pennsylvania DEPARTMENT OF AGING | pennsylvania INSURANCE DEPARTMENT | pennsylvania DEPARTMENT OF HUMAN SERVICES

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Glossary

Affordable Care Act (ACA):
The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or "Obamacare").

The law has 3 primary goals:

- Make affordable health insurance available to more people. The law provides consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the federal poverty level.
- Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs; Pennsylvania did expand Medicaid.)
- Support innovative medical care delivery methods designed to lower the costs of health care generally.

Catastrophic Health Plan:
Health plans that meet all of the requirements applicable to other Qualified Health Plans (QHPs) but that don't cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a Catastrophic plan, you must be under 30 years old OR get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage.

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

Children's Health Insurance Program (CHIP):
Insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance. In some states, CHIP covers pregnant women.

Each state offers CHIP coverage and works closely with its state Medicaid program. You can apply any time. If you qualify, your coverage can begin immediately, any time of year.

CHIP Managed Care:
Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Children's Health Insurance Program (CHIP) managed care provides for the delivery of CHIP health benefits through contracted arrangements between state CHIP agencies and managed care plans that accept a set per member per month (capitation) payment for these services.

COBRA:
A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA

(Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance:
The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Let's say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%.

- If you've paid your deductible: You pay 20% of $100, or $20. The insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, $100.

Example of coinsurance with high medical costs
Let's say the following amounts apply to your plan and you need a lot of treatment for a serious condition. Allowable costs are $12,000.

- Deductible: $3,000
- Coinsurance: 20%
- Out-of-pocket maximum: $6,850

You'd pay all of the first $3,000 (your deductible).
You'll pay 20% of the remaining $9,000, or $1,800 (your coinsurance).
So, your total out-of-pocket costs would be $4,800 — your $3,000 deductible plus your $1,800 coinsurance.

If your total out-of-pocket costs reach $6,850, you'd pay only that amount, including your deductible and coinsurance. The insurance company would pay for all covered services for the rest of your plan year.

Generally speaking, plans with low monthly premiums have higher coinsurance, and plans with higher monthly premiums have lower coinsurance.

Copayment:
A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible.

Let's say your health insurance plan's allowable cost for a doctor's office visit is $100. Your copayment for a doctor visit is $20.

- If you've paid your deductible: You pay $20, usually at the time of the visit.
- If you haven't met your deductible: You pay $100, the full allowable amount for the visit.

Copayments (sometimes called "copays") can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Generally plans with lower monthly premiums have higher copayments. Plans with higher monthly premiums usually have lower copayments.

Cost Sharing:
The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Deductibles:
The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself.

After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

- Many plans pay for certain services, like a checkup or disease management programs, before you've met your deductible. Check your plan details.
- All Marketplace health plans pay the full cost of certain preventive benefits even before you meet your deductible.
- Some plans have separate deductibles for certain services, like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

Exchange Assister:
In Pennsylvania, an Exchange Assister is an individual or organization, including a Navigator, Navigator Organization or Certified Application Counselor (CAC) who provides public education or assists consumers for or on behalf of the Affordable Care Act Marketplace. This term does not include a licensed insurance producer. This term also does not include an individual employed to provide insurance enrollment or coverage assistance by a health care facility as defined in section 103 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

Group Health Plan:
In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Health Coverage:
Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

Individual Health Insurance Policy:
Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

In-network:
The hospital or provider has a contract with your insurance company. Contact your insurance company or visit its website for a list of in-network hospitals and providers.

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

LIFE:
Living Independently for the Elderly (Life) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.

Marketplace:
Shorthand for the "Health Insurance Marketplace," a shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010.
In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families. On the web, it's found at HealthCare.gov.

- Fill out a Marketplace application and you'll find out if you qualify for lower monthly premiums or savings on out-of-pocket costs based on your income.
- You may find out if you qualify for Medicaid or the Children's Health Insurance Program (CHIP).

You can shop for and enroll in affordable medical insurance online, by phone, or with in-person help from a trained assister or an agent or broker (in Pennsylvania agents and brokers are called producers).

Medical Assistance (MA), also known as Medicaid:
Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Many states have expanded their Medicaid programs to cover all people below certain income levels.

Whether you qualify for Medicaid coverage depends partly on whether your state has expanded its program. Medicaid benefits, and program names, vary somewhat between states.

You can apply anytime. If you qualify, your coverage can begin immediately, any time of year.

Medicare:
A federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Medicare isn't part of the Health Insurance Marketplace

Medicare Advantage (Medicare Part C):
A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

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

Mini-COBRA:
Or Act 2 of 2009, is a Pennsylvania law that gives employees of small businesses (2-19 employees) who receive health insurance from their employers the right to purchase continuation health insurance after they leave.

