


A User's Guide to the Health Insurance Marketplace

Patient Advocate Foundation

How to Use This Guide

During annual open enrollment periods, consumers have access to a variety of new health insurance products through exchanges within each state, also known as "Health Insurance Marketplaces." Featured plans are designed to fit your budget and health care needs.

This guide is intended to help you better understand insurance enrollment through the Health Insurance Marketplace in your state, so that you can determine what coverage is right for you and your family.

Within this publication you will find:

- An introduction to the concept of health insurance
- An explanation of Health Insurance Marketplaces
- Information on health insurance coverage and plan options
- Affordability options available to you and your family through the Marketplace and
- Information on how to enroll in coverage

This guide also provides a list of state resources where you can find answers to questions specific to your state's individual Marketplace. Further assistance is also available at www.healthcare.gov or (800) 318-2596.

Additional Ways To Stay Informed And Get Help

Online at www.healthcare.gov or by phone
24/7 Support at (800) 318-2596
TTY: (855) 889-4325

YouTube
Visit Healthcare.gov's YouTube channel at http://www.youtube.com/user/HealthCareGov to watch videos highlighting important information about the Marketplace and featuring people like you who are looking forward to getting covered.

Facebook
"Like" on Facebook at facebook.com/Healthcare.gov and share your thoughts.

Twitter
Follow @HealthCareGov on Twitter for up-to-date Marketplace news.

Table of Contents

Preface 1

An Introduction to Health Insurance 2

What is health insurance?

Why do I need health insurance?

Where do I get health insurance?

Understanding Health Insurance Marketplaces 4

What are Health Insurance Marketplaces?

When and how do I enroll?

Will these plans cover what I need?

How do I determine which plan is best for me?

What if I still cannot decide on the best plan for me?

What if I need help with the application process?

Who runs these Marketplaces and does it matter?

What's the difference between a plan on the Marketplace and other commercial plans?

Can I keep my current doctor?

Can I get dental coverage?

What about vision coverage?

What do I need to start an enrollment application?

Am I buying government health insurance through the Marketplace?

Affordable Insurance and Appropriate Coverage 10

How will Health Insurance Marketplaces help me save money?

What if I still cannot afford coverage?

What if I need something that is not covered?

What if I am unemployed?

What options will I have?

What are catastrophic plans? Do I qualify?

Table of Contents

Special Enrollment Periods **12**

What happens if I miss my enrollment period?

What types of situations allow enrollment into a Marketplace plan outside of the open enrollment periods?

What happens if I move to another state?

What if I have a pre-existing medical condition?

Can I add a family member to my policy after enrollment?

FAQ for Special Situations **14**

What are my options as a non-citizen lawful US resident?

Is there an age limit for those who can purchase insurance in the Marketplaces?

What if I currently have COBRA insurance?

Can those living in US territories access a Marketplace?

I am self-employed. Can I enroll through a Marketplace?

I'm currently enrolled in a plan from my employer, but it is not meeting the needs of my family (or budget). Can I enroll in a plan from the Marketplace and forgo my employer's plan?

What if I choose not to purchase insurance?

What is not considered minimum essential coverage?

I was unable to enroll in a marketplace plan due to a technical issue.

What resources are available for Spanish-speakers?/¿Cuáles son los recursos para los hispano hablantes?

State Health Insurance Marketplace Websites **18**

Preface

In 2010, the President of the United States signed into law the Patient Protection and Affordable Care Act (ACA). This legislation introduced sweeping reform of the US health care system and increased coverage while implementing measures to control costs for consumers.

