# 2025

employer solutions staffing group LLC

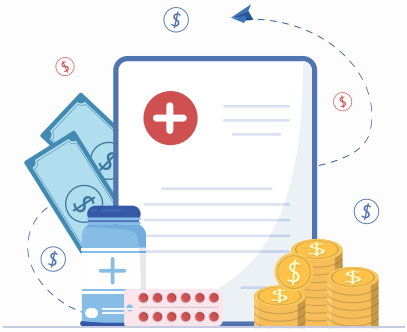
# BENEFITS ENROLLMENT GUIDE

## RESIDENTS OF NEW MEXICO & VERMONT

The American Worker®
Provided by Fringe Benefit Group

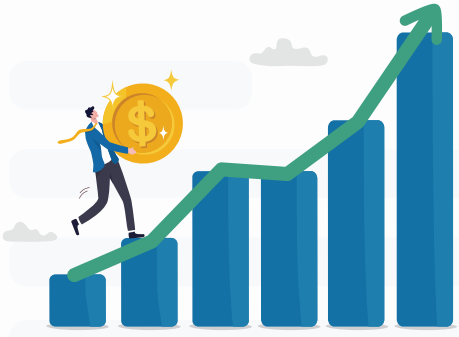
# MESSAGE TO OUR EMPLOYEES

Employer Solutions Staffing Group values the contributions of our employees, and we are pleased to offer a variety of affordable coverage options through The American Worker. It is important to us that you and your loved ones receive the coverage that you need. Please carefully review this enrollment guide to ensure you understand the benefits being provided and can make the right choices for you and your family.



## STOP PAYING FULL PRICE FOR SERVICES

## DON'T BE TURNED AWAY FOR SERVICES



## AVOID LARGE UPFRONT COSTS

## STAY HEALTHY!

# YOUR ENROLLMENT OPPORTUNITY

## AM I ELIGIBLE FOR BENEFITS?

As an employee of Employer Solutions Staffing Group, you are eligible to enroll in benefits. You must be actively at work to retain coverage. Dependent coverage is available to your legal spouse and your legal children up to age 26.

## WHEN CAN I MAKE A PLAN CHANGE OR TERMINATE MY COVERAGE?

Coverage can only be changed or canceled during Open Enrollment or within 30 days of a qualifying life event.

## HOW DO I ENROLL IN COVERAGE?

You can enroll in coverage online, by phone, or on your mobile device. If you do not enroll in coverage now, you will not be able to enroll until the next open enrollment period, unless you experience a qualifying life event.

## CURRENT HEALTH EZ & ESSENTIAL STAFFCARE (ESC) MEMBERS:

All current Health EZ and Essential StaffCare (ESC) members must re-enroll in the American Worker program. If you do not take action to enroll during this open enrollment period, you will not have any coverage.
Visit www.TheAmericanWorker.com or call 866-866-3424 to enroll in coverage.

**OPEN ENROLLMENT:** 05/05/2025 - 05/16/2025

**EFFECTIVE DATE:** 06/01/2025, 06/02/2025, OR 06/09/2025 DEPENDING ON YOUR PAY FREQUENCY AND FIRST CHECK DATE WITH A DEDUCTION.

**Enroll Online:** Visit www.TheAmericanWorker.com
1. Select **Login and Enroll**
2. Click on **Register & Enroll**

Available anytime, day or night

**Enroll by Phone:** Call **(866) 866-3424**
Monday - Friday
8:00 AM - 8:00 PM ET

Press 1 to enroll.
Press 2 for all other inquiries

## MEC ENHANCED PLAN

- 100% coverage when using in-network providers for ACA preventive services.
- Generic Prescription drug coverage at a $10 copay. Brand Name drugs are available at a discounted price.
- Medical price shopping tool to estimate out-of-pocket costs before choosing a provider or facility.
- Copays for doctor visits, diagnostic tests, and lab work.
- Telemedicine with free consultations.

## DON'T GO WITHOUT HEALTH COVERAGE!

Taking care of your health shouldn't be a gamble. Regular checkups and preventive care can catch small issues early, keeping you healthy and avoiding bigger problems down the road.

Our affordable plans make accessing basic healthcare services easy and convenient. Take control of your health & wellness and enroll today!

# SPECIALTY PLANS FOR YOU

## DENTAL COVERAGE

Pays up to $1,000 per year with a $20 deductible per visit.

## VISION COVERAGE

Coverage for eye exams and corrective eyewear.

## SHORT-TERM DISABILITY

Pays $150 per week for up to 26 weeks.

### DENTAL AND VISION BENEFITS

Healthy teeth and eyes are key to a healthy you. Poor oral and visual health can impact your overall well-being, leading to discomfort, missed work, and even bigger health problems down the road.

Our plans provide coverage for essential exams and screenings to help you catch potential issues early, ensuring a healthy smile and sharp vision for years to come.

### DISABILITY AND MORE

Be prepared for life's challenges. Accidents, illnesses, and loss can hit anyone. The financial burden on top of emotional stress can be overwhelming.

Our plans provide financial support during difficult times, helping you focus on recovery and providing a safety net for your loved ones. Don't let an unexpected event derail your life.

# MEC ENHANCED PLAN

The MEC Enhanced plans provide 100% ACA preventive coverage at in-network providers as well as copays for outpatient services such as doctor visits, labs, x-rays, and more at PHCS Limited Benefit Plan Network providers. The plan provides prescription drug copays and access to telemedicine consultations as well.

The MEC Enhanced Elite plan includes a daily benefit toward in-patient services like emergency room visits, anesthesia, surgery, and intensive care. This daily benefit does not require use of an in-network provider; however, you do have access to the PHCS Limited Benefit Plan Network www.multiplan.com/awp. When you use an in-network provider, a discount will be applied to your bill in addition to your daily benefit, decreasing the amount you pay out-of-pocket.

## WHY SHOULD YOU ENROLL IN A MEC ENHANCED PLAN?

- Preventive Services paid at 100% for in-network providers and facilities.
- Access to network discounts through the PHCS Limited Benefit Plan Network.
- Copays & discounts on prescription drugs.
- No additional out-of-pocket for services with a copay.
- Daily benefit toward non-preventive in-patient medical services incurred in or out-of-network in the MEC Enhanced Elite plan only.
- Additional ancillary benefits like telemedicine, accidental death and dismemberment, accident medical, and basic life coverage are included.
- In most cases, avoid paying out-of-pocket for services prior to your appointment by supplying your American Worker ID card as proof of coverage.

