Federal

Comply Anywhere Poster Pack

A portable compilation of federal notifications issued by DOL, HHS, OSHA, and EEOC.

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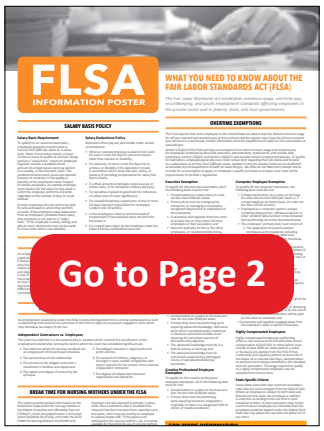
Employee Notice – Your Rights Are Protected: The federal government has established laws and regulations that protect the rights of employees. Various laws also require that employers fulfill specific notification and communication obligations. As your employer, we are providing this information to better inform you of your rights as an employee of our company. If you should have any questions regarding these attorney-reviewed resources, please contact the personnel office or your immediate supervisor.



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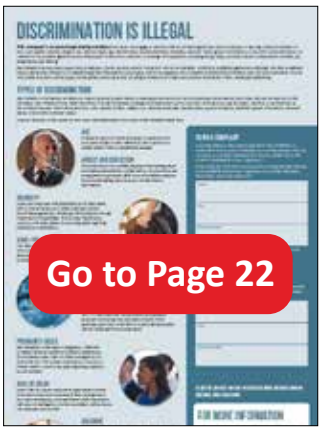

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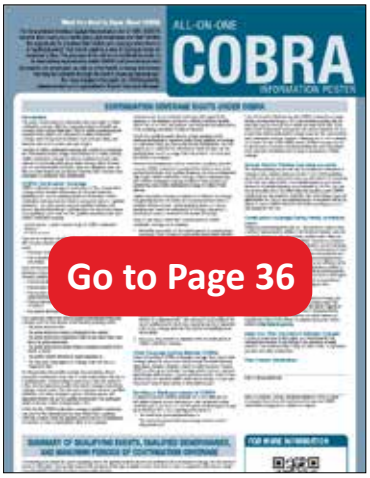

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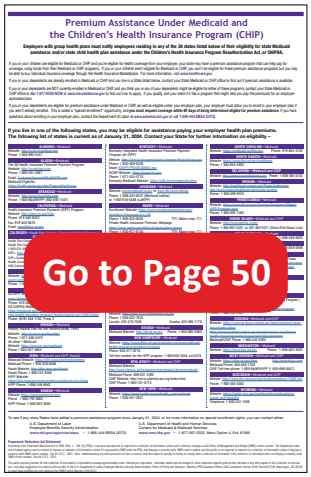

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Note: These notices are designed to provide accurate and authoritative information in regard to the subject matter covered. Businesses with one or more employees are required to comply with federal, state, and/or local law notification and posting requirements. This will not satisfy all posting and notification requirements that must be posted conspicuously in a location frequented by employees at a business. This guide should be used only as a supplementary product when space is limited.

www.personnelconcepts.com

FLSA
INFORMATION POSTER

WHAT YOU NEED TO KNOW ABOUT THE FAIR LABOR STANDARDS ACT (FLSA)

The Fair Labor Standards Act establishes minimum wage, overtime pay, recordkeeping, and youth employment standards affecting employees in the private sector and in federal, state, and local governments.

SALARY BASIS POLICY

Salary Basis Requirement

To qualify for an overtime exemption, employees generally must be paid at not less than $684 per week on a salary basis. (Note: Some states require a lower minimum salary to qualify as exempt). Being paid on a "salary basis" means an employee regularly receives a predetermined amount of compensation each pay period on a weekly, or less frequent, basis. The predetermined amount cannot be reduced because of variations in the quality or quantity of the employee's work. Subject to certain exceptions, an exempt employee must receive the full salary for any week in which the employee performs any work, regardless of the number of days or hours worked.

Exempt employees do not need to be paid for any workweek in which they perform no work. If the employer makes deductions from an employee's predetermined salary, that employee is not paid on a "salary basis." If the employee is ready, willing, and able to work, deductions may not be made for time when work is not available.

Salary Deductions Policy

Deductions from pay are permissible under certain circumstances:

- When an exempt employee is absent from work for one or more full days for personal reasons other than sickness or disability;
- For absences of one or more full days due to sickness or disability if the deduction is made in accordance with a bona fide plan, policy, or practice of providing compensation for salary lost due to illness;
- To offset amounts employees receive as jury or witness fees, or for temporary military duty pay;
- For penalties imposed in good faith for infractions of safety rules of major significance;
- For unpaid disciplinary suspensions of one or more full days imposed in good faith for workplace conduct rule infractions;
- In the employee's initial or terminal week of employment if the employee does not work the full week; or
- For unpaid leave taken by the employee under the Federal Family and Medical Leave Act.

TIPPED EMPLOYEES UNDER THE FLSA

An employer of a tipped employee is only required to pay $2.13 an hour in direct wages if that amount, plus the tips received, equals at least the federal minimum wage, the employee retains all tips and the employee customarily and regularly receives more than $30 a month in tips. If an employee's tips combined with the employer's direct wages of at least $2.13 an hour do not equal the federal minimum hourly wage, the employer must make up the difference. State law may adjust this rate (but not below $2.13 per hour).

Some states have minimum wage laws specific to tipped employees. Under the Consolidated Appropriations Act of 2018, an employer is prohibited from using an employee's tips for any reason other than as a credit against its minimum wage obligation to the employee ("tip credit") or in furtherance of a valid tip pool. Only tips actually received by the employee may be counted in determining whether the employee is a tipped employee and in applying the tip credit. As of May 2021, employers who do not take a tip credit need to update their recordkeeping to include non-tipped workers.

EMPLOYMENT RELATIONSHIP CLASSIFICATION

An employment relationship under the FLSA must be distinguished from a strictly contractual one. Such a relationship must exist for any provision of the FLSA to apply to any person engaged in work which may otherwise be subject to the Act.

Independent Contractors vs. Employees

The Court has held that it is the total activity or situation which controls the classification of the employment relationship. Among the factors which the Court has considered significant are:

1. The extent to which the services rendered are an integral part of the principal's business.
2. The permanency of the relationship.
3. The amount of the alleged contractor's investment in facilities and equipment.
4. The nature and degree of control by the principal.
5. The alleged contractor's opportunities for profit and loss.
6. The amount of initiative, judgment, or foresight in open market competition with others required for the success of the claimed independent contractor.
7. The degree of independent business organization and operation.

BREAK TIME FOR NURSING MOTHERS UNDER THE FLSA

This notice provides general information on the break time requirement for nursing mothers in the Patient Protection and Affordable Care Act ("PPACA"), which amended Section 7 of the Fair Labor Standards Act (FLSA), and under the 2022 PUMP for Nursing Mothers Act (PUMP Act).

Employers are required to provide "reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk." The frequency of breaks needed to express milk as well as the duration of each break will likely vary. State law may increase, but not decrease, this permissible duration after the child's birth.

Under the PUMP Act, employees are allowed to file monetary lawsuits against employers who deny them break time for nursing or any other nursing violations under the FLSA.

Employers are also required to provide "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk." If the space is not dedicated to the nursing mother's use, it must be available for the exclusive use of nursing mothers temporarily when needed in order to meet the statutory requirement.

The FLSA requirement of break time for nursing mothers to express breast milk does not preempt state laws that provide greater protections to employees. The law also prohibits retaliation against employees who file a or participate in a complaint under the FLSA.

Under the PUMP Act, pumping time counts as time worked when calculating minimum wage and overtime if an employee is not completely relieved from their work duties during the pumping break.

OVERTIME EXEMPTIONS

The FLSA requires that most employees in the United States be paid at least the federal minimum wage for all hours worked and overtime pay at time and one-half the regular rate of pay for all hours worked over 40 hours in a workweek. Further information from the Department of Labor on FLSA exemptions at www.dol.gov.

Section 13(a)(1) of the FLSA provides an exemption from both minimum wage and overtime pay for employees employed as bona fide executive, administrative, professional, and outside sales employees. Section 13(a)(1) and Section 13(a)(17) also exempt certain computer employees. To qualify for exemption, employees generally must meet certain tests regarding their job duties and be paid on a salary basis at not less than $684 per week. Updates to the per-weekly minimum are published occasionally by the Department of Labor at www.dol.gov. Job titles do not determine exempt status. In order for an exemption to apply, an employee's specific job duties and salary must meet all the requirements of the DOL's regulations.

Executive Exemption

To qualify for the executive exemption, all of the following tests must be met:

- Compensated on a salary basis at a rate not less than $684 per week;
- Primary duty must be managing the enterprise, or managing a customarily recognized department or subdivision of the enterprise;
- Customarily and regularly direct the work of at least two or more other full-time employees or their equivalent; and
- Have the authority to hire or fire other employees, or recommend the hiring, firing, or any other change of status of other.

Administrative Exemption

To qualify for the administrative exemption, all of the following tests must be met:

- Compensated on a salary or fee basis at a rate not less than $684 per week;
- Primary duty must be performing office or non-manual work directly related to the management or general business operations of the employer or the employer's customers; and
- Primary duty includes exercising discretion and independent judgment with respect to matters of significance.

Professional Exemption

To qualify for the learned professional exemption, all of the following tests must be met:

- Compensated on a salary or fee basis at a rate not less than $684 per week;
- Primary duty must be performing work requiring advanced knowledge, defined as work which is predominantly intellectual in character and which includes work requiring the consistent exercise of discretion and judgment;
- The advanced knowledge must be in a field of science or learning; and
- The advanced knowledge must be customarily acquired by a prolonged course of specialized intellectual instruction.

Creative Professional Employee Exemption

To qualify for the creative professional employee exemption, all of the following tests must be met:

- Compensated on a salary or fee basis at a rate not less than $684 per week;
- Primary duty must be performing work requiring invention, imagination, originality or talent in a recognized field of artistic or creative endeavor.

Computer Employee Exemption

To qualify for the computer exemption, the following tests must be met:

- Compensated either on a salary or fee basis at a rate not less than $684 per week or, if compensated on an hourly basis, at a rate not less than $27.63 an hour;
- Employed as a computer systems analyst, computer programmer, software engineer or other similarly skilled worker in the computer field performing the duties described below;
- The employee's primary duty must consist of:
  1. The application of systems analysis techniques and procedures, including consulting with users, to determine hardware, software or system functional specifications;
  2. The design, development, documentation, analysis, creation, testing or modification of computer systems or programs, including prototypes, based on and related to user or system design specifications;
  3. The design, documentation, testing, creation or modification of computer programs related to machine operating systems; or
  4. A combination of the aforementioned duties, the performance of which requires the same level of skills.

Outside Sales Employee Exemption

To qualify for the outside sales exemption, all of the following tests must be met:

- Primary duty must be making sales, or obtaining orders or contracts for services or for the use of facilities for which a consideration will be paid by the client or customer; and
- Customarily and regularly engaged away from the employer's place or places of business.

Highly Compensated Employees

Highly compensated employees performing office or non-manual work and paid total annual compensation of $107,432 or more [which must include at least $684 per week paid on a salary or fee basis] are exempt from the FLSA if they customarily and regularly perform at least one of the duties of an exempt executive, administrative or professional employee identified in the standard tests for exemption. The wage required to qualify as a highly compensated employee may be adjusted from time to time.

State-Specific Criteria

Some states have their own overtime exemption rules that are more stringent than the federal FLSA. Where an employee is subject to both state and federal overtime laws, the employee is entitled to overtime according to the one that is most beneficial to them. A state exemption may not be used to treat an employee less favorably than the employee would be treated under the federal FLSA. State law may adjust this rate (but not below $2.13 per hour).