Key features of the law include:

- No more pre-existing condition denials preventing insurance enrollment
- No more annual or lifetime dollar limits on most health insurance benefits
- Coverage for young adults on their parent's plans up to the age of 26
- Insurance companies cannot drop your coverage because of mistakes on your insurance application
- No more coverage denials without patients being allowed to appeal
- 80 percent of enrollee premiums collected by insurance companies must be spent on patient care and efforts to improve the quality of patient care
- Reduced enrollee cost-sharing for outpatient prescription drugs in Medicare Part D's "Donut Hole"
- Additional federal match to states electing to expand Medicaid coverage to childless adults with incomes up to 133 percent of the Federal Poverty Level
- Incentives for physicians to adopt electronic health records and capture and report certain quality measures
- Access to certain preventive care services such as screenings and annual checkups with no enrollee cost-sharing obligations under their health plans
- Provisions to detect waste, fraud, and abuse within the system, increase care coordination, review large premium increases by insurers, and incentivize innovation
- Insurance tax credits for individuals with incomes between 100-400 percent of the Federal Poverty Level to help pay for health care premiums
- Tax credits to help small businesses afford insurance for their employees
- Penalties for individuals for failing to obtain and maintain health insurance coverage
- Health Insurance Marketplaces, also known as exchanges

The ACA has taken important steps that increase patient access to care and control the burden of costs for patients. This publication provides information on one of the significant efforts of the law, the creation of Health Insurance Marketplaces. This document is intended to introduce potential consumers to the concept of health insurance in general, Health Insurance Marketplaces, how to navigate these Marketplaces, opportunities available for support, and ultimately how to arrive at the coverage right for them.

An Introduction to Health Insurance

What is health insurance?

At some point in life, everyone is a patient. We all get sick and will eventually require assistance from the health care system. This may be in the form of a doctor's visit, a hospital visit, or an emergency situation. However, medical care is often very expensive, especially for those expected to pay the whole amount on their own. This is the reason health insurance exists. Health insurance is a service in which you and/or an employer on your behalf pay a monthly sum, known as a premium, in return for a promise of partial cost coverage of an agreed upon set of medical services. Insurance companies offer different plans that cost different amounts and in return pay for different services. When you get sick or need medical attention, that organization will pay a share of any services that it has indicated will be covered under the plan you selected.

Why do I need health insurance?

Every citizen should have health insurance. There are many reasons for this:

5 reasons

1. If you get sick it will help pay for medical services that you may need to get better.
2. Payments from insurance companies for medical bills will help offset the costs when you get sick or injured, reducing the amount you have to pay.
3. If you have coverage you are more likely to seek preventive care, keeping you healthy and helping to avoid expensive acute care or hospitalizations.
4. The Affordable Care Act requires that most individuals obtain and maintain health insurance coverage or pay an annual penalty for failing to maintain coverage.
5. Medical costs for those without health insurance are paid by the rest of society. More people with coverage should result in decreased costs for society at large.

Where do I get health insurance?

Health insurance can be acquired in many ways.

Some people are eligible for government insurance programs. If you are age 65 or older, or are deemed to have a disability, you may be eligible for a federal government insurance program called Medicare. Details on this program can be found at www.medicare.gov. If you are a low-income individual you may be eligible for a government insurance program called Medicaid. Details on this program can be found at www.medicaid.gov. Some may receive coverage through the military, TRICARE, or the Department of Veterans Affairs.

Many receive commercial health insurance through their employer, which often requires the individual to pay some or all of the monthly premium through paycheck withholding. Others still will purchase health insurance directly from an insurance company that is active in their state.

Introduced in 2014, the Health Insurance Marketplace offers direct access to individual health insurance for those not eligible to obtain or afford coverage through other means. Consumers can view, compare and enroll in a plan online similar to the experience of shopping at a typical web-based retail store.

Understanding Health Insurance Marketplaces

What are Health Insurance Marketplaces?

A Health Insurance Marketplace is a website that acts as a virtual store for insurance where consumers can compare and contrast selected health insurance plans offered in their state. These virtual Marketplaces are comparable to websites consumers currently use to search for airline flights, such as Orbitz or Travelocity, in which an individual can compare and contrast different options at different costs. However, instead of airline flights, the products offered will be health insurance products called 'Qualified Health Plans,' or QHPs. These QHPs have been deemed qualified to be posted on each state's website, because they meet the basic requirements for coverage indicated in the Affordable Care Act. Coverage under these insurance plans will be presented in plain language so consumers can understand the difference between plans when it comes to costs, quality, and benefits covered.

When and how do I enroll?