## SAVE MONEY! – GO IN-NETWORK

When you go to an in-network provider, services like doctor's office visits and diagnostic tests are covered by just a copay. Here's an example of how going to an in-network provider can save you money on a doctor's visit if you are sick or have an injury. **Refer to benefit grid for actual benefit amount.**

### EXAMPLE

You go to the doctor for feeling sick or being injured.

This type of service often includes a charge for the office visit.

**IN-NETWORK**

$125 Office Visit Cost = **Your Cost $20 Copay**

**OUT-OF-NETWORK**

The out-of-network benefit will vary by plan. Review the plan design in this guide to see what the out-of-network benefit is.

# MEC ENHANCED PLAN

| | MEC ENHANCED PREFERRED PLAN |
|---|---|
| *SELF-FUNDED BENEFITS - PHCS NETWORK PROVIDER USE REQUIRED. | |
| Minimum Essential Coverage (MEC) | Plan pays 100% for all ACA required preventive services.<br>**You MUST visit a PHCS Network provider for services to be covered.** |
| Physician's Office Visit | $20 copay; Unlimited Visits |
| Specialists | $50 copay; Unlimited Visits |
| Urgent Care | $50 copay; Unlimited Visits |
| Diagnostic Tests & Lab Work | $60 copay; Unlimited Test Days |
| Chiropractic Care | $75 copay; Unlimited Visits |
| Advanced Imaging | $200 copay; Unlimited Visits |
| Prescription Drugs<br>-Generic<br>-Brand<br>-Annual Maximum | CerpassRx<br>$10 copay<br>Discounts<br>Unlimited |
| ADDITIONAL BENEFITS - ALL BELOW SERVICES PAY ON A CALENDAR YEAR BASIS PER PERSON, UNLESS STATED OTHERWISE. | |
| *PHCS Network | Physician and Hospital |
| *Teladoc Virtual Primary Care | No cost access to doctors<br>by phone or online |
| *Medical Price Shopping Tool | Estimate medical costs before scheduling |
| *Accident Medical Expense | $5,000 maximum benefit per injury |
| *Accidental Death &<br>Dismemberment | $15,000 Employee<br>$7,500 Spouse / $3,000 Child |
| WEEKLY RATES | MEC ENHANCED PREFERRED PLAN |
| Employee Only<br>Employee + Spouse<br>Employee + Child(ren)<br>Family | $26.44<br>$41.64<br>$37.40<br>$64.67 |

***Benefits not underwritten by Nationwide Life Insurance Company.**
**The MEC Enhanced Elite Policy is not available to residents of NM & VT. Benefits vary for KS & OH residents.**
**Certain benefits may share maximums. Refer to the plan certificate for more details.**

# MINIMUM ESSENTIAL COVERAGE (MEC)

The MEC Enhanced option includes Minimum Essential Coverage (MEC). Minimum Essential Coverage (MEC) makes preventive care simple. You get 100% coverage in-network for all preventive services required by the Affordable Care Act, including routine checkups, immunizations, screenings, preventive prescriptions, and COVID-19 vaccines. Only three over-the-counter COVID-19 tests are available annually.

You have access to the PHCS Limited Benefit Medical Network. Through this network you have access to 4,500 hospitals, 900,000 practitioners and 84,000 ancillary facilities.

All participating providers undergo an extensive and thorough credentialing process so you can be confident that you are choosing a quality healthcare provider.

## COVERED SERVICES

**Flu shots and routine immunizations**

**Medical screenings**

- Blood pressure
- Cholesterol
- Diabetes

**Annual well-woman exam**

**Well baby and well child exams**

**Contraception**

- FDA approved methods excluding abortifacient drugs
- Sterilization procedures

**Cancer screenings**

- Colorectal
- Breast

**Counseling on topics including:**

- Alcohol and drug abuse
- Depression
- Diet and obesity
- Domestic violence
- Sexually transmitted diseases
- Tobacco cessation

**EXAMPLE**

You go to the doctor for an annual physical exam. This type of service often includes a charge for the office visit and a lab screening.

**IN-NETWORK**

| $160 Office Visit Cost | + | $170 ACA Approved Lab Cost | = | $330 Exam Total Billed | Your Cost $0 |
|---|---|---|---|---|---|

**OUT-OF-NETWORK**

| $160 Office Visit Cost | + | $170 ACA Approved Lab Cost | = | $330 Exam Total Billed | Your Cost $330 |
|---|---|---|---|---|---|

**Please note, the U.S. Preventive Services Task Force periodically updates these lists and sets the requirements such as age, gender, or health conditions for services to be covered. For a current list including all requirements, visit www.healthcare.gov/preventive-care-benefits/.**

**IMPORTANT:** Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that you may be required to pay some costs for the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

# ADDITIONAL PLAN FEATURES

## PHCS LIMITED BENEFIT NETWORK

All plan designs provide access to a PPO Network that allows covered individuals to take advantage of network negotiated rates.

**FIND A NETWORK PROVIDER**

- **Limited Benefit Network:** www.Multiplan.com/awp
- **Call:** (888) 371-7427

## TELADOC VIRTUAL PRIMARY CARE

With Teladoc's Primary360, You will have Access to Primary Care, General Medical and Behavioral Health services. Quality and convenient care to help you stay healthy.

- **Primary Care:** New patient visit $165; Follow up visits $99
- **General Medical:** $0 per consult
- **Annual Wellness:** $165 per visit
- **Psychiatry:** New patient visit $235; Follow up visits $105
- **Therapist:** $95 per visit

Note: Additional Member Responsibility may apply, according to the underlying medical benefit design.

## MEDICAL PRICE SHOPPING TOOL: HEALTHCARE BLUEBOOK

Do you need medical attention for a non-preventive service? You can still get a discount on those services by going to an in-network provider. Use this medical price shopping tool to shop for medical procedures at in-network providers in your area to find the best price and get an out-of-pocket cost estimate.

It's easy to find savings with a simple search before scheduling. Access the medical price shopping tool through your member portal at www.TheAmericanWorker.com or call (855) 495-1190.

**The medical price shopping tool does not guarantee that cost estimates will be the price you are charged or pay for services.**

## CRUM & FORSTER ACCIDENT MEDICAL AND ACCIDENTAL DEATH & DISMEMBERMENT

Unforeseen accidents can occur leaving you or your loved ones with unplanned expenses. The Accident Medical and Accidental Death & Dismemberment benefits provide a cash payment to you or loved one's to help alleviate some of the financial burden after an accident-related crisis as occurred. This benefit is underwritten by Crum & Forster and administered by NAHGA.

