

PY27 Cert Training Module 1

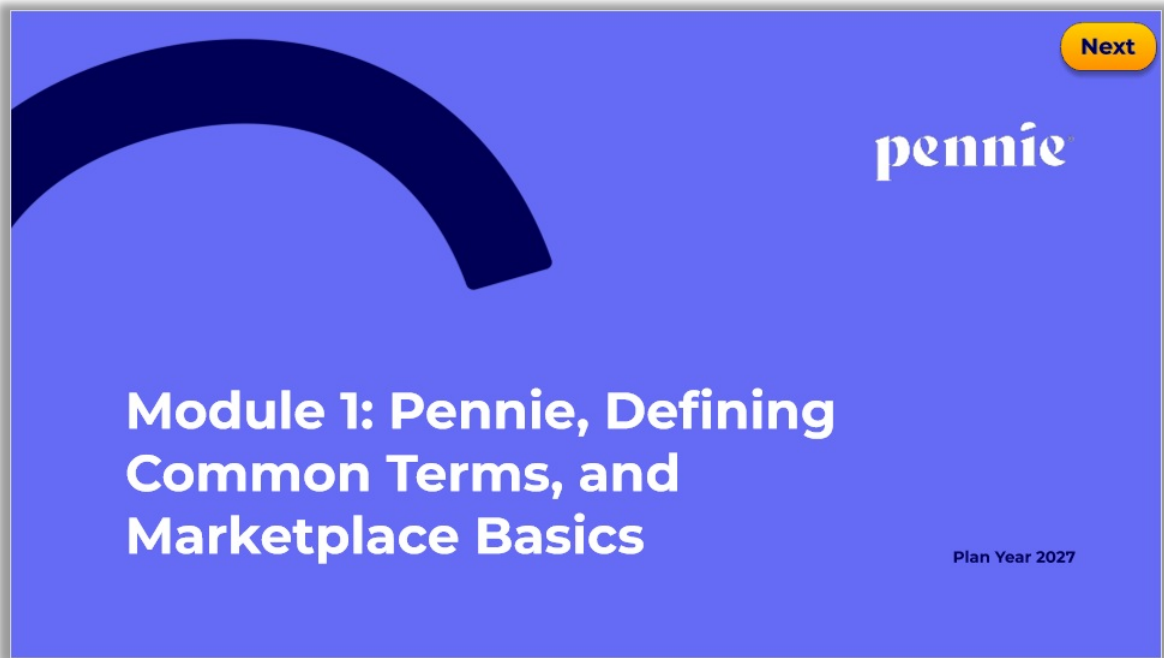
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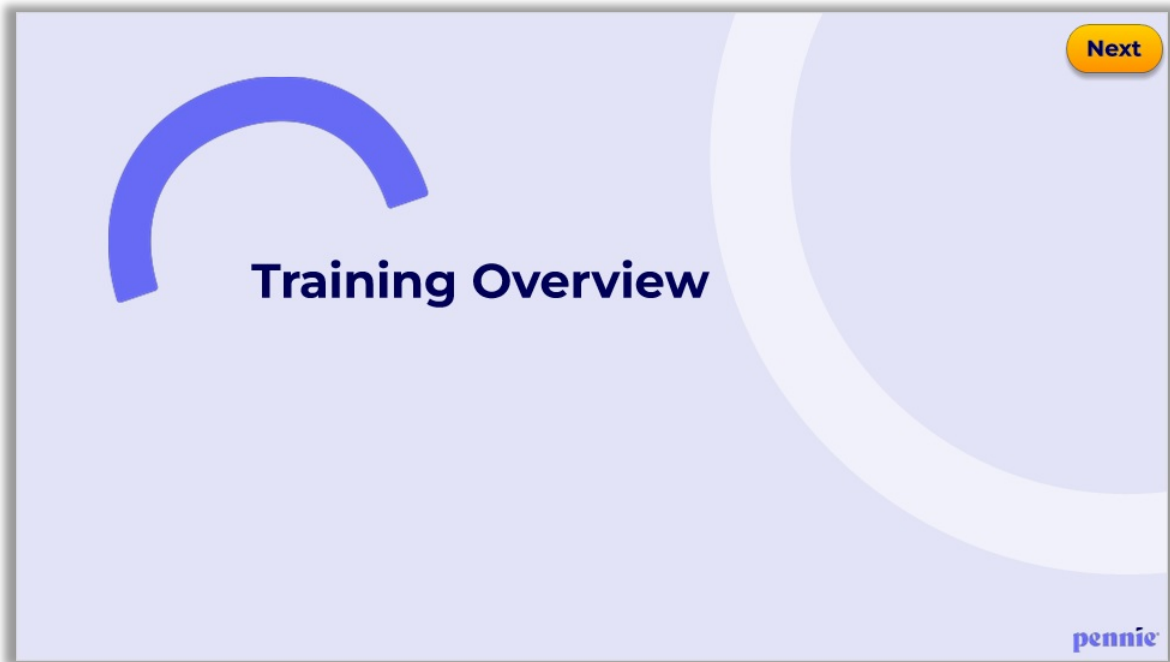
1. Title Slide