There will be a period of time each year, termed an 'annual open enrollment period' in which you can enroll in a health plan for the first time or change health plans through a Marketplace. Annual enrollment periods have shortened and are now only 45 days between November 1-December 15.

Enrollment can be performed through a single streamlined application that will determine eligibility not only for QHPs, but state Medicaid and Children's Health Insurance Programs (CHIP), financial assistance with cost-sharing and a premium tax credit as well. All of this information will be available on your state's Marketplace website, which you will find listed on pages 18-19. In addition to being able to access this information and apply directly through the Marketplace website, there is also a national toll-free hot line available for enrollment and questions at (800) 318-2596.

Will these plans cover what I need?

Health insurance plans sold within these Marketplaces must offer a certain minimum level of coverage. This minimum level of coverage consists of benefits, termed the 'Essential Health Benefits,' that include services in all of the following ten coverage categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive care, wellness services and chronic disease management
- Pediatric services, including oral and vision care

Requiring coverage in these ten categories ensures that many services important to your care are covered. To determine how much is covered in each of these categories, plans in a state must offer an amount of coverage equal to a pre-approved plan in the state known as the benchmark plan. Specific services offered within these ten categories will vary from plan to plan to offer flexibility and diversity that will suit the needs of different people.

How do I determine which plan is best for me?

The selection of the appropriate health insurance plan is an important task that requires some preparation on the part of the consumer.

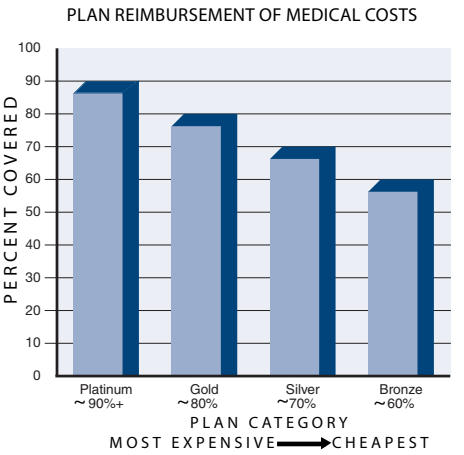
- First, it will be important to **evaluate your family health history** and any potential health concerns you may need addressed, including any doctors you need to visit and medications you need to take. This will help you determine which services you feel you will want to have covered.

- Second, it will be important to look at your personal finances and **establish a budget** for health care-related costs. Determine how much you are willing to pay each month in light of your health care needs, factoring in any eligible discounts or financial assistance. Also consider potential co-payments, deductibles, and co-insurance you may incur when visiting physicians, hospitals, and other medical facilities or paying for any medication you take.

- Finally, examine the plans on the health marketplace website. Evaluate each plan against what you have determined are important medical services to be covered, and your budget. **Note any special restrictions on coverage or exclusions that a plan** may have and whether they may interfere with you or your family's potential care. Research consumer and professional ratings of the insurance companies that offer your top few plans to get a better understanding of the quality of these companies. Also inquire if these plans cover services from providers close to you and how many.

PLATINUM GOLD SILVER BRONZE

All of the insurance products offered in a Marketplace will be categorized in four 'tiers' indicated by the metals 'bronze,' 'silver,' 'gold,' and 'platinum.' While the bronze plan will be the cheapest in terms of monthly payment or 'premium' required by the consumer, it will only cover approximately 60 percent of the medical bills up to an established out-of-pocket maximum. The silver plan will cover approximately 70 percent of medical bills, gold will cover approximately 80 percent of the medical bills, and platinum will cover approximately 90 percent and above of the medical bills up to an established out-of-pocket maximum, with higher monthly premiums for the patient to pay as the amount of coverage increases. After you reach your plan's established out-of-pocket maximum, the plan will pay 100 percent of all covered medical care.



If consumers know how much they are able to spend each month on health insurance, they can compare the different plan coverage options within the category that is most appropriate for their budget. In addition, consumers with lower annual incomes, up to 250 percent of the Federal Poverty Level, may qualify for additional cost-sharing assistance.

What if I still cannot decide on the best plan for me?

