MHC for Small Business Employee Guide

2025-2026

maryland health connection℠

for small business

Welcome to MHC for Small Business!

The Affordable Care Act enables small businesses to provide their employees with affordable health coverage. Offering competitive benefits is one way that companies distinguish themselves in attracting and retaining top talent. This guide will help you understand the basics of health insurance, how to enroll in MHC for Small Business employer-sponsored coverage, and what to expect after enrollment.

Advantages of an employer plan:

- Your employer does all of the work, choosing the plan options.
- Your employer often splits the cost of premiums with you.
- Your portion of the premium may be automatically deducted from your paycheck each pay period.
- Premium contributions from your employer are not subject to federal taxes, and your contributions can be made pre-tax, which lowers your taxable income.
- Your employer provides policy documents and answers questions about your plan.

How to Enroll

If your employer offers coverage through MHC for Small Business, you should receive a notification when it's time to sign up.

- You'll sign up for health insurance during the annual open enrollment period established by your employer.
- If you're a newly-hired employee or experience a qualifying life event such as but not limited to marriage, birth, adoption, or losing eligibility for other health insurance coverage, you'll be eligible to sign up for or modify your coverage within certain time limits. Make sure to talk to your employer early on so you meet deadlines.
- If you decline your employer's coverage for whatever reason or miss the deadline for a special enrollment period, you'll be able to sign up during your employer's next annual open enrollment period.
- Your employer will add you to the group's employee roster, filling in your profile with details like your name, date of birth, address, and contact information, including email. After the employer has selected the benefit package, you will receive an email prompting you to create an account that links to your employer's account. This will enable you to view the employer-sponsored coverage and enroll.

Important: An email is required because your enrollment in the group plan can only be finalized through the MHC for Small Business web portal. If you did not receive an email, please contact your employer.

Eligibility

Most full-time employees are considered eligible to participate in MHC for Small Business if you offer them coverage. Eligible employees may be added during the plan year if they experience a Special Enrollment Period (SEP) also known as a qualifying life event or during your annual open enrollment period. Effective dates for coverage are always the first of the month.
Part-time employees may be considered eligible at your discretion. To be counted in your participation rate calculation, part-time employees must be permanent employees who work between 20 and 29 hours per week and are actively engaged in your business. You are responsible for verifying that your employee is eligible when you submit your application for coverage.

Your employee may voluntarily elect to waive coverage. The employee must complete and sign the waiver section on the employee application. An employee who waives their coverage is not eligible to enroll in your health plan until your next open enrollment period or during a special enrollment period triggered by a qualifying event (See section Qualifying Life Events – Special Open Enrollment Window).

Dependent Eligibility

Should you elect to offer dependent coverage, enrollees and their dependents must enroll in the same health and/or dental plan. Dependents who qualify and are eligible for health coverage through MHC for Small Business must be under the age of 26. Dependents include adopted children, foster children, or those under legal guardianship. Disabled adult children (regardless of age) are also considered eligible dependents. Only dependents under the age of 19 are eligible for pediatric dental and pediatric vision coverage. Please refer to your Evidence of Coverage (EOC) for more information.

Reporting a Change in Employee/Dependent Eligibility

As a health plan sponsor, you are required to report any changes in your employees' eligibility to MHC for Small Business. Changes that must be reported include an employee's:

- Change of address
- Change in work hours or work relationship.
- Loss or gain to other health coverage.
- Change in dependent status.
- Termination of employment
- Death

All changes to your employee/dependent roster within your account must be submitted immediately, but no later than 30 days from the event.

New Hire Enrollment

Eligible employees added to the employer group policy are guaranteed coverage until the end of the plan year. A new hire is eligible for coverage on the first day of the month after completion of your company's waiting period. You choose the waiting period that is right for your business, but the total waiting period cannot exceed 60 calendar days. A newly eligible employee has 30 days to enroll in a qualified health plan, starting on the first day they become eligible.

Qualifying Life Events – Special Open Enrollment Window

Employees and their dependents can enroll outside of open enrollment if they experience a qualifying life event (QLE). If not, they must wait for the next annual open enrollment period to enroll or change their current coverage.