1.1 Title Slide



2. Training Overview

2.1 Training Overview



2.2 Training Overview

Training Overview

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This training course will prepare you to be an effective Pennie Certified Assister or Broker on the Pennie platform. The modules are to be taken in order and each one must be completed before you begin the next one.

After all modules have been completed, there is a final exam. A score of 80% or better is required to pass the exam and complete the training course. You will also be prompted to acknowledge, accept, and adhere to Assister Non-Exchange Entity Agreement, or the Producer General Agreement.

The information provided in this training course is not intended to take the place of the federal and state statutes, regulations, and formal policy guidance that it is based upon. This course summarizes current policy and operations as of the date it was uploaded to the Learning Management System.

In this course, there are some references and links to nongovernmental third-party websites. Pennie offers these links for informational purposes only, and inclusion of these websites should not be construed as an endorsement of any third-party organization's programs or activities.

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2.3 Training Overview

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Whether you are recertifying an existing Pennie account, or if you are creating one for the first time, **it is critical that you ensure the information entered on your TrainPA and Pennie accounts mirror your PA Insurance Department (PID) License or registration exactly.**

Your Pennie account only has fields for:

- First Name
- Last Name

Do not add any of the following to the First Name or Last Name fields on your Pennie or TrainPA Accounts:

- Middle Name
- Prefix or Suffix
- Certifications, degrees, designations, or any other text

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2.4 Training Overview

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For Brokers, **both the PA License Number on your Pennie account – and the Professional License Number on your TrainPA account – must match your PID License exactly.** This will be a 6- or 7-digit number without any text.

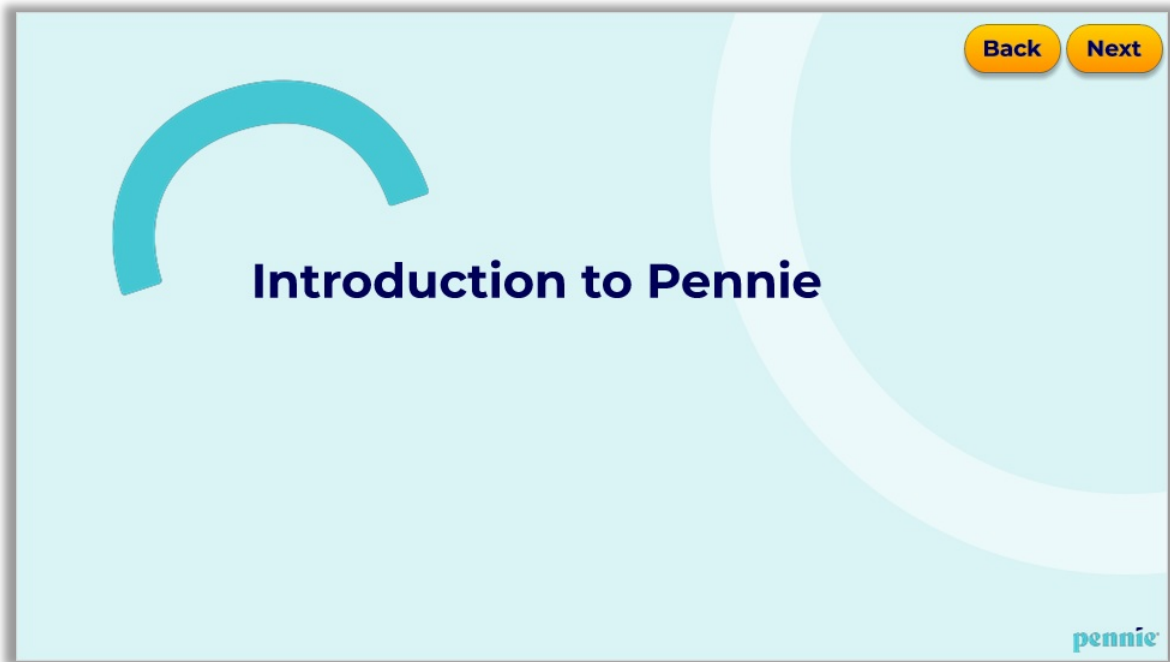
- Non-resident Brokers *must* use their PA License Number, not the license number from their home state
- *Do not* add any text or characters to either License Number fields on your TrainPA or Pennie accounts
- *Do not* use your National Producer Number (NPN)
 - There is a separate field on your Pennie account for your NPN

Failure to mirror the information on your accounts will prevent our ability to process your certification!