FOR MORE INFORMATION

Visit tinyurl.com/FLSA-Digital or scan this QR code for more information:

- **State Minimum Wages**
- **Employment Rights for Workers with Disabilities**
- **Child Labor Provisions**

Item# Y5190025-U Y5190026-L FD-FLSA-D 0523

WHAT YOU NEED TO KNOW ABOUT THE FAIR LABOR STANDARDS ACT (FLSA)

The Fair Labor Standards Act establishes minimum wage, overtime pay, recordkeeping, and youth employment standards affecting employees in the private sector and in federal, state, and local governments.

Disclaimer: The Fair Labor Standards Act (FLSA) establishes minimum wage, overtime pay, recordkeeping, and youth employment standards affecting employees in the private sector and in federal, state, and local governments. This notice is intended to be displayed or distributed solely by employers who fall under FLSA regulations. Personnel Concepts and its authorized distributors have no actual knowledge as to whether the employer or user of this notice has in fact performed their obligations under the applicable laws and regulations. This notice is not intended to be used to satisfy all of the compliance requirements for FLSA laws and regulations. It is intended to be used only by covered entities that have met their obligations as prescribed by federal, state, and local law. This notice is provided with the understanding that Personnel Concepts and any of its authorized distributors cannot be held responsible for changes in law, errors, omissions, or the applicability of this notice.

Fair Labor Standards Act (FLSA)

THE FEDERAL MINIMUM WAGE RATE IS $7.25 PER HOUR FOR NON-TIPPED EMPLOYEES

STATE MINIMUM WAGE RATES

The law requires employers to display both the Federal Minimum Wage as well as their State Minimum Wage where employees can readily see it. Where federal and state law have different minimum wage rates, the higher standard applies. Premium pay is additional pay authorized by Title 5, United States Code, for overtime (in excess of 40 hours a week unless otherwise indicated), night, holiday, Sunday work, and other types of work.
The following list of state minimum wage rates will be in effect as of January 2024.

STATE	Min. Wage
Alabama	$7.25
Alaska	$11.73
Arizona	$14.35
Arkansas *(4+ employees)*	$11.00
California	$16.00
Colorado - *Daily overtime threshold is 12 hours*	$14.42
Connecticut	$15.69
Delaware	$13.25
District of Columbia *(Effective 7/1/23)*	$17.00
Florida *(Effective 9/30/23)*	$12.00
Georgia *-Employers not covered by the FLSA* *-Employers covered by the FLSA*	 $5.15 $7.25
Hawaii *-An employee earning a guaranteed monthly compensation of $2,000 or more is exempt from the State minimum wage and overtime law*	$14.00
Idaho	$7.25
Illinois *(4+ employees)*	$14.00
Indiana *(2+ employees)*	$7.25
Iowa	$7.25
Kansas - *Weekly overtime threshold is 46 hours*	$7.25
Kentucky - *Premium pay required for 7th day when employee works a 7-day week*	$7.25
Louisiana	$7.25
Maine	$14.15
Maryland	$15.00
Massachusetts	$15.00
Michigan *(2+ employees)*	$10.33
Minnesota - *Weekly overtime threshold is 48 hours* *-Large employer (annual receipts > $500,000)* *-Small employer (annual receipts < than $500,000)*	$10.85 $8.85
Mississippi	$7.25
Missouri	$12.30

STATE	Min. Wage
Montana	$10.30
Nebraska *(4+ employees)*	$12.00
Nevada (Effective 7/1/23) *-w/no health insurance* *-w/health insurance*	 $11.25 $10.50
New Hampshire	$7.25
New Jersey	$15.13
New Mexico	$12.00
New York *(Effective 12/31/23)*	$15.00
North Carolina	$7.25
North Dakota	$7.25
Ohio	$10.45
Oklahoma *-Except where otherwise provided by the Minimum Wage Act*	$7.25
Oregon *(Effective 7/1/23)*	$14.20
Pennsylvania	$7.25
Puerto Rico *-Employers not covered by the FLSA* *-Employers covered by the FLSA (Effective 7/1/23)*	 $5.08 $9.50
Rhode Island	$14.00
South Carolina	$7.25
South Dakota	$11.20
Tennessee	$7.25
Texas	$7.25
Utah	$7.25
Vermont *(2+ employees)*	$11.67
Virginia *(4+ employees)*	$12.00
Washington	$16.28
West Virginia *(6+ employees)*	$8.75
Wisconsin	$7.25
Wyoming	$7.25

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EMPLOYMENT RIGHTS FOR WORKERS WITH DISABILITIES PAID AT SPECIAL MINIMUM WAGES

The United States Department of Labor Wage and Hour Division

Authority to pay special minimum wages to workers with disabilities applies to work covered by the Fair Labor Standards Act (FLSA), McNamara-O'Hara Service Contract Act (SCA), and/or Walsh-Healey Public Contracts Act (PCA). Such special minimum wages are referred to as "commensurate wage rates" and are less than the basic hourly rates stated in an SCA wage determination and less than the FLSA minimum wage of $7.25 per hour. A "commensurate wage rate" is based on the worker's individual productivity, no matter how limited, in proportion to the wage and productivity of experienced workers who do not have disabilities that impact their productivity when performing essentially the same type, quality, and quantity of work in the geographic area from which the labor force of the community is drawn.

The wages of all workers paid commensurate wages must be reviewed, and adjusted if appropriate, at periodic intervals. At a minimum, the productivity of hourly-paid workers must be reevaluated at least every six months and a new prevailing wage survey must be conducted at least once every twelve months. In addition, prevailing wages must be reviewed, and adjusted as appropriate, whenever the applicable state or federal minimum wage is increased.

Fringe Benefits

Neither the FLSA nor the PCA have provisions requiring vacation, holiday, or sick pay nor other fringe benefits such as health insurance or pension plans. State laws may set forth other requirements related to such fringe benefits. SCA wage determinations may require such fringe benefit payments (or a cash equivalent). Workers paid under a certificate authorizing commensurate wage rates must receive the full fringe benefits listed on the wage determination.

Worker Notification

Each worker with a disability and, where appropriate, the parent or guardian of such worker, shall be informed orally and in writing by the employer of the terms of the certificate under which such worker is employed. This will be provided at the time of hire, or if a disability arises during employment. Such a certificate will be provided by the employer after being notified of the disability.

Petition Process

Workers with disabilities paid at special minimum wages may petition the Administrator of the Wage and Hour Division of the Department of Labor for a review of their wage rates by an Administrative Law Judge. No particular form of petition is required, except that it must be signed by the worker with a disability or his or her parent or guardian and should contain the name and address of the employer. Petitions should be mailed to: Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W.,Washington, D.C. 20210.

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CHILD LABOR PROVISIONS

The FLSA child labor provisions are designed to protect the educational opportunities of minors and prohibit their employment in jobs under conditions detrimental to their health or well-being. The provisions include restrictions on hours of work for minors under 16 and lists of hazardous occupations orders for both farm and non-farm jobs declared by the Secretary of Labor to be too dangerous for minors to perform. No persons under 16 may be employed in manufacturing or on a PCA contract. Special provisions of GSA contracts may restrict the employment of persons under 16. These provisions may be incorporated by reference even if not specifically stated in a GSA contract.

Other state laws may have higher standards. When these apply, the more stringent standard must be observed. All states have child labor provisions and compulsory school attendance laws. Unless otherwise exempt, a covered minor employee is entitled to receive the same minimum wage, overtime, safety and health, and non-discrimination protections as adult workers.

Regulations governing child labor in non-farm jobs differ somewhat from those pertaining to agricultural employment. In non-farm work, the permissible jobs and hours of work, by age, are as follows:

1. Youths 18 years or older may perform any job, whether hazardous or not, for unlimited hours;
2. Minors 16 and 17 years old may perform any non-hazardous job, for unlimited hours; and
3. Minors 14 and 15 years old may work outside school hours in various non-manufacturing, non-mining, non-hazardous jobs under the following conditions: no more than 3 hours on a school day, 18 hours in a school week, 8 hours on a non-school day, or 40 hours in a non-school week. Also, work may not begin before 7 a.m., nor end after 7 p.m., except from June 1 through Labor Day, when evening hours are extended to 9 p.m.
4. States may require the written authorization of, or notice to, the minor's school prior to starting work. Certain full-time students, student learners, apprentices, and workers with disabilities may be paid less than the minimum wage under special certificates issued by the Department of Labor.

TIPPED EMPLOYEES UNDER THE FLSA

An employer of a tipped employee is only required to pay $2.13 an hour in direct wages if that amount, plus the tips received, equals at least the federal minimum wage, the employee retains all tips and the employee customarily and regularly receives more than $30 a month in tips. If an employee's tips combined with the employer's direct wages of at least $2.13 an hour do not equal the federal minimum hourly wage, the employer must make up the difference. State law may adjust this rate (but not below $2.13 per hour).

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To qualify for the executive exemption, all of the following tests must be met:

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Highly compensated employees performing office or non-manual work and paid total annual compensation of $107,432 or more [which must include at least $684 per week paid on a salary or fee basis] are exempt from the FLSA if they customarily and regularly perform at least one of the duties of an exempt executive, administrative or professional employee identified in the standard tests for exemption. The wage required to qualify as a highly compensated employee may be adjusted from time to time.

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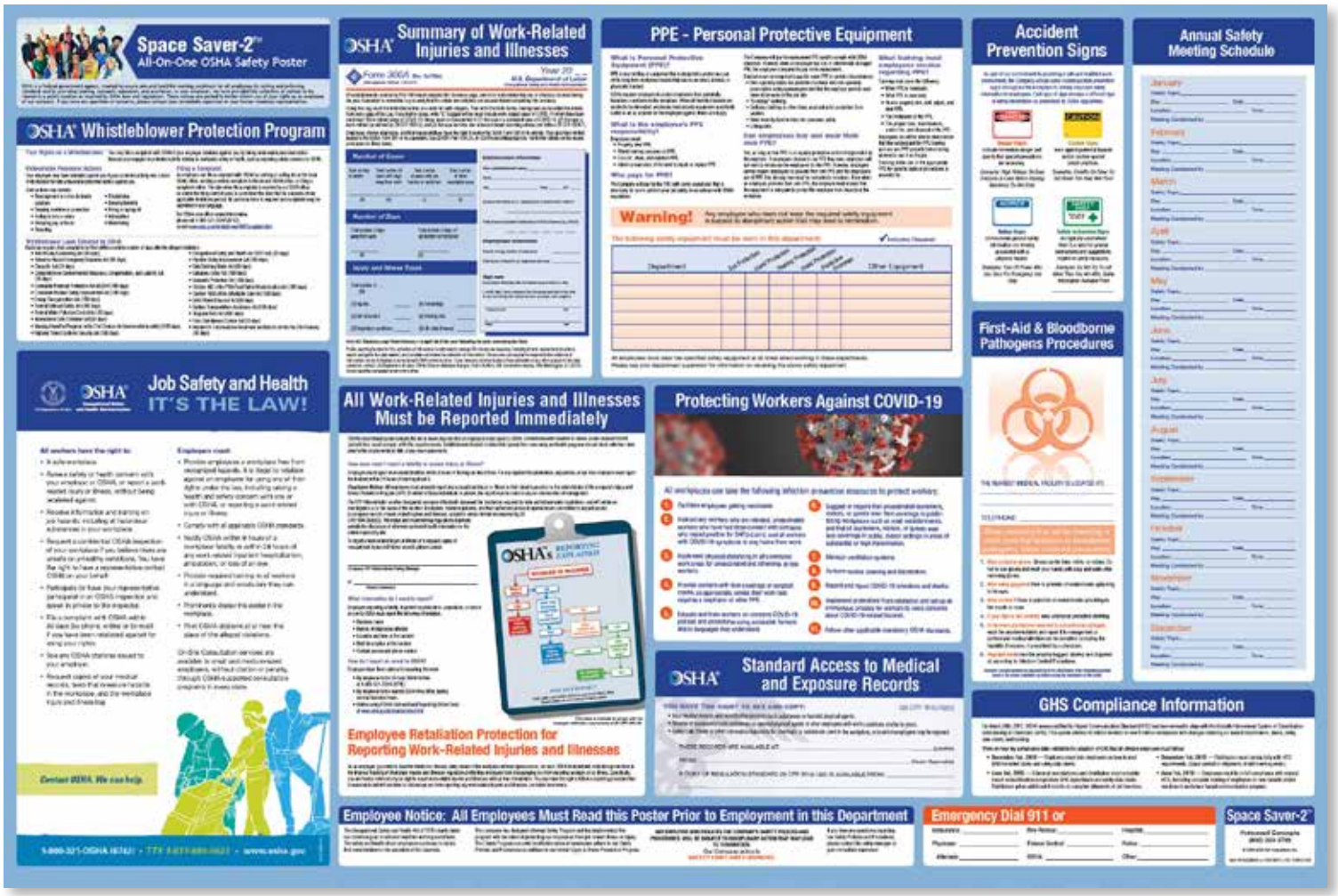
An employment relationship under the FLSA must be distinguished from a strictly contractual one. Such a relationship must exist for any provision of the FLSA to apply to any person engaged in work which may otherwise be subject to the Act.