Maryland Qualifying Life Events:

Qualifying Life Event	Time Frame for Application	Who Can Enroll?
Loss of other employer-sponsored plan or group health benefit plan	Up to 30 days	Eligible employee, spouse, or dependent
Exhaustion of COBRA continuation coverage	Up to 30 days (individual SEP window is 60 days)	Eligible employee, spouse or dependent
Marriage	Not less than 31 days (individual SEP window is 60 days)	Eligible employee, spouse or new dependent
Birth, adoption or placement for adoption/foster care	Not less than 31 days (individual SEP window is 60 days)	Eligible employee, spouse or new dependent
Child support order or other court order	Not less than 31 days	Eligible employee or spouse
Enrollee loss of dependent or no longer consider dependent due to divorce or legal separation	Not less than 31 days	Eligible employee or spouse
Death of eligible employee or employee dependent	Not less than 31 days (individual SEP window is 60 days)	Eligible employee or spouse
Pregnancy	90 days	Eligible employee, spouse, or dependent
Loss of MEC	At least 30 days (individual SEP window is 60 days before or after trigger)	Eligible employee or dependent
Violation of material provision by carrier	At least 30 days (individual SEP window is 30 days)	Eligible employee or dependent
Loss of Medicaid/MCHP	60 days	Eligible employee or dependent
Enrollment or non enrollment resulting from error, misrepresentation, inaction, or misconduct by the Exchange	At least 30 days (individual SEP window is 30 days)	Eligible employee or dependent
Gains/Maintains status as Indian	60 days	Eligible employee or dependent
Material error related to plan benefits, service area, or premium	At least 30 days (individual SEP window is 30 days)	Eligible employee or dependent
Delayed Medicaid ineligibility	(individual SEP window is 60 days)	Eligible employee or dependent

determination		
Exceptional circumstances	At least 30 days (not specified for individual SEP window)	Eligible employee or dependent
Victim of domestic abuse or spousal abandonment	At least 30 days	Eligible employee or dependent
Move	60 days	Eligible employee or dependent

Factors to Consider When Choosing a Plan

Maryland Health Connection for Small Business offers private health plans from insurance companies you recognize. All plans offer essential health benefits and preventive care.

Essential health benefits:

- Doctor visits
- Emergency care
- Hospitalization
- Laboratory tests
- Maternity and newborn care
- Mental and behavioral health care (includes counseling and psychotherapy)
- Pediatric care
- Prescriptions
- Preventive and wellness management (wellness visits, shots and screenings)
- Rehabilitative services
- Substance use disorder treatment (includes counseling and psychotherapy)

Metal level

Insurance companies use metal levels to describe different types of plans. These are Bronze, Silver, Gold, and Platinum. Generally, the lower your monthly payment, the higher your out-of-pocket costs when you need medical services.

If you qualify for cost-sharing reductions (reduced out-of-pocket costs like deductibles and copays), you can access these savings only by choosing a Silver plan.

Network/plan types

Some plans allow you to see almost any doctor or use any health care facility; others limit your choices to a network of doctors and facilities, or require you to pay more if you use providers outside the network.

Understand how much your plan will cost

Typically, with employer-sponsored plans, after employees have enrolled in a plan, your employer receives a monthly bill for all enrolled employees that must be paid on time to maintain an active policy for all enrolled in the plan. The employer typically sets up When you use medical services, you may have to pay other costs:

Deductible – the amount you owe for covered health care services before your health insurance or plan begins to pay.
Coinsurance – your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service. For example, you may pay a coinsurance of 20 percent of the cost for a medical test. Your plan pays for the rest.
Copayment – a fixed amount you pay (for example, $15) for a covered service, such as a doctor's visit when you are sick.

Find a doctor in your plan

You will pay the lowest costs for services when you see a doctor or provider in your plan’s network. Call your doctor’s office to ask if they accept your insurance, and check with your insurance company.

Use your coverage

All health plans sold through MHC-SB provide the same core benefits and some plans offer more. For example, preventive services, like annual wellness checkups, shots, and screenings, are covered for free even if you haven’t met your yearly deductible. A regular checkup or screening (like a mammogram) can help find problems before they get worse. A regular visit with your doctor will help you live a healthier life.

Telehealth Coverage

All insurance companies have telehealth coverage.
For questions or more information about telehealth coverage, visit your insurance company’s website:
CareFirst BlueCross BlueShield - https://www.carefirst.com/virtualcare/.

Kaiser Permanente -
https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/learn/understanding-telehealth

UnitedHealthcare -
https://www.uhc.com/member-resources/health-care-tools/telehealth-virtual-care

Wellness Resources

Total health and wellness go beyond the doctor's office. Most insurance companies offer free self-care apps, health classes and programs, wellness coaching, and discounts on fitness and exercise tools. Be sure to check with your group's broker or the insurance company you enrolled with for detailed information on the wellness benefits.

Affordability for Family Coverage

Employer coverage is considered affordable if the cost you pay annually for coverage is no greater than 9.02 percent of your annual household income.