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3. Introduction to Pennie

3.1 Introduction to Pennie



3.2 Origin of Pennie

Origin of Pennie

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The Pennsylvania Health Insurance Exchange Authority d/b/a Pennie® was created in July of 2019 as Governor Tom Wolf signed Act 42 of 2019 into law.

Act 42 was a unanimous, bipartisan effort to transition away from the federal exchange (HealthCare.gov) and to create a health insurance marketplace specifically for Pennsylvania.

Two main goals of this legislation:

1. Set up a state-based exchange, take local control of operations and customer service at a significantly lower cost than what Pennsylvanians paid for the operation of HealthCare.gov (\$98 million in 2018)
2. Use the savings to launch a reinsurance program to increase premium savings for middle-income families purchasing health insurance in the individual market

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3.3 Why Pennie

Why Pennie

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Pennie was established to help Pennsylvanians purchase high-quality insurance and access financial savings to make that coverage more affordable.

- Financial savings – such as income-based premium tax credits and cost-sharing reductions – **are only available through Pennie**
- All health insurance plans offered through Pennie are Qualified Health Plans (QHP) which are Affordable Care Act (ACA)-compliant and meet or exceed the guidelines for minimum essential coverage (MEC)
- Unlike the Federal Marketplace (HealthCare.gov), Pennie enrollees are also able to enroll in Qualified Dental Plans (QDP) even if they do not enroll in a Qualified Health Plan
- Pennie uses a single streamlined application to help customers determine if they're eligible for coverage through Pennie, or if they are potentially eligible for Medical Assistance ("MA" or "Medicaid") or the Children's Health Insurance Program (CHIP)



3.4 Who is Pennie for?

Who is Pennie for?

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Pennie is available to eligible Pennsylvanians and their families who:

- Are uninsured or underinsured
- Do not have insurance through an employer, or for those whose employer-sponsored coverage is unaffordable
- Do not qualify for insurance through other programs, such as MA, CHIP, or Medicare. This includes self-employed individuals or those who have retired before age 65 and are not yet Medicare eligible

To be eligible for coverage through Pennie, customers generally must:

- Be a U.S. citizen, U.S. national, or non-citizen who is lawfully present in the U.S. and meets Pennsylvania residency requirements
- Not be incarcerated (unless pending the disposition of charges, e.g., being held without having been formally convicted of a crime)



3.5 Providing Access to Coverage

Providing Access to Coverage

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Pennie's first Open Enrollment Period (OEP) was for the 2021 plan year. During that inaugural OEP, Pennie successfully transitioned more than 260,000 individuals from the Federal Marketplace (HealthCare.gov) to Pennie and added an additional 75,000 new enrollments.

By the end of the 2022 OEP, nearly 375,000 Pennsylvanians had signed up for coverage through Pennie, an 11% increase over the previous year.

As of the end of the 2025 OEP, Pennie enrolled more customers than ever before, as total enrollment grew to an all-time high of 496,661 customers.



Year	Enrollment
2021	337,722
2022	374,776
2023	371,516
2024	434,571
2025	496,661
2026	486,577

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4. Marketplace Terms

4.1 Marketplace Terms



Marketplace Terms

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4.2 Qualified Health Plans (QHPs)

Qualified Health Plans (QHPs)

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For a health plan to be considered "qualified," it must:

- Provide coverage for the **10 Essential Health Benefits (EHBs)** as defined by the ACA
- Follow established limits on cost-sharing, such as deductibles, copayments, and out-of-pocket maximum amounts
- Meet the requirements to be considered **minimum actuarial value**
- Meet all other minimum standards outlined by the ACA

As stipulated in the ACA, Qualified Health Plans offered through Pennie **cannot contain exclusions for pre-existing conditions, nor can those with pre-existing conditions be charged more for their coverage.**

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4.3 Cost Sharing

Cost Sharing

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Cost sharing refers to the out-of-pocket costs a customer is responsible for paying when receiving services covered by their insurance plan.