Minimum Essential Coverage (MEC):
Any insurance plan that meets the Affordable Care Act requirement for having health coverage. Examples of plans that qualify include: Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.

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

Network:
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Open Enrollment Period:

The yearly period when people can enroll in a health insurance plan. Open Enrollment for 2020 is over, but you may still be able to enroll in a Marketplace health insurance plan for 2020 if you qualify for a Special Enrollment Period.

You're eligible for a Special Enrollment Period if you have certain life events, like getting married, having a baby, or losing other health coverage.

- Job-based plans may have different Open Enrollment Periods. Check with your employer.
- You can apply and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year

Out-of-Network:
The hospital or provider **does not** have contract with your insurance company. Contact your insurance company or visit its website for a list of in-network hospitals and providers.

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

Qualified Health Plan (minimum essential coverage):
An insurance plan that's certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as "minimum essential coverage."

Examples of qualifying health coverage:

- Any health plan bought through the Marketplace
- Individual health plans bought outside the Marketplace, if they meet the standards for qualified health plans
- Any "grandfathered" individual insurance plan you've had since March 23, 2010, or earlier
- Any job-based plan, including retiree plans and COBRA coverage
- Medicare Part A or Part C (but Part B coverage by itself doesn't qualify)
- Most Medicaid coverage, except for limited coverage plans
- The Children's Health Insurance Program (CHIP)
- Coverage under a parent's qualified health plan
- Most student health plans (check with your school to see if the plan counts as qualifying health coverage)
- Health coverage for Peace Corps volunteers
- Certain types of veterans health coverage through the Department of Veterans Affairs
- Most TRICARE plans
- Department of Defense Nonappropriated Fund Health Benefits Program
- Refugee Medical Assistance

  See a more detailed list of types of plans that do and don't count as qualifying health coverage from the IRS.

Primary Care:
Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Primary Care Provider:
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prior authorization:
Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Self-Insured Plan (Self-Funded Plan):
Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.

Special Enrollment Period (SEP):
A time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you've had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the event to enroll in a plan. If you miss your Special Enrollment Period window, you may have to wait until the next Open Enrollment Period to apply.

You can enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year, whether you qualify for a Special Enrollment Period or not.

Job-based plans must provide a Special Enrollment Period of at least 30 days.

COVID-19 Testing/Treatment

*Items in green defined in glossary

Where can I find more information about COVID-19?

The Pennsylvania Department of Health has a dedicated page for COVID-19 that provides daily updates. For the most up to date information, click here.

If you are a patient who wants to be tested

Click here to visit the PA Department of Health's website for more information about testing.

Who pays for COVID-19 diagnostic testing/treatment if needed?

Group Health Plans, Self-Insured (Self-Funded) Plans and Individual or Group Coverage through the Marketplace

Lab Testing:
The federal Centers for Disease Control and Prevention (CDC) and the Pennsylvania Department of Health are covering the cost of the lab test for the presence of COVID-19 performed in federal or state labs when certain conditions are met. Click here to visit the PA Department of Health's website for more information. In order to help combat the spread of the virus, testing in commercial labs has also become available. Contact your insurance company to make sure your lab is in-network or check to see what provisions the insurer has put in place for out-of-network lab work. Hospitals and providers are expected to bill insurance companies for the fees associated with collecting the specimens, and labs are expected to bill for the actual testing. If the test is recommended by your doctor or other health care provider, the **Families First Coronavirus Response Act** requires coverage for the order of and administration of the test with no cost-sharing and no prior authorization or other medical management requirements for provider visits (office, urgent care, ER) including telehealth/telemedicine.

Treatment Coverage Includes:
These comprehensive health insurance plans typically provide health coverage for medically necessary treatment. Be sure to check with your insurance provider to understand how your coverage and cost sharing will apply. Also check your health insurance company's network list of providers and hospitals, and, if possible, try to go to a hospital that is considered in-network by your health insurance plan. Some health plans do not provide coverage for out-of-network care, although exceptions can be made in unique circumstances including emergencies.

If you are admitted into a hospital for monitoring and observation your co-payments, co-insurance, and deductibles may apply.

Telehealth Coverage:
Most insurers cover telehealth for both medical (sometimes called telemedicine) and behavioral health services. Check with your insurer to determine if co-pays, co-insurance, and deductible apply for COVID-19 treatment.

On March 10th, 2020 the Pennsylvania Insurance Department released a Bulletin notice regarding COVID-19 insurance coverage. Click here to view. In the notice, the Insurance Department discusses telehealth delivery of services. It states:

> *Telehealth Delivery of Services*. Given that COVID-19 is a communicable disease, some insureds may prefer to use telehealth services instead of in-person health care services. Health insurers are encouraged to review their respective participating telehealth service provider arrangements, provide coverage of costs related to telehealth services and to be prepared to meet any increased demand for that means of delivery.