Independent Contractors vs. Employees

The Court has held that it is the total activity or situation which controls the classification of the employment relationship. Among the factors which the Court has considered significant are:

1. The extent to which the services rendered are an integral part of the principal's business.
2. The permanency of the relationship.
3. The amount of the alleged contractor's investment in facilities and equipment.
4. The nature and degree of control by the principal.
5. The alleged contractor's opportunities for profit and loss.
6. The amount of initiative, judgment, or foresight in open market competition with others required for the success of the claimed independent contractor.
7. The degree of independent business organization and operation.

OSHA Safety


Space Saver-2™
All-On-One OSHA Safety Poster
OSHA Whistleblower Protection Program
Job Safety and Health
IT'S THE LAW!
Summary of Work-Related Injuries and Illnesses
PPE - Personal Protective Equipment
Warning!
All Work-Related Injuries and Illnesses Must be Reported Immediately
Employee Retaliation Protection for Reporting Work-Related Injuries and Illnesses
Protecting Workers Against COVID-19
Standard Access to Medical and Exposure Records
Accident Prevention Signs
First-Aid & Bloodborne Pathogens Procedures
Annual Safety Meeting Schedule
GHS Compliance Information
Employee Notice: All Employees Must Read this Poster Prior to Employment in this Department
Emergency Dial 911 or
Space Saver-2™

OSHA Safety

OSHA is a federal government agency, created to assure safe and healthful working conditions for all employees by setting and enforcing standards and by providing training, outreach, education, and assistance. As your employer, we have provided this collection of notices to be viewed in a public location as required by OSHA laws and regulations. These notices are provided to better inform you of your rights as an employee of our company. If you have any questions or concerns, please contact your immediate supervisor or your human resources representative.

OSHA® Whistleblower Protection Program

Your Rights as a Whistleblower

You may file a complaint with OSHA if your employer retaliates against you by taking unfavorable personnel action because you engaged in protected activity relating to workplace safety or health, such as reporting safety concerns to OSHA.

Unfavorable Personnel Actions

Your employer may have retaliated against you if your protected activity was a factor in its decision to take unfavorable personnel action against you.

Such actions may include:

- Reassignment to a less desirable position
- Denying overtime or promotion
- Failing to hire or rehire
- Reducing pay or hours
- Demoting
- Disciplining
- Denying benefits
- Firing or laying off
- Intimidation
- Blacklisting

Filing a Complaint

An employee can file a complaint with OSHA by visiting or calling his or her local OSHA office, sending a written complaint to the closest OSHA office, or filing a complaint online. The date when the complaint is received by an OSHA office, no matter the filing method used, is considered the date filed for purposes of any applicable limitations period. No particular form is required and complaints may be submitted in any language.

For OSHA area office contact information,
please call 1-800-321-OSHA (6742)
or visit www.osha.gov/whistleblower/WBComplaint.html.

Whistleblower Laws Enforced by OSHA

Each law requires that complaints be filed within a certain number of days after the alleged retaliation.

- Anti-Money Laundering Act (90 days)
- Asbestos Hazard Emergency Response Act (90 days)
- Clean Air Act (30 days)
- Comprehensive Environmental Response, Compensation, and Liability Act (30 days)
- Consumer Financial Protection Act of 2010 (180 days)
- Consumer Product Safety Improvement Act (180 days)
- Energy Reorganization Act (180 days)
- Federal Railroad Safety Act (180 days)
- Federal Water Pollution Control Act (30 days)
- International Safe Container Act (60 days)
- Moving Ahead for Progress in the 21st Century Act (motor vehicle safety) (180 days)
- National Transit Systems Security Act (180 days)
- Occupational Safety and Health Act (OSH Act) (30 days)
- Pipeline Safety Improvement Act (180 days)
- Safe Drinking Water Act (30 days)
- Sarbanes-Oxley Act (180 days)
- Seaman's Protection Act (180 days)
- Section 402 of the FDA Food Safety Modernization Act (180 days)
- Section 1558 of the Affordable Care Act (180 days)
- Solid Waste Disposal Act (30 days)
- Surface Transportation Assistance Act (180 days)
- Taxpayer First Act (180 days)
- Toxic Substances Control Act (30 days)
- Wendell H. Ford Aviation Investment and Reform Act for the 21st Century (90 days)

CONTINUED >>>

U.S. Department of Labor

OSHA® Occupational Safety and Health Administration

Job Safety and Health
IT'S THE LAW!

All workers have the right to:

- A safe workplace.
- Raise a safety or health concern with your employer or OSHA, or report a work-related injury or illness, without being retaliated against.
- Receive information and training on job hazards, including all hazardous substances in your workplace.
- Request a confidential OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions. You have the right to have a representative contact OSHA on your behalf.
- Participate (or have your representative participate) in an OSHA inspection and speak in private to the inspector.
- File a complaint with OSHA within 30 days (by phone, online or by mail) if you have been retaliated against for using your rights.
- See any OSHA citations issued to your employer.
- Request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

Employers must:

- Provide employees a workplace free from recognized hazards. It is illegal to retaliate against an employee for using any of their rights under the law, including raising a health and safety concern with you or with OSHA, or reporting a work-related injury or illness.
- Comply with all applicable OSHA standards.
- Notify OSHA within 8 hours of a workplace fatality or within 24 hours of any work-related inpatient hospitalization, amputation, or loss of an eye.
- Provide required training to all workers in a language and vocabulary they can understand.
- Prominently display this poster in the workplace.
- Post OSHA citations at or near the place of the alleged violations.

On-Site Consultation services are available to small and medium-sized employers, without citation or penalty, through OSHA-supported consultation programs in every state.

Contact OSHA. We can help.

1-800-321-OSHA (6742) • TTY 1-877-889-5627 • www.osha.gov

OSHA 3165-04R 2019

Summary of Work-Related Injuries and Illnesses

OSHA®

Form 300A (Rev. 04/2004)
Form approved OMB no. 1218-0176

Year 20 _ _
U.S. Department of Labor
Occupational Safety and Health Administration

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you make for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0." Logged entries must include work-related cases of COVID-19 which have been confirmed. Work-related cases of COVID-19 illness must be documented if: (1) the case is a confirmed case of COVID-19; (2) the case is work-related (as defined by 29 CFR 1904.5); and (3) the case involves one or more relevant recording criteria (set forth in 29 CFR 1904.7).

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and Illness Types

Total number of . . .
(M)

(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

Establishment information

Your establishment name _____

Street _____

City _____ State _____ ZIP _____

Industry description *(e.g., Manufacture of motor truck trailers)*

_____

North American Industrial Classification (NAICS), if known (e.g., 336212)

____ ____ ____ ____ ____ ____

Employment information

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

_____
Company executive Title

( ) -
_____
Phone Date

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 58 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

CONTINUED >>>

All Work-Related Injuries and Illnesses Must be Reported Immediately

OSHA's recordkeeping rule contains the list of severe injuries that all employers must report to OSHA. *Establishments located in states under federal OSHA jurisdiction must comply with the requirements.* Establishments located in states that operate their own safety and health programs should check with their state plan for the implementation date of any new requirements.

How soon must I report a fatality or severe injury or illness?

Employers must report work-related fatalities within 8 hours of finding out about them. For any inpatient hospitalization, amputation, or eye loss employers must report the incident within 24 hours of learning about it.

Employee Notice: All employees must promptly report any occupational injury or illness to their direct supervisor or the administrator of the company's Injury and Illness Prevention Program (IIPP). If neither of those individuals is present, the report must be made to any on-site member of management.

The IIPP Administrator or other designated company official will document the incident as required by state and federal safety regulations, and will initiate an investigation as to the cause of the incident. Employees, former employees, and their authorized personal representatives are entitled to request access to company records of work-related injuries and illnesses, subject to certain limitations imposed by 29 CFR 1904.35(b)(2). The statue and implementing regulations expressly permits the disclosure of otherwise protected health information to the extent required by law.

To report a work-related injury or illness or to request copies of occupational injury and illness records, please contact:

_____
Company IIPP Administrator/Safety Manager

at _____
Phone / Extension

What information do I need to report?

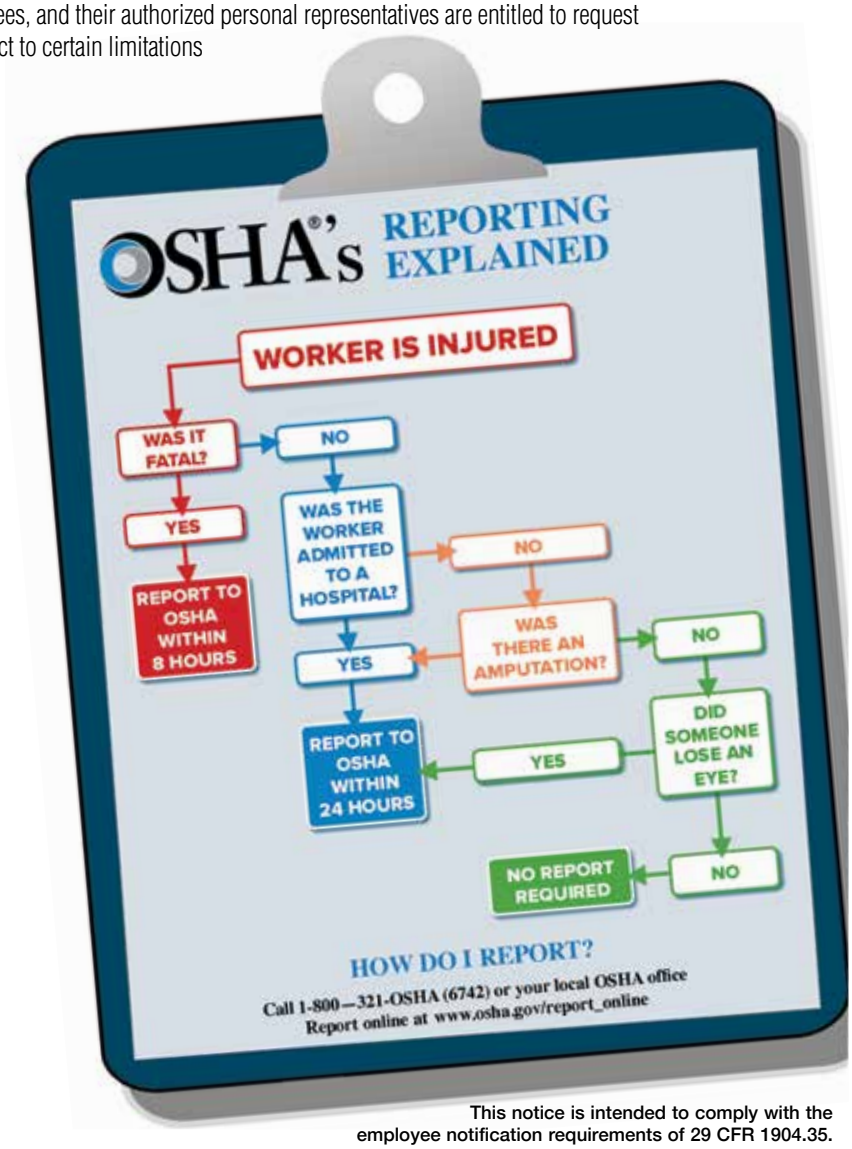
Employers reporting a fatality, inpatient hospitalization, amputation, or loss of an eye to OSHA must report the following information:

- Business name
- Names of employees affected
- Location and time of the incident
- Brief description of the incident
- Contact person and phone number

How do I report an event to OSHA?