- **Accident Medical Expense:** $5,000 maximum benefit per injury
- **Accidental Death & Dismemberment:** $15,000 Employee / $7,500 Spouse / $3,000 Child

# DENTAL

Keep a bright, healthy smile and support your overall well-being with affordable dental coverage. Regular dental care is important, so a dental plan that covers routine visits and offers in-network discounts is crucial. **You will not receive an ID card for this benefit, your Social Security Number will be used for identification.**

This plan is underwritten by Ameritas.

| DENTAL PLAN BENEFITS | | |
|---|---|---|
| PLAN MAXIMUMS | | |
| **Calendar Year Maximum** | Up to $1,000 per Covered Member | |
| **Deductible** | $20 per Visit | |
| COVERED BENEFITS | WAITING PERIOD | COINSURANCE |
| **Preventive and Diagnostic**<br>Routine Exams, Cleanings, X-rays, etc. | None | Covered at 100%<br>(MAC/MAB)* |
| **Basic Treatment**<br>Restorative Amalgams and Composites Endodontics, Periodontics, Extractions, etc. | 3 Months | Covered at 60%<br>(MAC/MAB)* |
| **Major Treatment**<br>Onlays, Crowns, Prosthodontics, etc. | 12 Months | Covered at 50%<br>(MAC/MAB)* |
| WEEKLY RATES | | |
| Employee<br>Employee + Spouse<br>Employee + Child(ren)<br>Family | $6.36<br>$15.87<br>$10.96<br>$16.64 | |

***The Maximum Allowable Charge (MAC) claim benefit is the maximum amount a network provider may charge. If you select a network provider, you may have lower out-of-pocket costs. In order to keep rates lower, if you visit an out-of-network dentist, the claim benefit is considered at the Maximum Allowable Benefit (MAB), which is equal to the lowest contracted fee in your ZIP Code. Any difference between the plan benefit and the dentist's charge will be an out-of-pocket expense for you.**

## LOCATE NETWORK PROVIDERS

Call (800) 659-2223
- Select option 3

Visit **www.Ameritas.com**
- Your network is the "CLASSIC PPO" Network.

# VISION

A regular eye exam won't just help you see better, it can also detect the first signs of serious health conditions. Visit a VSP Choice provider to get the most out of your vision plan. **You will not receive an ID card for this benefit, your Social Security Number will be used for identification.**

This plan is underwritten by Ameritas.

| VISION PLAN BENEFITS | | |
|---|---|---|
| PLAN MAXIMUM | | |
| **Deductible** | $10 Exam, $25 Eye Glass Lenses or Frames[1] | |
| COVERED BENEFITS | VSP CHOICE NETWORK | OUT-OF-NETWORK |
| **Annual Eye Exam** | Covered in Full | Up to $45 |
| **Lenses** (per pair)<br>Single Vision / Bifocal<br>Trifocal / Lenticular | <br>Covered in Full<br>Covered in Full | <br>Up to $30 / Up to $50<br>Up to $65 / Up to $100 |
| **Contacts**<br>Fit and Follow Up Exams<br>Elective<br>Medically Necessary | <br>$60 Copay<br>Up to $105<br>Covered in Full | <br>No Benefit<br>Up to $105<br>Up to $210 |
| **Frames** | Up to $105[2] | Up to $70 |
| **Frequency**<br>Exam / Lens / Frames | Based on Date of Service<br>12 Months / 12 Months / 24 Months | |
| WEEKLY RATES | | |
| Employee<br>Employee + Spouse<br>Employee + Child(ren)<br>Family | $2.12<br>$4.19<br>$3.91<br>$5.98 | |

[1]**Deductible applies to a complete pair of glasses or frames, whichever is selected.**
[2]**The Costco benefit will be the wholesale equivalent.**

## LOCATE NETWORK PROVIDERS

Call **(800) 877-7195**

Visit **www.Ameritas.com**

- Your network is "VISION: VSP"

## SHORT-TERM DISABILITY

Daily life depends on consistent income, but accidents and serious illnesses can keep you out of work. This plan can help you cover your expenses by paying you cash if you get sick or injured and can't work.

| SHORT-TERM DISABILITY | |
|---|---|
| **Weekly Maximum Benefit** | Plan pays $150 Lump Sum |
| **Maximum Benefit Period** | 26 weeks |
| **Waiting Period** | 7 days (Accidents and Illnesses) |
| BENEFIT TIER | WEEKLY RATE |
| Employee Only | $3.50 |

Coverage includes disability due to pregnancy and childbirth.
**This coverage is not available to residents of VT.**
**Residents of VT have state sponsored disability.**

# PAYING FOR BENEFITS

## HOW DO I PAY FOR COVERAGE?

Your premium will be deducted from your paycheck.

## WHAT HAPPENS IF I DON'T HAVE A PAYROLL DEDUCTION?

Your benefits will be suspended. Your benefits will resume when you have a paycheck with a deduction.

## WHAT HAPPENS IF I HAVE A CLAIM WHEN MY BENEFITS ARE SUSPENDED?

Your claim will be denied and you will pay for 100% of the cost for the care you received. If you are within 30 days of the missed deduction, you can pay The American Worker directly for that missed period. Your claim will automatically be reprocessed.

## HOW DO I KEEP MY COVERAGE IF I MISS A DEDUCTION?

You can make a payment directly to The American Worker to avoid having coverage suspended.

## HOW DO I MAKE A PAYMENT IF I MISSED A DEDUCTION?

You can pay online, by phone or by mail. Payment options include credit or debit card, personal check, and money order. You can also set up an automatic payment from your credit card or bank account to pay for missed deductions.

**Online:** Visit www.TheAmericanWorker.com and login to your employee portal
**Phone:** Call The American Worker at **(866) 866-3424**
**Mail:** 11910 Anderson Mill Rd #401, Austin, TX 78726

**NOTE:** If you setup automatic payments, you must contact The American Worker to cancel the automatic payment when your employment ends. If you do not, your account will be charged for coverage and you will not receive a refund.

## HOW LONG DO I HAVE TO MAKE A PAYMENT FOR A MISSED DEDUCTION?

You have 30 days from the date of your paycheck without a deduction to make a premium payment. If you do not pay for the missed deduction within 30 days, you will not be able to pay for that coverage period at a later date.