Beginning Dec. 12, 2022, affordability for family members will be determined based on the cost an employee has to pay for family coverage. For purposes of employer-sponsored coverage, family means the employee, spouse (if filing a joint tax return), and any dependents claimed on the tax return. Non-dependents who could enroll as members of the coverage unit through the "under-26 rule" are not considered part of the tax family.

Use Maryland Health Connection's employer tool worksheet to help you gather information about employers that offer traditional health coverage.

See the example below where the employer-sponsored plan in this example is assumed to meet the minimum value requirements:

Employee's monthly household income = $3,344 (about $40,000 per year)
9.02 percent of the employee's monthly household income = $301
The monthly cost to the employee for the lowest-priced plan the employer offers for self-only coverage = $270

Is the plan affordable?
YES, the employee's share of the lowest-cost self-only plan ($270) is less than 9.02 percent of the employee's household income ($301). The employee does not qualify for financial help to lower the cost of a health plan.

Contact the group's assigned broker for help with employer-sponsored coverage or enrollment questions.

Coverage Models

Your employer has the following three coverage models to select from:

- ❖ Single Plan: Offer a single plan from one insurance company.

- ❖ Employer Choice: Offer one insurance company, and employees may choose any plan from any metal level that the insurance company offers.

- ❖ Employee Choice: Offer up to two consecutive metal levels of coverage with a reference plan. Employees may choose the reference plan or any plan offered by all the insurance companies that offer plans at those metal levels.

What is a Reference Plan?

Your employer chooses the reference plan to determine the amount he/she will contribute toward your employee premium. This plan is selected annually at your group's annual renewal period. The table below shows how an established reference plan acts as a benchmark to assist employees in their decision to either buy up or buy down into other plans based on their individual coverage needs.

Age	Reference Plan			Enrolled Plan (Buy Up)			Enrolled Plan (Buy Down)		
	Silver Plan	Employer Pays (80%)	Employee Pays (20%)	Gold Plan	Employer Pays (Same as Ref Plan)	Employee Pays	Bronze Plan	Employer Pays (Less as Ref Plan)	Employee Pays
40	$ 600	$ 480	$ 120	$ 700	$ 480	$ 220	$ 250	($350)	0
50	$ 800	$ 640	$ 160	$ 900	$ 640	$ 260	$ 400	($400)	0
60	$ 1,000	$ 800	$ 200	$ 1,000	$ 800	$ 200	$ 600	($400)	0

Effective Dates

Effective dates for group coverage are always on the 1st of each month. Once the employer selects a coverage start date, the system will establish a deadline to finalize your plan selection with a set open enrollment period. Your employer will determine the open enrollment window.

Terminating Coverage

To terminate coverage for an employee who has left employment or is ineligible should be updated in the employer account. The employee can also request to terminate their plan within their account. Termination requests must be received prior to the last day of coverage. If an employee would like to

terminate their coverage and/or the coverage of a dependent, the employee must submit a termination request based on the reason as outlined below:

Termination Reason	Termination Effective Date
Death	The date of death
Termination or End of Employment	The last day of the month following termination
Ineligible	The last of the month following the eligibility change
Entitlement to Medicare	The last day of the month following eligibility for Medicare
Loss of dependent child	Employer determines (last day the month or year the dependent child turns 26)

Enrollment and Change Requests are typically processed within 3-5 business days. MHC for Small Business will mail the terminated employee or dependent a notice of termination. The employee or dependent may be eligible for Federal COBRA or Maryland State Continuation coverage.

Continuing coverage allows certain former employees and other participants such as retirees, spouses, former spouses, and dependent children the right to continuation of health coverage of your company's health plan rates. Continuing coverage, however, is only available when health coverage is lost due to a qualifying event.

COBRA/Maryland State Continuation

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on the day of a qualifying event that caused him or her to lose coverage. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary.

Continuing Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) and Maryland State Continuation offer employees and their dependents who lose their health benefits the opportunity to continue their coverage under your health benefit plan for limited periods. Under certain qualifying events such as voluntary or involuntary job loss for any reason other than gross misconduct, reduction in the hours worked, death, divorce, and other qualifying life events.

If a former employee elects to continue the group health insurance, the coverage given will be the same coverage that is currently available to active employees and their families as well as the same benefits, choices, and services such as:

- The rights to open enrollment to choose among available coverage options.
- The right to add qualified beneficiary dependents.
- The rights to remove dependents voluntary; and
- The right to remove dependents when they are no longer eligible for coverage.