Employers have three options for reporting the event:

- By telephone to the 24-hour OSHA hotline at 1-800-321-OSHA (6742).
- By telephone to the nearest OSHA Area Office during normal business hours.
- Online using OSHA's Serious Event Reporting Online Form at www.osha.gov/pls/ser/serform.html.



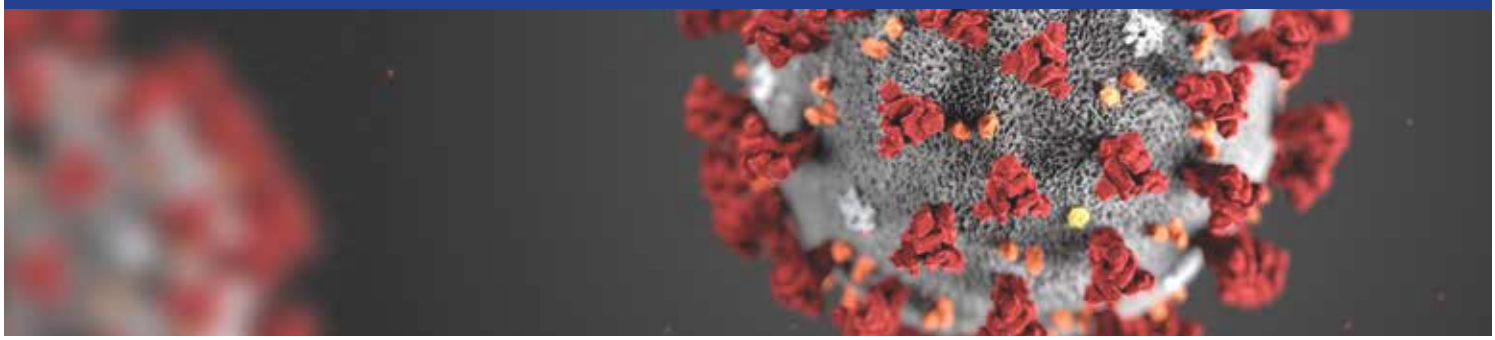
This notice is intended to comply with the employee notification requirements of 29 CFR 1904.35.

CONTINUED >>>

Employee Retaliation Protection for Reporting Work-Related Injuries and Illnesses

As an employee, you need to have the freedom to discuss safety issues in the workplace without repercussions. As such, OSHA included anti-retaliation protections in the Improve Tracking of Workplace Injuries and Illnesses regulation prohibiting employers from discouraging you from reporting an injury or an illness. Specifically, you are hereby informed of your right to report work-related injuries and illnesses without fear of retaliation. You also have the right to follow a reporting procedure that is reasonable and will not deter or discourage you from reporting any work-related injuries and illnesses, no matter how severe.

Protecting Workers Against COVID-19



All workplaces can take the following infection prevention measures to protect workers:

1. Facilitate employees getting vaccinated.
2. Instruct any workers who are infected, unvaccinated workers who have had close contact with someone who tested positive for SARS-CoV-2, and all workers with COVID-19 symptoms to stay home from work.
3. Implement physical distancing in all communal work areas for unvaccinated and otherwise at-risk workers.
4. Provide workers with face coverings or surgical masks, as appropriate, unless their work task requires a respirator or other PPE.
5. Educate and train workers on company COVID-19 policies and procedures using accessible formats and in languages they understand.
6. Suggest or require that unvaccinated customers, visitors, or guests wear face coverings in public-facing workplaces such as retail establishments, and that all customers, visitors, or guests wear face coverings in public, indoor settings in areas of substantial or high transmission.
7. Maintain ventilation systems.
8. Perform routine cleaning and disinfection.
9. Record and report COVID-19 infections and deaths.
10. Implement protections from retaliation and set up an anonymous process for workers to voice concerns about COVID-19-related hazards.
11. Follow other applicable mandatory OSHA standards.

CONTINUED >>>

PPE - Personal Protective Equipment

What is Personal Protective Equipment (PPE)?

PPE is any clothing or equipment that is designed to protect any part of the body from workplace hazards that can be absorbed, inhaled, or physically touched.

OSHA requires employers to protect employees from potentially hazardous conditions in the workplace. When all identified hazards are unable to be eliminated, employers must provide equipment specifically suited to act as a barrier for the employee against illness and injury.

What is the employee's PPE responsibility?

Employees must:

- Properly wear PPE.
- Attend training sessions on PPE.
- Care for, clean, and maintain PPE.
- Inform a supervisor of the need to repair or replace PPE.

Who pays for PPE?

The Company will pay for the PPE (with some exceptions) that is necessary for you to perform your job safely in accordance with OSHA regulations.

The Company will pay for replacement PPE used to comply with OSHA standards. However, when an employee has lost or intentionally damaged PPE, the employee is required to pay for its replacement**.**

Employers are not required to pay for some PPE in certain circumstances:

- Non-specialty safety-toe protective footwear and non-specialty prescription safety eyewear provided that the employer permits such items to be worn off the job site.
- "Everyday" clothing.
- Ordinary clothing or other items used solely for protection from weather.
- Items worn by food workers for consumer safety.
- Lifting belts.

Can employees buy and wear their own PPE?

Yes, as long as that PPE is as equally protective as the kind provided by the employer. If employees choose to use PPE they own, employers will not need to reimburse the employees for the PPE. However, employers cannot require employees to provide their own PPE and the employee's use of PPE they already own must be completely voluntary. Even when an employee provides their own PPE, the employer must ensure that the equipment is adequate to protect the employee from hazards at the workplace.

What training must employees receive regarding PPE?

Training must cover the following:

- When PPE is necessary.
- What PPE is necessary.
- How to properly don, doff, adjust, and wear PPE.
- The limitations of the PPE.
- The proper care, maintenance, useful life, and disposal of the PPE.

Employees should be able to demonstrate that they understand the PPE training and can use PPE properly before being allowed to use it on the job.

Training in the use of the appropriate PPE for specific tasks or procedures is provided by:

_____

CONTINUED >>>

OSHA Safety

Warning! Any employee who does not wear the required safety equipment is subject to disciplinary action that may lead to termination.

The following safety equipment must be worn in this department:

✔ Indicates Required

Department	Eye Protection	Hand Protection	Hearing Protection	Head Protection	Protective Footwear	Other Equipment

All employees must wear the specified safety equipment at all times when working in these departments. Please see your department supervisor for information on receiving the above safety equipment.

CONTINUED >>>

Standard Access to Medical and Exposure Records

YOU HAVE THE RIGHT TO SEE AND COPY: (29 CFR 1910.1020)

- Your medical records and records of exposure to toxic substances or harmful physical agents.
- Records of exposure to toxic substances or harmful physical agents of other employees with work conditions similar to yours.
- Safety Data Sheets or other information that exists for chemicals or substances used in the workplace, or to which employees may be exposed.

THESE RECORDS ARE AVAILABLE AT: _____ (Location)

FROM: _____ (Person Responsible)

A COPY OF REGULATION STANDARD 29 CFR 1910.1020 IS AVAILABLE FROM:

_____

GHS Compliance Information

On March 20th, 2012, OSHA announced that its Hazard Communication Standard (HCS) had been revised to align with the Globally Harmonized System of Classification and Labeling of Chemicals (GHS). This update affected 43 million workers in over 5 million workplaces with changes centering on hazard classification, labels, safety data sheets, and training.

There are four key compliance dates related to the adoption of GHS that all affected employers must follow:

- **December 1st, 2013** — Employers must train employees on how to read GHS formatted labels and safety data sheets.
- **June 1st, 2015** — Chemical manufacturers and distributors must complete hazard reclassification and produce GHS styled labels and safety data sheets. Distributors get an additional 6 months to complete shipments of old inventory.
- **December 1st, 2015** — Distributors must comply fully with HCS requirements. (Grace period for shipments of old inventory ends.)
- **June 1st, 2016** — Employers must be in full compliance with revised HCS, including complete training of employees on new hazards and/or revisions to workplace hazard communication program.

CONTINUED >>>

Annual Safety Meeting Schedule

January
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

February
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

March
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

April
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

May
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

June
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

July
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

August
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

September
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

October
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

November
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

December
Safety Topic _____
Day _____ Date _____
Location _____ Time _____
Meeting Conducted by _____

CONTINUED >>>

Employee Notice: All Employees Must Read this Poster Prior to Employment in this Department

The Occupational Safety and Health Act of 1970 clearly states our common goal of safe and healthful working conditions.

The safety and health of our employees continues to be the first consideration in the operation of this business.

This company has designed a formal Safety Program and has implemented this program with the intent of protecting our employees from job related illness or injury. This Safety Program can only be effective when all employees adhere to our Safety Policies and Procedures as outlined in our formal Injury & Illness Prevention Program.

ANY EMPLOYEE WHO VIOLATES THE COMPANY'S SAFETY POLICIES AND PROCEDURES WILL BE SUBJECT TO DISCIPLINARY ACTION THAT MAY LEAD TO TERMINATION.

Our Company policy is

SAFETY FIRST AND FOREMOST.

If you have any questions regarding our Safety Policies and Procedures, please contact the safety manager or your immediate supervisor.

Emergency Dial 911 or

Ambulance: _____	Fire-Rescue: _____	Hospital: _____
Physician: _____	Poison Control: _____	Police: _____
Alternate: _____	OSHA: _____	Other: _____

CONTINUED >>>

Accident Prevention Signs

As part of our commitment to providing a safe and healthful work environment, the Company utilizes color-coded accident prevention signs throughout the workplace to convey important safety information to employees. Each type of sign conveys a different type of safety information as prescribed by OSHA regulations.

Danger Signs
indicate immediate danger and specify that special precautions are necessary.

Examples: High Voltage; Be Sure Everyone Is Clear Before Starting Machines; Do Not Enter

Caution Signs
warn against potential hazards and/or caution against unsafe practices.

Examples: Forklifts Go Slow; Do Not Block This Area; Wet Floor

Notice Signs
communicate general safety information not directly associated with a physical hazard.