Examples of cost sharing include:

- Deductibles
- Copayments
- Coinsurance
- Out-of-Pocket Limits

There are five common factors that affect premiums and cost-sharing amounts:

- Age
- Place of residence
- Use of tobacco
- Individual vs. family plan
- Plan metal level

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4.4 Deductibles

Deductibles

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A **deductible** is the amount a customer must pay for covered healthcare services before their insurance plan begins to pay a portion (or all) of the cost. For example, if a plan has a \$2,000 deductible, the customer must pay the first \$2,000 of incurred expenses out-of-pocket.

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.

In general, plans with lower monthly premiums will have higher deductibles, while plans with higher monthly premiums generally have lower deductibles.

After the customer meets their deductible, they will usually only be required to pay a **copayment** or **coinsurance** amount for covered services. The insurance company will cover the rest.

All health plans purchased through Pennie will pay the full cost of certain preventive benefits, like a check-up or disease management programs, prior to meeting the deductible.



4.5 Copayments & Coinsurance

Copayments & Coinsurance

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A **copayment** ("copay") is a fixed-dollar payment made by the customer for a covered service after their deductible has been met.

Copayment amounts can vary for different services within the same plan. For example, a copay for lab work may be different from the copay amount for a specialist office visit.

In general, plans with lower monthly premiums have higher copayments, while plans with higher monthly premiums usually have lower copayments.

Coinsurance is the customer's share of the cost for a covered healthcare service after their deductible has been met.

Where copays are a set dollar amount per service, coinsurance is calculated as a percentage of the amount of the charge for the service.

Example: a customer schedules a visit with a specialist for which they receive a \$40 bill. Since the customer's plan has 20% coinsurance after the deductible for specialist office visits, the \$40 is the 20% the customer is responsible for. In other words, the customer pays 20% (\$40) of the entire charge (\$200).



4.6 Other Terms

Other Terms

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Explanation of Benefits (EOB): a document provided by the insurance company after services are received that shows the breakdown of the cost of care. The purpose of EOBs is to provide clarity as to what was charged by the provider, what the plan pays, and what the member's potential financial responsibility will be. EOBs are not a bill – they are generated when their provider submits a claim for the services received.

Summary of Benefits and Coverage (SBC): an SBC is a document that provides a more detailed description of how the health plan covers services across different categories. SBCs will include details such as the plan deductible amount, Out-of-Pocket Maximum, copay and coinsurance amounts, visit limits, and if a prior authorization is required (for non-prescription services).

Modified Adjusted Gross Income (MAGI): MAGI is the figure used to determine eligibility for Advanced Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs) which lower the cost of health coverage through Pennie. MAGI is equal to Adjusted Gross Income (AGI) plus the following, if applicable: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

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4.7 Other Terms

Other Terms

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Premium: The amount the customer pays for health insurance every month. Premiums are billed on a monthly basis, however customers can pay for more than one month's coverage at a time.

Binder Payment: The first month's premium payment. **Customers must make the first month's premium binder payment to complete the enrollment process.** If they don't make the binder payment, their policy will not take effect and they will not be enrolled in coverage.

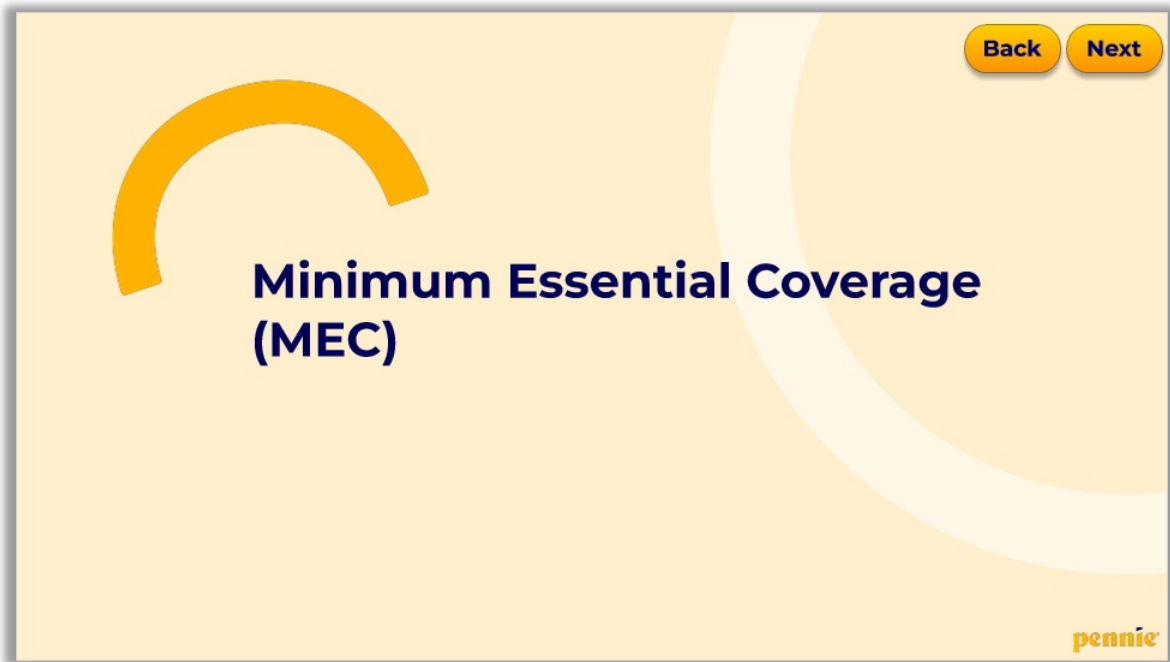
Grace Period: Customers will automatically enter a grace period with the insurer if a monthly premium payment was missed or not paid in full (**not applicable for binder payments**). If the customer is receiving financial savings and has paid their binder payment, their grace period will be **90 days**. If they enroll without financial savings, the grace period is determined by the insurer but can be no less than **30 days**.

