



SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)
MARKETPLACE
SHOP MARKETPLACE EMPLOYEE ENROLLMENT
USER GUIDE

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SHOP Marketplace – Employee Enrollment Application

In most states, the SHOP Marketplace is open to employers with 1-50 full-time equivalent (FTE) employees, though small employers with 1-100 FTEs can participate in the SHOP Marketplace in California, Colorado, New York, Vermont and Virginia. If you already have SHOP Marketplace coverage through your employer, you'll need to visit HealthCare.gov to [renew or change your coverage](#). Learn more about renewing your SHOP Marketplace coverage at [marketplace.cms.gov/outreach-and-education/shop-marketplace-coverage-renewal-user-guide](#).

If your employer is in one of these states, use this document to guide you through the process of responding to your employer's SHOP Marketplace coverage offer on HealthCare.gov.

Alabama	Nevada
Alaska	New Hampshire
Arizona	New Jersey
Delaware	North Carolina
Florida	North Dakota
Georgia	Ohio
Illinois	Oklahoma
Indiana	Pennsylvania
Iowa	South Carolina
Kansas	South Dakota
Louisiana	Tennessee
Maine	Texas
Michigan	Virginia
Missouri	West Virginia
Montana	Wisconsin
Nebraska	Wyoming

If your employer is in a state that's not listed above, that means the state is running its own SHOP Marketplace. You'll need to follow your state's application process. To find your state's SHOP Marketplace, visit [HealthCare.gov/small-businesses/employees](#) and select your state from the drop down menu, or contact the SHOP Call Center at 1-800-706-7893. TTY users should call 711 to reach a call center representative.

You can work with your employer's authorized agent or broker to help you complete the SHOP Marketplace employee application.

IMPORTANT: You can save your information at any point in the application and return later to complete it. The system will time out after 30 minutes of inactivity.

Create a HealthCare.gov account

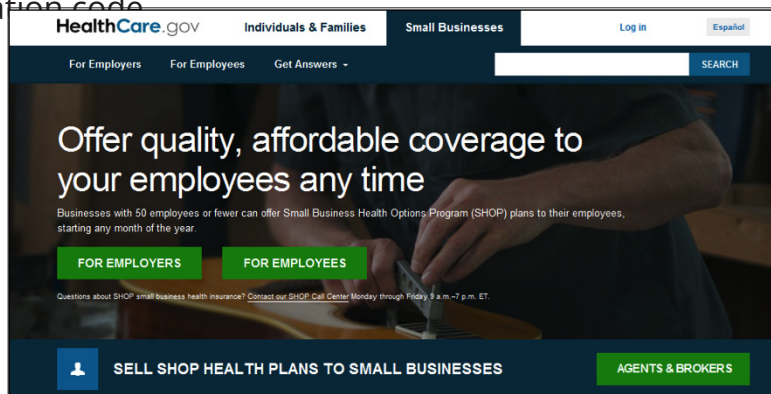
If your employer is offering coverage through the SHOP Marketplace, you'll get a notice with a participation code. You'll use this information to view your employer's coverage offer. Before you view the coverage offer, you must create an account on [HealthCare.gov](https://www.healthcare.gov).

Select your state. Visit the small business employee's page on [HealthCare.gov/small-businesses](https://www.healthcare.gov/small-businesses) and select the state where your employer's primary business address is located. Then select **SEE HOW TO ACCEPT OR DECLINE**.

- Select **"If you don't have a HealthCare.gov account, create one"** if you've never set up an account.
- Select **"If you already have an account, just log in"** if you have an account you created previously to apply for individual and family coverage. Don't create a different account for your small business employee actions.

Note: You'll need your Social Security Number (SSN) and your SHOP participation or "unique" code to create an account and enroll.

If you think your employer is offering SHOP coverage and you haven't gotten a notice with your participation code, contact your employer, not the SHOP Marketplace. Your employer can provide your participation code.



- **Answer a few questions.** On the **Create an account** page, you'll enter your first and last name, email address, and preferred password.

Next you'll answer a few security questions. These questions will be helpful in case you forget your username and/or password and have trouble logging in.

- Select the box about news and updates if you want us to email information to you.
- Check the box stating that you understand and agree with HealthCare.gov's privacy policy and select **CREATE ACCOUNT**.

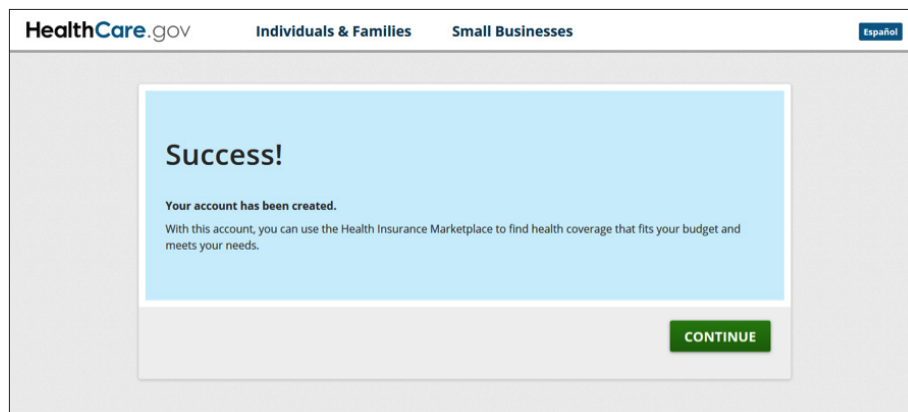
Note: When you create your account, the information you provide is case sensitive. Remember to enter the information the same way when you log in.

The screenshot shows the 'Create an account' page on HealthCare.gov. The page has a dark blue background with white text. At the top, there is a navigation bar with 'HealthCare.gov', 'Individuals & Families', 'Small Businesses', 'Log in', and 'Español'. The main heading is 'Create an account' with a sub-heading 'Create an account to apply for and manage your Marketplace coverage.' Below this, there is a link for logging in and a link for help. The form includes fields for 'First name', 'Last name', 'Email address', 'Password', and 'Retype password'. There is a checkbox for receiving news and updates. Below the password fields, there are three security questions, each with a dropdown menu for the question and a text box for the answer. At the bottom, there is a checkbox for agreeing to the privacy policy and two buttons: 'CREATE ACCOUNT' and 'I ALREADY HAVE AN ACCOUNT'.

- **Verify your email address.** You must verify that the email address you gave for the account is correct. You'll get an email with a link that's unique to you. Select the link and follow the instructions on the screen. **Note:** If you don't see the verification email in your inbox, check your junk mail.



- After you finish verifying your email address, you'll see a page with "Success!" letting you know that your account has been created. Select **Continue** to create your profile and verify your identity.