Examples: Turn Off Power After Use; Door For Emergency Use Only

Safety Instruction Signs
are typically used where there is a need for general instructions and suggestions relative to safety measures.

Examples: Do Not Try To Lift More Than You Are Able; Safety Information Available From

_____.

First-Aid & Bloodborne Pathogens Procedures

THE NEAREST MEDICAL FACILITY IS LOCATED AT:

_____

_____

TELEPHONE: _____

When providing first aid for bleeding or other potential exposure to bloodborne pathogens, follow universal precautions:

1. Wear protective gloves. Gloves can be latex, nitrile, or rubber. Do not re-use gloves and wash your hands with soap and water after removing gloves.
2. Wear safety goggles if there is potential of contaminants splashing in the eyes.
3. Wear a mask if there is potential of contaminants splashing in the mouth or nose.
4. If your skin is not covered, wear additional protective clothing.
5. In the event you become exposed to a bloodborne pathogen, wash the area immediately and report it to management so professional medical attention can be provided, including the hepatitis B vaccine, if prescribed by a physician.
6. Regulated waste must be properly bagged, labeled, and disposed of, according to Infection Control Procedures.

DISCRIMINATION IS ILLEGAL

This company is an equal opportunity employer and we do not engage in practices that discriminate against any person employed or seeking employment based on race, color, gender identity, religion, sex, national origin, age, marital status, sexual orientation, disability, veterans' status, genetic information, or any other protected status. It is unlawful to discriminate against a person with respect to any term, condition, or privilege of employment, including hiring, firing, promotion, layoff, compensation, benefits, job assignments, and training.

Discrimination by executives, supervisors, employees, clients, vendors, and/or contractors will not be tolerated. In addition, retaliation against any individual who has complained about unlawful discrimination, or retaliation against individuals for cooperating with an investigation of a complaint of unlawful discrimination, also will not be tolerated. Persons who violate this policy will be subject to disciplinary action up to and including termination of employment, and/or termination of the contractual relationship.

TYPES OF DISCRIMINATION

Discrimination is defined as the failure to treat all persons equally where no reasonable distinction can be found between those favored and those who are not favored. In the workplace, discrimination is the unfair treatment or denial of standard privileges of employment (such as benefits, working hours, pay increases, transfers, or promotions) by the employer because of an individual's race, color, gender identity, religion, sex, national origin, age, marital status, sexual orientation, disability, genetic information, veterans' status, or any other protected status.

Scan the QR Code on this poster to view more information about the types of discrimination listed here:

AGE

Employers may not treat an employee or applicant who is 40 years of age or older differently than a person in a similar position who is substantially younger.

ARREST AND CONVICTION

Federal law does not prohibit employers from asking about an employee/applicant's criminal history. But, federal equal employment opportunity (EEO) laws do prohibit employers from discriminating when they use criminal history information.

DISABILITY

Under the Americans with Disabilities Act of 1990 (ADA) and its Amendments Act of 2008, employers cannot discriminate against any individuals with physical or mental impairments or disabilities. This includes interference, coercion, or threats related to exercising rights regarding disability accommodation.

EQUAL PAY

The right of employees to be free from discrimination in their compensation is protected under several federal laws enforced by the U.S. Equal Employment Opportunity Commission (EEOC).

GENETIC INFORMATION

The Genetic Information Nondiscrimination Act (GINA) prohibits discrimination against applicants, employees, and their family members based on their genetic information.

NATIONAL ORIGIN

Is enforced under Title VII and Code of Federal Regulations 29 C.F.R. Part 1606, and can be defined as treating an applicant or employee less favorably because of the particular place they come from or a particular association with an individual from a certain area.

PREGNANCY-BASED

Discrimination on the basis of pregnancy, child birth, or related medical conditions constitute unlawful sex discrimination under Title VII of the Civil Rights Act of 1964 (Title VII). This includes interference, coercion, or threats related to exercising rights regarding pregnancy accommodation.

RACE OR COLOR

Under Title VII, equal employment opportunities cannot be denied to any person because of their racial group or perceived racial group, personal characteristics associated with race or marriage to, or other association with someone of a particular race or color.

RELIGIOUS

Employers may not treat employees or applicants more or less favorably because of their actual or perceived religious beliefs or practices.

SEX, GENDER IDENTITY, OR SEXUAL ORIENTATION

A person's sex, gender, sexual orientation, and/or gender identity (how the person identifies regardless of the anatomical or assigned gender at birth) must never be allowed to be a factor in employment decisions, absent a bona-fide reason for a distinction being made by an employer or prospective employer.

FILING A COMPLAINT

If you feel that you have been subjected to discrimination or harassment by any person employed by or doing business with this company, or you have witnessed such activity, please report the incident immediately to your supervisor.*

If reporting the incident to your supervisor is inappropriate because your complaint involves your supervisor, or you fear retaliation, then please report the incident to:

Name

Title

Phone Number

*Any form of retaliation for filing a charge, reasonably opposing discrimination, or participating in a discrimination lawsuit, investigation, or proceeding is prohibited under EEO laws.

RECEIVING A COMPLAINT

Anyone that receives a complaint of discrimination or harassment must treat the matter seriously and conduct a prompt, impartial, and thorough investigation and report it to:

Name

Title

Phone Number

SCAN THE QR CODE ON THIS POSTER FOR MORE INFORMATION ON INTERNAL INVESTIGATIONS.

FOR MORE INFORMATION

Visit tinyurl.com/EEO-Digital or scan this QR code for more information on Equal Employment Opportunity (EEO) laws, including:

- Discrimination in the workplace
- Types of discrimination
- Examples of discrimination
- Avoiding harassment
- Internal discrimination and harassment investigations

DISCRIMINATION IN THE WORKPLACE

IT IS ILLEGAL TO DISCRIMINATE IN ANY TERM, CONDITION, OR PRIVILEGE OF EMPLOYMENT INCLUDING:

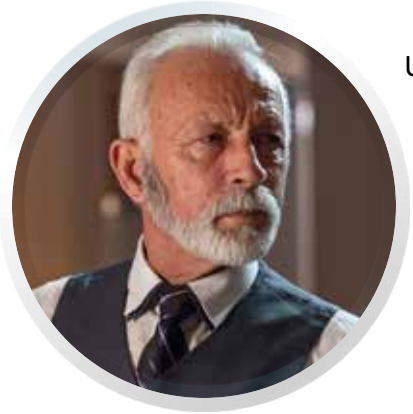
- hiring and firing;
- compensation, assignment, referral or classification of employees;
- transfer, promotion, layoff, or recall;
- job advertisements;
- recruitment;
- testing;
- failure to provide reasonable accommodations;
- use of company facilities;
- training and apprenticeship programs;
- benefits;
- pay, retirement plans, and disability leave;
- or other terms and conditions of employment.

Disclaimer: The Equal Employment Opportunity Commission (EEOC) establishes and regulates various anti-discrimination and anti-harassment laws affecting employees in the private sector and in federal, state, and local governments. This notice is intended to be displayed or distributed solely by employers who fall under EEOC regulations. Personnel Concepts and its authorized distributors have no actual knowledge as to whether the employer or user of this notice has in fact performed their obligations under the applicable laws and regulations. This notice is not intended to be used to satisfy all of the compliance requirements for EEOC laws and regulations. It is intended to be used only by covered entities that have met their obligations as prescribed by federal, state, and local law. This notice is provided with the understanding that Personnel Concepts and any of its authorized distributors cannot be held responsible for changes in law, errors, omissions, or the applicability of this notice.

CONTINUED >>>

TYPES OF DISCRIMINATION

AGE DISCRIMINATION



Unlawful age discrimination, as enforced under the Age Discrimination in Employment Act (ADEA), is treating an employee or applicant who is 40 years of age or older differently than a person in a similar position who is substantially younger. The related Older Worker Benefits Protection Act of 1990 (OWBPA) strictly prohibits denying benefits to older workers, and places specific time requirements on any waivers by employees of their rights against age discrimination when voluntarily or involuntarily ending employment.

ARREST AND CONVICTION DISCRIMINATION

Federal law does not prohibit employers from asking about an employee or applicant's criminal history. But, federal EEO laws do prohibit employers from discriminating when they use criminal history information. Using criminal history information to make employment decisions may violate Title VII of the Civil Rights Act of 1964, as amended (Title VII).

- Title VII prohibits employers from treating people with similar criminal records differently because of their race, national origin, or another Title VII protected characteristic.
- Title VII prohibits employers from using policies or practices that screen individuals based on criminal history information if:
  - They significantly disadvantage Title VII-protected individuals such as African Americans and Hispanics; AND
  - They do not help the employer accurately decide if the person is likely to be a responsible, reliable, or safe employee.

Three factors that are relevant to assessing whether an exclusion is job related for the position in question and consistent with business necessity:

(1) The nature and gravity of the offense or conduct;

(2) The time that has passed since the offense or conduct and/or completion of the sentence; and

(3) The nature of the job held or sought.

It is important to note also that certain state laws do have explicit ban-the-box regulations that explain how employers can use prior criminal history records. Employers need to know what state or local laws might require them to do in this situation.

CONTINUED >>>

Equal Opportunity Employer (EEO)

DISABILITY DISCRIMINATION

Under the Americans with Disabilities Act of 1990 (ADA) and its Amendments Act of 2008, employers cannot discriminate against an individual who:

(1) has a physical or mental impairment that substantially limits at least one major life activity;

(2) has a past history of an impairment; or

(3) is regarded as having a disability.

The ADA applies to employers with 15 or more employees, and also prohibits covered entities from conducting a medical examination or making inquiries of a job applicant as to whether they are an individual with a disability or as to the nature or severity of such disability, unless the exam or inquiry is pertinent to the essential functions of the job. Notwithstanding these restrictions, it is acceptable for an employer to make pre-employment inquiries into the ability of an applicant to perform functions which are essential to a given job. If the employee has a qualified disability (a full list is available from the EEOC), the employer must provide a reasonable accommodation, unless it causes the employer an undue hardship in light of the employer's size, financial resources, and business operations.

EQUAL PAY DISCRIMINATION

The right of employees to be free from discrimination in their compensation is protected under several federal laws enforced by the U.S. Equal Employment Opportunity Commission (EEOC), including the Equal Pay Act of 1963 (EPA), Title VII of the Civil Rights Act of 1964 (Title VII), the Age Discrimination in Employment Act of 1967 (ADEA), and Title I of the Americans with Disabilities Act of 1990 (ADA). Employers may not pay unequal wages to men and women who perform jobs that require substantially equal skill, effort, and responsibility, and that are performed under similar working conditions within the same establishment. Employers also may not pay workers less due to their older age (over 40) or a protected physical or mental disability.

GENETIC INFORMATION DISCRIMINATION

The Genetic Information Nondiscrimination Act (GINA) prohibits discrimination against applicants, employees, and their family members based on their genetic information. Genetic information includes information about genetic tests, diseases or disorders, family medical history, and requests for or receipt of genetic services. Title I of GINA addresses the use of genetic information in health insurance. Title II of GINA prohibits the use of genetic information in the employment context, including hiring, promotion, discharge, job training, classification, and all other material aspects of employment. GINA prohibits the intentional acquisition of genetic information about applicants and employees, and imposes strict confidentiality requirements on employers who acquire such information.

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Equal Opportunity Employer (EEO)

NATIONAL ORIGIN DISCRIMINATION

National origin discrimination, enforced under Title VII and Code of Federal Regulations 29 C.F.R. Part 1606, can be defined as treating an applicant or employee less favorably because of the particular place they come from; their marriage or association with someone of a particular nationality; their ethnicity, accent, or name; the church they attend or social group they participate in; or, the belief they are of a particular ethnic background. National origin discrimination is prohibited whether the national origin is actual or perceived. It is also unlawful to discriminate against anyone because they do not belong to a particular ethnic group.