Medicare

Lab Testing:
Medicare covers the lab tests for COVID-19 with no out-of-pocket costs and the deductible does not apply when the test is ordered by your doctor or other health care provider.

Treatment Coverage includes:
Medicare also covers all medically necessary hospitalizations. This includes if you're diagnosed with COVID-19 and might otherwise have been discharged from the hospital after an inpatient stay, but you need to stay in the hospital under quarantine.

While there is currently no vaccine for COVID-19, if one becomes available, it will be covered by all Medicare Prescription Drug Plans (Part D).

Telehealth Coverage:
Types of Virtual Services:

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries: Medicare telehealth visits, virtual check-ins and e-visits.

Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person. For additional information view the Medicare Telemedicine Health Care Provider Fact Sheet.

Services paid the same as if they were rendered face-to-face for both behavioral and physical health

Medicare Advantage

Lab Test and Treatment Coverage:
If you have a Medicare Advantage Plan, you have access to the same benefits as **Medicare**. Medicare allows these plans to waive cost-sharing for COVID-19 lab tests with no prior authorization or utilization management requirements.

Medical Assistance (MA) and Managed Care Organizations (MCOs)

Lab Testing:
For Medical Assistance (MA) and MCOs, all lab tests, including tests for COVID-19, are covered without copayments or prior authorization

Treatment coverage includes:

- X-rays and diagnostic testing (no prior authorization required)
- Hospital care (inpatient and outpatient)
- Emergency Ambulance Transportation
- Non-emergency transportation to MA covered appointments
- Home health services
- Nursing facility care
- Prescription drugs (early refills and extended supplies now available)
- Any medically necessary service for people under the age of 21

Telemedicine Coverage - Medical Assistance:

Telemedicine preferred when patient is quarantined or self-isolating. Patient can receive services provided through telemedicine at home. Hospital clinics, outpatient clinics, CRNPs, physicians, physician's assistants, certified nurse midwives, and early intervention therapists can provide services through telemedicine. Service must be rendered in the same way it would have been in-person. Audio-visual connectivity is strongly preferred, but telephone-only may be used if A/V is not available. Services paid the same as if they were rendered face-to-face for both behavioral and physical health

Telemedicine Coverage - MCOs:
MCOs must offer coverage for services through telemedicine that meets or exceeds coverage under fee-for-service. Many MCOs offer more expansive coverage and have specific apps that they offer to patients. MCOs have been instructed to make network providers and enrollees aware of their telehealth options.

For specific coverage information, please contact the Medical Assistance fee-for-service program if you only have an ACCESS card, or your managed care organization if you have another insurance card in addition to your ACCESS card.

Services paid the same as if they were rendered face-to-face for both behavioral and physical health.

Community Health Choices (CHC)

Lab Tests:
If you have a Community Health Choices plan, all lab tests, including tests for COVID-19, are covered without copayments or prior authorization

Treatment coverage includes:

- X-rays and diagnostic testing (no prior authorization required)
- Hospital care (inpatient and outpatient)
- Emergency Ambulance Transportation
- Non-emergency transportation to MA covered appointments
- Home health services
- Nursing facility care
- Prescription drugs (early refills and extended supplies now available)
- Any medically necessary service for people under the age of 21

*note most CHC enrollees are dually eligible, so Medicare is the primary payer. Only people over the age of 21 are enrolled in CHC.

Telemedicine Coverage:
CHCs follow the Medicare telehealth policy
Types of Virtual Services:

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries: Medicare telehealth visits, virtual check-ins and e-visits.

Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person. For additional information view the Medicare Telemedicine Health Care Provider Fact Sheet.

Services paid the same as if they were rendered face-to-face for both behavioral and physical health

PEBTF (Pennsylvania Employees Benefit Trust Fund)

Lab testing:
If you have a PEBTF plan, the COVID -19 diagnostic test is covered without copays and deductibles. The policy will cover the test kit for members who meet CDC guidelines for testing in any approved laboratory location.

Treatment coverage includes:
As a comprehensive health insurance plans, PEBTF provides health coverage for medically necessary treatment. Be sure to check with your insurance company to understand how your coverage and cost sharing will apply. Also check your health insurance company's network list of providers and hospitals, if possible. Try to go to a hospital that is considered in-network by your health insurance plan. Some

health plans do not provide coverage for out-of-network care, although exceptions can be made in unique circumstances including emergencies.

If you are admitted into a hospital for monitoring and observation your co-payments, co-insurance, and deductibles may apply.

