



Health Insurance for Small Business

**A BUYER'S GUIDE FOR
EMPLOYERS**

SANFORD[®]
HEALTH PLAN



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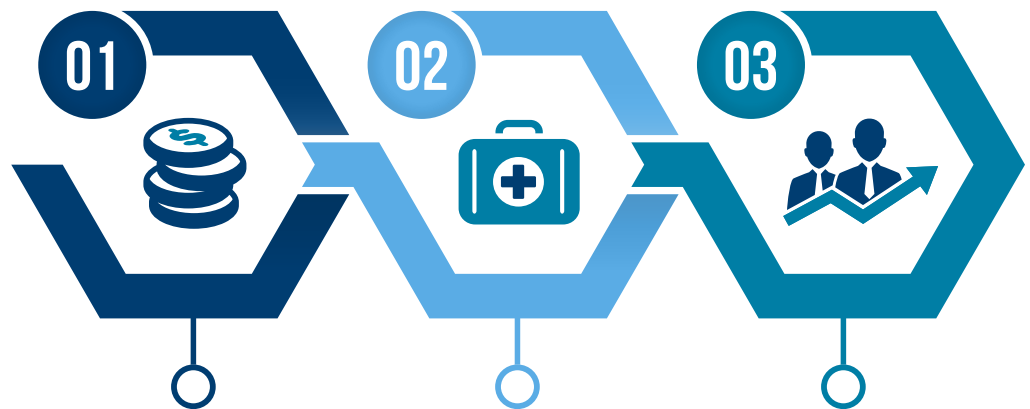
SECTION 1



THE BASICS

Why is it important to have health insurance? What type of insurance products are available? What should you know related to key concepts and terminology? All of these questions and more are covered in this section we call “The Basics”. By the end of this guide – you’ll feel ready to shop and compare plans – and make the health insurance decisions that are right for you, your business and your employees.

Why should you have and/or offer health insurance as a small business owner?



Health insurance protects your finances.

Health insurance protects your health.

Health insurance can help protect your business, too

We're here to help.

With Sanford Health Plan, you receive local agent expertise and service every step of the way. Let us answer your questions and provide a quote for coverage. Call (888) 535-4831 or visit sanfordhealthplan.com today.



Essentially, health insurance helps small business owners in the following ways:

1. Health insurance protects your finances

Discounted rate: Small group insurance plans provide you with discounted rates for medical care. Insurance companies negotiate rates with health care providers. Without coverage, the fee charged for a regular office visit and other medical services can be much higher.

Protection against the unexpected: Health insurance can protect you from unexpected medical costs. Even if your health plan requires you to pay certain costs out of pocket, being covered can protect you from bankruptcy in case of injury or hospitalization.

2. Health insurance protects your health

As a health plan member, your insurance gives you access to quality care through a network of health care providers.

Access to critical care: When you're insured you have better access to care for medical emergencies and chronic conditions.

Access to preventive care: When you're insured, you may be more likely to take advantage of regular checkups and preventive care often offered at no cost to the member.

3. Health insurance can help protect your business, too

Protection against the unexpected: As a small business owner, unexpected personal medical expenses can take away from your ability to run your business. By limiting your personal liability for medical costs, health insurance can help keep your business operating.

Hiring and retention: Health insurance can help you hire and retain the best workers. Employer-sponsored group health insurance coverage is a valuable enticement in a total compensation package.

SECTION 2



KEY CONCEPTS

The Difference Between Individual and Employer-Sponsored Plans

There are two primary categories of health insurance for small business owners to choose from:

1) Individual or 2) Employer-Sponsored health insurance. Almost everyone can apply for individual/family insurance, and depending on the number of employees you have and the regulations in your state, you may qualify to offer employer-sponsored coverage.

GROUP INSURANCE	VS.	Individual Insurance
YES	Can provide coverage for self and family	YES
YES	Can provide coverage for employees	NO
YES	May have to qualify as business in your state in order to purchase	NO
No	Can provide financial assistance through advance premium tax credits (APTC) based on your income to help with monthly premiums and cost-sharing benefits if you qualify.	YES

Individual plans

These are health insurance plans purchased by individuals to cover themselves or their families. Almost anyone can purchase an individual health insurance plan, and it's no longer possible to be denied for coverage based on your medical history. You generally need to enroll during the annual open enrollment period, which runs from November 1 through December 15 for a January 1 effective date. Outside of open enrollment, you may only be able to enroll after you've experienced a qualifying life event such as marriage or divorce, the birth or adoption of a child, the loss of coverage, or moving to a new coverage area. Federal assistance may be available to help qualifying individuals with monthly premium assistance and cost-sharing benefits.