RACE OR COLOR DISCRIMINATION

Under Title VII, equal employment opportunities cannot be denied to any person because of their racial group or perceived racial group, personal characteristics associated with race (e.g., hair texture, color, facial features), marriage to, or other intimate association with, someone of a particular race or color. Also, a person cannot be treated unfavorably due to cultural practices commonly linked to a certain race or ethnicity, such as dress, diet, holiday observance, or manner of speech. Employment decisions based on stereotypes and assumptions about abilities, traits, or the performance of individuals of certain racial groups are also strictly prohibited.

RELIGIOUS DISCRIMINATION

Employers may not treat employees or applicants more or less favorably because of their actual or perceived religious beliefs or practices. Title VII and Code of Federal Regulations 29 C.F.R. Part 1605 protect not only members of traditional religions, but any applicant or employee holding a sincere religious, ethical, or moral belief. The law also protects garb, grooming, dietary requirements, holiday observances, and other religious practices which must be reasonably accommodated by the employer, unless, according to the 2023 Supreme Court decision in *Groff v. DeJoy*, the employer demonstrates that the "burden of granting an accommodation would result in substantial increased costs in relation to the conduct of its particular business."

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Equal Opportunity Employer (EEO)

SEX, GENDER IDENTITY, OR SEXUAL ORIENTATION DISCRIMINATION

A person's sex, gender, sexual orientation, and/or gender identity (how the person identifies regardless of the anatomical or assigned gender at birth) must never be allowed to be a factor in employment decisions, unless there is a bona-fide reason for a distinction being made by an employer or prospective employer (e.g., hiring a male or female actor for a certain role).

Although Title VII of the Civil Rights Act does not explicitly include sexual orientation or gender identity, the U.S. Supreme Court in the 2020 *Bostock* case and the EEOC in its regulations have said that Title VII absolutely protects against these types of discrimination, which are another form of sex-based discrimination. An employment policy or practice that applies to everyone, regardless of sex, can still be illegal if it has a negative or disparate impact on the employment of a certain sex and is not job-related or necessary to the operation of the business.

EXAMPLES OF DISCRIMINATION

- Harassment on the basis of race, color, religion, sex, national origin, disability, gender identity, sexual orientation, or age;
- Retaliation against an individual for filing a charge of discrimination, participating in an investigation, or opposing discriminatory practices;
- Employment decisions based on stereotypes or assumptions about the abilities, traits, or performance of individuals of a certain sex, race, age, religion, genetic information, or ethnic group, or individuals with disabilities;
- Denying employment opportunities to a person because of marriage to, or association with, an individual of a particular race, religion, national origin, or an individual with a disability. Title VII also prohibits discrimination because of participation in schools or places of worship associated with a particular racial, ethnic, or religious group;
- Verbal abuse, offensive innuendo, or derogatory words concerning a person's race, color, gender identity, sex, age, sexual orientation, religion, ethnic or national origin, disability, veterans' status, or any other protected status;
- Having employer policies or procedures that appear neutral but have a particularly negative effect on a group with a common race, color, sex, national origin, religion, age, genetic information, gender identity, sexual orientation, or disability status. This is known as disparate impact and its effect does not have to be intended.

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Equal Opportunity Employer (EEO)

AVOIDING HARASSMENT: EQUALITY IS THE LAW

Harassment is a form of employment discrimination that violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967 (ADEA), the Americans with Disabilities Act of 1990 (ADA), the Equal Pay Act of 1963(EPA), and the Genetic Information Nondiscrimination Act of 2008 (GINA). It is defined as unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability, or genetic information. Harassment becomes unlawful where:

(1) enduring the offensive conduct becomes a condition of continued employment; or

(2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive. The harasser can be the victim's supervisor, a supervisor in another department or area of the office or plant, a co-worker, or even a client or a customer.

INTERNAL HARASSMENT AND DISCRIMINATION INVESTIGATIONS

Investigations and resolutions will be handled with as much privacy, discretion, and confidentiality as possible without compromising diligence and fairness.

If, after the investigation, it is found that inappropriate conduct occurred, immediate action will be taken, which may include, but is not limited to, reprimand, suspension, change in assignments, mandatory training, loss of privileges, termination, and/or ending of the contractual relationship for cause. Where appropriate, the investigation outcome and results will be communicated to the complainant, alleged harasser, and other involved parties.

In addition, a complaint of discrimination or harassment may be filed with either the appropriate state or federal agency. Failure to first utilize the internal company complaint process available to you may result in an unfavorable ruling.

U.S. Equal Employment Opportunity Commission
P.O. Box 7033, Lawrence, Kansas 66044
800-669-4000
TTY 800-669-6820
www.eeoc.gov

State Office
Phone Number

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HIPAA Privacy Rule

How It Came About

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form.

The HIPAA Privacy Rule, in effect since 2001, establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections. The rule applies to Covered Entities and their business associates (subcontractors, providers and the like).

What the Rule Does

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records.
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data – for example, to protect public health.
- For patients – it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections.
- It empowers individuals to control certain uses and disclosures of their health information.

What Information Is Protected

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow these laws

Who Is Not Required to Follow the Rule

Examples of organizations that do not have to follow the Privacy and Security Rules include:

- Life insurers
- Employers
- Workers compensation carriers
- Most schools and school districts
- Many state agencies like child protective service agencies
- Most law enforcement agencies
- Many municipal offices

Covered Entities

Under the HIPAA Privacy Rule, Covered Entities and their business associates must guard against the misuse of an individual's identifiable health information and limit the sharing of such information.

Covered Entities include, but are not limited to, the following:

- Health Care Provider (hospitals, doctors, dentists, psychologists, clinics, pharmacies, nursing homes, and laboratories)
- Health Plans (via health insurance or self-insurance) Dental Plans (via health insurance or self-insurance) Vision Providers (via health insurance or self-insurance)
- Employee Assistance Plans that provide health benefits (via health insurance or self-insurance)
- Health insurance providers
- PPOs, HMOs, and managed health care organizations
- Health Care Spending or Reimbursement Accounts (flexible spending accounts under a cafeteria plan)
- Medical billing services
- Health Care Clearinghouse

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HIPAA Privacy Rule Continued

Your Rights Over Your Health Information

Health insurers and providers who are covered entities must comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can:
  - File a complaint with your provider or health insurer
  - File a complaint with HHS

You should get to know these important rights, which help you protect your health information.

You can ask your provider or health insurer questions about your rights.

Who Can Look at and Receive Your Health Information

The Privacy Rule sets rules and limits on who can look at and receive your health information.

To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer
- Use or share your information for marketing or advertising purposes or sell your information

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HIPAA and the Definition of Spouse and Family

Following a Supreme Court decision in 2015 that legalized same-sex marriage, sections of HIPAA were modified and expanded to incorporate the new definitions of spouse and family. Pursuant to the decision in *United States v. Windsor,* the term spouse now includes individuals who are in a legally valid same-sex marriage. The term marriage includes both same-sex and opposite-sex marriages, and family member includes dependents of either type of marriage.

These new definitions are relevant to the HIPAA Privacy Rule itself; to the HIPAA section concerning permission of covered entities to share protected health information (PHI) with family members; to the section concerning the Use and Disclosure of Genetic Information for Underwriting Purposes; and to other sections where spouse or family member is mentioned.

In 2016, the Department of Health and Human Services (HHS) issued a final rule on "Nondiscrimination in Health Programs and Activities" to expand discrimination protections under the Affordable Care Act and HIPAA. Individuals are now protected against discrimination in health care based on:

- Race • Color • National Origin • Age
- Disability • Sex and Gender Identity

Statement of HIPAA Portability Rights

Pre-existing condition certification no longer needed

Under HIPAA, you and your family members cannot be denied eligibility or benefits based on certain health factors, including pre-existing conditions, when enrolling in a health plan. In addition, you may not be charged more than similarly-situated individuals based on any health factors.

The pre-PPACA (before the Patient Protection and Affordable Care Act) requirement for HIPAA certifications on pre-existing condition or certificates of creditable coverage are no longer required.

Right to get special enrollment in another plan

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption and may have longer enrollment periods.)

Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor

Under HIPAA, a group health plan may not exclude you (or your dependents) from the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly-situated individual.

Special Enrollment Rights

Special enrollment allows individuals who previously declined health coverage to enroll for coverage outside of a plan's open enrollment period. There are two types of special enrollment:

Loss of eligibility for other coverage — Employees and dependents who decline coverage due to other health coverage and then lose eligibility or employer contributions have special enrollment rights. For example, an employee who turns down health benefits for herself and her family because the family already has coverage through her spouse's plan can request special enrollment for her family in her own company's plan.

Certain life events — 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.

State flexibility

This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information

If you have questions about your HIPAA rights, please contact your benefit plan administrator and/or the individual listed below:

_____
(HIPAA Compliance Officer or Plan Administrator)

at _____
Phone Number

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HIPAA Security Rule

What Is It?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Secretary of HHS to publish national standards for the security of electronic protected health information (e-PHI), electronic exchange, and the privacy and security of health information.

HIPAA called on the Secretary to issue security regulations regarding measures for protecting the integrity, confidentiality, and availability of e-PHI that is held or transmitted by covered entities. HHS developed a proposed rule and released it for public comment on August 12th, 1998. The final regulation, the Security Rule, was published February 20th, 2003.

Who's Covered by the Security Rule?

The Security Rule applies to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with a transaction for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities") and to their business associates. The HITECH Act of 2009 expanded the responsibilities of business associates under the HIPAA Security Rule. Any telehealth providers also need to meet HIPAA Security Rule regulations.

What Information Is Protected?

The HIPAA Privacy Rule protects the privacy of individually identifiable health information, called protected health information (PHI), as explained in the Privacy Rule. The Security Rule protects a subset of information covered by the Privacy Rule, which is all individually identifiable health information a covered entity creates, receives, maintains or transmits in electronic form. The Security Rule calls this information "electronic protected health information" (e-PHI). The Security Rule does not apply to PHI transmitted orally or in writing.

General Rules

The Security Rule requires covered entities and their business associates to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting e-PHI.

Specifically, covered entities must:

- Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the information;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by their workforce.

The Security Rule defines "confidentiality" to mean that e-PHI is not available or disclosed to unauthorized persons. The Security Rule's confidentiality requirements support the Privacy Rule's prohibitions against improper uses and disclosures of PHI. The Security rule also promotes the two additional goals of maintaining the integrity and availability of e-PHI. Under the Security Rule, "integrity" means that e-PHI is not altered or destroyed in an unauthorized manner. "Availability" means that e-PHI is accessible and usable on demand by an authorized person.

Mental Health

Information for the NICS

On January 4th, 2016, the Department of Health and Human Services (HHS) modified the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to expressly permit certain covered entities to disclose to the National Instant Criminal Background Check System (NICS) the identities of those individuals who, for mental health reasons, already are prohibited by federal law from having a firearm.

The final rule gives states improved flexibility to ensure accurate but limited information is reported to the NICS. This rulemaking makes clear that, under the Privacy Rule, certain covered entities are permitted to disclose limited information to the NICS. The information that can be disclosed is the minimum necessary identifying information about individuals who have been involuntarily committed to a mental institution or otherwise have been determined by a lawful authority to be a danger to themselves or others or to lack the mental capacity to manage their own affairs.