Recognizing that selecting a health insurance plan can be overwhelming, the Affordable Care Act created the 'navigator program,' to provide assistance to help you search for the health plan that is best for you. Recent changes to the individual market may affect the program but assistance may still be available to you. These Navigators will inform you of coverage options (but not select one for you), help facilitate enrollment in a plan, and help you understand your rights and responsibilities. They will also assist with troubleshooting, highlight financial assistance opportunities, make sure you are put in touch with someone that can accommodate your cultural and language needs, and help direct you to the appropriate office to express a complaint.

Navigators are intended to be completely unbiased. These specialists are not associated with any insurance company or plan and cannot receive payment for recommending one plan over another. Navigators exist as an advocate for you to make the appropriate choice. If you are in need of assistance from a Navigator, you can locate one through your state's Marketplace website, located on pages 18-19, or by going to www.healthcare.gov.

What if I need help with the application process?

If you need assistance with the application process you may use a Navigator, as outlined above. In addition, Marketplaces may also have 'certified application counselors' that can provide you with direct assistance online, by phone or in person. These counselors will be trained to help you in your application process and maintain confidentiality.

Who runs these marketplaces and does it matter?

The Affordable Care Act gave each state the option of setting up a Marketplace itself, allowing the Federal Government to set up a Marketplace in the state, or partnering with the Federal Government as a joint effort. Each Marketplace has a wide variety of insurance options available regardless of who is running it.

What's the difference between a plan on the Marketplace and other commercial plans?

No matter how you buy your health insurance - through the Marketplace in your state or directly from an insurance company - all plans sold in the individual and small group markets must offer the consumer rights and protections provided under the health care law. In addition, all plans sold in the individual and small group markets (except for certain grandfathered plans) may not charge or refuse to cover you if you have a pre-existing condition, and must cover Essential Health Benefits (see page 4).

However, the only way you may receive federal assistance such as tax credits or subsidies to get lower costs for your premium based on income is by purchasing your insurance through the Marketplace. Premium Insurance Tax Credits (PITCs) are available to individuals between 100-400 percent of the Federal Poverty Level. A PITC is based on your household income and size. Your eligibility for and assistance from PITCs is determined during the enrollment process within the Marketplace.

Can I keep my current doctor?

Most health insurance plans have a network that includes a specific set of hospitals, doctors, specialists, pharmacies, and other health care providers that they contract with to provide services to patients enrolled in their plans. If you would like to keep your current doctor, you will need to research the network of any plan you are interested in to ensure that your current doctor is covered.

When comparing plans in the Marketplace, you will have the opportunity to view a list of providers in each plan's network. You may also work with a Navigator or certified application counselor to make sure your doctor is covered in the network of the plans you are considering.

Can I get dental coverage?

In the Health Insurance Marketplace, you may get dental coverage as part of a health plan or by itself through a separate, stand-alone dental plan.
Dental coverage is available two ways:

- Health plans that include dental coverage. In the Marketplace, dental coverage will be included in some of the health plans available. You'll be able to see which plans include dental coverage when you compare them. You'll also see explanation of the specific dental benefits within each plan. If a health plan includes dental coverage, the premium shown for the plan includes both health and dental coverage.

- Separate, stand-alone dental plans. In some cases separate, stand-alone plans will be offered. You may want to choose this option if the health coverage you plan to enroll in doesn't include dental coverage or if you want different dental coverage. If you choose a separate dental plan, you'll pay a separate, additional premium for the dental plan.

Under the Affordable Care Act, dental insurance is treated differently for adults and children 18 and under. Dental coverage for children is an Essential Health Benefit, and thus must be made available in either stand-alone plans or included within plans that cover children.
However, dental coverage is not considered an Essential Health Benefit for adults, and thus is an optional benefit that adults may select if they desire. Insurance companies do not have to offer adult dental coverage, however you are likely to see plans in your Marketplace that do offer dental plans for adults either included or as stand-alone policies. Included dental benefits, if any, will be identified in the coverage summary for each plan.

What about vision coverage?