Telehealth Coverage:

PEBTF covers telehealth visits and is currently waiving the associated cost-sharing

To learn more visit www.PEBTF.org

Children's Health Insurance Program (CHIP)

Lab Testing:
If you have a plan through CHIP, all lab tests, including tests for COVID-19, are covered **without** copayments or prior authorization

Treatment coverage includes:

- Physician services including sick and urgent care visits, house-calls in the physician's service area and telehealth services with a family practitioner, general practitioner or pediatrician (copays waived)
- Urgent care services.
- X-rays and diagnostic testing with an order from your Primary Care Physician, specialist or facility provider.
- Hospital care (Inpatient and Outpatient).
- Emergency ambulance transportation
- Home health and home and community-based health care services.
- Nursing care services.
- Prescription drugs.
- Over-the-counter medications for fever relief, cough preparations as well as medications related to the treatment of virus symptoms when prescribed by your physician and part of the CHIP MCO's formulary. Co-pays may apply.

Telehealth Coverage:
A CHIP Managed Care Organization is authorized to utilize telehealth the same as a physician office visit for examination, diagnosis and treatment of an illness provided the service is provided by the family practitioner, general practitioner or pediatrician.

TRICARE, Coverage for Veterans, and Coverage for Federal Civilians

TRICARE has created a list of frequently asked questions related to COVID-19. You can visit TRICARE's website by clicking here. Topics include:

- COVID-19 Testing
- TRICARE Health Plan
- Pharmacy and prescriptions
- Quarantine
- MTF Management
- Medical Care

Indian Health Services

Indian Health Services has created information related to the federal response in Indian Country. You can visit the Indian health services webpage by clicking here. Topics include:

- General information
- Testing
- Access to personal protective equipment
- Funding
- Emergency Planning
- Service delivery during a pandemic

Common Questions

What should I do if I got a bill for testing?

If you get a bill for testing that you believe is in error, start by calling your doctor's office and ask if you got the bill by mistake. Doctors and insurance companies have changed their billing processes quickly to respond to COVID-19, and there might have been an error.
If your doctor's office can't resolve the bill, call the customer service line for your health care coverage. You can also call the Pennsylvania Insurance Department's Help Line at (877) 881-6388.

What should I do if I have health concerns that require emergency medical services?

NOTE: Individuals who have had COVID-19 symptoms or who believe they may have come in contact with the virus, have not usually needed emergency services.

In the event emergency medical services are needed, however, insurance carriers must cover services for an emergency medical condition at in-network levels. Emergency services include transportation, such as ambulance services, as well as inpatient and outpatient hospital services necessary to stabilize the patient.

What should I do if I don't have health insurance?

Whether you are experiencing symptoms or not, now is a good time to see if you are eligible for enrollment in health insurance coverage. Some health programs, like Medical Assistance (MA) and CHIP will enroll you at any time throughout the year. Some health insurance coverage, like the Marketplace, may only be available if there is a Special Enrollment Period.

The Pennsylvania Association of Community Health Centers (PACHC) offers free, personal, no pressure, no obligation, non-biased enrollment assistance. PACHC and its network of Community Health Centers are available to assist you in navigating and enrolling in the Health Insurance Marketplace, Medical Assistance (MA), Medicare and CHIP. Certified Exchange Assisters are available throughout Pennsylvania to help you enroll in these programs.

Here is a **list of exchange assisters in your area.** You can also search by using the **find a health center page**. If you have additional questions or need further assistance, please contact the PACHC's Navigator Hub at 1-866-944-CARE (2273)

You can also use COMPASS to sign up for Medical Assistance. COMPASS is an online tool for Pennsylvanians to apply for many health and human service programs like Medicaid and CHIP. Visit COMPASS at www.compass.state.pa.us.

If you would prefer to research signing up for a Marketplace plan without assistance, you can visit www.healthcare.gov

If you remain uninsured, the Families First Coronavirus Response Act may provide coverage for the COVID-19 testing administered during emergency period and associated visit.

What should I do if I've been laid off and I no longer have health insurance?

Cobra coverage and the Marketplace

When you lose job-based insurance, you may be offered COBRA (Consolidated Omnibus Budget Reconciliation ACT) continuation coverage by your former employer.

- If you're losing job-based coverage and haven't signed up for COBRA, learn about your rights and options under COBRA from the U.S. Department of Labor by clicking here. If you are entitled to elect COBRA coverage, you must be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you could lose coverage) to choose whether or not to elect continuation.

- If you decide not to take COBRA coverage or once your COBRA coverage period ends, you may enroll in a Marketplace plan instead. Losing job-based coverage qualifies you for a Special Enrollment Period. This means you have 60 days to enroll in a health plan, even if it's outside the annual Open Enrollment Period. You may click here to learn more at healthcare.gov.

