The MNsure Marketplace
Your one-stop shop for health insurance

2017 open enrollment is November 1, 2016 – January 31, 2017

Financial help is available
Depending on income and household size, you may qualify for a discounted plan from a private insurance company, or free- or low-cost coverage from a state-subsidized public program. **MNsure is the only place** Minnesotans can qualify for financial help, such as tax credits toward monthly premiums, cost-sharing reductions for medical costs, or coverage through Medical Assistance or MinnesotaCare.

### Private Health Plans
Also called “qualified health plans” or QHPs, these are health plans offered by insurance companies. Financial help is available depending on your income, household size and the cost of insurance in your area. **Plans must be purchased through MNsure to qualify.**

### MinnesotaCare
Covers Minnesotans with lower incomes who don’t have access to affordable health care coverage and aren’t eligible for Medical Assistance. Low monthly premiums are determined by income and family size. Eligible individuals can enroll year-round.

### Medical Assistance
Minnesota’s Medicaid program covers many people with low incomes, especially children and pregnant women. There is no monthly premium. Eligible individuals can enroll year-round.

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This table shows what financial help you could qualify for depending on household income and size.

<table>
<thead>
<tr>
<th>People in household</th>
<th>Medical Assistance for adults over age 18</th>
<th>Medical Assistance for children</th>
<th>Medical Assistance for pregnant women</th>
<th>MinnesotaCare</th>
<th>Tax credits for private health plans</th>
<th>Private health plans with monthly premiums. Not eligible for tax credits.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly/Annual income (up to)</td>
<td>Monthly/Annual income (up to)</td>
<td>Monthly/Annual income (up to)</td>
<td>Annual income* (up to)</td>
<td>Annual income (above)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$1,316 / $15,800</td>
<td>$2,722 / $32,670</td>
<td>does not apply</td>
<td>$23,760</td>
<td>$47,520</td>
<td>$47,520</td>
</tr>
<tr>
<td>2</td>
<td>$1,777 / $21,333</td>
<td>$3,675 / $44,110</td>
<td>$3,715 / $44,591</td>
<td>$32,040</td>
<td>$64,080</td>
<td>$64,080</td>
</tr>
<tr>
<td>3</td>
<td>$2,238 / $26,866</td>
<td>$4,629 / $55,550</td>
<td>$4,679 / $56,156</td>
<td>$40,320</td>
<td>$80,640</td>
<td>$80,640</td>
</tr>
<tr>
<td>4</td>
<td>$2,699 / $32,398</td>
<td>$5,582 / $66,990</td>
<td>$5,643 / $67,720</td>
<td>$48,600</td>
<td>$97,200</td>
<td>$97,200</td>
</tr>
<tr>
<td>5</td>
<td>$3,160 / $37,931</td>
<td>$6,535 / $78,430</td>
<td>$6,607 / $79,285</td>
<td>$56,880</td>
<td>$113,760</td>
<td>$113,760</td>
</tr>
<tr>
<td>6</td>
<td>$3,622 / $43,464</td>
<td>$7,489 / $89,870</td>
<td>$7,570 / $90,850</td>
<td>$65,160</td>
<td>$130,320</td>
<td>$130,320</td>
</tr>
<tr>
<td>7</td>
<td>$4,083 / $48,997</td>
<td>$8,442 / $101,310</td>
<td>$8,534 / $102,415</td>
<td>$73,460</td>
<td>$146,920</td>
<td>$146,920</td>
</tr>
<tr>
<td>8</td>
<td>$4,544 / $54,530</td>
<td>$9,395 / $112,750</td>
<td>$9,498 / $113,980</td>
<td>$81,780</td>
<td>$163,560</td>
<td>$163,560</td>
</tr>
<tr>
<td>For each additional person add</td>
<td>$461 / $5,532</td>
<td>$953 / $11,440</td>
<td>$963 / $11,564</td>
<td>$8,320</td>
<td>$16,640</td>
<td>$16,640</td>
</tr>
</tbody>
</table>

* Slightly lower income limits apply to MinnesotaCare and tax credit eligibility for coverage starting before January 1, 2017.
This is for informational use only. Income guidelines are approximate. You need to complete an application to determine your actual eligibility.
To find certified navigators, agents and brokers and walk-in enrollment centers near you, visit MyHealthECoach.org/help.