## WILL MY COVERAGE BE TERMINATED IF I DON'T PAY MY PREMIUM?

**Employees that are paid weekly** and do not have a deduction for 4 consecutive weeks will have their coverage terminated for non-payment.

**Employees paid biweekly or semi-monthly** that do not have a deduction for 2 consecutive pay periods will be terminated for non-payment.

**Monthly employees** that have 1 missed period will be terminated for non-payment.

**Please review your paycheck to make sure your premium is deducted. If it is not, contact The American Worker immediately to make a payment and avoid having your coverage terminated.**

## WILL I RECEIVE AN ID CARD?

When you enroll in medical coverage for the first time, an ID card and policy information will be mailed to your home address we have on file. If you make a change to your medical coverage, a new ID card will be mailed to your address. You can request a new ID card by contacting Member Services or access a temporary ID card by logging into www.TheAmericanWorker.com.

For any non-medical coverage you elect, policy information will be mailed to your home address. You will not receive an ID card for non-medical coverage.

## HOW DO I USE MY COVERAGE?

When seeking medical care, you should always ask your provider if they participate in the network associated with your plan. Present your medical ID card to your provider and ask them to call the customer service number to verify coverage. Be sure to locate an in-network provider prior to seeking care.

When making a Dental or Vision appointment, tell your provider your benefits are with Ameritas and they can verify coverage using your Social Security Number.

## CONTACTS

| BENEFIT | CONTACT | WEBSITE | PHONE NUMBER |
|---|---|---|---|
| Medical | The American Worker | **www.TheAmericanWorker.com** | (855)495-1190 |
| Accident Medical and AD&D (Included in MEC Enhanced Plans) | Crum & Forster administered by NAHGA | **www.NCSR@nahgaclaims.com** | (800)952-4320 |
| Telemedicine | Teladoc | **www.Teladoc.com** | (800)835-2362 |
| Short-Term Disability | Nationwide administered by The American Worker | **www.TheAmericanWorker.com** | (855)495-1190 |
| MEC Enhanced PPO Network | PHCS Limited Benefit Plan Network | **www.multiplan.com/awp** | (888)371-7427 |
| Dental | Ameritas | **www.Ameritas.com** | (800)659-2223 |
| Vision | Ameritas | **www.Ameritas.com** | (800)877-7195 |

## INTRODUCTION

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description, which will be mailed to you following your enrollment in the plan.

## WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to one of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to any of the following qualifying events:

- Your spouse or domestic partner dies
- Your spouse's or domestic partner's hours of employment are reduced
- Your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct
- Your spouse or domestic partner's becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse or domestic partner

Your dependent children will become qualified beneficiaries if they lose coverage under the plan due to any of the following qualifying events:

- The parent/employee dies
- The parent/employee's hours of employment are reduced
- The parent/employee's employment ends for any reason other than his or her gross misconduct.
- The parent/employee becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the plan as a "dependent child"

## WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Record-keeper if any of the following qualifying events occur: the end of employment, a reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

# DISCLAIMERS

**Refer to official insurance policy and plan documents for more extensive information concerning your benefit plans. In the event of any conflict between this guide and the official plan documents, the plan documents, policy and certificate of coverage will govern.**

**Nationwide: New Mexico and Vermont residents are not eligible for any of the benefit programs offered by The American Worker.**

**Nationwide and Nationwide N and Eagle are service marks of Nationwide Mutual Insurance Company.** The coverage is underwritten by Nationwide Life Insurance Company, Columbus, Ohio (CA COA #7032). The Limited Benefit Plan applicable to policy form SRCP 2000 or state equivalent. PRAM RX plan is applicable to policy forms GPDP AO L20 and is not available in all states. This product provides prescription coverage only, it does not cover basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. NSM-0301AO (06/23). The coverages are distributed by Fringe Benefit Group. Nationwide and Fringe Benefit Group are separate and non-affiliated companies.

**Minimum Essential Coverage (MEC) and MEC Enhanced Plans:** These plans provide Plan Participants with minimum essential coverage under the federal income tax rules. Individuals that do not enroll in these plans may be eligible for a federal tax credit that lowers their monthly premium or a reduction in certain cost-sharing if they enroll in a health insurance plan through the federal or state exchange. Individuals that enroll in these plans may not be eligible for a federal tax credit though a federal or state exchange while enrolled in these plans. These plans do not provide comprehensive health insurance. Limitations and exclusions apply.

**Limited Benefit:** This program is not intended nor recommended to replace any comprehensive program of insurance in which you currently participate, or intend to participate. This plan is not designed to replace or provide major medical or catastrophic coverage. This brochure is for summary purposes only. The insurance benefits of the Limited Benefit plan are offered by Nationwide Life Insurance Company. Additional information will be provided upon enrollment in the program. Plan exclusions and limitations apply. **Massachusetts residents** are eligible for the Limited Benefit plan, but this plan does NOT meet Minimum Creditable Coverage standards. **The Limited Benefit Plan is (a) not a substitute for minimum essential health coverage under the Affordable Care Act (ACA); and (b) does not qualify as minimum essential coverage under the ACA.**

**Section 125 Disclaimer:** By enrolling, you elect to participate in the American Worker plan for benefits available under the Internal Revenue Code Section 79, 105,106,125, and these sections as amended. You understand that the plan will automatically convert to pretax status and eligible payroll deductions which are provided through the Plan. You understand that by participating in this Plan your Social Security benefits may be reduced sine these premiums will be deducted before your salary is taxed. This election will remain in effective for the entire Plan Year. Your election CANNOT be changed during the Plan Year in accordance with the Internal Revenue Service Guidelines unless a qualifying event occurs. Qualifying events include: marriage, divorce, legal separation, death of spouse, birth or legal adoption of a child, death of a child, or spousal change of employment affecting insurance coverage. By enrolling you have accepted the terms detailed about.

**Accident Medical Expense:** This is a brief summary of the Accident coverage available under this plan. The issued Policy contains the compete limitations, exclusions, definitions and plan provisions. Plan features and availability may vary by state. Full details of the coverage are contained in the Policy on file with the Policyholder. If any conflict should arise between the contents of this summary and the respective Policy, the terms of the Policy will govern in all cases.