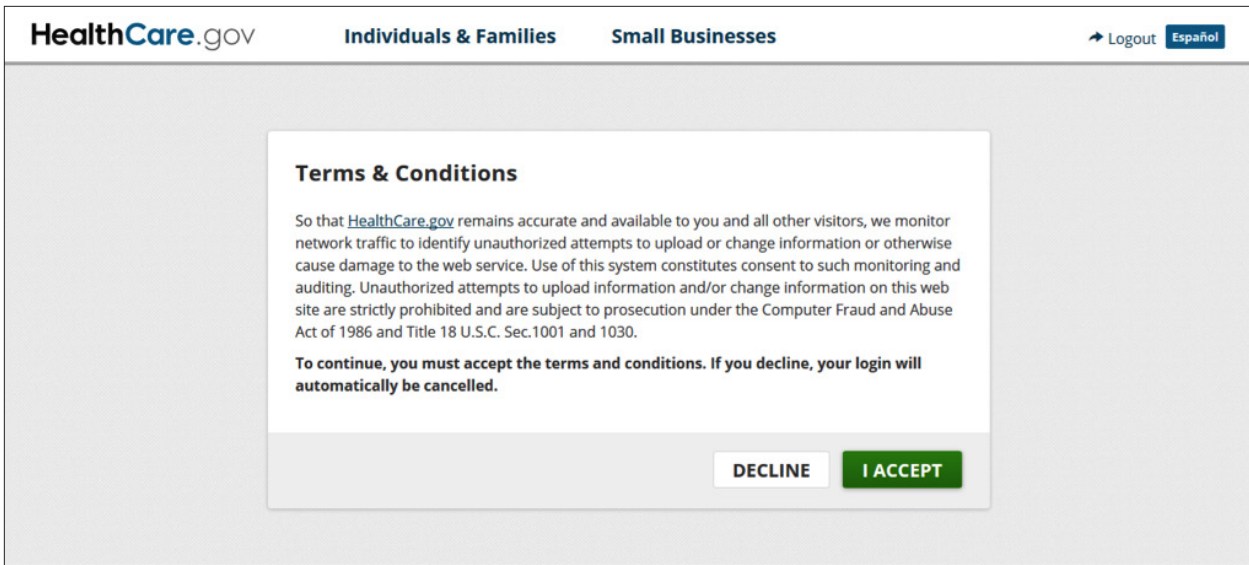


- **Note:** If you don't verify your email address within 48 hours of getting the email, the link in the email will expire. You'll need to get another verification email before you try to log into your account.
- If you try to log into your account without verifying your email address, you'll get an expiration notice. Select **Resend Verification Email** and follow the steps on the previous page to verify your email address.

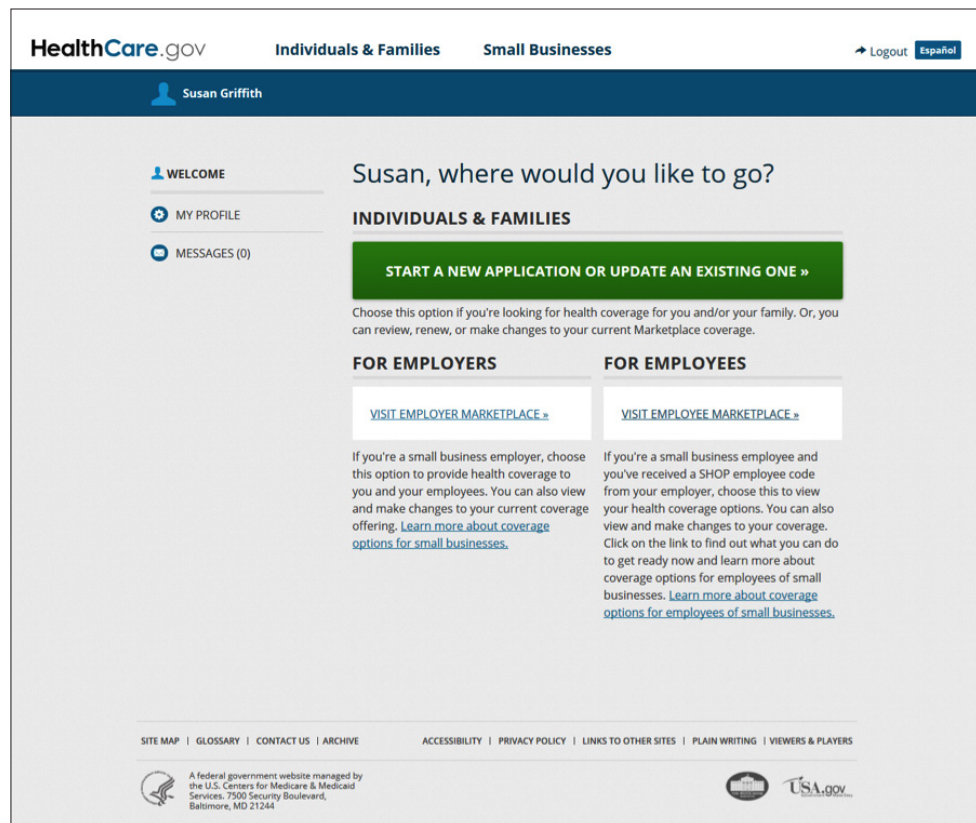
Confirm eligibility

- **Log into your HealthCare.gov account.** Enter your new username and password, select **LOG IN**, then select **I ACCEPT** on the **Terms & Conditions** page.

The screenshot shows the HealthCare.gov login interface. At the top, there is a navigation bar with 'HealthCare.gov', 'Individuals & Families', 'Small Businesses', and a 'Español' button. The main heading is 'Log in'. Below the heading, a note states 'All fields are required unless they're marked optional.' There are two input fields: 'Username' with a 'Forgot your username?' link, and 'Password' with a 'Forgot your password?' link. A prominent green 'LOG IN' button is centered below the fields. Underneath the button, there is a link: 'Don't have an account? [Create one now.](#)' Below this is an 'Important' section with text: 'Your username may be your email address. If you'd like to apply or enroll over the phone, [give us a call.](#)' and a link: '[See tips for remembering your username and password.](#)' At the bottom is a 'Note' section: 'If you're using a shared computer or a computer in a public place, like a library or community center, don't forget to close all browser windows and tabs and log out when you're done. This will help keep your information secure.'



- **Select the employee application.** On the **WELCOME** page, select **VISIT EMPLOYEE MARKETPLACE**.



- **Enter the SHOP participation code.** On the **My employer** page, enter the participation code that was emailed to you, or your employer gave to you, and your Social Security Number (SSN). You should do this even if you don't want coverage now. Select **VERIFY**.

HealthCare.gov My account Get assistance ▾ Español

Log out bob2smith@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

My employer

Enter your SHOP participation code given to you by your employer. If you don't plan to accept your employer's offer of coverage, you should still enter the code below. Even if you don't want coverage now, you must enter some basic information so your employer knows about your decision.

Contact your employer if you don't have a SHOP participation code.

If you need help, call 1-800-706-7893. TTY users should call 711. To talk with a trained representative, select "Get assistance."

Enter your participation code and Social Security Number (SSN)/Alternate SSN.