At this time, any separate vision plans available on the Marketplace would be at the discretion of the insurance company offering coverage. If you are seeking additional coverage related to your eye health (commonly including eye exams, contacts, eyeglasses, etc), we encourage you to look specifically at the Marketplace within your state to find out what is available, or ask your current eye care provider for information on the vision networks in your area. As with dental coverage, the Affordable Care Act treats vision coverage differently for adults and children 18 and under. Vision coverage for children is an Essential Health Benefit, so it must be made available in either stand-alone plans or included within plans that cover children.

What do I need to have to start an enrollment application?

Consumers can research and review available plan details at their Marketplace website beginning on the first day of open enrollment. When ready to begin an enrollment application you may need to gather the following information in order to accurately answer questions along the way.

Required information needed to finalize a Marketplace application:

- Social Security Numbers (or document numbers for legal immigrants) for individuals seeking insurance.
- If you are employed, you will need your employer contact information and wage information for each household member. You will also need to include information about any additional sources of income you may have, if any.
- Information about any current health insurance you may have.
- Information about your children or other family members who will be covered.

After you complete the enrollment application, you will receive information about your eligibility for tax credits and subsidies and can work with a Navigator or certified application counselor to find an insurance plan that is right for you.

Am I buying government health insurance through the Marketplace?

Every health insurance plan purchased through a Marketplace is provided by a private insurance company - not the government. The premiums will be paid directly to the insurance company that issues the plan. If you are eligible, the federal government may provide you with financial assistance to help pay these premiums, in the form of Premium Insurance Tax Credits for people who qualify based on their household income and size.

If you are deemed eligible for your state's Medicaid insurance or CHIP program, the marketplace will connect you to that program's office to finish enrollment.

Affordable Insurance and Appropriate Coverage

How will Health Insurance Marketplaces help me save money?

The theory behind Health Insurance Marketplaces is that presenting the coverage available from each health insurance plan through an easy-to-understand summary of costs and benefits in a centralized location will allow for consumer comparison. This simplified comparison will encourage increased competition between insurance companies, resulting in better benefits and lower costs to attract consumers to their plans. That is, health insurance companies will be competing over you.

What if I still cannot afford coverage?

The Marketplace will inform you of any financial assistance available to help reduce your medical costs. One example of such financial assistance will be the Premium Insurance Tax Credits (PITC), available to individuals between 100-400 percent of the Federal Poverty Level. In addition, extra savings known as cost-sharing assistance may be available only to individuals enrolling in a Silver plan, with annual incomes at or below 250 percent of the Federal Poverty Level.

Your eligibility for financial assistance is determined when you fill out your application during enrollment and is based on both income and the size of your family. Once you complete your application, you should be informed about the amount you would be able to receive in assistance immediately.

While the PITC is technically a tax credit, unlike other tax credits, you do not have to wait until you file your taxes to receive it. The PITC is provided as an advanced payment at the beginning of your coverage and is sent directly to your insurance plan to help reduce your monthly premium.

What if I need something that is not covered?

If your health plan is unable to cover everything you need, you have multiple options. You can pay for the non-covered services out-of-pocket; you can purchase supplemental health insurance through the commercial market to cover any gaps in your health plan's coverage; or you can appeal the decision to not cover a service. Specific appeals instructions will vary by state and information can be found on your state's Marketplace website. Navigators may also be able to help you with appeals.

What if I am unemployed?

You can still enroll in a Qualified Health Plan through a Marketplace. In addition, you may also qualify for Medicaid, the Children's Health Insurance Program (CHIP), the Premium Insurance Tax Credit and/or lower cost-sharing related to a plan purchased through a Marketplace based on your household income and size. Your eligibility for these programs will be determined during the enrollment process.

What options will I have?

When you apply for Marketplace coverage you will report your Modified Adjusted Gross Income from your most recent tax return and estimate your income for the upcoming year. Based on household income and size, unemployed or low-income individuals may qualify for any of the following:

- Medicaid. Medicaid provides coverage to millions of children, pregnant women, parents of Medicaid-eligible children who meet certain income requirements, and low-income seniors. Each state's Medicaid eligibility requirements are different. Many states have expanded Medicaid through the health care law to cover childless adults with incomes up to 133 percent of the Federal Poverty Level. You can apply for Medicaid through your state's Health Insurance Marketplace to see if you are eligible.