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# DISCLAIMERS

**Ameritas Disclaimers**
Plans are not available in Massachusetts, New Mexico or for groups with less than 50 eligible employees in Washington. Plan designs may vary in some states and are subject to individual state regulations. This piece is not for use in New Mexico. All plans are underwritten by Ameritas Life Insurance Corp. (Ameritas Life) or Ameritas Life Insurance of New York (Ameritas Life of New York). Dental and Vision products (9000 Rev. 03-16 or 9000 NY Rev.03-15) individual dates may vary by state. Ameritas and the bison design are service marks or registered service marks of Ameritas Life, affiliate Ameritas Holding Company or Ameritas Mutual Holding Company.

Limitations and Exclusions:
Dental
- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within eight years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the plan member is covered under the dental expense benefit, it will be a Covered Expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan member is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth. This limitation is waived for groups with 35 or more employees covered on the effective date of the contract.
- for any procedure begun before the plan member was covered under the dental expense benefit.
to replace lost or stolen appliances. for appliances, restorations, or procedures to:
alter vertical dimension;
restore or maintain occlusion;
splint or replace tooth structure lost because of abrasion or attrition
- for any procedure which is not shown on the Table of Dental Procedures.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.

The complete list of exclusions and limitations can be found in the Limitations Section and Table of Dental Procedures in the Certificate of Coverage.
Vision
- vision examinations, lenses or frames more than the frequency as indicated on the plan summary page.
- examinations performed or frames or lenses ordered before the member was covered under the eye care expense benefits.
- subject to extension of benefits, any examination performed or frame or lens ordered after the member's coverage under the eye
care expense benefits ceases.
- sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- non-prescription lenses.
- replacement or repair of lost or broken lenses or frames except at normal intervals.
- any eye examination or corrective eyewear required by an employer as a condition of employment.
- medical or surgical treatment of the eyes.
- coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

The complete list of exclusions and limitations can be found in the Limitations Section and Table of Eyecare Procedures in the Certificate of Coverage.

The complete list of exclusions and limitations can be found in the Limitations Section and Table of Dental Procedures in the Certificate of Coverage. Plans are not available in Massachusetts, New Mexico or for groups with less than 50 eligible employees in Washington. Plan designs may vary in some states and are subject to individual state regulations. For a complete list of Limitations and exclusions refer to your certificate. This piece is not for use in New Mexico. All plans are underwritten by Ameritas Life Insurance Corp. (Ameritas Life) or Ameritas Life Insurance of New York (Ameritas Life of New York). Dental and Vision products (9000 Rev. 03-16 or 9000 NY Rev.03-15) individual dates may vary by state. Ameritas and the bison design are service marks or registered service marks of Ameritas Life, affiliate Ameritas Holding Company or Ameritas Mutual Holding Company.

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

| GEORGIA – Medicaid | INDIANA – Medicaid |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website:<br>https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |

| MONTANA – Medicaid | NEBRASKA – Medicaid |
|---|---|
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |

| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
|---|---|
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP)<br>Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website:<br>https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website:<br>https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

# FAQs on HIPAA Portability and Nondiscrimination Requirements for Workers

U.S. Department of Labor
Employee Benefits Security Administration

### What is the Health Insurance Portability and Accountability Act (HIPAA)?

HIPAA offers protections for workers and their families. The law provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events. HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information.

## Taking Advantage of Special Enrollment Opportunities

### What is Special Enrollment?

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents.

Under the second, employees, spouses, and new dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

## What are some examples of events that can trigger a loss of eligibility for coverage?

Loss of eligibility for coverage may occur when:

- Divorce or legal separation results in you losing coverage under your spouse's health insurance;
- A dependent is no longer considered a "covered" dependent under a parent's plan;
- Your spouse's death leaves you without coverage under his or her plan;
- Your spouse's employment ends, as does coverage under his employer's health plan;
- Your employer reduces your work hours to the point where you are no longer covered by the health plan;
- Your plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time);
- You no longer live or work in the HMO's service area.

These should give you some idea of the types of situations that may entitle you to a special enrollment right.

## How long do I have to request special enrollment?

It depends on what triggers your right to special enrollment. The employee or dependent must request enrollment within 30 days after losing eligibility for coverage or after a marriage, birth, adoption, or placement for adoption.

The employee or dependent must request enrollment within 60 days of the loss of coverage under a state CHIP or Medicaid program or the determination of eligibility for premium assistance under those programs.

## After I request special enrollment, how long will I wait for coverage?

It depends on what triggers your right to special enrollment. Those taking advantage of special enrollment as a result of a birth, adoption, or placement for adoption begin coverage no later than the day of the event.

For special enrollment due to marriage or loss of eligibility for other coverage, your new coverage will begin on the first day of the first month after the plan receives the enrollment request. If the plan receives the request on January 3, for example, coverage would begin on February 1.

## What coverage will I get when I take advantage of a special enrollment opportunity?

Special enrollees must be offered the same benefits that would be available if you are enrolling for the first time. Special enrollees cannot be required to pay more for the same coverage than other individuals who enrolled when first eligible for the plan.

### Can my new group health plan deny me benefits because I have a preexisting condition?

While HIPAA previously provided limits on preexisting condition exclusions, new protections under the Affordable Care Act (ACA) prohibit group health plans from imposing any preexisting condition exclusion. Under this protection, a plan generally cannot limit or deny benefits relating to a health condition that was present before your enrollment date in the plan.

### Where do I find out more about special enrollment in my plan?

A description of special enrollment rights should be included in the plan materials you received when initially offered the opportunity to enroll.

### How will I know if I am eligible for assistance with group health plan premiums under CHIP or Medicaid?

You need to contact your state's CHIP or Medicaid program to see if your state will subsidize group health plan premiums and to determine if you are eligible for the subsidy under these programs. For information on the program in your state, call 1-877-KIDSNOW (543-7669) or visit **InsureKidsNow.gov** on the Web. If you are eligible for this premium assistance, you need to contact your plan administrator or employer to take advantage of the special enrollment opportunity and enroll in the group health plan.

## HIPAA's Protections from Discrimination

### What are HIPAA's protections from discrimination?

Under HIPAA, you and your family members cannot be denied eligibility or benefits based on certain "health factors" when enrolling in a health plan. In addition, you may not be charged more than similarly situated individuals based on any health factors. The questions and answers below define the health factors and offer some examples of what is and is not permitted under the law.

### What are the health factors under HIPAA?

The health factors are:

- Health status;
- Medical conditions, including physical and mental illnesses;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability (see below); and
- Disability.