A field with an asterisk () before it is a required field.*

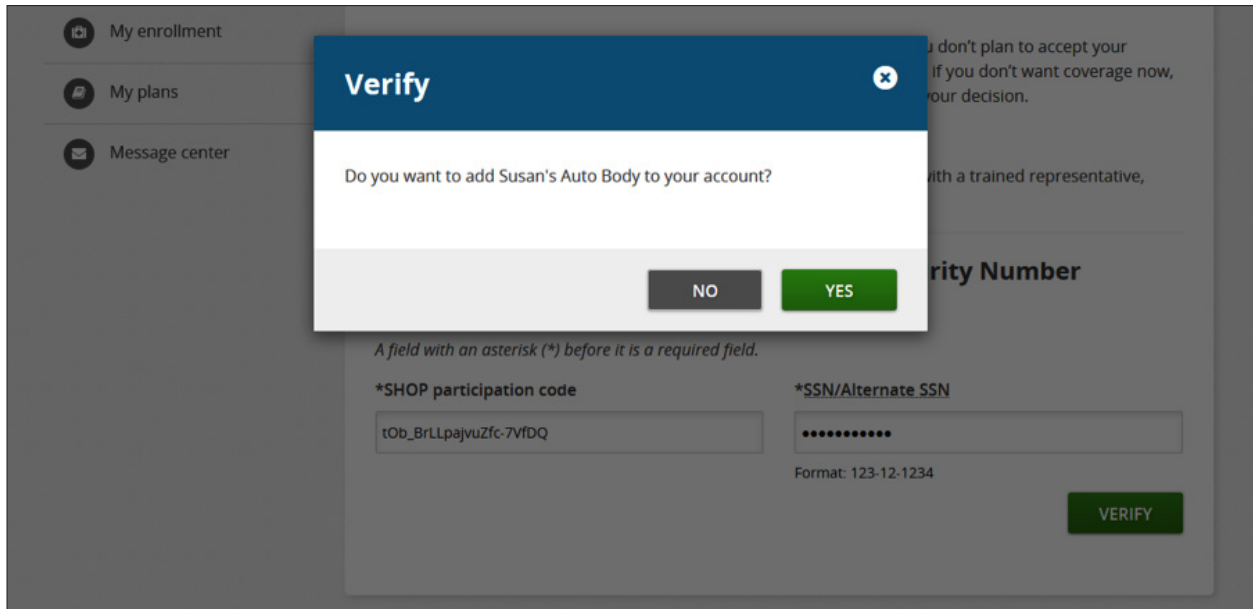
*SHOP participation code

*SSN/Alternate SSN

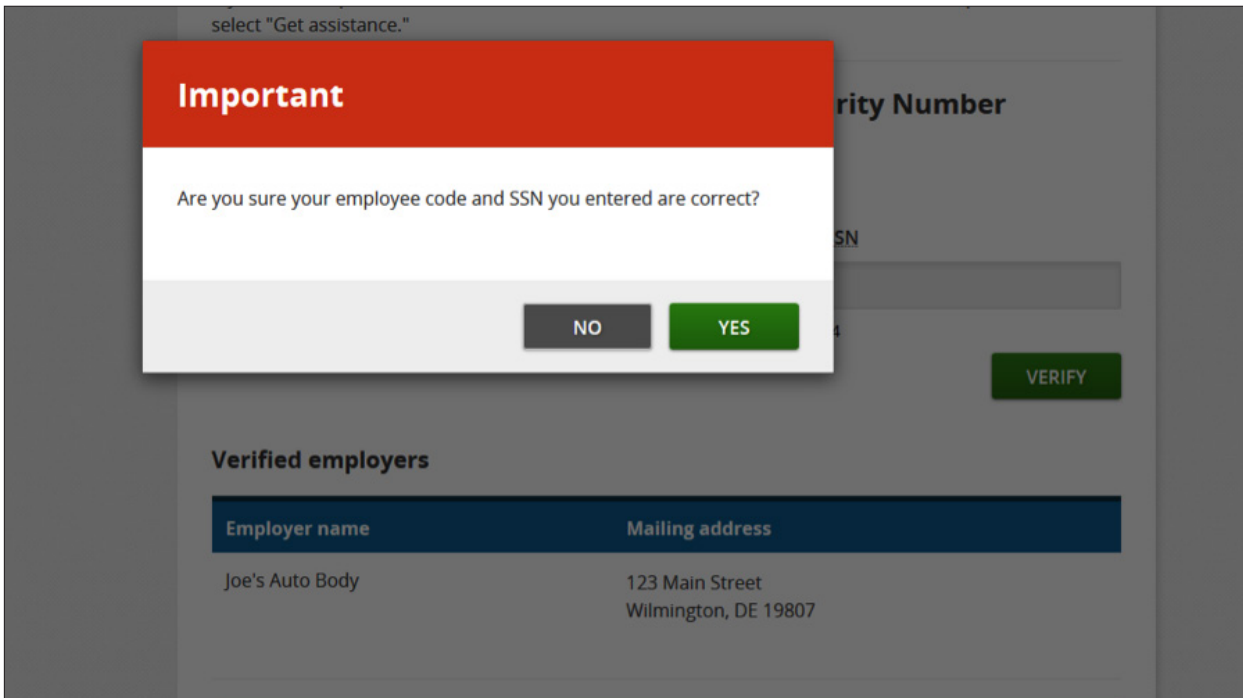
Format: 123-12-1234

VERIFY

- The system determines your eligibility by comparing the SHOP Marketplace participation code, your name, and SSN that you entered when you created your Healthcare.gov account to the information given by your employer on the employee roster. Make sure the information you provide exactly matches the information your employer gave.
- After the information is validated, select **YES** to add the employer to your account. If you select **NO**, you'll return to the **My Employer** page where you entered your participation code and SSN.



- If you entered the SHOP Marketplace participation code and/or SSN incorrectly, you'll get a message asking if you're sure the employee code and SSN entered are correct.



If you select **NO**, you'll go back to the **My Employer** page to re-enter the correct participation code and SSN.

HealthCare.gov My account Get assistance ▾ Español

Log out bob2smith@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

My employer

Enter your SHOP participation code given to you by your employer. If you don't plan to accept your employer's offer of coverage, you should still enter the code below. Even if you don't want coverage now, you must enter some basic information so your employer knows about your decision.

Contact your employer if you don't have a SHOP participation code.

If you need help, call 1-800-706-7893. TTY users should call 711. To talk with a trained representative, select "Get assistance."

Enter your participation code and Social Security Number (SSN)/Alternate SSN.

A field with an asterisk () before it is a required field.*

*SHOP participation code

*SSN/Alternate SSN

Format: 123-12-1234

VERIFY

If you select **YES**, you'll get a message letting you know that you're ineligible for the SHOP Marketplace. This message also includes a link to the SHOP Marketplace appeals page. Before you submit an appeal, check with your employer to see if your name and SSN are correct on the employee roster.

HealthCare.gov My account Get assistance - Español

Log out akywappyj-3098@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

My employer

Important: Enter a valid SHOP participation code and SSN/Alternate SSN. If it doesn't work, check with your employer to make sure you have the right code. If your code still doesn't work, it means you're not eligible to participate in the SHOP Marketplace. If you don't agree with this eligibility determination, you may be able to **file an appeal**. To continue, call the SHOP Call Center at 1-800-706-7893 (TTY 711).

Enter your SHOP participation code given to you by your employer. If you don't plan to accept your employer's offer of coverage, you should still enter the code below. Even if you don't want coverage now, you must enter some basic information so your employer knows about your decision.

Contact your employer if you don't have a SHOP participation code.

If you need help, call 1-800-706-7893. TTY users should call 711. To talk with a trained representative, select "Get assistance."

Enter your participation code and Social Security Number (SSN)/Alternate SSN.

A field with an asterisk () before it is a required field.*

*SHOP participation code

*SSN/Alternate SSN

Format: 123-12-1234

VERIFY

Review SHOP Marketplace coverage offer

- On the **My Employer** page, select **BEGIN** to start reviewing your employer's coverage offer.

HealthCare.gov My account Get assistance - Español

Log out bob2smith@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

My employer

✓ Employer added successfully.

Enter your SHOP participation code given to you by your employer. If you don't plan to accept your employer's offer of coverage, you should still enter the code below. Even if you don't want coverage now, you must enter some basic information so your employer knows about your decision.

Contact your employer if you don't have a SHOP participation code.

If you need help, call 1-800-706-7893. TTY users should call 711. To talk with a trained representative, select "Get assistance."

Enter your participation code and Social Security Number (SSN)/Alternate SSN.

A field with an asterisk () before it is a required field.*

*SHOP participation code

*SSN/Alternate SSN

Format: 123-12-1234

VERIFY

Verified employers

Employer name	Mailing address
Susan's Auto Body, LLC.	123 Test st Test, DE 19805

Important: You have an offer of coverage from Susan's Auto Body - 2016.

Start enrollment period on	Last day employees have to enroll
09/24/2015	09/24/2015

Enrollment status: Not started

BEGIN

HealthCare.gov My account Get assistance - Español

Log out bob2smith@yopmail.com

My profile
My employer
 My enrollment
 My plans
 Message center

My employer-Susan's Auto Body, LLC.

[BACK TO MY EMPLOYER](#)

Employer's offer of coverage

Employer name		Employer address	
Susan's Auto Body		123 Test st	
Employee ID		Estimated effective date	
1		01/01/2016	
Enrollment period		Estimated effective date	
09/24/2015 to 09/24/2015		01/01/2016	
Health plan		Dental plan	
Employer's contribution % for employee	50.00%	Employer's contribution % for employee	50.00%
Employer's contribution % for dependent	50.00%	Employer's contribution % for dependent	50.00%

Health Coverage Waiver

Will you accept this health coverage offered by your employer? Select "yes" or "no" below. You can return to this page to make your choice after viewing health plans.

Yes, I plan to accept this coverage through my employer.

No, I decline this coverage through my employer.

- You'll see a summary of information for your employer, including:
 - Employer name and address
 - Employer ID
 - Enrollment period
 - Estimated effective date
 - Medical and dental plan categories
 - Percentage employer is contributing towards your premium

Health Coverage Waiver

Will you accept this health coverage offered by your employer? Select "yes" or "no" below. You can return to this page to make your choice after viewing health plans.