An individual who seeks help for mental health problems or receives mental health treatment is not automatically legally prohibited from having a firearm; nothing in this final rule changes that.

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Protected Health Information (PHI)

What is Protected Health Information (PHI)?

Under the HIPAA Privacy Rule, protected health information, or "PHI," refers to individually identifiable health information that is created, received, stored, or transmitted in any form or medium by a covered entity or their business associate in relation to the provision of healthcare, healthcare operations, and payment for healthcare services. Individually identifiable health information is that which can be linked to a particular person. Specifically, this information can relate to:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or,
- The past, present, or future payment for the provision of health care to the individual; or
- The individual's genetic information.

PHI includes 18 identifiers that can be used to identify a patient, including:

- Name
- Address (including subdivisions smaller than state such as street address, city, county, or zip code)
- Any dates (except years) that are directly related to an individual, including birthday, date of admission or discharge, date of death, or the exact age of individuals older than 89
- Telephone and fax numbers
- Email address
- Social Security number
- Medical record number
- Health plan beneficiary number
- Account number
- Certificate/license number
- Vehicle identifiers, serial numbers, or license plate numbers
- Device identifiers or serial numbers
- IP address and Web URLs
- Biometric identifiers such as fingerprints or voice prints
- Full-face photos
- Any other unique identifying numbers, characteristics, or codes

What is Electronic Protected Health Information (ePHI)?

"Electronic Protected Health Information," or "ePHI," means Protected Health Information that is maintained in or transmitted by electronic media.

Uses & Disclosures of PHI

Covered entities must safeguard PHI by implementing policies and procedures to restrict access to and use of PHI. Furthermore, a covered entity must only use or disclose the minimum amount of PHI necessary.

Required disclosures include:

- To an individual when requested and required by Section 164.524 (Access) & Section 164.528 (Accounting)
- To HHS, to investigate or determine compliance with Privacy Rule
- To the FBI and the National Instant Criminal Background Check System (NICS) for mental health issues regarding gun possession

Besides required disclosures, covered entities also may disclose PHI to their patients/health plan enrollees so that:

- Health plans can contact their enrollees, and
- Providers can talk to their patients

Permitted Uses and Disclosures

A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) provided to the individual (unless required for access or accounting of disclosures); (2) used for treatment, payment, and health care operations; (3) granting opportunity to agree or object; (4) as an incident to an otherwise permitted use and disclosure; (5) for public interest and benefit activities; and (6) as a limited data set for the purposes of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

Breach Notification

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) requires HIPAA-covered entities and business associates to follow specific rules relating to the discovery of a breach of protected health information. These rules require covered entities and business associates to do the following when a security breach is discovered:

- Provide notification to affected individuals and to the Secretary of HHS following the discovery of a breach of unsecured protected health information.
- Provide notice to prominent local media outlets if there is a breach affecting more than 500 residents of a state or jurisdiction.
- In the case of a breach of unsecured protected health information at or by a business associate of a covered entity, the Act requires the business associate to notify the covered entity of the breach.

A "breach" is defined as the acquisition, access, use, or disclosure of protected health information in an impermissible manner which compromises its security or privacy.

A covered entity shall, following the discovery of a breach of unsecured protected health information, notify each individual whose unsecured protected health information has been, or is reasonably believed by the covered entity to have been, accessed, acquired, used, or disclosed as a result of such breach.

The covered entity must send the required notification without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

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Anti-Discrimination Notice

General

Under current law, a group health plan may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor that relates to that individual or a dependent of that individual.

Health Factors

The term "health factor" means, in relation to an individual, any of the following health status-related factors:

- Health status;
- Medical condition (including both physical and mental illnesses);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability (including conditions arising out of acts of domestic violence or out of participations in recreational activities);
- Disability.

Eligibility Rules

Rules for eligibility include rules relating to any of the following:

- Enrollment;
- The effective date of coverage;
- Waiting (or affiliation) periods;
- Late and special enrollment;
- Eligibility for benefit packages;
- Benefits (including copayments and deductibles);
- Continued eligibility;
- Terminating coverage (including disenrollment) of any individual under the plan.

Nonconfinement and Actively-At-Work Provisions

A plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution or whether the individual is actively at work (including continuous employment).

Similarly-Situated Individuals

Distinctions among groups of similarly-situated individuals may not be based on a health factor. Group health plans may limit or exclude coverage or benefits if the restriction is applied uniformly to all similarly-situated individuals and is not directed at any individual participants or beneficiaries based on a health factor.

Exceptions for Wellness Programs

Special rules and exceptions apply to wellness programs (programs designed to promote health or prevent disease) that provide benefit incentives.

What You Need to Know About COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most group health plans give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. The purpose of this all-in-one notification poster is to meet notice requirements under COBRA and provide important information for employees, as well as other health coverage alternatives that may be available through the Health Insurance Marketplace. For more detailed information on COBRA benefits, please contact your organization's Human Resource Manager.

ALL-ON-ONE COBRA INFORMATION POSTER

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This poster contains important information about your right to COBRA continuation coverage, which is a temporary extension of health care coverage under a group health plan (Plan) or flexible spending account. Included on this poster is an explanation of COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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. 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 -or- ❑ aren't required to pay for COBRA continuation coverage.

HR: Check one option

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

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

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because 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; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If a Plan provides retiree health coverage, then sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to a Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under a Plan, the retired employee becomes a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if the bankruptcy results in the loss of their coverage under a Plan.

A Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee has become entitled to Medicare Benefits (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of the event.

For all other qualifying events (divorce or legal separation of the employee and spouse or dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs, or longer if the Plan allows it. You must send this notice to the employer.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

1. **Disability extension of 18-month period of continuation coverage.** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
2. **Second qualifying event extension of 18-month period of continuation coverage.** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
3. **State law** may mandate an extension of the 18-month period of COBRA continuation coverage.

Other Coverage Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare Instead of COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

Special Rule for Flexible Spending Accounts

The Flexible Spending Account will only be available for continuation of coverage if your available balance at the time of the COBRA qualifying event is more than the total contributions you will make for the remainder of the Plan Year under COBRA. Your available balance is your annual election for the flexible spending account benefits for the Plan Year less any reimbursable claims submitted before the qualifying event. COBRA contributions for the remainder of the Plan Year shall include a 2-percent administrative fee. You or your qualified spouse or dependent will not be eligible to make a COBRA election for the flexible spending account in any subsequent Plan Year.

Continuation Coverage During Family or Medical Leave

During any period during which you are a participant in a Plan and take a family or medical leave as defined in the Family and Medical Leave Act, any benefit elections in force for you shall remain in effect. While you are on paid leave, contributions shall continue. If you are on an unpaid leave, you may elect to prepay required contributions (on a pre-tax basis if the employer provides such a plan) before the commencement of such unpaid leave. Alternatively, you may elect to make such payments on a monthly basis (after-tax only) in accordance with an arrangement that the Plan Administrator shall provide. If coverage is not continued during the entire period of the family or medical leave because you decline to pay the premium, the coverage must be reinstated upon reemployment with no exclusions or waiting periods. If you do not return to work upon completion of the leave, you must pay the full cost of any healthcare coverage that was continued on your behalf during the leave.

If You Have Any Questions

If you have questions about your COBRA continuation coverage, you should contact the benefits administrator, the company owner, the human resources officer, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at http://www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

_____

Name of group health plan

_____

Name (or position), address, and phone number of officer or owner of company (from whom information about the plan and COBRA continuation coverage can be obtained on request)

SUMMARY OF QUALIFYING EVENTS, QUALIFIED BENEFICIARIES, AND MAXIMUM PERIODS OF CONTINUATION COVERAGE

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered, based on the type of qualifying event. Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.

Qualifying Event	Qualified Beneficiaries	Maximum Period
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse, Dependent Child	18 months*
Employee enrollment in Medicare	Spouse, Dependent Child	36 months**
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of employee	Spouse, Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

*In certain circumstances, qualified beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months)

**The actual period of continuation coverage may vary depending on factors such as whether the Medicare entitlement occurred prior to or after the end of the covered employee's employment or reduction in hours.

FOR MORE INFORMATION

Visit tinyurl.com/COBRA-Digital or scan this QR code for more information on the Consolidated Omnibus Reconciliation Act of 1985 (COBRA)

ALL-ON-ONE COBRA INFORMATION

What You Need to Know About COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most group health plans give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. The purpose of this all-in-one notification is to meet notice requirements under COBRA and provide important information for employees, as well as other health coverage alternatives that may be available through the Health Insurance Marketplace. For more detailed information on COBRA benefits, please contact your organization's Human Resources Manager.

CONTINUED >>>

COBRA Information

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This poster contains important information about your right to COBRA continuation coverage, which is a temporary extension of health care coverage under a group health plan (Plan) or flexible spending account. Included on this poster is an explanation of COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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. 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 -or-
❏ aren't required to pay for COBRA continuation coverage.

HR: Check one option

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

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

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because 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; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If a Plan provides retiree health coverage, then sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to a Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under a Plan, the retired employee becomes a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if the bankruptcy results in the loss of their coverage under a Plan.

A Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee has become entitled to Medicare Benefits (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of the event.

For all other qualifying events (divorce or legal separation of the employee and spouse or dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs, or longer if the Plan allows it. You must send this notice to the employer.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA Information

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

1. **Disability extension of 18-month period of continuation coverage.** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
2. **Second qualifying event extension of 18-month period of continuation coverage.** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
3. **State law** may mandate an extension of the 18-month period of COBRA continuation coverage.

Other Coverage Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare Instead of COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

Special Rule for Flexible Spending Accounts

The Flexible Spending Account will only be available for continuation of coverage if your available balance at the time of the COBRA qualifying event is more than the total contributions you will make for the remainder of the Plan Year under COBRA. Your available balance is your annual election for the flexible spending account benefits for the Plan Year less any reimbursable claims submitted before the qualifying event. COBRA contributions for the remainder of the Plan Year shall include a 2-percent administrative fee. You or your qualified spouse or dependent will not be eligible to make a COBRA election for the flexible spending account in any subsequent Plan Year.

Continuation Coverage During Family or Medical Leave

During any period during which you are a participant in a Plan and take a family or medical leave as defined in the Family and Medical Leave Act, any benefit elections in force for you shall remain in effect. While you are on paid leave, contributions shall continue. If you are on an unpaid leave, you may elect to prepay required contributions (on a pre-tax basis if the employer provides such a plan) before the commencement of such unpaid leave. Alternatively, you may elect to make such payments on a monthly basis (after-tax only) in accordance with an arrangement that the Plan Administrator shall provide. If coverage is not continued during the entire period of the family or medical leave because you decline to pay the premium, the coverage must be reinstated upon reemployment with no exclusions or waiting periods. If you do not return to work upon completion of the leave, you must pay the full cost of any healthcare coverage that was continued on your behalf during the leave.

CONTINUED >>>

COBRA Information

If You Have Any Questions

If you have questions about your COBRA continuation coverage, you should contact the benefits administrator, the company owner, the human resources officer, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at http://www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

_____

Name of group health plan

_____

Name (or position), address, and phone number of officer or owner of company (from whom information about the plan and COBRA continuation coverage can be obtained on request)

IMPACT OF AFFORDABLE CARE ACT (ACA) EFFECTS ON COBRA

With the emergence of the Health Insurance Marketplace, in accordance with the Affordable Care Act, those seeking continuation of coverage using COBRA benefits now have additional options for choosing health insurance. Beginning on October 1st, 2013, all employers subject to the Fair Labor Standards Act (FLSA) must provide a notice informing all employees of the Health Insurance Marketplace. Beginning January 1st, 2014, you'll be able to buy coverage using the options provided by the notice. In the Health Insurance Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), the Health Insurance Marketplace, or Medicaid, even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after your group health coverage ends because of the qualifying event.