Group health insurance plans (Small Employers)

Sometimes referred to as small business plans or group health insurance, this is employer-sponsored health coverage. Costs are typically shared between the employer and the employee, and coverage may also be extended to spouse and/or dependents. These plans also require insurance carriers to no longer ask health questions to quote the group, or deny coverage based on medical history.

Health Plan Types to Know

Whether you're looking at individual or group health insurance, there are several different types of health plans available. Some are designed to provide you with as many choices as possible when it comes to doctors and hospitals. Others are designed to keep costs in check by limiting you to a network of doctors and hospitals. Which type is best for you will depend on how much convenience and protection you want, and how much you are willing to spend. Here's a brief review of four popular types of health insurance plans.

PPO

PPO stands for Preferred Provider Organization. Like the name implies, persons covered under a PPO plan generally need to get their medical care from doctors or hospitals on the insurance company's list of preferred providers in order for claims to be paid at the highest level. It's your responsibility to make sure that the health care providers you visit participate in the PPO. Services rendered by out-of-network providers may not be covered or may be paid at a lower level.

A PPO plan may be right for you if:

- Your favorite doctor already participates in the network
- You want some freedom to direct your own health care but don't mind working within a list of preferred providers

HMO

HMO stands for Health Maintenance Organization. HMO plans offer a wide range of health care services through a network of providers that contract with the HMO, or who agree to provide services to members. Members of HMO plans will typically need to select a



primary care physician (PCP) to provide most of their health care and refer them to HMO specialists as needed. Health care services obtained outside of the HMO are typically not covered, except in an emergency.

An HMO plan may be right for you if:

- You're willing to play by the rules and coordinate your care through a primary care physician
- You want to save every dollar possible; many HMO plans typically have lower monthly premiums than comparable PPO plans

EPO

EPO stands for Exclusive Provider Organization. EPO plans are similar to PPO plans but may be somewhat more restrictive when it comes to your network of doctors and hospitals. EPO plans typically do not provide you with coverage outside your network, except in emergencies. EPO plans are becoming more popular with health insurance shoppers, and health insurance companies are offering more of them as well. You're generally not required to select a single primary care doctor with an EPO plan.

An EPO plan may be right for you if:

- You don't mind getting your care through a specific network of doctors and medical providers
- You prefer not to coordinate your medical care through a primary care doctor

HSA-eligible Plans

These plans are designed especially for use with Health Savings Accounts (HSAs). Similar to a flexible spending account (FSA) or 401(k), an HSA is a special bank account that allows participants to save money on a pre-tax or tax-deductible basis to be used specifically for medical expenses in the future. Unlike FSAs, the money in an HSA rolls over every year and can also earn interest. By pairing an eligible plan with an HSA account, participants can save money on health care and earn a tax write-off.



An HSA-eligible plan may be right for you if:

- You would like to pay for health care expenses with pre-tax dollars (up to an annual limit)
- You're relatively young and healthy and don't often visit the doctor
- You prefer a cheaper monthly premium even if it means having more cost-sharing in the event of unexpected injury or illness



SECTION 3



INSURANCE TERMS TO KNOW

When shopping for health insurance, terminology can be a barrier to fully understanding your options. Below we highlight five key health insurance terms you should get to know as you consider your insurance options.

In addition: You can use the glossary of health insurance terms online at [sanfordhealthplan.com/health-insurance-101](https://www.sanfordhealthplan.com/health-insurance-101).

Premium

Your premium is the amount you pay to the health insurance company each month to maintain your coverage. When trying to understand the cost of a health insurance plan, the premium is the first thing to consider. But make sure to balance it against other costs, such as copayments, deductibles and coinsurance.



HELPFUL TIP: Choose a lower premium/higher deductible plan if you are relatively healthy and want to save money up front. Choose a higher premium/lower deductible plan if you want lower costs when you actually receive medical services.

Copayment

Your copayment, or copay, is the specific dollar amount you may be required to pay up front for a specific type of medical service. For example, your health insurance plan may require a \$20 copayment for an office visit or brand name prescription drug, after which the insurance company may pay the remainder of the charges.



HELPFUL TIP: If you make frequent doctors' office visits, make sure you choose a plan with an affordable and consistent copayment.



Deductible

Your annual deductible is the amount you may be required to pay out of pocket before the insurance company will begin paying for your covered medical claims. Keep in mind, your monthly premiums and copayments will not count toward your deductible. Not all plans require a deductible, but choosing a plan with a higher deductible can keep your monthly premiums lower.



HELPFUL TIP: Limit your deductible to no more than 5 percent of your gross annual income if possible.