Yes, I plan to accept this coverage through my employer.
 No, I decline this coverage through my employer.

Dental Coverage Waiver

Will you accept this dental coverage offered by your employer? Select "yes" or "no" below. You can return to this page to make your choice after viewing dental plans.

Yes, I plan to accept this coverage through my employer.
 No, I decline this coverage through my employer.

Self

i Important: Verify all information before you submit. You won't be able to make changes once you sign and submit your application.

First name	Middle name	Last name	Suffix
<input type="text" value="Bob"/>	<input type="text"/>	<input type="text" value="Smith"/>	<input type="text" value="Suffix"/>

*SSN/Alternate SSN	*Date of birth
<input type="text" value="*****"/>	<input type="text" value="10/11/1980"/>

Format: 123-12-1234

***Sex**

Male Female

Home address

*Street address	Apt./Ste. #
<input type="text"/>	<input type="text"/>

*City	*ZIP code	*County	*State
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- **Accept or decline your employer's coverage offer.** The application automatically defaults to **"Yes, I plan to accept coverage through my employer."** You can return and change your response after viewing health plans.

If you accept the coverage offer, enter employee details, like mailing address and other contact information. All fields marked with an asterisk are required.

- **Add dependents.** If your employer is offering dependent coverage, select **ADD DEPENDENT(S)**.

Note: Make sure your information is correct before you submit. You may not be able to make changes after you sign the application and your employer submits the enrollment application to the SHOP Marketplace.

- **Sign the enrollment application.** Enter your name in the box to sign the application. After you enter your name, the date will be automatically entered. Select **SAVE & CONTINUE**.

Contact preferences

*Email address

*Phone number Ext. Phone type

Second phone number Ext. Phone type

Preferred spoken language Preferred written language

Notices will be sent to the email address you listed above. Check here if you also want to get paper notices in the mail.

Race (optional)

If of Hispanic, Latino, or Spanish origin, select ethnicity (optional)

Are you a member of a federally recognized tribe?
 Yes
 No

* Within the past 6 months, have you used tobacco regularly (4 or more times per week on average excluding religious or ceremonial use)?
 Yes
 No

If your employer is offering dependent coverage, select **ADD DEPENDENT** to give your employer and insurance company information about your spouse/partner and dependent children.

+ ADD DEPENDENT

I know that I must tell the SHOP if information I listed on this application changes.

I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information. In addition, I know that my coverage and the coverage for my dependents (if applicable) may be impacted if I provide false or untrue information.

Following federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

***Electronic signature**

Bob Smith
Date: 09/24/2015

CANCEL **SAVE & CONTINUE**

If you decline the coverage offer, select the reason from the drop down menu.

- **Verify your decision to decline coverage.** Read and agree with the statements.
- **Sign the enrollment application.** Enter your name in the box to sign the application, then select **SUBMIT**. **If you decline coverage, you don't need to do anything else.** If you select **BACK TO MY EMPLOYERS** or **CANCEL**, you'll return to the **My Employer** page.

Enrollment selection for dependents

If your employer is offering dependent coverage and you have elected to enroll, you can choose which dependents you want to enroll in health and/or dental coverage.

HealthCare.gov My account Get assistance - Español

Log out bob2smith@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

Select members for coverage

Information: You can select dependents only if your employer is offering dependent coverage and you're getting coverage for yourself.

Select coverage for yourself and your family. You can't make changes after you submit the application.

Health plan

Employee	Dependents
Bob Smith	<input type="checkbox"/> Dave Smith

Dental plan

Employee	Dependents
Bob Smith	<input type="checkbox"/> Dave Smith

BACK SAVE & CONTINUE

Review and select plan(s)

Health plans are put into 4 categories (Bronze, Silver, Gold, and Platinum) based on how you and the plan can expect to share the costs for health care. The health plan category your employer chooses determines what you'll pay for things like deductibles and copayments, and the total amount you'll spend out-of-pocket for the year if you need a lot of care. The categories don't reflect the quality or amount of care the plans provide.

There are 2 dental plan categories (Low and High) based on how you and the plan can expect to share the costs of covered services. The dental plan category your employer chooses affects the total amount you'll likely spend out-of-pocket for dental benefits during the year.

To learn more about health and dental plans, visit marketplace.cms.gov/outreach-and-education/things-to-think-about-shop-2016.pdf.

In this section of the employee enrollment application, you can review the plan(s) offered by your employer. You'll either see one health and/or dental plan offered by your employer, or your employer will offer you a choice of health and/or dental plans. If you're offered a choice of plans, this is called "Employee Choice." This means that your employer will select one plan category and you can choose any health or dental plan (if offered) from any insurance company in that category.

- **Review employer's health coverage.** The plan(s) you'll see are based on your employer's primary business address. Select **View plan details** to see plan details, like copayments, laboratory and outpatient services, medical devices, emergency care, and inpatient hospital services. If your employer is offering you a choice of plans, you'll see a list of plans to compare.
 - **Compare plans.** If you have multiple plans listed, you can select up to 3 plans to compare side-by-side. Select the **Compare** checkbox for each plan you want to compare. Then select **Compare plans**.
 - **Sort plans.** Select **Sort by** on the drop down menu to see your options. You can sort by:
 - Employer's monthly share high to low
 - Employer's monthly share low to high
 - Employee's monthly share high to low
 - Employee's monthly share low to high
 - Annual deductible high to low
 - Annual deductible low to high

My profile

My employer

My enrollment

My plans

Message center

Review employer's health coverage

PRINT

1 Plan(s) offered with effective date 01/01/2016

Sort by...

NARROW YOUR RESULTS:

FILTER MANUALLY

Estimated employer contribution
Between \$0.00 - \$801.50



Estimated employee contribution
Between \$0.00 - \$801.50



Yearly deductible (per employee)
Between \$0.00 - \$300.00



Shopping for Gold

INDEMNITY | GOLD

DETAILS

SELECT

Cost details

Total monthly premium	Yearly deductible	Estimated employer contribution	Estimated employee contribution
\$1,603.00	\$300.00 per person	\$801.50 per month	\$801.50 per month
	\$4,000.00 per family		

BACK

SAVE & CONTINUE

- **Filter plans.** You can use the menu listing on the left side of the page to narrow your plan search based on certain criteria. You can move the bars on the left to increase or decrease the dollar amounts. You can filter by:
 - Employee estimated contribution
 - Yearly deductible (per person or per family)
 - Insurance company
 - Plan category
- **Plan details.** To view the benefits of the plan, including a list of covered drugs, select **DETAILS**.

- **Find covered drugs.** Under the details view, select **List of covered drugs** to view each plan's covered drug information.

HealthCare.gov My account Get assistance Español

0 Cart Log out bob2smith@yopmail.com

My profile
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 Message center

Plan details

[BACK TO PLAN LIST](#) [DOWNLOAD IN EXCEL](#) [PRINT](#)

[SELECT](#)

Shopping for Gold

INDEMNITY | Gold

Cost details			
Total monthly premium	Yearly deductible	Estimated employer contribution	Estimated employee contribution
\$1,603.00	\$300.00 per person \$4,000.00 per family	\$801.50 per month	\$801.50 per month

Plan documents

List of Covered Drugs

[Refer to formulary](#)

Plan brochure

No data available

Prescription drug deductible

See Plan Brochure

Prescription drug out-of-pocket maximum

See Plan Brochure

Summary of Benefits

No data available

Select one health plan and one dental plan (if offered). To choose plan(s) for you and your dependents, select **SELECT** next to the health plan information. Then select **SAVE & CONTINUE**.

- If your employer is offering health and dental coverage, you can enroll in health coverage only, dental coverage only, or both health and dental coverage. You're not required to enroll in health coverage to enroll in a dental plan.
- If your employer offers dependent coverage, you and your dependents must enroll in the same health and/or dental plan. However, you can choose which dependent to enroll in your selected plan(s). You must enroll in health and/or dental coverage if you want to enroll your dependents.
- If your employer is offering health and dental plans, you can select **SAVE & CONTINUE** without selecting a health plan.
- If you select another health plan, you'll see a message letting you know that this selection will replace your current plan selection.