- Children's Health Insurance Program (CHIP). CHIP provides coverage for children, in some states pregnant women, within families with incomes too high for Medicaid but too low to afford private insurance. You can apply for CHIP in your state to find out if you are eligible.

- Commercial Plans Sold by Private Insurers. If your income is higher than your state eligibility for Medicaid or CHIP, you will be provided a variety of options for individual plans, sorted by bronze, silver, gold or platinum benefit levels.

What are catastrophic plans? Do I qualify?

Catastrophic plans are Qualified Health Plans (QHPs) sold through the Marketplace that are similar to High Deductible Health Plans. Catastrophic plans do not cover any benefits other than three primary care visits per year before you meet the plan's deductible. The premium amount you pay each month for health care is generally lower than for other QHPs, but the initial out-of-pocket costs are generally higher. To qualify for a catastrophic plan, you must be under 30 years old or obtain a 'hardship exemption' because the Marketplace determined that you are unable to afford other health coverage. Only those that meet these eligibility options will be offered catastrophic plans to choose from.

If you enroll in a catastrophic plan, you will not be eligible for Premium Insurance Tax Credits or cost-sharing assistance regardless of your household income.

Special Enrollment Periods

What happens if I miss my enrollment period?

Enrollment periods typically begin each fall and are now only open for 45 days. If you miss the enrollment period and are not able to enroll through one of the conditions listed, you will have to wait until the next enrollment period in the fall.

If you miss the open enrollment period and are not covered under another health insurance plan, you may need to pay a penalty for not being covered.

What types of situations allow enrollment into a Marketplace plan outside of the open enrollment periods?

Most people will need to complete the enrollment process during the annual enrollment period each fall.

However, in certain circumstances you may be eligible to enroll at other times throughout the year. Common situations that allow consumers to be eligible for a Special Enrollment Period (SEP) are:

- Immediately following a marriage, birth or adoption
- When you gain citizenship or qualifying immigration status
- If you lose minimum essential coverage, such as through loss of employer-based coverage or turning 26 and coming off your parents plan
- If you gain or lose eligibility for Premium Insurance Tax Credits or assistance with cost-sharing
- If you move your permanent residence to a new state
- Other exceptional circumstances

Beginning June 2017, a person already enrolled in Marketplace coverage can only use an SEP to change plans within the same metal level as his or her current plan. The only exception is if there are no other plans available within the same metal level — in that case, a person will be allowed to enroll in an adjacent metal level plan.

Note: Outside of the enrollment period, you cannot enroll in a QHP through a Marketplace unless you meet one of these situations and must seek other coverage or pay the penalty. In order to qualify under any of these scenarios, you may need to provide documentation to show that you meet the above listed exceptions for special enrollment.

What happens if I move to another state?

If you move to another state permanently you will need to change insurance to a plan in your new state. Moving to a new state meets one of the special enrollment periods exceptions, so you will not have to wait for the new open enrollment period and can enroll in a plan in your new state right away. Your state may provide a grace period until you are able to secure new insurance coverage, during which your previous insurance would continue to cover you with limited benefits. However, it is important to remember that you may be seeking coverage out of network during this time.

What if I have a pre-existing medical condition?

As a result of health care reform, health insurance plans now cannot refuse to cover you or charge you more just because you have a pre-existing health condition. Additionally, a plan cannot impose any waiting periods before they cover treatment for a pre-existing condition. This is true even if you have been turned down or refused coverage due to a pre-existing condition in the past.

There is an exception for grandfathered health plans sold on the individual market. If you have one of these plans you can switch to a QHP sold through a Marketplace during open enrollment and get coverage for your pre-existing condition.

Can I add a family member to my policy after enrollment?

Once a SEP is triggered, generally all family members are eligible to enroll in coverage or to change plans. During SEPs, you can add a new dependent to current plan or enroll the dependent in a separate plan up to 60 days AFTER birth, adoption, foster care placement, or child support court order. If you'd like to enroll an existing dependent in a marketplace plan outside of a SEP, you can do so through the 45 day annual open enrollment period.