Whether you are experiencing symptoms or not, now is a good time to see if you are eligible for enrollment in health insurance coverage. Some health programs, like Medicaid and CHIP, will enroll you at any time throughout the year. Some health insurance coverage, like the Marketplace, may only be available if you qualify for a Special Enrollment Period. The Pennsylvania Association of Community Health Centers (PACHC) offers free, personal, no pressure, no obligation, non-biased enrollment assistance. PACHC and its network of Community Health Centers are available to assist you in navigating and enrolling in the Health Insurance Marketplace, Medical Assistance Medicare and CHIP. Certified Exchange Assisters are available throughout Pennsylvania to help you enroll in these programs.

Here is a **list of exchange assisters in your area.** You can also search by using the **find a health center page**. If you have additional questions or need further assistance, please contact the PACHC's Navigator Hub at 1-866-944-CARE (2273)

You can also use COMPASS to sign up for Medical Assistance. COMPASS is an online tool for Pennsylvanians to apply for many health and human service programs like Medicaid and CHIP. Visit COMPASS at www.compass.state.pa.us.

If you would prefer to research signing up for a Marketplace plan without assistance, you can visit www.healthcare.gov

If you are uninsured, the Families First Coronavirus Response Act may provide coverage for the COVID-19 testing administered during emergency period and associated visit.

COBRA Questions

What benefits must be covered under COBRA?
If you elect to purchase COBRA, the coverage should be the same as what you had with your employer coverage

How long do I have to elect COBRA Coverage?
If you are offered COBRA coverage, you must be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

Why is COBRA coverage expensive?
COBRA coverage is expensive because your employer is no longer contributing towards the cost. You may want to contact a local exchange assister to determine to review all the options available to you for health insurance coverage.

What if my company closed or went bankrupt? Am I still eligible for COBRA?
If there is no longer a health plan, there is no COBRA coverage available. If, however, there is another plan offered by the company, you may be covered under that plan. Union members who are covered by a collective bargaining agreement that provides for a medical plan also may be entitled to continued coverage.

Do deductibles start over with COBRA?
No. If you already satisfied your deductible and out-of-pocket expenses, you do not start over again in the same plan year.

For additional information about COBRA coverage, click here to view the U.S. Department of Labor's COBRA information. For additional information about the questions above click here to review Frequently Asked Questions about COBRA.

Mini-COBRA

What is "mini-COBRA"?
Mini-COBRA, or Act 2 of 2009, is a Pennsylvania law that gives employees of small businesses (2-19 employees) who receive health insurance from their employers the right to purchase continuation health insurance after they leave employment. It allows eligible employees and dependents to purchase health insurance through their former employer for nine months after their employment ends, as long as their former employer's coverage is continued.

Why is it called "mini-COBRA"? Is it different from federal COBRA?
Mini-COBRA is modeled after the federal COBRA law, but with some important differences. The federal COBRA law allows employees at larger businesses (20 or more employees) to purchase continuation health coverage after they leave employment for 18 months (or, in some cases, 36 months) after their employment ends. Pennsylvania's Mini-COBRA applies to employees of smaller businesses (2-19 employees) and it is for a shorter length of time (nine months, with no extensions).
Who is eligible for Mini-Cobra continuation coverage?

Covered employees and their eligible dependents who lose group health insurance coverage through a small employer as a result of a "qualifying event" are eligible for Mini-COBRA continuation coverage. The covered employees and eligible dependents must have been continuously insured under the group policy or for similar benefits under any group policy which it replaced, for three consecutive months ending with the employee's termination.

Also, continuation coverage is not available for anyone who is covered or is eligible for coverage under Medicare; who fails to verify that he is ineligible for employer-based group health insurance as an eligible dependent; or is or could be covered by any other insured or uninsured group health coverage arrangement and under which the person was not covered immediately prior to such termination (this last condition excludes Medical Assistance and CHIP.

What is a "qualifying event"?
A qualifying event is an event that would result in the loss of coverage for the covered employee or eligible dependent, including:

- death of the covered employee,
- termination of employment (either voluntary or involuntary, but not for the employee's gross misconduct),
- reduction in hours,
- divorce or legal separation,
- eligibility for Medicare,
- dependent child ceasing to be dependent,
- bankruptcy of the employer.

For more information about Mini COBRA click here

What should I do if my insurance won't cover COVID-19 testing or treatment?
If you have an excepted benefit policy, short-term, limited duration health insurance coverage, or a health care sharing ministry plan, the Families First Coronavirus Response Act may provide coverage for your COVID-19 testing as an uninsured person.

However, if you believe your insurance company should be covering COVID-19 testing or treatment but is not, you can file a complaint with the Pennsylvania Insurance Department. The Pennsylvania Insurance Department consumer services team can be reached by visiting insurance.pa.gov or by phone at (877) 881-6388.