Knock on the door of your local community organizations providing free face-to-face enrollment help.

3 Ways to get free application and enrollment help:

- A toll-free hotline: Fully trained specialists available.
  1-855-366-7883 (1-855-3-MNSURE)

- Picking a plan: Enrollment help and advice for choosing the right coverage.

- Training and licensed professionals:
  Navigators, Agents and Brokers

Protection for Consumers:

All health plans include these essential health benefits:

- Out-of-pocket costs
- Annual or lifetime dollar limits on medical expenses
- Deductibles, copayments or coinsurance
- Exclusive or in-network providers

Where you choose health coverage.

MNSURE is a marketplace where Minnesotans can shop, compare and choose health insurance coverage.

Get complete health care coverage through MNSURE.

Choice, quality, convenience.
GLOSSARY OF HEALTH INSURANCE TERMS

A

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Annual Household Income
For most taxpayers, the household Modified Adjusted Gross Income (MAGI) is the same as Adjusted Gross Income (AGI) which can be found on Line 4 on a Form 1040EZ, Line 21 on a Form 1040A, or Line 37 on a Form 1040.

Taxpayers who receive non-taxable Social Security benefits, earn income living abroad, or earn non-exempt interest should add back that income to AGI to calculate MAGI.

Medicaid eligibility will be determined excluding the following types of income: scholarships, awards, or fellowship grants used for education purposes and not for living expenses, and certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance.

Annual Limit
Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for essential benefits for plan years beginning after Sept. 23, 2010.

Appeal
A request for a fair review of a decision or action, to see if an error was made.

B

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Co-Insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-Payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

D

Deductible
The amount you must pay out-of-pocket for health care for services covered by your health insurance or plan before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Eligibility determination
A notice sent by MNsure to let a MNsure consumer know the decision about whether the consumer qualifies (is eligible) for MNsure programs.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Maintenance Organization (HMO)
Prepaid health plans in which you pay a monthly premium and the HMO covers your doctor's visits, hospital stays, emergency care, surgery, preventive care, checkups, lab tests, X-rays, and therapy. You must choose a primary care physician who coordinates all of your care and makes referrals to any specialists you might need. In an HMO, you must use the doctors, hospitals and clinics that participate in your plan's network.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-Network Co-Insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.
GLOSSARY OF HEALTH INSURANCE TERMS

In-Network Co-Payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

M

Medicaid/Medical Assistance
A joint federal-state health insurance program that is run by the states and covers certain low-income people (especially children and pregnant women), and disabled people.

MinnesotaCare
MinnesotaCare is a subsidized health care coverage program for lower income Minnesotans who do not have access to affordable employer-based health care coverage and are not eligible for Medical Assistance. Enrollees pay a monthly premium, determined by a sliding-fee scale based on family size and income.

N

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

Non-Preferred Provider
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

O

Out-of-Network Co-Insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-Payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

P

Pre-authorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

S

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

T

Third-Party Payer
Any payer of health care services other than you. This can be an insurance company, an HMO, a PPO, or the federal government.
Employer Sponsored Health Insurance Coverage

In order to determine your employee's eligibility for MNsure sponsored health insurance; ALL of this document must be completed and provided to your employee. Call 333-6838 if you have questions or need more information.