Conditions arising from acts of domestic violence as well as participation in activities like motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, and skiing are

considered "evidence of insurability." Therefore, a plan cannot use them to deny you enrollment or charge you more for coverage. (However, benefit exclusions known as "source of injury exclusions" could affect your benefits. These exclusions are discussed in more detail below.)

### Can a group health plan require me to pass a physical examination before I am eligible to enroll?

No. You do not have to pass a physical exam to be eligible for enrollment. This is true for individuals who enroll when first eligible, as well as for late and special enrollees.

### Can my plan require me to fill out a health care questionnaire in order to enroll?

Yes, as long as the questionnaire does not ask for genetic information (including family medical history) and the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

### My group health plan required me to complete a detailed health history questionnaire and then subtracted "health points" for prior or current health conditions. To enroll in the plan, an employee had to score 70 out of 100 total points. I scored only 50 and was denied a chance to enroll. Can the plan do this?

No. In this case the plan used health information to exclude you from enrolling in the plan. This practice is discriminatory, and it is prohibited.

### My group health plan booklet states that if a dependent is confined to a hospital or other medical facility at the time he is eligible to enroll in the plan, that person's eligibility is postponed until he is discharged. Is this permitted?

No. A group health plan may not delay an individual's eligibility, benefits, or effective date of coverage based on confinement to a hospital or medical facility at the time he becomes eligible. Additionally, a health plan may not increase that person's premium because he was in a hospital or medical facility.

### My group health plan has a 90-day waiting period before allowing employees to enroll. If an individual is in the office on the 91st day, health coverage begins then. However, if an individual is not "actively at work" on that day, the plan states that coverage is delayed until the first day that person is actually at work. I missed work on the 91st day due to illness. Can I be excluded from coverage?

No. A group health plan generally may not deny benefits because someone is not "actively at work" on the day he would otherwise become eligible.

However, a plan may require employees to begin work before health plan coverage is effective. A plan may also require an individual to work full time (say, 250 hours per quarter or 30 hours per week) in order to be eligible for coverage.

## Can my group health plan exclude or limit benefits for certain conditions or treatments?

Group health plans can exclude coverage for a specific disease or limit or exclude benefits for certain treatments or drugs, but only if the restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.).

However, compliance with this rule under HIPAA does not affect whether the plan provision or practice is permitted under other laws including the ACA such as the requirement to offer essential health benefits in the individual and small group markets.

## How do you determine "similarly situated individuals"?

HIPAA states that plans may distinguish among employees only on "bona fide employment-based classifications" consistent with the employer's usual business practice. For example, part time and full time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as different groups of similarly situated individuals.

A plan may draw a distinction between employees and their dependents. Plans can also make distinctions between beneficiaries themselves if the distinction is not based on a health factor. For example, a plan can distinguish between spouses and dependent children, or between dependent children age 26 and older based on their age or student status.

## I have a history of high claims. Can I be charged more than others in the plan based on my claims experience?

No. Group health plans cannot charge an individual more for coverage than a similarly situated individual based on any health factor.

However, be aware that HIPAA does allow an insurer to charge one group health plan (or employer) a higher rate than it does another. When an insurance company establishes its rates, it may underwrite all covered individuals in a specific plan based on their collective health status. The result can be that one employer health plan whose enrollees have more adverse health factors can be charged a higher premium than another for the same amount of coverage. Note that compliance with this rule under HIPAA does not affect whether the practice is permitted under the ACA including the rating requirements in the small group market.

Think of it this way: HIPAA's protections from discrimination apply within a group of similarly situated individuals, not across different groups of similarly situated individuals. For example, an employer distinguishes between full-time and part-time employees. It can charge part-time employees more for coverage, but all full-time employees must pay the same rate, regardless of health status.

Also, for insured plans, state law may govern rates for health coverage. More information is available at **NAIC.org**.

### I am an avid skier. Can my employer's plan exclude me from enrollment because I ski?

No. Participation in activities such as skiing would be "evidence of insurability," which is a health factor. Therefore, it cannot be used to deny eligibility.

### Can my health plan deny benefits for an injury based on how I got it?

It depends. A plan can deny benefits based on an injury's source, unless an injury is the result of a medical condition or an act of domestic violence.

Therefore, a plan cannot exclude coverage for self-inflicted wounds, including those resulting from attempted suicide, if they are otherwise covered by the plan and result from a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or from domestic violence. For example, a plan generally can exclude coverage for injuries in connection with an activity like bungee jumping. While the bungee jumper may have to pay for treatment for those injuries, her plan cannot exclude her from coverage for the plan's other benefits.

### My group health plan says that dependents are generally eligible for coverage only until they reach age 26. However, this age restriction does not apply to disabled dependents, who seem to be covered past age 26. Does HIPAA permit a policy favoring disabled dependents?

Yes. A plan can treat an individual with an adverse health factor (such as a disability) more favorably by offering extended coverage.

### Are all family members, including a spouse, covered by HIPAA?

If your group health plan permits coverage of family members ("dependents"), and if they participate in the plan, then they will have the same HIPAA protections as employees.

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) expands the HIPAA nondiscrimination provisions discussed above by generally prohibiting the use of genetic information to adjust group premiums or contributions, the collection of genetic information and requests for individuals to undergo genetic testing.

# HIPAA and Wellness Programs

## I've learned that my health plan will include a wellness program next year. What is a wellness program?

Wellness programs encourage employees to work out, stop smoking or generally adopt healthier lifestyles by offering some type of financial or other incentive. If a wellness program is part of a group health plan, it must comply with rules created by HIPAA and the ACA that prevent the employee from being impermissibly discriminated against based on a health factor.

There are two types of wellness programs - participatory and health-contingent. A participatory wellness program is one that offers a reward simply for participating in the program. For example, the program reimburses employees for all or part of the cost for membership in a fitness center. Participatory wellness programs are allowed under the nondiscrimination rules as long as they are available to all similarly situated individuals.

A health-contingent wellness program is one that rewards an employee for satisfying a standard related to a health factor. If the standard is an activity-only one, you need to perform or complete an activity, like walking or other exercise, to get the reward. If the standard is outcome-based, you must achieve a specific health outcome, like a certain result on a health screening, to get the reward. Health-contingent wellness programs must meet certain requirements.

## I belong to a group health plan that rewards individuals who volunteer to be tested for early detection of health problems, such as high cholesterol. Can a plan do this?

