Health Insurance for Small Business

A BUYER'S GUIDE FOR EMPLOYERS

SANFORD HEALTH PLAN

TABLE OF CONTENTS

IN THIS GUIDE

SECTION 1

THE BASICS

Why is it important to have health insurance? What types of insurance plans are available? What key concepts and terms should you know? 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 best health insurance decisions for you, your employees and your business.

Why should you have health insurance as a small business owner?

Health insurance protects your finances

Health insurance protects your health

Health insurance protects your business operations

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.

As a small business owner, health insurance offers you protection in three essential areas:

1. Health insurance protects your finances

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

Protection against the unexpected: Health insurance also protects you from unexpected medical costs. Even if your plan requires you to pay certain costs out of pocket, coverage can protect you from bankruptcy after an injury or hospitalization.

2. Health insurance protects your health

Access to critical care: With a health insurance plan, you have access to quality care through a network of health care providers. You also have better access to care for medical emergencies and chronic conditions. Additionally, you're more likely to take advantage of regular checkups and preventive care often offered at no cost.

3. Health insurance protects your business operations

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

Hiring and retention: Health insurance also increases your chances of attracting and retaining the best employees. As part of your compensation package, employer-sponsored group health insurance gives you a competitive edge and 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		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
YES	Can provide tax savings and pre-tax benefits if you qualify.	NO

VS.

Individual plans

These are health insurance plans purchased by individuals to cover themselves or their families. Almost anyone can purchase individual health insurance and you can no longer be denied coverage based on medical history. Generally, you need to enroll during the annual open enrollment period, which runs from November 1 through December 15 to have your coverage start on January 1.

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 by moving to a new coverage area. Federal assistance may be available to help qualifying members with monthly premium assistance and cost-sharing benefits.

Group health insurance plans

Sometimes referred to as small business plans, group health insurance plans are employer-sponsored health coverage. Costs are typically shared between the employer and the employee, and coverage may also be extended to spouses and dependents. Insurance carriers cannot 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, several different types of health plans are available. Some are designed to provide you with as many choices as possible. Others are designed to keep costs in check by limiting you to a network of doctors and hospitals. The best type of plan for you depends on how much convenience and protection you want and how much you're willing to spend.

Here's a breakdown of four popular types of health insurance plans.

PPO

Under a Preferred Provider Organization (PPO) plan, members generally must receive their medical care from their insurance company's list of preferred providers for claims to be paid at the highest level. It's your responsibility to make sure your health care providers participate in the PPO. If you receive care from an out-of-network provider, your care 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 the freedom to direct your own health care but don't mind working within a list of preferred providers.

HMO

Health Maintenance Organization (HMO) plans offer a wide range of health care services through a network of providers who contract with the HMO, meaning they agree to provide services to members. Under this type of plan, members typically need to select a primary care physician who will provide most of their health care and refer them to HMO specialists as needed. Health care services 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 coordinate your care through a primary care physician.
- You want to save every dollar possible. HMO plans typically have lower monthly premiums compared to PPO plans.

EPO

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. With an EPO plan, members are generally not required to select one primary care physician. They also do not typically provide coverage outside their network except in an emergency.

EPO plans are becoming popular among health insurance shoppers and more health insurance companies are offering these types of plans.

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

HSA-eligible plans are designed for use in conjunction with a health savings account (HSA). Similar to a flexible spending account (FSA) or 401(k), this type of savings account allows members to save money on a pre-tax or tax-deductible basis to pay for future medical expenses. Unlike FSAs, the funds in an HSA roll over each year and can earn interest. By pairing an eligible plan with an HSA account, members can save on health care expenses 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 need frequent doctor visits.
- You prefer a lower monthly premium, even if it means having more cost-sharing in the event of an 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.*

Premium

A premium is an amount you pay to your 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 you'll want to consider. But make sure to balance it against other costs, such as copayments, deductibles and coinsurance.

Tip: Choose a lower premium/higher deductible plan if you are relatively healthy and want to save money upfront. Choose a higher premium/lower deductible plan if you want lower costs when receiving medical services. .

Copayment

A copayment, or copay, is the amount you may be required to pay 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 you pay this amount, your insurance company will pay the remaining amount.

Tip: If you make frequent doctors' office visits, choose a plan with affordable and consistent copayments

Deductible

The annual deductible is the amount you may be required to pay out of pocket before your insurance company begins 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.

Tip: If possible, limit your deductible to no more than 5% of your gross annual income. Keep this in mind for your employees too.

Coinsurance

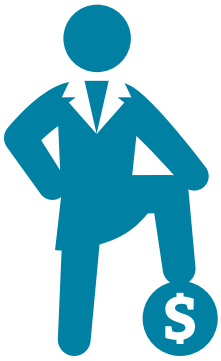
Coinsurance is the amount you may be obligated to pay for covered medical services after you've satisfied any copayment or deductible required by your health insurance plan.

Here's an example: Your insurance company may limit coverage for certain services to 80%. If you receive an X-ray and your insurance benefit covers 80% of the cost, 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

It's important to know your maximum out-of-pocket cost when considering a new health plan. This amount sets a limit on your annual financial liability. Once you have paid out-of-pocket to the maximum amount – typically through deductibles, copayments or coinsurance – your insurance company will pay for any additional covered medical services 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 everyone who is self-employed or who owns a small business is affected by the Affordable Care Act – also known as the ACA or Obamacare – in the same way.

The ACA defines large businesses as those with 50 or more full-time or full-time equivalent employees and small businesses as those with fewer than 50 employees.

Large employers

Businesses who employ the equivalent of 50 or more full-time workers are required to provide group health insurance coverage or face financial penalties.

Small employers

Small businesses with fewer than 50 full-time workers are generally not required to provide group health insurance coverage.

Those who do not receive group health insurance coverage through an employer-based plan have the option to purchase coverage on their own. They can do this through the Health Insurance Marketplace at healthcare.gov or directly through a health plan licensed to sell individual plans in their county or state.

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 your employees prefer to pay more upfront or less if they become sick?

For example, many 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 between your monthly premium and deductible to choose a plan that fits the needs of as many people in your group as possible.

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

Although federal privacy laws prevent you from asking your employees for information about their personal medical history, you may still be able to ask them about the benefits they value the most. Are they more interested in catastrophic coverage in case of a serious illness or hospitalization or low deductibles or copayments? Understanding what's most important to your employees can help you find a plan that fits their needs.

SECTION 6

5 CRITERIA TO USE WHEN SHOPPING FOR A HEALTH INSURANCE PLAN

1. **Monthly premiums:** To maintain your coverage, you'll be required to pay a monthly fee known as your premium. Make sure this amount stays within your budget. You'll also want to know what you may be required to pay toward the monthly premiums of a spouse or dependent covered under your plan.

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, and some plans pay more toward prescription drugs than others. Sanford Health Plan has a prescription drug coverage comparison tool so you can see what you're estimated to pay based on your prescription needs.

5. **Member perks and discounts:** At Sanford Health Plan, we go beyond health insurance coverage by giving our members access to a variety of discounts from local and national retailers on products and services in a variety of categories. We also offer virtual care at no cost under certain plans and monthly gym reimbursements at participating facilities.

   These perks can add up to savings, putting more money back in your pocket and increasing employee satisfaction.

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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