A. ABOUT THE EMPLOYEE

1. Name: ____________________________
   First                    Middle                    Last

2. Employment Start Date: ____________
   Month/date/year

3. Is this seasonal employment? YES NO (circle one)

B. ABOUT THE EMPLOYER

4. Employer/Agency Name ____________________________
   (as written on employer’s legal documents)

5. Employer Identification Number/FEIN: ____________

6. Employer’s Address:
   Street Address ____________________________
   City ____________________________ State ____________________________ Zip Code ____________________________

7. Person Completing this Form: ____________________________ Title: ____________________________

8. Telephone: ____________________________ E-mail: ____________________________

C. AVAILABILITY OF EMPLOYER SPONSORED HEALTH INSURANCE

10. Does your agency offer any type of health insurance coverage to employees? YES NO (If you answer “no” to #10 you may stop here)

   (This may include a group plan or a medical stipend)

11. Is this employee eligible for health insurance through your organization? YES NO

   IF NO: why? ❑ We don’t provide health insurance
             ❑ The employee is not employed enough hours to qualify
             ❑ The employee’s position with the agency doesn’t meet coverage requirements
             ❑ There is a waiting period (see question #12 below)
             ❑ Other: ____________________________

   If you have answered “no” to the above question skip to section D of this form.

12. What date is this employee eligible for health insurance with your organization? ____________________________

13. What are the dates of your company’s annual open enrollment period? From ____________ TO ____________

14. Does your insurance plan meet the Minimal Essential coverage requirements set out by the Affordable Care Act? To qualify your organization’s plan must pay at least 60% of the annual medical costs associated with the plan, for the employee, in any given year AND include all of the following services:

   a) Laboratory Services
   b) Mental Health & Substance Abuse Disorder Services
   c) Maternity and Newborn Care
   d) Emergency Services
   e) Prescription Drugs
   f) Pediatric Services including Oral and Vision Care
   g) Rehabilitative and Habilitative Services and Devices
   h) Ambulatory Patient Services
   i) Hospitalization
   j) Preventative and Wellness Services and Chronic Disease Management

   YES our plan qualifies ❑ ❑ NO our plan does not Qualify (check one)

For more details about the ACA and Minimal Essential Coverage see: www.obamacarefacts.com
D. INSURANCE PLAN DETAILS AND ASSOCIATED COSTS

Most organizations offer a variety of health plans with varying amounts of deductibles and premiums. Looking at the LEAST EXPENSIVE plan you offer for a SINGLE EMPLOYEE (not including coverage for additional family members) answer the following:

15. Name of the least expensive plan your company offers to employees that IS NOT a Catastrophic Plan (even if this employee does not have the least expensive plan offered – provide information about your least expensive plan for a single person):

Company Name: Example Medica  
Plan Name: Example Applause Silver  
Group Number: Example YES47-07

*Note; even if your employee does not choose the least expensive, non-catastrophic plan available through your employer sponsored coverage... the questions below pertain ONLY to the least expensive, single person (employee only) plan that you make available through your group plan.

<table>
<thead>
<tr>
<th>EMPLOYEES cost per paycheck for the least expensive plan offered to a single employee</th>
<th>EMPLOYERS cost per paycheck for the least expensive plan offered to a single employee</th>
<th>Does the company contribute to health insurance coverage for the employee's family?</th>
<th>Does the company allow family members (spouse/children) to be added to the employee's health insurance EVEN IF no compensation for their coverage is provided by the company?</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

16. How many pay periods does your organization have per year: (check one)

Weekly (52)  Bi-Weekly (26)  Twice per month (24)  Monthly (12)  
Other: (explain) ____________________________________________

D. SIGNATURE

Signature of the person completing this form

Date

Signature of the employee

Date

This is NOT a legal document and is not intended to present as one. Without this information Community Resource Connections, Certified Navigators for MNsure, may not be able to accurately determine your employee's eligibility for MNsure Health Insurance Benefits. If you have questions on how to complete this form, or the purpose behind each question, please contact Ruth Sherman at 218-333-6838 or rsherman@crctinform.org  Thank You for your assistance!