Out-of-Pocket Maximum: The most a customer would have to pay for covered services in a plan year. If a customer accrues the amount of the plan's Out-of-Pocket Maximum through deductibles, copayments, and coinsurance, their health plan will begin to pay 100% of the costs of covered benefits for the remainder of the plan year. Note: The out-of-pocket limit does not premium payments for non-covered services.

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5. Minimum Essential Coverage (MEC)

5.1 Minimum Essential Coverage (MEC)



5.2 Minimum Essential Coverage (MEC)

Minimum Essential Coverage (MEC)

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Any health insurance plan that meets the ACA standards for comprehensive coverage is referred to as a Qualified Health Plan (QHP).

All plans available through Pennie must meet the QHP standards, including coverage of the Essential Health Benefits. Therefore, all plans offered on the Exchange meet the threshold to be considered Minimum Essential Coverage (MEC).

This means that the plans available **cannot exclude coverage for pre-existing conditions**, nor will those with pre-existing conditions be charged more for their coverage, as stipulated in the ACA.

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5.3 Minimum Essential Coverage (MEC)

Minimum Essential Coverage (MEC)

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The following are types of health coverage that qualify as MEC:

- Any Marketplace QHP, including coverage through Pennie
- Employer-sponsored insurance (ESI), including retiree plans and COBRA coverage
- Medicare Part A (premium free)
- Medicare Part C
- MA coverage (except emergency MA)
- Children's Health Insurance Program (CHIP)
- Health coverage for Peace Corps volunteers
- Coverage under a parent's plan (that qualifies as MEC)
- Certain types of veterans' health coverage through the Department of Veterans Affairs
- Most TRICARE plans
- Department of Defense Non-appropriated Fund Health Benefits Program
- Refugee MA

Other types of coverage that qualify as MEC can be found at [IRS.gov](https://www.irs.gov).

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5.4 Minimum Essential Coverage (MEC)

Minimum Essential Coverage (MEC)

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The following are types of health coverage that *do not* qualify as MEC:

- Coverage only for vision care or dental care
- Workers' compensation
- Limited-benefit coverage through MA (i.e., "Family Planning" coverage)
- Coverage only for a specific disease or condition
- Plans that offer only discounts on medical services
- Short-term Limited Duration Health Insurance (STLDIs)
- Health sharing ministries
- Travel insurance

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6. The Affordable Care Act: Eligibility & Provisions

6.1 The Affordable Care Act: Eligibility & Provisions



6.2 Overview of the Affordable Care Act (ACA)

Overview of the Affordable Care Act (ACA)

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The ACA is a comprehensive healthcare reform law enacted in March of 2010. The law was designed to expand access to quality, affordable health coverage and care while providing numerous consumer protections.

The law has three main goals:

1. Make health insurance more affordable for more people
2. Expand MA
3. Lower the cost of healthcare

In addition, the ACA established the health insurance marketplaces where eligible customers can shop and enroll for coverage for themselves and their families.