Note: You can choose which dependents you want to enroll in either your health or dental coverage. You don't have to enroll all your listed dependents in all your selected plans. Remember, whatever plan(s) you select for each dependent can't be changed after the enrollment is submitted, unless you experience a life change that qualifies you for a Special Enrollment Period.

My profile

My employer

My enrollment

My plans

Message center

Review employer's health coverage

PRINT

1 Plan(s) offered with effective date 01/01/2016

Sort by...

NARROW YOUR RESULTS:

FILTER MANUALLY

Estimated employer contribution

Between \$0.00 - \$801.50



Estimated employee contribution

Between \$0.00 - \$801.50



Yearly deductible (per employee)

Between \$0.00 - \$300.00



Shopping for Gold

INDEMNITY | GOLD

DETAILS

SELECT

Cost details

Total monthly premium	Yearly deductible	Estimated employer contribution	Estimated employee contribution
\$1,603.00	\$300.00 per person	\$801.50 per month	\$801.50 per month
	\$4,000.00 per family		

BACK

SAVE & CONTINUE

My profile

My employer

My enrollment

My plans

Message center

Review employer's dental coverage

PRINT

1 Plan(s) offered with effective date 01/01/2016

Sort by...

NARROW YOUR RESULTS:

FILTER MANUALLY

Estimated employer contribution

Between \$0.00 - \$5.01



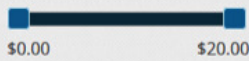
Estimated employee contribution

Between \$0.00 - \$5.00



Yearly deductible (per employee)

Between \$0.00 - \$20.00



Yearly deductible (per family)

Between \$0.00 - \$20.00



FFM Dental

INDEMNITY | HIGH

DETAILS

SELECT

Cost details

Total monthly premium

\$10.01

Yearly deductible

\$20.00
per person

\$20.00
per family

Estimated employer contribution

\$5.01
per month

Estimated employee contribution

\$5.00
per month

BACK

SAVE & CONTINUE

Complete enrollment

- **Review plan selection(s) and cost.** Read the summary of your health and dental plan (if offered). This includes the total monthly employee premium across all your plans.
- **Confirm plan choice(s).** Select **CONFIRM** to submit your application.

HealthCare.gov My account Get assistance - Español

Log out bob2smith@yahoo.com

My profile
My employer
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Message center

Review & confirm your plans

Medical Plan

Selected for **Bob Smith, Dave Smith**

Shopping for Gold

INDEMNITY | Gold

Cost details			
Total monthly premium	Yearly deductible	Estimated employer contribution	Estimated employee contribution
\$1,603.00	\$300.00 per person \$4,000.00 per family	\$801.50 per month	\$801.50 per month

Dental Plan

Selected for **Bob Smith, Dave Smith**

FFM Dental

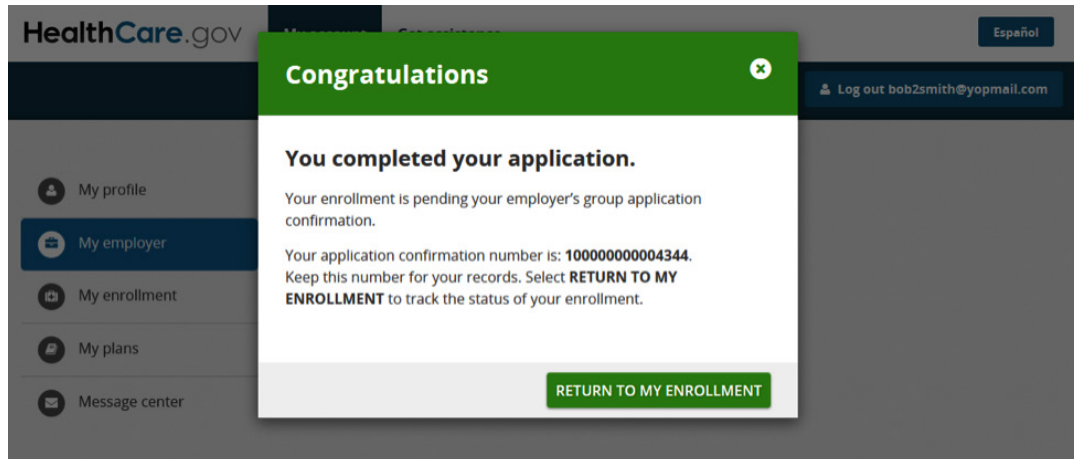
INDEMNITY | HIGH coverage category

Cost details			
Total monthly premium	Yearly deductible	Estimated employer contribution	Estimated employee contribution
\$10.01	\$20.00 per person \$20.00 per family	\$5.01 per month	\$5.00 per month

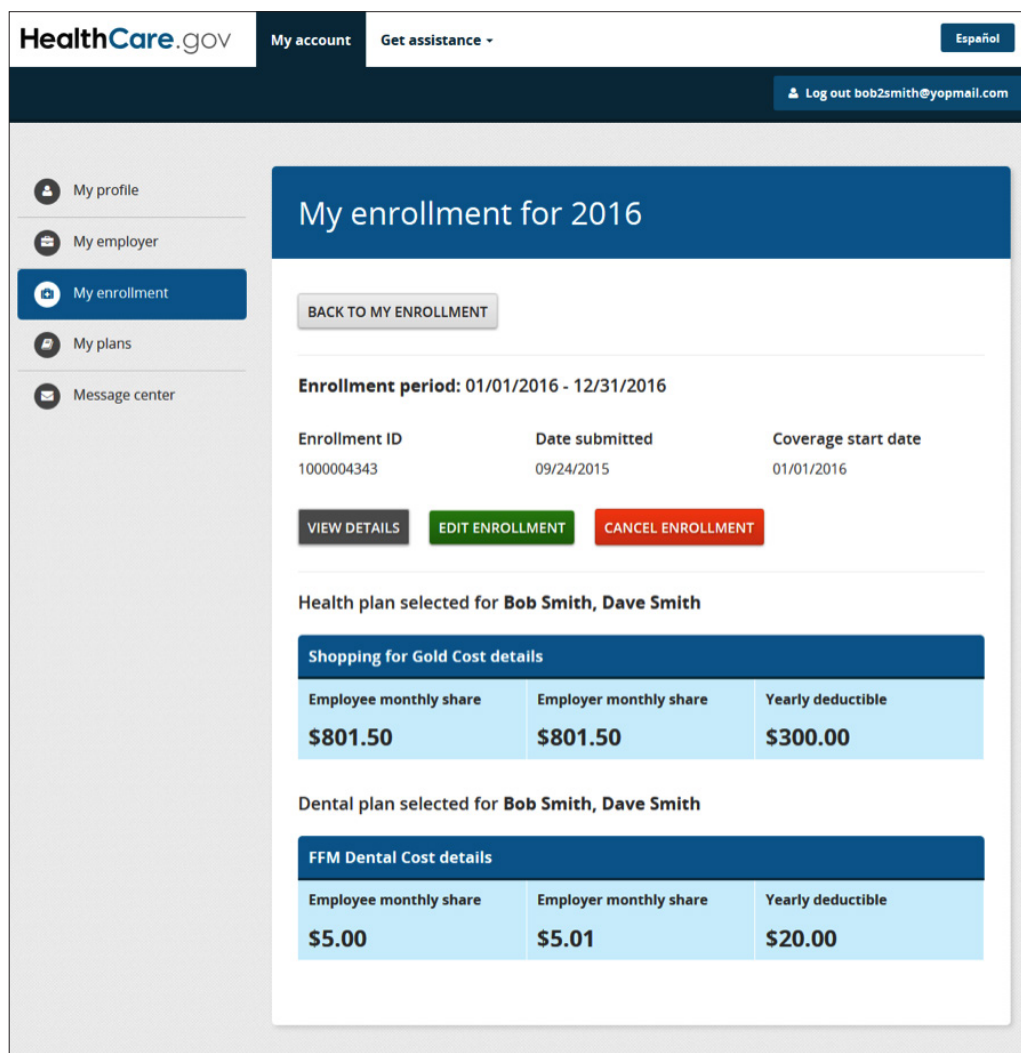
\$806.50
Total monthly premium

DECLINE BACK CONFIRM

- **Get a confirmation.** You'll get a confirmation letting you know that your application is complete. It includes a confirmation number that you should keep for your records.