What should I do if I want to refill my prescriptions early to have more on hand?
The Pennsylvania Insurance Department has encouraged insurers to cover refills even when the scheduled refill date has not been reached. (This recommendation does not apply to prescription drugs with a high likelihood of abuse, such as opioids.) If you are thinking about requesting additional supplies of medication, discuss your options with your provider, including whether your one-month supply can be increased to three. With the COVID-19 pandemic, many insurers are giving consideration to 90-day refills, but you should contact your provider and your insurance company if you have questions.

Medicare beneficiaries enrolled in the PACE Program can refill prescriptions prior to using 75% of the medication, except for medications with the potential for abuse.
What should I do if I want to receive assistance via the use of telehealth from a provider outside of the Commonwealth of Pennsylvania?

Governor Wolf granted the Department of State's request to allow licensed practitioners in other states to provide services to Pennsylvanians via the use of telehealth, without obtaining a Pennsylvania license, for the duration of the emergency. Out-of-state practitioners must:

- Be licensed and in good standing in their home state, territory or country.
- Provide the Pennsylvania board from whom they would normally see licensure with the following information prior to practicing telehealth with Pennsylvanians
    - Their full name, home or work mailing address, telephone number, and email address;
    - Their license type, license number or other identifying information that is unique to the practitioner's license, and the state or governmental body that issued the license.

Be sure to check with your insurance company before receiving assistance from an out-of-state provider to find out if that provider is in your network or if the services will be covered as if in-network.

Can my insurance carrier cancel or refuse to renew my insurance policy if I am diagnosed with COVID-19? Can they deny my claim for a pre-existing condition?

Health insurers may not cancel or refuse to renew your individual or group health insurance policy if you are diagnosed with COVID-19.

Federal and state regulations provide protections against pre-existing condition exclusions in individual and group health insurance coverage.

Those pre-existing condition protections do not apply to short-term, limited-duration health insurance coverage or excepted benefit policies.

If you have questions or need assistance related to your health insurance, contact the Pennsylvania Insurance Department consumer services team at (877) 881-6388. The consumer services team is available to answer questions about insurance coverage and benefits. The Insurance Department may also help if you receive an unexpected bill related to COVID-19 or other health care services.

What should I do if I have Medical Assistance or CHIP coverage?

If you are enrolled in Medical Assistance and have questions regarding coverage, contact your managed care organization or the Fee for Service Recipient Service Center at 1-800-537-8862.

If you are enrolled in CHIP and have questions regarding coverage, please contact your CHIP insurance company or call 1-800-986-KIDS (5437)

What should I do if I have questions about Medicare or Caregiver Inquiries?

Yes. If you have questions regarding Medicare beneficiaries and caregiver inquiries, please call CMS at (800) 548-9034.

Federal Legislation

What has the federal government done in response to the COVID-19 pandemic?
Congress has passed the following legislation:

- Families First Coronavirus Response Act
- Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020

In addition, Congress is considering additional legislation and economic stimulus measures.

How does the Families First Coronavirus Response Act impact what I pay?

Group Health Plans, Self-Insured (Self-funded) Plans and Individual or Group Coverage through the marketplace.

- Requires coverage of testing with no cost-sharing and no prior authorization or other medical management requirements
    - Provider visits (office, urgent care, ER) including telehealth, that result in order or administration of the test
    - Must relate to furnishing or administration of those products, or evaluating need for the products
    - The test must be medically necessary for COVID-19.

Medicare

- Provides for 100% of payment for COVID-19 testing with no cost sharing and the deductible does not apply

Medicare Advantage Program

- Provides for coverage of clinical diagnostic lab tests during the emergency with no cost sharing and no prior authorization or utilization management requirements

Medical Assistance (Medicaid)

- Provides for coverage of testing and medical visit related to testing "for which payment may be made under the State plan" with no cost-sharing

CHIP

- Provides coverage for testing with no cost-sharing

TRICARE, Coverage for Veterans, and Coverage for Federal Civilians

- Provides coverage for testing with no cost-sharing for TriCare, VA, and Federal Civilians

Indian Health Services

- Provides coverage for testing with no cost-sharing for Indians receiving care through Indian Health Service

Scams

During this time of social distancing, Pennsylvanians are spending more time on their phones and computers for home, work, shopping and entertainment. Cyber criminals take advantage of widespread fear, panic and worry. They may use your extra screen time and time at home as an opportunity.

Protect yourself by being aware of different types of scams.

According to the U.S. Department of Justice, the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC), there are several ways scammers will use COVID-19 to target people.