Yes, as long as the program is available to all similarly situated individuals. If the health plan offers a reward based on participation in the program and not on test results, the program is considered a participatory wellness program and the plan does not have to comply with the additional requirements applicable to health-contingent wellness programs. For instance, a health plan can offer a premium discount for those who voluntarily test for cholesterol, as long as the discount is available to everyone who takes the test and not just those who get a certain result. If the discount was based on individuals having certain results, additional requirements discussed below would apply.

## My plan's wellness program offers a lower deductible to those who participate in a specific walking program. How can I tell if this is permissible?

Because the reward (the lower deductible) is available to all who participate in a walking program, this is an activity-only health-contingent program. The program will be permissible if:

- Individuals have a chance to qualify for the reward at least once per year;
- The total reward for all of the plan's health-contingent wellness programs is not more than 30% of the cost of employee-only coverage in the plan. If dependents can participate, the reward cannot be more than 30% of the cost of the coverage in which an employee and dependents are enrolled. For wellness programs designed to prevent or

reduce tobacco use the allowable percentage is higher – the reward for those programs cannot be more than 50% of the cost of coverage;
- The walking program is reasonably designed to promote health or prevent disease;
- A reasonable alternative standard (or a waiver of the walking requirement) is offered to those for whom it is unreasonably difficult because of a medical condition, or medically inadvisable, to participate in the walking program; and
- The plan discloses the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program.

### I would like to participate in my plan's wellness program. Under the program, to get a discount on my premiums, my body mass index (BMI) must be 26 or lower. Is there any way for me to get the premium discount if my BMI is higher than 26?

Yes. The reward is provided to those who achieve a specific health outcome (BMI of 26 or lower), so this is an outcome-based health-contingent wellness program. If your BMI is above 26, the plan must provide you with a reasonable alternative standard to qualify for the reward. The reasonable alternative standard could be activity-based such as completion of an educational program, participation in a diet program, or following the recommendations of your personal physician; it could also be another outcome-based standard, such as a one-point reduction in your BMI over a set period of time. If it is unreasonably difficult because of a medical condition, or medically inadvisable, for you to complete the alternative, the plan must work with you to find a second alternative based on your physician's recommendations.

In addition, as with an activity-only program, you must be given the chance to qualify for the reward at least once per year; the total reward for the plan's health-contingent wellness programs cannot be more than 30% (or 50% for tobacco-related programs) of the cost of employee-only coverage (or the cost of the coverage enrolled in if dependents can participate); and the plan must disclose the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program. This notice must also be included in any disclosure that you did not satisfy the initial standard.

### Can a plan charge a lower premium for nonsmokers than it does for smokers?

The plan is offering a reward based on an individual's ability to stop smoking so this is an outcome-based program. For this type of wellness program to be permissible:

- Individuals must have a chance to qualify for the nonsmoker's discount at least once a year;
- The difference in premiums between nonsmokers and smokers cannot be more than 50% of the cost of employee-only coverage (or 50% of the cost of coverage if dependents can participate);
- The program must be reasonably designed to promote health and prevent disease;
- There is a reasonable alternative standard to those who do not meet the otherwise applicable standard. For example, the reasonable alternative standard could include discounts in return for attending educational classes or for trying a nicotine patch; and
- Plan materials describing the premium discount (and any disclosure that an individual did not satisfy the standard) describe the availability of a reasonable alternative standard to qualify for the lower premium.

# Coordination with Other Laws

## Can states modify HIPAA's requirements?

State laws may complement HIPAA by allowing more protections than the Federal law. For example, states may increase the number of days parents have to enroll newborns, adopted children, and children placed for adoption or require additional circumstances that entitle you to special enrollment periods beyond those in the Federal law. However, these state laws only apply if your plan provides benefits through an insurance company or HMO (an insured plan). To determine if your plan offers insured coverage, consult your Summary Plan Description (SPD) or contact your plan administrator. You also can visit your state insurance commissioner's office or the National Association of Insurance Commissioners' Website (select your state) for more information.

## How can I use HIPAA in conjunction with COBRA to extend my health coverage?

COBRA is a law that can help if you lose your job or if your hours are reduced to the point where the employer no longer provides you with health coverage. COBRA can provide a temporary extension of your health coverage – as long as you and your family members, if eligible, belonged to the previous employer's health plan and generally the employer had 20 or more employees. Usually, you pay the entire cost of coverage (both your share and the employer's, plus a 2 percent administrative fee). As long as the prior plan exists, COBRA coverage lasts up to 18 months for most people, although it can continue as long as 36 months in some cases.

If you enroll in COBRA, HIPAA provides you with the opportunity to request special enrollment in a different group health plan if you have a special enrollment event, such as marriage, the birth of a child, or if you exhaust your continuation coverage. To exhaust COBRA, you must receive the maximum period of continuation coverage available (usually 18 months for job loss) without early termination. If you choose to terminate your COBRA early, or fail to pay your COBRA premiums, you generally will not be entitled to special enroll in other group health coverage.

## Do I have other special enrollment rights?

In addition to the special enrollment rights in a group health plan under HIPAA (described above), there are also special enrollment rights under the ACA for individual coverage including through the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance and other options (such as Medicare and CHIP coverage). Losing your job-based coverage, marriage, birth, and adoption are a few of the special enrollment events that may allow you to purchase Marketplace or other coverage outside of the regular enrollment period.

To qualify for special enrollment, you must select a plan either within 60 days before losing your job-based coverage or within 60 days after losing your job-based coverage.

You can apply for Marketplace coverage online or get more information at **HealthCare.gov** or by calling 1-800-318-2596 (TTY users should call 1-855-889-4325). When you fill out a

Marketplace application, you also can find out if you and your family qualify for free or low-cost coverage from Medicaid and/or the Children's Health Insurance Program (CHIP).

## Where can I get more information on my rights under HIPAA?

The Employee Benefits Security Administration offers more information on HIPAA and other laws mentioned above. Visit the Employee Benefits Security Administration's **Website** to view the following publications. To order copies or to request assistance from a benefits advisor, **contact EBSA** electronically or call toll free 1-866-444-3272.