- **View enrollment.** Select **RETURN TO MY ENROLLMENT** to view the details of your enrollment.



- **Don't want to buy coverage?** Select **DECLINE**.

HealthCare.gov My account Get assistance - Español

Log out bob2smith@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

Review & confirm your plans

Medical Plan

Selected for **Bob Smith, Dave Smith**

Shopping for Gold

INDEMNITY | Gold

Cost details			
Total monthly premium	Yearly deductible	Estimated employer contribution	Estimated employee contribution
\$1,603.00	\$300.00 per person \$4,000.00 per family	\$801.50 per month	\$801.50 per month

Dental Plan

Selected for **Bob Smith, Dave Smith**

FFM Dental

INDEMNITY | HIGH coverage category

Cost details			
Total monthly premium	Yearly deductible	Estimated employer contribution	Estimated employee contribution
\$10.01	\$20.00 per person \$20.00 per family	\$5.01 per month	\$5.00 per month

\$806.50
Total monthly premium

DECLINE BACK CONFIRM

On the page that says **I'm declining this coverage offer**, select the health coverage you currently have or will have once your employer's coverage is effective. Then select **CONTINUE**.

The screenshot shows a modal window titled "I'm declining this coverage offer" with a close button (X) in the top right corner. The main question is "Will you have any of these sources of health coverage once this employer's SHOP plan is effective?". Below this, there are two checked checkboxes: "I waive this health coverage." and "I waive this dental coverage.". Between these two checkboxes is a list of radio button options: "Individual private health insurance", "Insurance from another job", "Insurance through another person's job", "Medicare", "Medicaid", "TRICARE", "VA health care programs", "Indian Health Service", and "No other coverage". At the bottom of the modal, there are two buttons: "CANCEL" and "CONTINUE". The "CONTINUE" button is highlighted with a red rectangular box, and a red arrow points to it from the right. In the background, partially obscured by the modal, is a form with a "Coverage start date" of "01/01/2016" and two "Yearly deductible" fields with values "\$4,000.00" and "\$2,000.00". At the very bottom of the page, there is a footer with navigation links: "GLOSSARY | CONTACT US | ARCHIVE" on the left and "ACCESSIBILITY | PRIVACY POLICY | USING THIS SITE | PLAIN WRITING | VIEWERS & PLAYERS" on the right.

Your HealthCare.gov account

Account profile

Select the **My profile** tab to view and update your profile information. You can only make changes to certain fields. When you're finished, select **SAVE**.

The screenshot shows the 'My profile' page on HealthCare.gov. The page has a dark blue header with the HealthCare.gov logo, 'My account', 'Get assistance -', and a 'Español' button. A user is logged in as 'Log out akywappjy.3098@yopmail.com'. A left sidebar contains navigation links: 'My profile' (selected), 'My employer', 'My enrollment', 'My plans', and 'Message center'. The main content area is titled 'My profile' and contains a blue information box stating: 'Below you can view and edit your personal profile information.' Below this is a note: 'A field with an asterisk (*) before it is a required field.' The form is organized into sections: 'Basic information' with fields for *First name (Ronnie), Middle name, *Last name (Hillman), Suffix (dropdown), Account number (1443405892967), *Email address (ronnie@broncos.com), *SSN (masked), and Date of birth (02/25/1991). 'Home address' section includes *Street address (123 E St), Apt./Ste. #, *City (Wilmington), *ZIP code (19807), *County (NEW CASTLE), and *State (DE). 'Contact phone' section has two entries: one for a Cell phone (921) 945-1251 and one for a Home phone. 'Contact preferences' section includes Preferred spoken language (English), Preferred written language (English), and Preferred method of contact (Email address selected, Mailing address unselected). A green 'SAVE' button is at the bottom right.

My enrollment

Select the **My enrollment** tab to view the details of your coverage, edit your plan selection(s), and cancel your enrollment.

HealthCare.gov My account Get assistance ▾ Español

Log out bob2smith@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

My enrollment for 2016

[BACK TO MY ENROLLMENT](#)

Enrollment period: 01/01/2016 - 12/31/2016

Enrollment ID	Date submitted	Coverage start date
1000004343	09/24/2015	01/01/2016

[VIEW DETAILS](#) [EDIT ENROLLMENT](#) [CANCEL ENROLLMENT](#)

Health plan selected for **Bob Smith, Dave Smith**

Shopping for Gold Cost details

Employee monthly share	Employer monthly share	Yearly deductible
\$801.50	\$801.50	\$300.00

Dental plan selected for **Bob Smith, Dave Smith**

FFM Dental Cost details

Employee monthly share	Employer monthly share	Yearly deductible
\$5.00	\$5.01	\$20.00

- Select **VIEW DETAILS** on the **My enrollment** page to view your employer, SHOP Marketplace application number, and enrollment status. The enrollment status lets you know where you are in the enrollment process (like “Not started” or “Completed”).

HealthCare.gov My account Get assistance - Español

Log out akywappyj-3098@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

Enrollment details for 2015

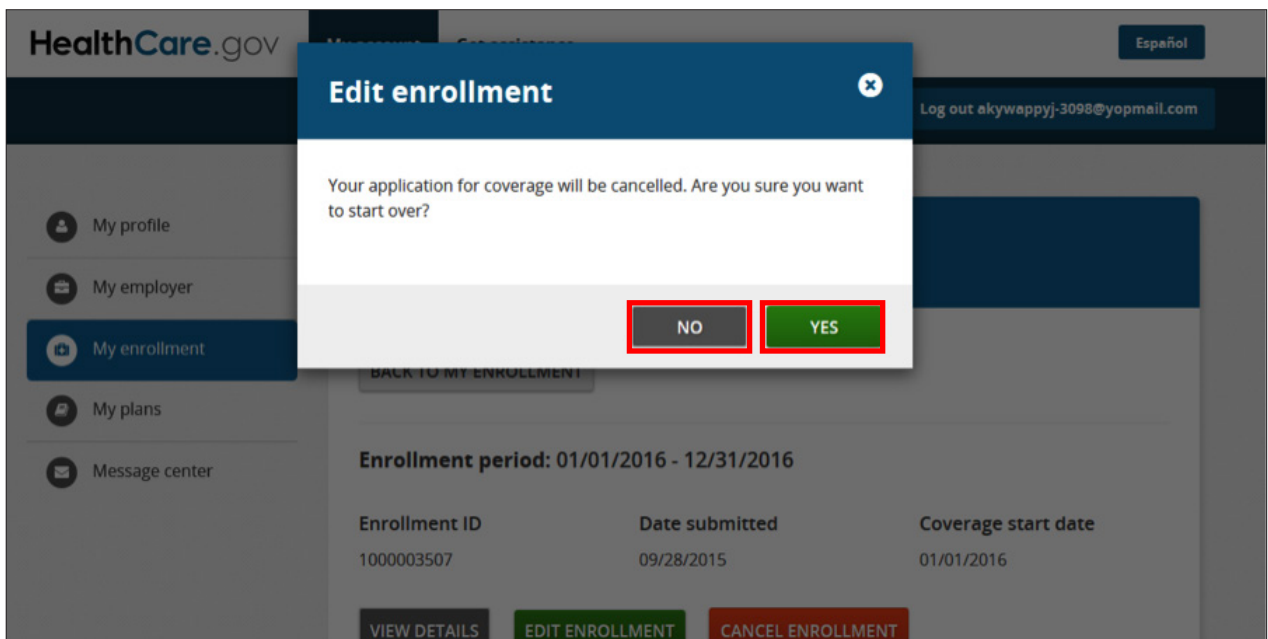
[BACK TO MY ENROLLMENT](#)

Employee ID
123

Enrollment participation per plan

ID	Member name	Relationship with employee	Plan name	Enrollment status	Coverage start date	Coverage end date
	Ronnie Hillman	Self	DE Bronze HNOly 5700 100% HSA	Submitted	01/01/2015	12/31/2015

- Select **EDIT ENROLLMENT** on the **My enrollment** page to make changes to your coverage. When you see the **Edit enrollment** message:
 - Select **YES** to cancel your current application. You'll return to the **My Employer** page to start the application process and select a plan.
 - Select **NO** to return to the **Enrollment Details**.
- Select **CANCEL ENROLLMENT** on the **My enrollment** page to cancel your coverage selection. You'll only see this button if you're still within an Open Enrollment Period. When you cancel your coverage, you're declining your employer's coverage offer and must provide other coverage information.



