that continues Part II.

Allow 2 weeks for delivery

THE ROLE OF AGENTS AND BROKERS DURING TAX SEASON

Agents and brokers may:

- Help consumers understand what Form 1095-A is and what it means for the consumer as they prepare their tax returns
- Help consumers understand the timing for receiving Form 1095-A, what to look for in the mail, and that it is an important tax document
- Show consumers how to access Form 1095-A in their online account
- Help consumers understand how Form 1095-A relates to Form 8962 or 8965 for claiming exemptions
- Explain how to review Form 1095-A for accuracy
- Ensure consumers are aware of the potential implications of not providing the information on their taxes
- Help consumers understand how to reconcile their Advanced Premium Tax Credit and Premium Tax Credit

Agents and brokers may not provide tax advice or assistance to consumers with filing their tax returns.



QUESTIONS?

OutreachandSales@covered.ca.gov

THANK YOU!

OutreachandSales@covered.ca.gov

Questions for IRS/DOL Webinar: 1/20/16

1. Question: What qualifies as a short coverage gap?

IRS Answer: In general, a gap in coverage that lasts less than three months qualifies as a short coverage gap. If you have more than one short coverage gap during a year, the short coverage gap exemption only applies to the first gap. If you have a coverage gap of 3 months or more, you are not exempt for any of those months.

If you do not have coverage for a continuous period that begins in one taxable year and ends in the next, for purposes of applying the short coverage gap rules to the first taxable year, the months in the second taxable year included in the continuous period are not counted. For purposes of applying the short coverage gap rules to the second year, the months in the first taxable year are counted. For example, if you lacked coverage from November 1, 2015 until February 1, 2016, November and December of 2015 are treated as a short coverage gap on your 2015 tax return. On your 2016 return, however, November and December of 2015 are included in the continuous period that includes January 2016. That continuous period is not less than 3 months so, on your 2016 return, January of 2016 is not an exempt month under the short coverage gap exemption.

2. Question: Do I have to be covered for an entire calendar month to avoid the shared responsibility payment liability for not having minimum essential coverage for that month?

IRS Answer: No. You will be treated as having minimum essential coverage for a month as long as you have coverage for at least one day during that month.

3. Question: If I change health coverage during the year and end up with a gap when I am not covered, will I owe a payment?

IRS Answer: Individuals are treated as having minimum essential coverage for a calendar month if they have coverage for at least one day during that month. Additionally, as long as the gap in coverage is less than three consecutive months, you may qualify for an exemption and not owe a payment. See question 22 for more information on the exemption for a short coverage gap.

4. Question: How do I find information about my employer's group health plan, including claims and appeals' procedures?

DOL Answer: You can request and read Your Plan's Summary Plan Description (SPD) for the Wealth of Information It Provides about your health plan.

Your health plan administrator should provide a copy. It outlines your benefits and your legal rights under the Employee Retirement Income Security Act (ERISA), the Federal law that protects your health benefits. It also should contain information about the coverage of dependents, what services will require a co-payment or coinsurance, and the circumstances under which your employer can change or terminate a health benefits plan. You also can find many of the answers to your questions in the Summary of Benefits and Coverage (SBC), a short, easy-to-understand summary of what a plan covers and what it costs. You should receive a copy with your enrollment materials. Save the SPD, the SBC, and all other health plan brochures and documents, along with memos or correspondence from your employer relating to health benefits.

5. **Question:** How does one go about an external review once all internal appeals are exhausted?

DOL Answer: There is the possibility of a private accredited IRO (Internal Review Organization)

-OR-

A State external review process if the State allows access

6. **Question:** I am a retiree, and I am too young to be eligible for Medicare. I receive my health coverage through a retiree plan made available by my former employer. Is the retiree plan minimum essential coverage?

IRS Answer: Yes. Retiree health plans generally are minimum essential coverage.

7. **Question:** What happens if I owe an individual shared responsibility payment, but I cannot afford to make the payment when filing my tax return?

IRS Answer: The IRS routinely works with taxpayers who owe amounts they cannot afford to pay. The law prohibits the IRS from using liens or levies to collect any individual shared responsibility payment. However, if you owe a shared responsibility payment, the IRS may offset that liability against any tax refund that may be due to you.

8. **Question:** Do my spouse and dependent children have to be covered under the same policy or plan that covers me?

IRS Answer: No. You, your spouse and your dependent children do not have to be covered under the same policy or plan. However, you, your spouse and each dependent child for whom you may claim a personal exemption on your federal income tax return must have minimum essential coverage or qualify for an exemption, or you will owe a shared responsibility payment when you file a return.

9. Question: Where can I find a complete list of preventative services?

DOL Answer: Recommended Preventive Services:

A complete list of recommendations and guidelines that are required to be covered:

<http://www.Healthcare.Gov/center/regulations/prevention.html>

10. Question: Are there any instances where there may still be cost-sharing with respect to preventative services?

DOL Answer: If the recommended preventive service is not billed separately and the primary purpose of the office visit is the delivery of the recommended preventive service, then a plan or issuer may not impose cost-sharing with respect to the office visit;

However, if the recommended preventive service is not billed separately and the primary purpose of the office visit is not delivery of the recommended preventive service, then a plan or issuer may impose cost-sharing with respect to the office visit.