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6.3 Customer Protections

Customer Protections

BackNext

There are several key protections under the ACA that make health coverage more accessible. Qualified customers in Pennsylvania are generally able to:

- Access affordable health coverage through Pennie, regardless of any pre-existing conditions they have
- Keep existing health coverage for young adults under a parent's health plan
- Obtain certain preventive services included in their health coverage without cost sharing

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6.4 Requirements for Health Insurance Companies

Requirements for Health Insurance Companies

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The ACA requires health insurance companies and the marketplace plans they offer to:

- Provide a standardized SBC so customers can easily understand their coverage and compare it to other available options
- Provide coverage for customers with pre-existing conditions
- Refrain from terminating coverage after they've already agreed to cover customers (unless an exception applies)
- Offer a core comprehensive set of 10 categories of EHBs, when offering coverage to individual customers and small employers
- Prohibit annual and lifetime dollar limits on coverage of EHB
- Cover preventive services at no cost to the customer

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6.5 The ACA Essential Health Benefits (EHB)

The ACA Essential Health Benefits (EHB)

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The ACA requires health plans in the individual and small group markets cover Essential Health Benefits (EHBs), which include services in the following ten benefit categories:

- **Ambulatory patient services** (outpatient care without being admitted to a hospital)
- **Hospitalization**
- **Pregnancy, maternity and newborn care**
- **Mental health and substance use disorder services**
- **Rehabilitative and habilitative services and devices** (services and devices to help people with injuries, disabilities, or chronic conditions)
- **Preventive and wellness services** (including chronic disease management)
- **Pediatric services** (including oral/dental and vision care [Note: Dental coverage is not an EHB for adults])
- **Laboratory services**
- **Prescription drugs**
- **Emergency services**

While every plan must cover these benefits, coverage levels vary across plans.

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6.6 Summary of Benefits and Coverage (SBC)

Summary of Benefits and Coverage (SBC)

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Health insurance companies are required to provide clear, consistent, and comparable information about health benefits and coverage by providing a standard SBC for each plan they offer.

- Each plan's SBC must be written and presented in a standard format and use basic terms
- Health insurance companies must also provide customers with a uniform glossary of commonly used terms

Summary of Benefits and Coverage: What This Plan Covers & What You Pay for Covered Services
Insurer PPO Plan 1: \$30,000/\$600
Coverage Period: 01/01/2025 - 12/31/2025
Coverage for: Individual and Family | Plan Type: PPO

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, call 1-866-379-4488. For general definitions of common terms, such as [deductible amount](#), [balance billing](#), [copayment](#), [coinsurance](#), [out-of-pocket limit](#), [out-of-pocket maximum](#), or other [unfamiliar](#) terms, see the Glossary. You can view the Glossary at [www.healthcare.pennie.com/terms](#) or call 1-866-379-4488 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Preferred provider: \$4,500 / individual or \$9,000 / family Non-preferred provider: \$10,000 / individual or \$20,000 / 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 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.pennie.com/preventive-services .
Are there other deductibles for specific services?	Yes: \$800 / individual or \$1,600 / family for prescription drug coverage.	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?	Preferred provider: \$8,100 / individual or \$16,200 / family Non-preferred provider: \$15,000 / individual or \$30,000 / family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription balance billing charges, and health care for 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.healthcare.pennie.com or call 1-866-379-4488 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.
Do you need a referral to see a specialist?	No.	You can see the specialists you choose without a referral.

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6.7 Coverage for Young Adults

Coverage for Young Adults

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Prior to the ACA, states could limit how long young adults were able to remain enrolled in coverage through their parent's health insurance plan.

Now, the ACA requires health issuers in all states to allow children up to age 26 to stay on their parent's health insurance plans (if the plans cover dependent children).

In Pennsylvania, children can enroll on their parent's health insurance **through the end of the calendar year in which the child turns age 26**.

At renewal, the aging-out child will not be eligible to renew on their parent's health insurance and will need to sign up for their own coverage.

Disabled children can remain enrolled in their parent's plan past age 26.

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6.8 Health Plan Metal Levels

Health Plan Metal Levels

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QHPs in the Marketplace are separated into five health plan categories:

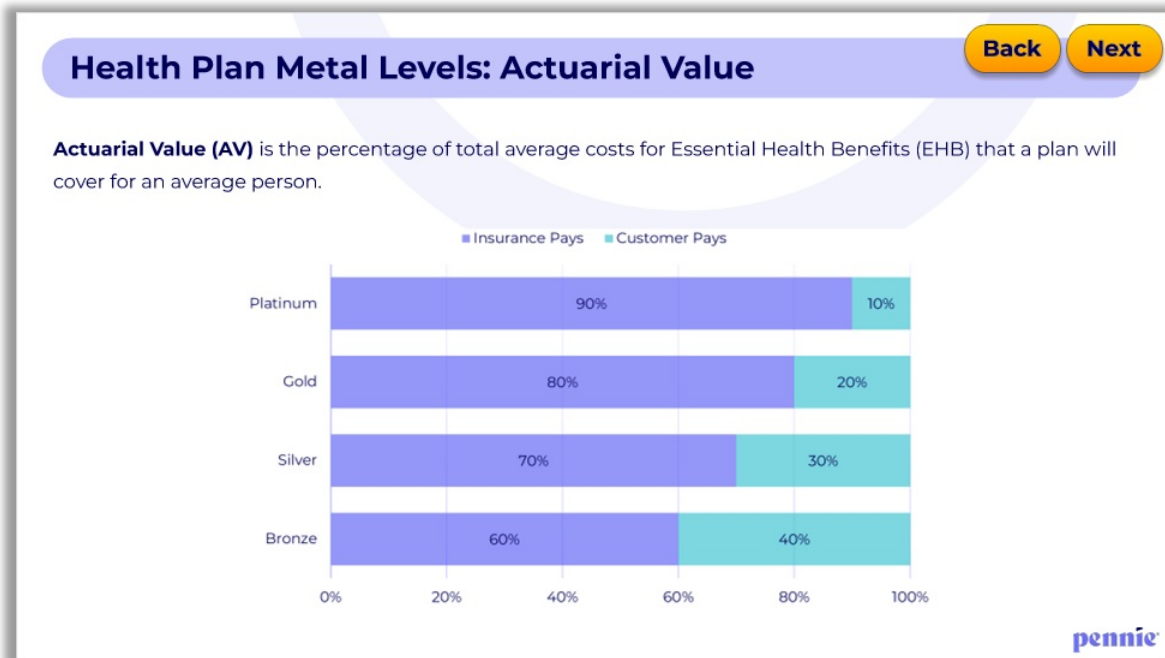
- Platinum
- Gold
- Silver
- Bronze
- Catastrophic

Health plan metal levels are based on each plan's **actuarial value (AV)** – that is, the percentage of the total average cost for EHBs that a plan will cover.

The percentage a customer pays for benefits under plans in each health plan category is an "average" for a typical population. These percentages do not necessarily reflect the exact amount a customer will pay for a particular service when using a specific plan.

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6.9 Health Plan Metal Levels: Actuarial Value



6.10 Catastrophic Health Insurance Plans

Catastrophic Health Insurance Plans Back Next

Catastrophic-level plans are available to individual market customers:

- under age 30; or
- age 30 or older who are eligible for a hardship or affordability exemption

These plans may be useful in protecting customers from very large, unforeseen ("catastrophic") medical bills, while costing very little in the way of monthly premium.

While these plans typically have lower premiums than the other metal level plans, customers are responsible for high deductibles and other cost-sharing requirements when accessing services.

In addition, customers cannot use financial savings to lower the costs of a catastrophic plan like they can with other health plan categories.

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7. Medical Assistance, CHIP, and Medicare

7.1 Medical Assistance, CHIP, and Medicare



7.2 Pennie's "No Wrong Door" Policy

Pennie's "No Wrong Door" Policy

Pennie strives to connect all Pennsylvanians with high-quality, affordable health and dental insurance. To do this, Pennie operates a "No Wrong Door" policy to ensure those deemed eligible for programs like **MA** or **CHIP** are connected to coverage.

When an individual or family is assessed as potentially eligible for MA or CHIP, their application is automatically transferred to the Pennsylvania Department of Human Services (DHS) to check if they are eligible for coverage through those programs.

Similarly, customers who apply for MA or CHIP and are denied are transferred to Pennie to apply and enroll.

During Open Enrollment 2024, over 50,000 households were sent to DHS from Pennie. In turn, DHS referred over 80,000 households who were denied MA or CHIP coverage to Pennie, with over 10,000 enrolling in coverage through the marketplace.

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7.3 Medical Assistance (“MA” / “Medicaid”)

Medical Assistance (“MA” / “Medicaid”)

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MA is a health coverage program for low-income families and individuals, including:

- Most adults with household income at or below 138% of the federal poverty level (FPL)
- Pregnant women and children under 1 year old with a yearly household income at or below 220% FPL.
- Children ages 1-5 with household income at or below 162% FPL
- Children who are recipients of adoption assistance and foster care under Title IV-E of the Social Security Act
- Former foster children (until age 26) regardless of what state's foster care system they were in, as long as:
 - They were in the foster care system and enrolled in MA on their 18th birthday
 - They aged out of the foster care system while enrolled in MA

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7.4 Children’s Health Insurance Program (CHIP)

Children’s Health Insurance Program (CHIP)

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CHIP is a health coverage program for uninsured children up to age 19 in families with household incomes too high to qualify for MA.