- My profile
- My employer
- My enrollment**
- My plans
- Message center

My enrollment for 2016

[BACK TO MY ENROLLMENT](#)

Enrollment period: 01/01/2016 - 12/31/2016

Enrollment ID	Date submitted	Coverage start date
1000004343	09/24/2015	01/01/2016

[VIEW DETAILS](#)

[EDIT ENROLLMENT](#)

[CANCEL ENROLLMENT](#)

Health plan selected for **Bob Smith, Dave Smith**

Shopping for Gold Cost details

Employee monthly share	Employer monthly share	Yearly deductible
\$801.50	\$801.50	\$300.00

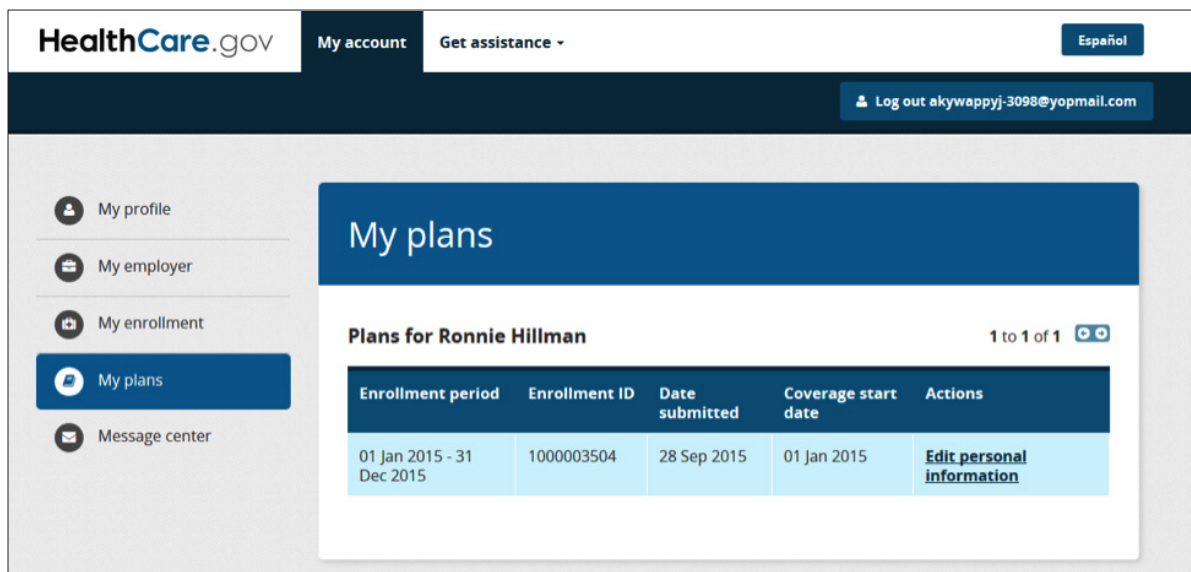
Dental plan selected for **Bob Smith, Dave Smith**

FFM Dental Cost details

Employee monthly share	Employer monthly share	Yearly deductible
\$5.00	\$5.01	\$20.00

My plans

Select the **My plans** tab to view the health and dental plans (if offered) you enrolled in.



HealthCare.gov My account Get assistance - Español

Log out akywappyj-3098@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

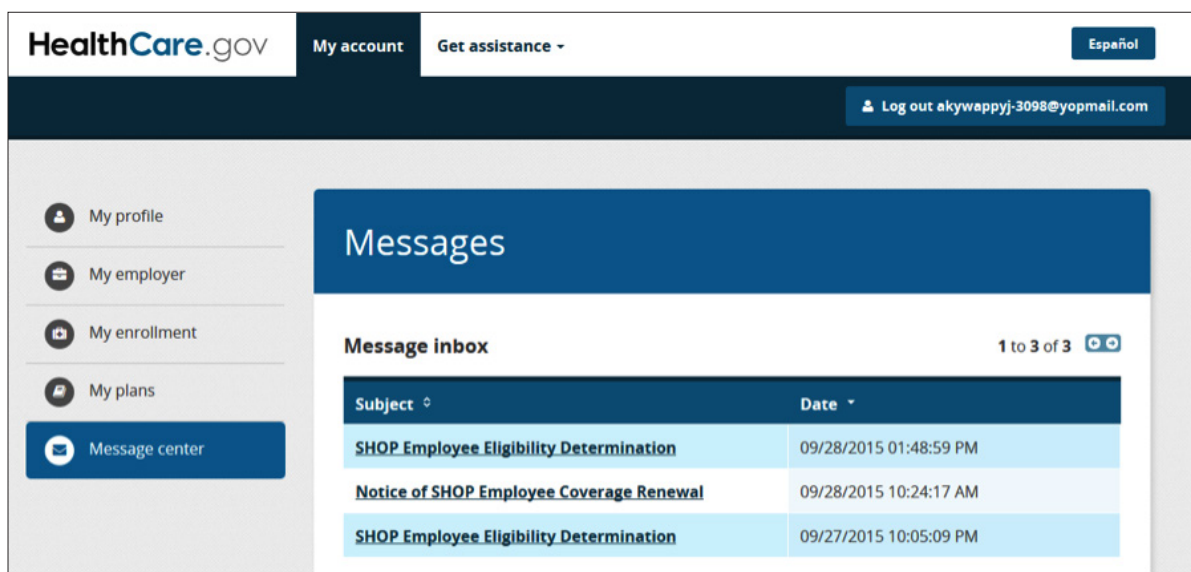
My plans

Plans for Ronnie Hillman 1 to 1 of 1

Enrollment period	Enrollment ID	Date submitted	Coverage start date	Actions
01 Jan 2015 - 31 Dec 2015	1000003504	28 Sep 2015	01 Jan 2015	Edit personal information

Message center

Select the **Message center** tab to view messages about your coverage from the SHOP Marketplace.



HealthCare.gov My account Get assistance - Español

Log out akywappyj-3098@yopmail.com

My profile
My employer
My enrollment
My plans
Message center

Messages

Message inbox 1 to 3 of 3

Subject	Date
SHOP Employee Eligibility Determination	09/28/2015 01:48:59 PM
Notice of SHOP Employee Coverage Renewal	09/28/2015 10:24:17 AM
SHOP Employee Eligibility Determination	09/27/2015 10:05:09 PM

Special Enrollment Period

You and your dependents (if dependent coverage is offered) may have a right to sign up for employer coverage, or make changes to your coverage choices outside of the employer's initial Open Enrollment Period. Job-based plans must provide this Special Enrollment Period (SEP) of 30 days following certain life events that involve a change in dependent status or loss of other health coverage. If you don't make a change during the SEP, you'll have to wait until your employer renews coverage. If your employer doesn't offer dependent coverage, the SEP applies only to qualified employees. [Learn more about the SEP](https://marketplace.cms.gov/outreach-and-education/buying-shop-coverage-2016.pdf) and qualifying life events at marketplace.cms.gov/outreach-and-education/buying-shop-coverage-2016.pdf.