FAQ for Special Situations

What are my options as a non-citizen lawful US resident?

You are eligible to participate in the Marketplace, as well as receive Premium Insurance Tax Credit assistance.

Is there an age limit for those who can purchase insurance in the Marketplaces?

No. Insurance products will be available on Marketplaces for people of all ages.

However, if you are over 65 and already enrolled into a Medicare plan or are Medicare-eligible, there is no need for you to utilize the Marketplace for your insurance needs. Rather, you can apply and enroll in Medicare. Marketplaces are useful for seniors who are NOT Medicare eligible and are seeking insurance coverage (for example, older adults that have not worked for at least 10 years in Medicare-covered employment are not Medicare-eligible). For minors, income documentation from parents will be used to determined eligibility for reduced costs or Medicaid.

What if I currently have COBRA insurance?

If you currently have, or are eligible for COBRA continuation health coverage, you can choose to enroll in a Marketplace plan if you prefer under these circumstances:

- During the forty-five day annual open enrollment period; or
- If your employer terminates COBRA coverage, making you eligible for a SEP
- If COBRA coverage expires, making you eligible for a SEP

Note: You are **not** eligible for a SEP if **you** decide to end COBRA coverage early or if coverage is terminated due to a failure to pay premiums.

Can those living in US territories access a Marketplace?

Marketplaces are only available to residents of the fifty states and the District of Columbia. If you live in any of the U.S. territories, including the Virgin Islands, Guam, Puerto Rico, American Samoa or the Northern Mariana Islands, you are not eligible to use the Marketplace to apply for health insurance. Check with your territory's government offices to learn more about health coverage options available to you.

I am self-employed. Can I enroll through a Marketplace?

Yes, if you are self-employed and have no employees, you may buy insurance through the Marketplace.

I'm currently enrolled in a plan from my employer, but it is not meeting the needs of my family (or budget). Can I enroll in a plan from the Marketplace and forgo my employer's plan?

Yes, you may purchase health insurance through a Marketplace instead of through your employer. However, you will no longer receive employer contributions toward your health insurance premiums and you will not be eligible for the Premium Insurance Tax Credit or for assistance with your cost-sharing obligations, regardless of your household income and/or size if the health insurance offered through your employer is deemed 'affordable' (less than 9.5 percent of your annual household income) and provides minimum value. For more information on this, visit www.healthcare.gov or request assistance through one of the resources provided at the end of this publication.

What if I choose not to purchase insurance?

If you do not purchase insurance that meets the definition of minimal essential coverage, you may be required to pay an annual penalty if you are uninsured for three months or more in a given year.

In 2016 and beyond, the penalty is $695 per adult and $347.50 per child, with a maximum penalty of $2,085 per family, OR 2.5 percent of family income, whichever is greater.

However, you are not required to pay the penalty even if you are uninsured if:

- You are not required to file a tax return because your income is below the amount that requires you to file;
- You have to pay more than 8.05 percent of your annual income to obtain health insurance, after taking into account any employer contributions or tax credits;
- You would qualify under the new income limits for Medicaid, but your state has chosen not to expand Medicaid eligibility;
- You are a member of a federally recognized Indian tribe;
- You are a member of a recognized religious sect with religious objections to health insurance; or
- You are incarcerated.

What is not considered minimum essential coverage?

'Minimum essential coverage' is defined to include coverage under a government-sponsored plan (including Medicare, Medicaid, CHIP, TRICARE or Veterans health care programs), health plans sold through Marketplaces, employer plans and health plans purchased on the individual market.

Plans that do not meet minimum essential coverage requirements and would cause individuals to incur the penalty for failure to maintain minimum essential coverage include:

- Plans that only cover dental or vision
- Short-term and long-term disability insurance or workers' compensation plans
- Long-term care insurance, nursing home or community-based care plans
- Cancer, hospital, or accident-only insurance
- Health care, medical and pharmacy discount cards or coupon programs
- Medical payment coverage within an automobile insurance plan
- Medicare supplemental insurance

I was unable to enroll in a marketplace plan due to a technical issue.