CHIP coverage includes, but is not limited to:

- Routine checkups
- Immunizations
- Doctor visits
- Prescriptions
- Dental and vision care
- Inpatient and outpatient hospital care
- Laboratory and X-ray services
- Emergency services

Similar to MA, if child is assessed as potentially eligible for CHIP, their application will be automatically transferred to DHS to determine if they are eligible for coverage.

Households with incomes up to 213% FPL are eligible for **No-cost CHIP**. Households with incomes from 213% – 314% FPL are eligible for **Low-cost CHIP**.

Note: Pennie only sends applications for **No-cost** or **Low-cost CHIP** directly to DHS for eligibility determinations, **not for Full-cost CHIP**.

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7.5 Applying for MA or CHIP

Applying for MA or CHIP

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Customers can apply for MA and/or CHIP at any time during the year and without a QLE. You can help customers apply in one of three ways:

1. Apply through the DHS via the COMPASS portal, or call DHS Customer Service (1-877-395-8930)
2. Submit an application online through Pennie, and depending on the income reported, their application may be transferred to DHS to be assessed for MA/CHIP eligibility
3. Contact a Pennie Customer Service member (1-844-844-8040)

Sometimes, it's faster and more straightforward for customers to apply for MA/CHIP coverage directly through the DHS COMPASS portal rather than through Pennie. This is particularly true for individuals who have disabilities and those who are enrolled in other public benefits programs like the **Supplemental Nutrition Assistance Program (SNAP)** or **Temporary Assistance for Needy Families (TANF)**.



7.6 Medicare

Medicare

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Medicare is a health coverage program made up of different parts (A, B, C & D) that each provide different benefits and have their own eligibility requirements. If one or more of the following situations applies to a customer, they may be eligible for Medicare:

- They are age 65 or older
- They have end-stage renal disease
- They have a disability, regardless of age

Premium-free Medicare Part A and Medicare Part C are considered qualifying health coverage, or minimum essential coverage (MEC)

Customers enrolled in either Parts A or C are not eligible for financial savings through Pennie

Medicare enrollees who do not have dental coverage from Medicare Part C are eligible to enroll in a stand-alone dental plan through Pennie. This can be done by calling the Pennie Contact Center.



7.7 Can a Customer Choose Pennie Coverage instead of Medicare?

Can a Customer Choose Pennie Coverage instead of Medicare?

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It is against the law to knowingly sell a Marketplace plan to someone enrolled in Medicare. However, there are situations where a customer can choose a Marketplace plan instead of Medicare:

1. If the customer is paying a premium for Medicare Part A
 - In this case, a customer can drop their Medicare Part A and B coverage and get a Marketplace plan instead
2. If they are eligible for Medicare, but aren't enrolled



7.8 Can a Customer Choose Pennie Coverage instead of Medicare?

Can a Customer Choose Pennie Coverage instead of Medicare?

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Before choosing a Marketplace plan over Medicare, customers must be aware that:

- If they enroll in Medicare after their initial enrollment period ends, they may have to pay a **late enrollment penalty for as long as they have Medicare**
- Generally, they can only enroll in Medicare during the annual Medicare enrollment period

Note: If a customer is getting Social Security retirement or disability benefits before they're eligible for Medicare, they will automatically be enrolled in Medicare once they are eligible.



7.9 Transitioning from Pennie to Medicare

Transitioning from Pennie to Medicare**Back****Next**

Pennie is not notified when a customer becomes eligible for – or enrolls in – Medicare coverage. This means that **customers' coverage through Pennie is not terminated automatically when they become eligible for – or enroll in – Medicare coverage.**

Current Pennie enrollees who just became eligible for Medicare should:

- Update their application indicating enrollment in Medicare (or call Pennie Customer Service)
 - Customers can update their application with their Medicare start date up to three months in advance
- Request termination of their coverage through Pennie *before* their Medicare start date

Note: If a customer forgets to request termination before Medicare coverage begins, the earliest coverage end date will be end of the current month. This will lead to a dually-enrolled period. **Customers who qualify for APTC will be required to reconcile the APTC for that month on their annual tax return.**

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8. Final Slide

8.1 Final Slide

Back**Exit**

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