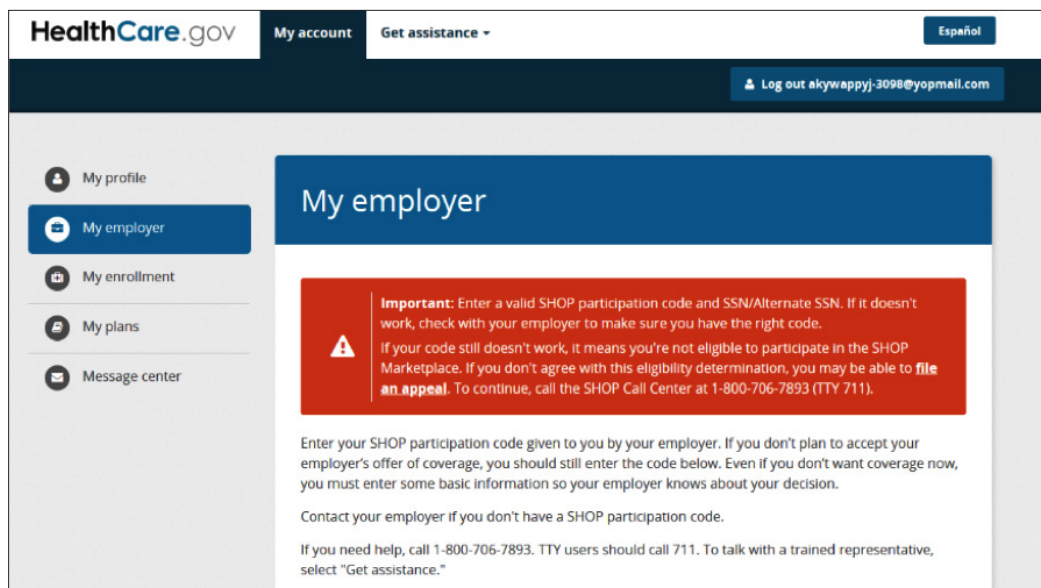
If you want to report a life event that may qualify you for an SEP, contact your employer as soon as possible. Your employer or the employer's agent/broker can report the event by logging into their HealthCare.gov account, or by calling the SHOP Call Center.

Account changes

You can make some changes to your account, like updating your email or mailing address and phone number, by logging into your HealthCare.gov account.

Submit an appeal

To submit an appeal, select **Submit appeal** in the **Actions** field to get the appeal request form. Print the appeal request form and mail it to the address on the form. You'll be notified by mail of the outcome of the appeal request within 90 days of the date you submit your appeal request. You have 90 days from the date in your SHOP Marketplace eligibility determination notice to request an appeal. Learn more about SHOP Marketplace appeals at marketplace.cms.gov/outreach-and-education/shop-marketplace-appeals-2016.pdf.

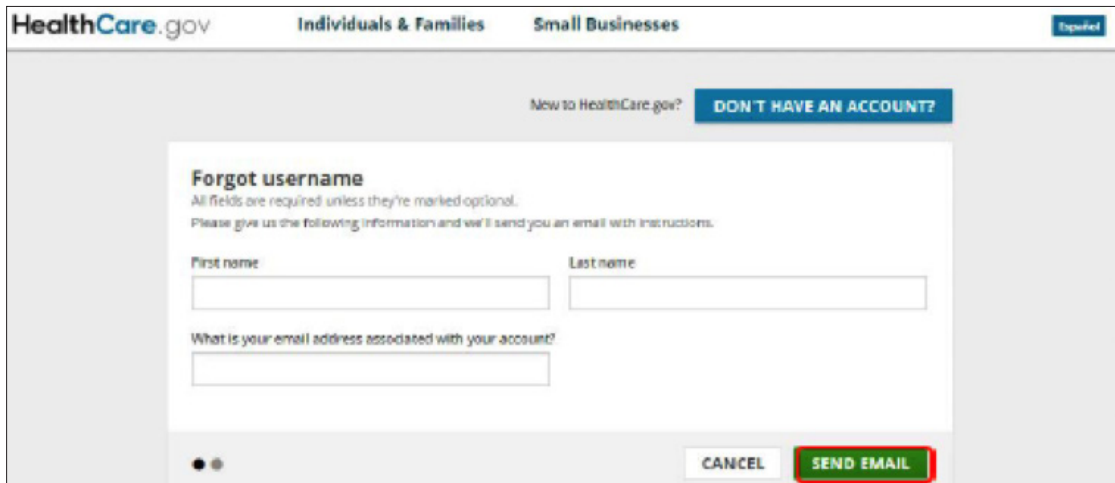


Username and password recovery

Forgot username

If you forget your username:

- Enter your email address, first name, and last name.
- Select **SEND EMAIL**. You'll get an email with your username.

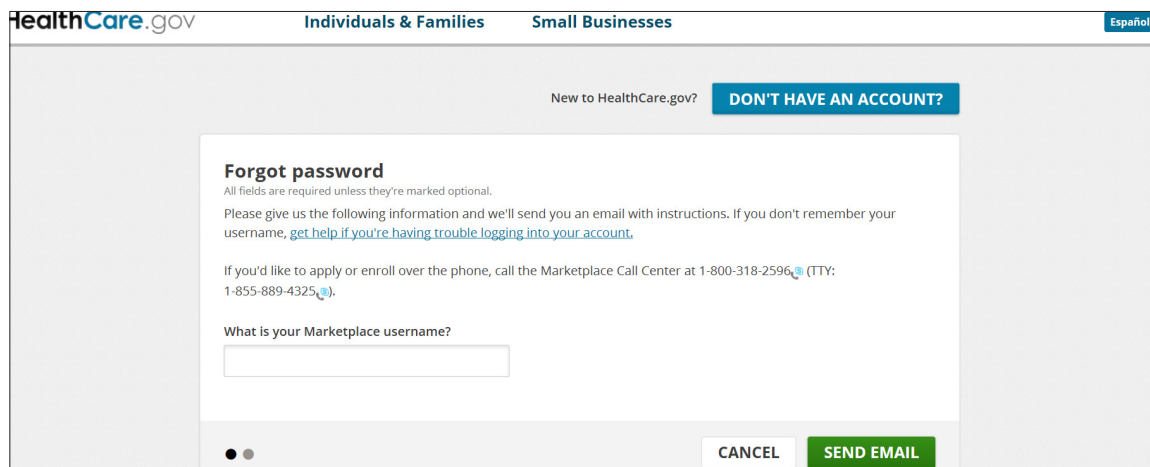


The screenshot shows the HealthCare.gov website interface. At the top, there are navigation links for "Individuals & Families" and "Small Businesses", along with a "Español" language option. A blue button labeled "DON'T HAVE AN ACCOUNT?" is visible. The main content area is titled "Forgot username" and includes the following text: "All fields are required unless they're marked optional. Please give us the following information and we'll send you an email with instructions." Below this text are three input fields: "First name", "Last name", and "What is your email address associated with your account?". At the bottom of the form, there are two buttons: "CANCEL" and "SEND EMAIL", with the "SEND EMAIL" button highlighted in green.

Forgot password

If you forget your password:

- Enter your HealthCare.gov username (the email address you entered to create your account).
- Select **SEND EMAIL**. You'll get an email with directions and a link to a page to create a new password. Your new password must be at least eight (8) characters, but no more than 20 characters long, and have a mixture of uppercase and lowercase letters, and at least one number.



The screenshot shows the HealthCare.gov website interface. At the top, there are navigation links for "Individuals & Families" and "Small Businesses", along with a "Español" language option. A blue button labeled "DON'T HAVE AN ACCOUNT?" is visible. The main content area is titled "Forgot password" and includes the following text: "All fields are required unless they're marked optional. Please give us the following information and we'll send you an email with instructions. If you don't remember your username, [get help if you're having trouble logging into your account](#)." Below this text is a single input field labeled "What is your Marketplace username?". At the bottom of the form, there are two buttons: "CANCEL" and "SEND EMAIL", with the "SEND EMAIL" button highlighted in green.

Unlock your account

To unlock your account, contact the SHOP Call Center at 1-800-706-7893 Monday through Friday, 9 a.m. – 7 p.m. ET. TTY users should call 711 to reach a call center representative.

Have questions or need help?

For more information on the SHOP Marketplace, visit [HealthCare.gov/small-businesses](https://www.healthcare.gov/small-businesses). You can also contact the SHOP Call Center at 1-800-706-7893, Monday through Friday, 9 a.m. – 7 p.m. ET. TTY users should call 711 to reach a call center representative.