There are two types of continuing coverage. The number of employees within your company determines the type of continuing coverage that applies to your company.

Federal COBRA provides continuation of coverage for individuals under the employer group health plans that have 20 or more eligible employees. It is your company's responsibility to be informed of your responsibilities and obligations under COBRA including the required notices. COBRA is administered by MHC for Small Business on your behalf. For more information on Federal COBRA coverage, contact your broker or visit https://www.dol.gov/general/topic/health-plans/cobra.

Maryland State Continuation provides continuation of coverage for individuals under employer group health plans that have under 19 eligible employees. Maryland Continuation is administered by MHC for Small Business on your behalf. MHC for Small Business also administers the extension for coverage expiring under Federal COBRA. For more information on Maryland State Continuation coverage, contact your broker or visit Maryland Continuation Coverage.

Administration of COBRA/State Continuation Coverages

Coverage Type	Who Qualifies?	Administration	Spouse/ Dependents
Federal COBRA	Employers with 20 or more eligible employees	MHC for Small Business	Employer
Maryland State Continuation	Employers with 19 or fewer eligible employees	MHC for Small Business	Employer

Continuing Coverage Qualifying Events

Continuing coverage qualifying events occur when an individual, whether an employee, spouse, or dependent, loses health coverage. The following table below shows the specific qualifying events, the qualified beneficiaries who are entitled to continuation of coverage, and the maximum period of continuation of coverage that must be offered based on the type of qualifying event.

Qualifying Events (QE)	Qualifying Beneficiaries	Federal COBRA Length Of Coverage	Maryland State Continuation Length Of Coverage
Voluntary or involuntary termination of employment (for reasons other than gross misconduct)	Employee, Spouse, Dependents	18 months*	18 months
Death of Covered Employee	Spouse, Dependents	3 years	AM
Divorce	Spouse, Dependents	3 years	Indefinite
Cessation of Dependency for Child	Dependents	3 years	N/A
Reduction in work hours	Employee, Spouse, Dependents	18 months	18 months
Employee becomes entitled to Medicare	Spouse, Dependents	3 years beginning the date the employee becomes entitled to Medicare	N/A

* In certain circumstances, qualified beneficiaries entitled to 18 months of federal COBRA coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months). Under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain retirees and their family members who receive post-retirement health coverage from employers have special COBRA rights in the event that the employer is involved in bankruptcy proceedings begun on or after July 1, 1986.

Events That Do Not Qualify for Continuing Coverage

Certain events may cause loss of coverage but do not qualify for continuing coverage. These non-qualifying events include when an employee:

- Waives coverage.
- Fails to timely elect to continue coverage.

- Voluntarily removes their dependent's coverage.
- Is terminated due to gross misconduct.

Termination

Continuing coverage begins on the date that a loss of coverage occurred and will end at the end of the maximum continuing coverage period. Continuing coverage may end earlier than the maximum period if premiums are not paid on time, if you choose not to maintain your group health plan, or if your former employee obtains other coverage after enrolling in continuing coverage. Generally, MHC for Small Business will send termination of coverage notices to participants. However, if you choose to end group coverage with MHC for Small Business, you are responsible for notifying beneficiaries of their option to change their plan to any other group plan that you offer for the remainder of their continuing coverage period.

Coverage Payment

Federal COBRA and State Continuation Premiums for participants will be directly invoiced to participants.

Glossary

This resource is designed to clarify key terminology and enhance your understanding as you navigate through the content. For a full list of terms and definitions, visit https://www.marylandhealthconnection.gov/glossary/

Broker: An authorized insurance broker can help you choose an insurance company and health plan that meets your and your family's needs and helps with any administrative problems. There is no fee when you use an authorized insurance broker. They are licensed by the Maryland Insurance Administration and authorized by Maryland Health Connection.

Crosswalk: the transfer of enrollees from one plan to another. This typically happens when a plan is no longer available, and the enrollee needs to be transitioned to a similar plan. This is also known as mapping.

Minimum Essential Coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act is called “minimum essential coverage.”

Open Enrollment: A designated period of time each year during which individuals or employees can enroll in a health insurance plan or make changes to their coverage

Qualifying Life Event: A change in your life that can make you eligible for a special enrollment period to enroll in health coverage. Examples of qualifying life events are changes in your family size (for example, if you marry, divorce, or have a baby), pregnancy, certain changes in your income, or losing current coverage.

Special Enrollment Period: A time outside of the open enrollment period during which you and your family may have a right to sign up for health coverage. You qualify for a special enrollment period through Maryland Health Connection, generally 60 days after certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage.

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