You may qualify for a SEP if you were not enrolled in a plan or were enrolled in the wrong plan because of an error or delay occurred that was beyond your control, including situations where:

- Misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity to help you enroll (like an insurance company, navigator, certified application counselor, agent or broker)

- A technical error or other Marketplace-related enrollment delay

- Wrong plan data (like benefit or cost-sharing information) displayed on www.HealthCare.gov at the time that you chose your health plan (with proof)

- You can prove your Marketplace plan violated a material provision of its contract. If you or a family member applied for Medicaid or Children's Health Insurance Program (CHIP) coverage during the Marketplace Open Enrollment Period, or after a qualifying event, and your state Medicaid or CHIP agency determined you (or a member in your household) weren't eligible

- You can show you had an exceptional circumstance that kept you from enrolling in coverage for an extended length of time during enrollment, like being incapacitated or a victim of a natural disaster.

What resources are available for Spanish-speakers?
¿Cuáles son los recursos para los hispano hablantes?

Spanish-speaking consumers who have questions about the Marketplaces should visit www.cuidadodesalud.gov, which is an informational website presented entirely in Spanish. In addition, representatives are available to answer questions in Spanish and other languages through a toll-free hotline, at (800) 318-2596.

El sitio de web www.cuidadodesalud.gov está completamente disponible en español para ayudar a los consumidores con las cuestiones sobre el Mercado de Seguros Médicos. Adicionalmente, los representantes pueden plantear preguntas en español y otros idiomas por medio de una línea de traducción, al llamar a (800) 318-2596.

State Health Insurance Marketplace Websites

The list below identifies each state's website that should serve as your starting point when seeking individual plans.

State	Website
Alabama	www.HealthCare.gov
Alaska	www.HealthCare.gov
Arizona	www.HealthCare.gov
Arkansas	www.HealthCare.gov
California	www.coveredca.com
Colorado	www.connectforhealthco.com
Connecticut	www.accesshealthct.com
Delaware	www.HealthCare.gov
District of Columbia	DChealthlink.com
Florida	www.HealthCare.gov
Georgia	www.HealthCare.gov
Hawaii	www.HealthCare.gov
Idaho	www.yourhealthidaho.org
Illinois	www.HealthCare.gov
Indiana	www.HealthCare.gov
Iowa	www.HealthCare.gov
Kansas	www.HealthCare.gov
Kentucky	www.HealthCare.gov
Louisiana	www.HealthCare.gov
Maine	www.HealthCare.gov
Maryland	www.marylandhealthconnection.gov
Massachusetts	www.mahealthconnector.org
Michigan	www.HealthCare.gov

State	Website
Minnesota	www.mnsure.org
Mississippi	www.HealthCare.gov
Missouri	www.HealthCare.gov
Montana	www.HealthCare.gov
Nebraska	www.HealthCare.gov
Nevada	www.HealthCare.gov
New Hampshire	www.HealthCare.gov
New Jersey	www.HealthCare.gov
New Mexico	www.HealthCare.gov
New York	www.nystateofhealth.ny.gov
North Carolina	www.HealthCare.gov
North Dakota	www.HealthCare.gov
Ohio	www.HealthCare.gov
Oklahoma	www.HealthCare.gov
Oregon	www.HealthCare.gov
Pennsylvania	www.HealthCare.gov
Rhode Island	www.healthsourceri.com
South Carolina	www.HealthCare.gov
South Dakota	www.HealthCare.gov
Tennessee	www.HealthCare.gov
Texas	www.HealthCare.gov
Utah	www.HealthCare.gov
Vermont	portal.healthconnect.vermont.gov
Virginia	www.HealthCare.gov
Washington	www.wahealthplanfinder.org
West Virginia	www.HealthCare.gov
Wisconsin	www.HealthCare.gov
Wyoming	www.HealthCare.gov

Health Insurance Marketplace

Open Enrollment from

November 1 to December 15

www.healthcare.gov