- **Vaccine and treatment scams.** Scammers may advertise fake cures, vaccines and advice on unproven treatments for COVID-19. Scammers may even go door to door claiming to be from the CDC (Centers for Disease Control and Prevention) offering you the opportunity to be part of a vaccine program. Unfortunately, to date, there isn't a vaccine for COVID-19 and the CDC isn't offering such a program.
- **Shopping Scams.** Scammers may create fake stores, e-commerce websites, social media accounts, and email addresses claiming to sell medical supplies currently in high demand. Supplies might include things like hand sanitizer, toilet paper and surgical masks. Scammers will keep your money but never provide you with the merchandise.
- **Medical scams.** Scammers may call and email people pretending to be doctors and hospitals that have treated a friend or relative for COVID-19 and demand payment for treatment.
- **Charity scams.** Scammers sometimes ask for donations for people and groups affected by COVID-19.
- **Phishing and Malware scams.** During the COVID-19 crisis, phishing and malware scams may be used to gain access to your computer or to steal your credentials.
    - Malware is malicious software such as spyware, ransomware, or viruses that can gain access to your computer system without you knowing. Malware can be activated when you *click* on email attachments or install risky software.
    - When Phishing is used, bad actors send false communications from what appears to be a trustworthy source to try to convince you to share sensitive data such as passwords or credit card information.
    - For example, scammers may pose as national and global health authorities, including the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) and send phishing emails designed to trick you into downloading malware or providing your personal and financial information.
- **App scams.** Scammers may create mobile apps designed to track the spread of COVID-19 and insert malware into that app, which will compromise users' devices and personal information. Be sure to use only trusted sources. You should visit trusted resources such as the Pennsylvania Department of Health at www.health.pa.gov or the CDC at www.CDC.gov .
- **Investment scams.** Scammers may offer online promotions on things like social media, claiming that products or services of publicly traded companies can prevent, detect, or cure COVID-19, causing the stock of these companies to dramatically increase in value as a result.

(Source: U.S. Department of Justice and the Pennsylvania Insurance Department)

Here are some DO's and DON'Ts when it comes to finding Cornavirus (COVID-19) Scams:

DO:

- DO watch out for vaccinations and home test kits offers. There are currently no vaccines, pills, potions, lotions, lozenges or other prescription or over-the-counter products available to treat or cure COVID-19
- DO watch for emails claiming to be from the Centers for Disease Control and Prevention (CDC) or experts saying they have information about the virus. For the most up-to-date information about the Coronavirus, visit the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) or the Pennsylvania Department of Health
- DO be careful while shopping online. If you see someone selling THE in-demand products, like toilet paper, medical supplies or cleaning supplies, they may not have it.
- DO your homework when donating to a charity. Don't let anyone rush you into making a donation. If someone wants donations in cash, by gift card, or by wiring money, don't do it.

DON'T

- DON'T believe everything you read on the internet. DON'T share information that hasn't been verified. Before you hit send, make sure the information is accurate and from a trusted source.
- DON'T click on links from sources you don't know. They could download viruses onto your computer or device.
- DON'T respond to a text or email about checks from the government. The details are still being worked out. Anyone who tells you they can get you the money now isn't telling the truth.
- DON'T feel the need to answer robocalls. Just hang up! DON'T press any numbers. Scammers are using illegal robocalls to sell anything from Coronavirus treatments to work-at-home schemes. Even if the recording says you will speak to a live operator or be added to the do not call list, DON'T press the number but it might lead to more robocalls.

(source: Federal Trade Commission and the Pennsylvania Insurance Department)

Price Gouging- The Office of Attorney General's new tool is available to everyone in the Commonwealth, effective immediately. Any instance of price gouging should be reported to pricegouging@attorneygeneral.gov.

Where to go for Help:

If you have individual, small group employer, or large group employer coverage:
The Pennsylvania Insurance Department
Web: www.insurance.pa.gov
Phone: 1-877-881-6388 or 717-783-3898

If you have employer self-insured coverage:

The United States Department of Labor
Web: www.dol.gov/EBSAOpens In A New Window
Phone: 1-866-275-7922

If you have Medicare coverage:
Medicare
Web: www.medicare.govOpens In A New Window
Phone: 1-800-MEDICARE

If you have Pennsylvania Medical Assistance (Medicaid):
The Pennsylvania Department of Human Services
Web: www.healthchoicespa.com
Phone: 1-866-550-4355

If you have Children's Health Insurance Program (CHIP) coverage:
Pennsylvania's Children's Health Insurance Program
Web: www.chipcoverspakids.com
Phone: 1-800-986-KIDS (5437)

If you have State Veterans Services

Contact your County Director of Veterans Affairs to discuss benefits and eligibility, the nearest office of the Department of Military and Veterans Affairs or visit www.dmva.pa.gov.