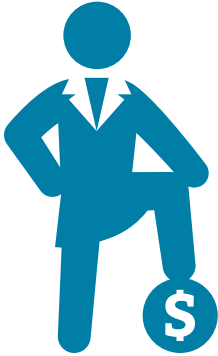
Coinsurance

Coinsurance is the amount you may be obliged to pay for covered medical services after you've satisfied any copayment or deductible required by your health insurance plan. Think about it this way: the insurance company may limit coverage for certain services to, say, 80% of charges. So, for example, if your insurance benefits cover 80% of x-ray charges, you will need to pay the remaining 20%, even if your annual deductible is already met. That 20% is considered coinsurance.

Maximum Out-of-pocket Cost

Pay attention to this amount when considering a new health plan. Your maximum out-of-pocket cost sets a limit to your annual financial liability. Once you have paid out-of-pocket (typically through deductibles, copayments or coinsurance) to the maximum amount, the insurance company pays the full charges for any additional covered medical services rendered that year. Your monthly premium will not count toward your maximum out-of-pocket costs.

SECTION 4



WHAT HEALTH REFORM MEANS FOR YOU

Understanding the Affordable Care Act

Not all self-employed persons and small businesses are affected by the Affordable Care Act (also known as the ACA or Obamacare) in the same way. The law defines businesses with the equivalent of 50 or more full-time employees as large, and those with fewer than 50 employees as small.

Businesses that employ the equivalent of 50 or more full-time workers are required to provide group health insurance coverage to their employees or face financial penalties. Small businesses with fewer than the equivalent of 50 full-time workers are generally not required to provide group health insurance coverage.

Individuals who do not receive group health insurance coverage through an employer-based plan have the option to purchase coverage on their own through the exchange at healthcare.gov or directly through a health plan licensed to sell to individuals in the county or state in which they reside.



SECTION 5



SMALL BUSINESSES AND HEALTH INSURANCE

As you read on, our guide will lead you through a four-step process designed to help you shop for and find the coverage best suited to your needs.

1. Determine the needs of your small business

Is cost your number one concern? What kind of coverage is most valuable to you and your employees? Consider the following questions and discuss some of them with your employees to help you gauge your overall needs.

Answer the following questions to define your needs:

Who will be covered under this plan?

- You and your family?
- Your employees' spouses and/or dependents?

Key considerations:

- The plan you choose will need to be affordable for all who participate. It should meet the medical and financial needs of those it will cover.
- Are your employees interested in joining your small group plan? Or are they already covered through a spouse or individual plan?

2. How much cost-sharing can you afford as an employer?

Group health insurance is employer-sponsored coverage, but monthly premiums are typically paid for by both the employer and employees. In many states, employers are generally required to cover at least 50 percent of the monthly premium for their employees. Keep this in mind when considering quotes for health plans later in the shopping process.



3. Would employees rather pay more up front and less when sick, or vice versa?

Oftentimes, plans with less expensive monthly premiums come with higher annual deductibles and plans with lower deductibles come with higher monthly premiums. It's important to find a balance of monthly premium and deductible that works for as many people in your group as possible.

4. What kinds of benefits are most important to you and your employees?

While federal privacy laws prevent you from asking your employees for information about their personal medical history, you may still ask them about which kinds of benefits they consider most valuable. Are they more interested in catastrophic coverage in case of serious illness or hospitalization, or in low deductibles or copayments? Understanding the benefits most valued by your employees can help you find a plan more likely to meet everyone's needs.



SECTION 6



5 CRITERIA TO USE WHEN SHOPPING FOR A HEALTH INSURANCE PLAN

- 1 Monthly premiums:** Know what you and your employees will be required to pay on a monthly basis to maintain your coverage. You'll also want to know what you and your employees may be required to pay toward the monthly premiums of covering a spouse and/or dependents.
- 2 Deductibles, copayments and coinsurance:** These forms of cost-sharing only come into play when you receive medical care. Make sure they're affordable for you and your employees, both for regular medical care as well as care for more serious or unexpected medical conditions.
- 3 Medical provider networks:** If you have a preferred doctor or hospital, make sure they're in-network for any plan you're considering. Otherwise your claims may be denied or paid at a lower level. Sanford Health Plan has tools to see which plans your doctor accepts.
- 4 Prescription drug coverage:** Some plans cover different prescription drugs than others, or pay more toward them. Sanford Health Plan has a prescription drug coverage comparison tool that can show you what you're estimated to pay based on your personal Rx needs.
- 5 Member perks and discounts:** At Sanford Health Plan, we focus on going beyond health insurance coverage. Therefore, our members get access to discounts on vision, dental, hearing, weight loss services. In addition, we offer no cost virtual care on certain plans and monthly gym reimbursements at participating providers. These perks can all add up to added savings - and for very happy employees.



Sanford Health Plan highly recommends that you speak with a licensed agent for customized assistance as you shop for small business health insurance. Find an agent at sanfordhealthplan.com/agents or call (888) 535-4831. You can also request a quote at sanfordhealthplan.com.

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