- **Retirement and Health Care Coverage...Questions and Answers for Dislocated Workers**
- **An Employee's Guide to Health Benefits Under COBRA**
- **Top 10 Ways to Make Your Health Benefits Work for You**
- **Life Changes Require Health Choices...Know Your Benefit Options**

# YOUR RIGHTS AFTER A MASTECTOMY

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

# Your Rights After A Mastectomy

**If you have had a mastectomy or expect to have one, you may be entitled to special rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The following questions and answers clarify your basic WHCRA rights.**

### I've been diagnosed with breast cancer and plan to have a mastectomy, which my plan covers. Will my health plan cover reconstructive surgery too?

If your group health plan or health insurance company covers mastectomies, it must provide certain reconstructive surgery and other benefits related to the mastectomy, including:

- all stages of reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses, and
- treatment of physical complications of the mastectomy, including lymphedema.

The plan must consult with you and your attending physician when determining how this coverage will be provided.

### I must have a mastectomy for medical reasons, although I have not been diagnosed with cancer. Does WHCRA apply to me?

Yes, the law applies if your group health plan or health insurance company covers mastectomies and you are receiving benefits in connection with a mastectomy – whether or not you have cancer. Despite its name, nothing in the law limits WHCRA rights to cancer patients.

### Do all group health plans and health insurance companies have to provide reconstructive surgery benefits?

Generally, WHCRA applies to all group health plans that provide coverage for medical and surgical benefits with respect to a mastectomy, as well as their insurance companies. However, there are exceptions for some "church plans" and "government plans." If your coverage is provided by a "church plan" or "governmental plan," check with your plan administrator.

### Will I have to pay a deductible or coinsurance?

Possibly. Group health plans or health insurance companies may impose deductibles or coinsurance requirements on mastectomies and post-mastectomy treatment, but no more than those established for other benefits. In other words, the deductible for post-mastectomy reconstructive surgery should be similar to the deductible for any similar procedure covered by the plan.

### Before I changed jobs, I had a mastectomy and chemotherapy which were covered under my previous employer's plan. Now I am enrolled under my new employer's plan and want reconstructive surgery. Is my new employer's plan required to cover it?

If you request reconstructive surgery, your new employer's plan generally must cover it if:

- the plan provides coverage for mastectomies, and
- you are receiving benefits under the plan that are related to your mastectomy.

In addition, your new employer's plan generally must cover the other benefits specified in WHCRA, even if you were not enrolled in your new employer's plan when you had the mastectomy.

The Patient Protection and Affordable Care Act includes additional protections. A group health plan generally cannot limit or deny benefits relating to a health condition that existed before you enrolled in your new employer's plan. For more information, visit **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families** or **HealthCare.gov**.

### My employer's group health plan provides coverage through an insurance company. After my mastectomy, my employer changed insurance companies. The new insurance company refuses to cover my reconstructive surgery. Is that legal?

Not if:

- the new insurance company provides coverage for mastectomies,
- you are receiving benefits under the plan related to your mastectomy, and
- you elect to have reconstructive surgery.

If these conditions apply, then the new insurance company must provide coverage for breast reconstruction as well as the other benefits required under WHCRA. It does not matter that you were not covered by the new company when you had the mastectomy.

### I understand that my group health plan must provide me with a notice of my WHCRA rights when I enroll in the plan. What information does this notice include?

Plans must provide a notice to all employees when they enroll in the health plan that:

- describes the benefits that WHCRA requires the plan and its insurance companies to cover, which includes:
  - coverage of all stages of reconstruction of the breast on which the mastectomy was performed,
  - surgery and reconstruction of the other breast to produce a symmetrical appearance,
  - prostheses, and
  - treatment of physical complications of the mastectomy, including lymphedema;
- states that mastectomy-related benefits coverage will be provided in a manner determined in consultation with the attending physician and the patient;
- describes any applicable deductibles and coinsurance limitations that apply to the coverage specified under WHCRA. Deductibles and coinsurance limitations may be imposed only if they are consistent with those established for other benefits under the plan or coverage.

### What information does the annual WHCRA notice from my health plan include?

Your annual notice should describe the four categories of coverage required under WHCRA and how to obtain a detailed description of the mastectomy-related benefits available under your plan. For example, an annual notice might look like this:

"Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator [phone number here] for more information."

Your annual notice may be the same notice provided when you enrolled in the plan if it contains the information described above.

### My state also requires health insurance companies to cover minimum hospital stays in connection with a mastectomy (which is not required by WHCRA). If I have a mastectomy and breast reconstruction, am I also entitled to the minimum hospital stay?

If your employer's group health plan provides coverage through an insurance company, you are entitled to the minimum hospital stay required by the state law. Many state laws provide more protections than WHCRA for coverage provided by an insurance company or "insured coverage."

| If your employer's group health plan provides... | You are entitled to... |
|---|---|
| Coverage through an insurance company | Federal and state protections (in states that provide them) |
| Self-insured coverage | Federal protections only |

To find out if your group health coverage is "insured" or "self-insured," check your health plan's Summary Plan Description (SPD) or contact your plan administrator.

If your coverage is "insured" and you want to know if you have additional state law protections, contact your state insurance department.

### I have health coverage through an individual policy, not through an employer. Am I covered under WHCRA?

WHCRA rights apply to individual coverage as well. These requirements are generally within the jurisdiction of the state insurance department. Call your state insurance department or the Department of Health and Human Services toll free at **1-877-267-2323**, extension **6-1565**, for more information.

### Can I get breast cancer screening or similar preventive services for free?

Possibly. Under the Affordable Care Act, you may receive certain recommended preventive services, such as breast cancer mammography screenings for women aged 40 and older, with no copayment, coinsurance, deductible, or other cost-sharing. For more information, visit **HealthCare.gov/coverage/preventive-care-benefits/**. WHCRA does not require coverage for preventive services related to the detection of breast cancer.

## Resources

WHCRA is administered by the U.S. Departments of Labor and Health and Human Services.

**Department of Labor**
For more information about your WHCRA rights under an employer-sponsored group health plan and other health coverage topics, visit **dol.gov/agencies/ebsa**. To order publications, learn more about our programs and services, or discuss questions about your benefits, contact EBSA at **askebsa.dol.gov** or call toll-free: **1-866-444-3272**.

**Department of Health and Human Services**
For more information on WHCRA, visit **www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html** or call toll-free: **1-877-267-2323**, extension **6-1565**.

**National Association of Insurance Commissioners**
To find the contact information for your state office, visit **naic.org/state_web_map.htm**.

**EMPLOYEE BENEFITS SECURITY ADMINISTRATION**
UNITED STATES DEPARTMENT OF LABOR

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**Benefits Enrollment Guide**

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