Pa Link to Aging and Disability Services

PA Link partners work together to connect individuals with all available resources related to care, medication, nutrition, insurance, housing, transportation, employment, behavioral health services, and other supports regardless of an individual's age, physical or developmental disability, or ability to pay. To contact PA Link, call 800-753- 8827 on weekdays from 9 a.m. until 5 p.m. or email carelink@pa.gov.

Older Adults can always contact their local Area Agency on Aging for services and supports in their area.

Additional Medicare Information

MEDICARE PART A – HOSPITAL INSURANCE Benefits: Medicare Part A helps pay for:

- Inpatient hospital care
- Inpatient skilled nursing facility care
- Home health care
- Hospice care
- Inpatient care in a religious nonmedical health care institution In most cases there is no premium for Medicare Part A, however if you are not eligible for free Part A and you didn't buy it when you were first eligible, your monthly premium may be higher.

MEDICARE PART B – MEDICAL INSURANCE Benefits: Medicare Part B helps pay for:

Doctor's services:

- Outpatient hospital services
- Various medical services and supplies
- Preventative benefits A monthly premium must be paid for Part B.

MEDICARE PART D – PRESCRIPTION DRUG COVERAGE Benefit: Medicare Prescription Drug Coverage is available to everyone with Medicare and is provided by private insurance companies. You choose the plan and pay a monthly premium. Some plans may also have a deductible and other cost-shares such as co-pays or co-insurance, however, some individuals may qualify for help with these costs through the Social Security Administration's Low-Income Subsidy also known as Extra Help.

Additional Medicare Advantage Program Information

Medicare Advantage Program

- Provides for coverage of clinical diagnostic lab tests during the emergency with no cost sharing and no prior authorization or utilization management requirements
- The APPRISE Program provides free, objective, in-person or telephone assistance to help guide Medicare beneficiaries through their many health insurance options including Medicare and Medicaid, Medicare supplement insurance plans, Medicare Advantage Plans, Medicare prescription (Part D), long-term care insurance policies, and public 47 benefit programs. Contact: The APPRISE Program at 800-783-7067 from 9 a.m. to 4 p.m. Monday-Friday.

HEALTHY HORIZONS

To ensure adequate health care for low-income seniors and individuals with disabilities and allow them more spendable income by paying their Medicare premiums, the state developed a special Medical Assistance program – Healthy Horizons. Contact your local Department of Human Services County Assistance Office or call (800) 692- 7462 from 9 a.m. until 4:30 p.m. Monday-Friday

PACE AND PACENET

The Pharmaceutical Assistance Contract for the Elderly (PACE and PACENET) programs offer comprehensive prescription coverage to qualified older Pennsylvanians. The programs cover most medications that require prescriptions, including insulin and insulin syringes. PACE or PACENET wrap

around Medicare Part D prescription coverage, supplementing this coverage to offer older Pennsylvanians the best 70 benefits of both programs. Older adults continue to receive the same prescription benefits while, in many cases, they save more money, and often have $0 co-pays.

PACE/ PACENET provides a one-month supply of medication for a small co-pay.

• For PACE, $6 for each generic and $9 for each brand-name prescription drug

- As of March 5, 2020, PACE will now reimburse prescription refills even though the required 75% of the days' supply has not passed – except for opioids and other controlled substances – which will be handled on a case by case basis. Enrollees wishing to receive that exception must have their pharmacy provider contact PACE at 1-800-835-8040, 24 hours a day, seven days a week, to make that request. The program has traditionally not offered this exception unless an enrollee's medications were lost or stolen. Enrollees who have difficulties obtaining their refills can call cardholder services at 1-800-225-7223

• For PACENET, $8 for each generic and $15 for each brand name prescription drug

• For PACE, the Program pays Medicare Part D premiums if card holder is enrolled in a premium payment plan.

• For PACENET, the cardholder is responsible for paying the monthly premium.

Find enrollment applications online at PACECares.magellanhealth.com

For more information, call 866-712-2060

PENNSYLVANIA PATIENT ASSISTANCE PROGRAM CLEARINGHOUSE

Pennsylvania Patient Assistance Program Clearinghouse (PA PAP) assists anyone needing prescription help, regardless of income. If you are uninsured, under-insured, over the age of 18 and do not currently have Medicaid or PACE coverage, PA PAP will help you apply for prescription assistance through various patient assistance programs that you may not have known about. Contact: For more information, call 800-955-0989.

PENNSYLVANIA PRESCRIPTION PRICE FINDER

On the Price Finder website, consumers shop for the best medication prices for commonly used drugs. The website includes prices, pharmacy location, store hours, where to find low-cost generics, and drug education materials. Contact: For more information, call 800-835-4080 or visit www.parxpricefinder.com.