Marketplace Client Information

No one plans to get sick or hurt, but most people need medical care at some point. Health insurance covers these costs and protects you from very high expenses.

All private health insurance plans offered in the Marketplace will offer the same set of essential health benefits. These are services all plans must cover.

The essential health benefits include at least the following items and services:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Essential health benefits are minimum requirements for all plans in the Marketplace. Plans may offer additional coverage. You will see exactly what each plan offers when you compare them side-by-side in the Marketplace.

Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs)

HMOs and EPOs may limit coverage to providers inside their networks. A network is a list of doctors, hospitals, and other health care providers that provide medical care to members of a specific health plan. If you use a doctor or facility that isn't in the HMO's network, you may have to pay the full cost of the services provided.

HMO members usually have a primary care doctor and must get referrals to see specialists. This is generally not true for EPOs.

Preferred Provider Organizations (PPOs) and Point-of-Service plans (POS)

These insurance plans give you a choice of getting care within or outside of a provider network. With PPO or POS plans, you may use out-of-network providers and facilities, but you'll have to pay more than if you use in-network ones. If you have a PPO plan, you can visit any doctor without a referral.

If you have a POS plan, you can visit any in-network provider without a referral, but you'll need one to visit a provider out-of-network

High Deductible Health Plan (HDHP)

High Deductible Health Plans typically feature lower premiums and higher deductibles than traditional insurance plans. As of 2013, HDHPs are plans with a minimum deductible of $1250 per year for individual coverage and $2500 for family coverage. If you have an HDHP, you can use a health savings account or a health reimbursement arrangement to pay for qualified out-of-pocket medical costs. This can lower the amount of federal tax you owe.

Catastrophic Health Insurance Plan

A catastrophic health insurance plan covers essential health benefits but has a very high deductible. This means it provides a kind of "safety net" coverage in case you have an accident or serious illness. Catastrophic plans usually do not provide coverage for services like prescription drugs or shots. Premiums for catastrophic plans may be lower than traditional health insurance plans, but deductibles are usually much higher. This means you must pay thousands of dollars out-of-pocket before full coverage kicks in.

In the Marketplace, catastrophic plans are available only to people under 30 and to some low-income people who are exempt from paying the fee because other insurance is considered unaffordable or because they have received "hardship exemptions". Marketplace catastrophic plans cover 3 annual primary care visits and preventive services at no cost. After the deductible is met, they cover the same set of essential health benefits that other Marketplace plans offer. People with catastrophic plans are not eligible for lower costs on their monthly premiums or out-of-pocket costs.

Do you expect a lot of doctor visits or need regular prescriptions?

- **If you do,** you may want a Gold or Platinum plan.
- **If you don't,** you may prefer a Bronze or Silver plan. But keep in mind that if you get in a serious accident or have an unexpected health problem, Bronze and Silver plans will require you to pay more of the costs.

- All Marketplace insurance plan categories offer the same set of essential health benefits. The categories do not reflect the quality or amount of care the plans provide.

- The category you choose affects how much your premium costs each month and what portion of the bill you pay for things like hospital visits or prescription medications. It also affects your total out-of-pocket costs —the total amount you'll spend for the year if you need lots of care.

- In general, when choosing your health plan, keep this in mind: the lower the premium, the higher the out-of-pocket costs when you need care; the higher the premium, the lower the out-of-pocket costs when you need care.

- For example, at the bronze category, if a consumer's medical treatment costs $100, the bronze plan covers approximately 60%, or $60, of that cost. The consumer is then responsible for $40 in out-of-pocket expenses for that treatment. The five health plan categories are:

- Bronze Health Plans– Insurance company pays 60% of covered medical expenses.
- Silver Health Plans– Insurance company pays 70% of covered medical expenses.
- Gold Health Plans– Insurance company pays 80% of covered medical expenses.
- Platinum Health Plans– Insurance company pays 90% of covered medical expenses.
- Catastrophic Health Plans – Health plans that meet all of the QHP requirements but cover only three primary care visits each year until consumers meet the plan's deductible. To qualify, consumers must be under 30 years of age or receive a hardship exemption.

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

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Pay lower costs for premiums each month

- In the Health Insurance Marketplace you may be able to lower the costs of your health insurance coverage by paying lower monthly premiums. You'll see the amount of savings you're eligible for when you fill out your Marketplace application. Prices shown for insurance plans will reflect the lower costs.

- These lower costs are handled with a tax credit called the Advance Premium Tax Credit. But these tax credits can be applied directly to your monthly premiums, so you get the lower costs immediately.

Savings depends on income and family size

- The amount you save depends on your family size and how much money your family earns. In general, if your income falls within the following ranges you'll qualify to save money on your premiums in 2014. The lower your income within these ranges, the more you'll save. (The amounts below are based on 2013 numbers and are likely to be slightly higher in 2014.)

  $11,490 to $45,960 for individuals
  $15,510 to $62,040 for a family of 2
  $19,530 to $78,120 for a family of 3
  $23,550 to $94,200 for a family of 4
  $27,570 to $110,280 for a family of 5
  $31,590 to $126,360 for a family of 6
  $35,610 to $142,440 for a family of 7
  $39,630 to $158,520 for a family of 8

  If your income falls below the amounts shown, you may qualify for coverage under your state's Medicaid program. But if your state is not expanding Medicaid in 2014--and you don't qualify for Medicaid under your state's rules--you can't get lower costs on Marketplace coverage based on your income. You'd have to pay the entire cost of a Marketplace insurance plan.

Life Changes

- Consumers must report life changes (like marriage, changes in income, relocation, etc.) to the Marketplace. Consumers may report changes at any time. Life changes may or not have an effect on consumers' eligibility, depending on multiple factors, such as the type of change and the time that consumers report a change. The Marketplace will re-assess consumers' eligibility after any reported change and notify consumers of any resulting changes in eligibility and next steps.

Annual Redetermination & Renewal Process (Individual Marketplace)

- Each year, the Marketplace will complete an automatic eligibility redetermination for all consumers. The Marketplace completes redeterminations using the information available in consumers' accounts. The Marketplace will review the income information in consumers' accounts and notify them of any resulting changes in eligibility and next steps. Consumers are responsible for notifying the Marketplace of any changes in their information. If consumers do not report changes to the Marketplace, they may receive the incorrect amount of premium tax credits, which may result in more tax owed.

Marketplace 1-800-318-2596
MMDHD Clinton 989-224-2195 Option 2
MMDHD Gratiot 989-875-3681 Option 2
MMDHD Montcalm 989-831-5237 Option 2