Special enrollment allows individuals who previously declined health coverage the option to enroll for coverage. Rights arise regardless of a plan's open enrollment period. There are two types of special enrollment: 1) upon loss of eligibility for other coverage; and 2) 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 can then request enrollment in her own company's plan for herself and her dependents. Under the second, employees, spouses, and new dependents are eligible for special enrollment 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. In these cases, the employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance. If the employee or beneficiaries cannot take advantage of special enrollment within the allotted time frame, the Health Insurance Marketplace will still be available to them with the appropriate tax credits for purchasing coverage.

CONTINUED >>>

COBRA Information

SUMMARY OF QUALIFYING EVENTS, QUALIFIED BENEFICIARIES, AND MAXIMUM PERIODS OF CONTINUATION COVERAGE

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered, based on the type of qualifying event. Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.

Qualifying Event	Qualified Beneficiaries	Maximum Period
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse, Dependent Child	18 months*
Employee enrollment in Medicare	Spouse, Dependent Child	36 months**
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of employee	Spouse, Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

*In certain circumstances, qualified beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months)

** The actual period of continuation coverage may vary depending on factors such as whether the Medicare entitlement occurred prior to or after the end of the covered employee's employment or reduction in hours.

STATE CONTINUATION COVERAGE LAW

Although federal law requires at least 20 employees on staff to be covered under COBRA, individual state law may require continuation of coverage for employers with less than 20 employees. The following states have enacted laws at a state level which require continuation of coverage for employers with fewer than 20 employees:

Arizona	Hawaii	Minnesota	North Carolina	Tennessee
Arkansas	Illinois	Mississippi	North Dakota	Texas
California	Iowa	Missouri	Ohio	Utah
Colorado	Kansas	Nebraska	Oklahoma	Vermont
Connecticut	Kentucky	Nevada	Oregon	Virginia
Delaware	Louisiana	New Hampshire	Pennsylvania	Washington
District of Columbia	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming

Where no state continuation of coverage obligation exists, employers are only required to offer COBRA when they have 20 or more employees. The following states do not have a state continuation coverage requirement:

Alabama	Alaska	Idaho	Indiana	Michigan	Montana

For information on how your state's continuation coverage differs from federal law, please see your Human Resources Manager.

CONTINUED >>>

COBRA Information

EMPLOYER NOTICE REQUIREMENTS

Under COBRA, group health plans must provide covered employees and their families with specific notices explaining their COBRA rights. They must also have rules for how COBRA continuation coverage is offered, how qualified beneficiaries may elect continuation coverage, and when it can be terminated.

Quick Reference Guide to COBRA Notices

Type of Notice	Description	Trigger / Timing
Summary Plan Description (SPD)	A written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works.	Must be provided to each participant an SPD within 90 days after becoming a plan participant (or within 120 days after the plan is first subject to ERISA's reporting and disclosure provisions).
General Notice	Includes general information about continuation coverage, notice requirements, the types of qualifying events, and where the individual can obtain more information about plan benefits. The content of this notice must comply with 2590.606-1 of the EBSA's Final Rules on COBRA Notices.	Must be sent to employees and spouses within 90 days of becoming covered under the employer's group health plan.
Notice of Qualifying Event	Notice to the administrator of the plan of the occurrence of a qualifying event that is the covered employee's death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, Medicare entitlement, or employer filing for bankruptcy. The content of this notice must comply with 2590.606-2 of the EBSA's Final Rules on COBRA Notices.	Must be sent to COBRA plan administrator within 30 days of employee's loss of coverage or qualifying event.
Election Notice	A notice describing the rights of the qualified beneficiary to elect COBRA continuation of health benefits under the employer's group health plan or flexible health spending account. This notice must include an Election Form that the beneficiary fills out to communicate whether or not they wish to obtain continuation coverage. The content of this notice must comply with Sec. 2590.606-4(b) of the EBSA final COBRA notice rules.	Must be sent to a qualified beneficiary by the COBRA Administrator within 14 days of notice of a qualifying event (i.e. termination, reduction in hours, death, Medicare entitlement, etc.). If the employer is also the COBRA plan administrator, the notice must be sent within 44 days of the date on which the qualifying event occurred.
Early Termination Notice	A notice sent to a qualified beneficiary informing him / her that continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to such qualifying event. The content of this notice must comply with Sec. 2590.606-4(c) of the EBSA final COBRA notice rules.	The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.
Denial / Unavailability Notice	A notice that is sent to individuals who are not entitled to COBRA coverage despite reporting a qualifying event, second qualifying event, or determination of disability by the Social Security Administration. The content of this notice must comply with Sec. 2590.606-4(d) of the EBSA final COBRA Notice rules.	The plan must give the denied individual a notice of unavailability of continuation coverage within 14 days after the request is received, and explain the reason for denying the request.

ACA INFORMATION
The Affordable Care Act (ACA)

KEY PROVISIONS
(Coverage of Preventative Services)

In March 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA, aka "health care reform" or "Obamacare"), into law. The ACA is intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs. It provides a number of mechanisms — including mandates, subsidies, and tax credits — to employers and individuals to increase the coverage rate and health insurance affordability.

Individual Shared Responsibility

The Individual Shared Responsibility provision of the law applies to the self-employed and requires that each individual, beginning in January 2014, have basic health insurance coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing a federal income tax return starting in 2015. Individuals will not have to make a payment under these rules if coverage is unaffordable, you spend less than three consecutive months without coverage, or you qualify for an exemption for several other reasons, including hardship and religious beliefs.

Health Insurance Marketplaces

Also known as the "Health Insurance Marketplace," the Affordable Insurance Exchange is a new, transparent, competitive insurance marketplace where individuals and small businesses can purchase affordable and qualified health benefit plans. The Marketplace for small employers, known as the Small Business Health Options Program (SHOP), and the Individual Marketplace for consumers and those who are self-employed, opened in all states in 2014.

Essential Health Benefits

The Affordable Care Act ensures that health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include services within at least ten core categories, among them emergency services; maternity and newborn care; prescription drugs; and preventive and wellness services.

Premium Tax Credits for Consumers & Self-Employed Individuals

Consumers and self-employed individuals may be eligible for a tax credit that can be used right away to lower the monthly health plan premiums. Individuals who qualify can take the premium tax credit in the form of advance payments to lower their monthly health plan premiums starting in 2014, which can help make insurance more affordable. The value of the tax credit an individual is eligible for depends on how much income they or their family expects to earn.

Tax Credits for Small Businesses

The ACA enacted Section 45R of the Internal Revenue Code, which contains provisions for tax credits available to certain small businesses that offer health insurance coverage to their employees. Effective June 20th, 2014, the IRS published final regulations that affect small employers that may be eligible for any taxable year in the credit period. The final regulations define an eligible small employer as an employer with no more than 25 full-time equivalent employees (FTEs), whose employees have average annual wages of no more than $50,000 per FTE, and that has a qualifying arrangement where the employer pays a uniform percentage (not less than 50 percent) of the premium costs offered by the employer to its employees through a Small Business Health Options Program (SHOP) Exchange.

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) EXCLUSION LIMITED

Health Flexible Spending Accounts (FSAs) are benefit plans that employers can sponsor to allow their employees to be reimbursed on a tax-favored basis for certain medical expenses that are not covered by the employer's major medical plan. Generally, employees decide before the beginning of the plan year how much money they want to contribute to the FSA. Throughout the year, they can draw from this account for qualified medical expenses that are not covered by their employer's main health plan. This can include copays, deductibles, and various medical services and products – from dental and vision care to eyeglasses and hearing aids.

Under the Affordable Care Act, beginning with calendar year 2013, the maximum amount an employee can exclude from income for contributions to a flexible spending account is limited to $2,500. That limit is per person so both the employee and their spouse can each set aside $2,500, where applicable. The new limit is based only on the calendar year regardless of the plan year of the plan.

The $2,500 limit applies only to salary reduction contributions under a health care FSA and does not limit the amount allowed for reimbursement under an FSA for dependent care assistance or adoption care assistance. Likewise, it also doesn't apply to salary reduction or any other contributions to a health savings account (HSA) or to amounts made available by an employer under a health reimbursement arrangement (HRA).

HEALTH INSURANCE MARKETPLACE NOTICE

You May Be Eligible to Shop for Coverage at the Marketplace

Beginning January 1st, 2014, individuals and employees of small businesses have access to affordable coverage through a new competitive private health insurance market – the Health Insurance Marketplace.

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Open enrollment for health insurance coverage through the Marketplace began October 1st, 2013. Section 1512 of the Affordable Care Act (ACA) creates a new Fair Labor Standards Act (FLSA) section 18B requiring a notice to employees of coverage options available through the Marketplace.

Background

Section 18B of the FLSA, as added by section 1512 of the Affordable Care Act, generally provides that, in accordance with regulations promulgated by the Secretary of Labor, an applicable employer must provide each employee at the time of hiring (or with respect to current employees, not later than October 1st, 2013), a written notice:

1. Informing the employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;
2. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code if the employee purchases a qualified health plan through the Marketplace; and
3. If the employee purchases a qualified health plan through the Marketplace, that the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer. All or a portion of such contribution may be excludable from income for federal income tax purposes.

What is the Marketplace?

The Marketplace is a way to find health coverage that fits your budget and meets your needs. With one application, you can see all your options and enroll.

When you use the Health Insurance Marketplace, you'll fill out an application and find out if you can get lower costs on your monthly premiums for private insurance plans. You'll find out if you qualify for lower out-of-pocket costs.

The Marketplace will also tell you if you qualify for free or low-cost coverage available through Medicaid or the Children's Health Insurance Program (CHIP).

Open enrollment occurs between November 1 and January 15. Coverage began January 1st, 2014.

The Health Insurance Marketplace is sometimes known as the health insurance "exchange."

If your state does not operate a Health Insurance Exchange, you can visit HealthCare.gov to seek further information and check eligibility – even apply for insurance.

WHISTLEBLOWER NOTICE

The Affordable Care Act (ACA) contains various provisions to make health insurance more affordable and accountable to consumers. To further these goals, the Affordable Care Act's section 1558 provides protection to employees against retaliation by an employer for reporting alleged violations of Title I of the Act or for receiving a health insurance tax credit or cost sharing reductions as a result of participating in a Health Insurance Exchange, or Marketplace.

Title I includes a range of insurance company accountability requirements, such as the prohibition of lifetime limits on coverage or exclusions due to pre-existing conditions. Title I also includes requirements for certain employers.

An employer may not discharge or in any manner retaliate against an employee because he or she:

- provided information relating to any violation of Title I of the ACA, or any act that he or she reasonably believed to be a violation of Title I of the ACA to the employer, the federal government, or a state attorney general;
- testified, assisted, or participated in a proceeding concerning a violation of Title I of the ACA, or is about to do so; or
- objected to or refused to participate in any activity that he or she reasonably believed to be in violation of Title I of the ACA.

In addition, an employer may not discharge or in any manner retaliate against an employee because he or she received a credit under section 36B of the Internal Revenue Code of 1986 or a cost-sharing reduction under section 1402 of the ACA.

If an employer takes retaliatory action against an employee because he or she engaged in any of these protected activities, the employee can file a complaint with the Occupational Safety and Health Administration (OSHA), the agency charged with whistleblower law enforcement.

WELLNESS PROGRAMS

The Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. The Departments of Health and Human Services, Labor, and the Treasury have jointly released regulations on wellness programs to reflect the changes to existing wellness provisions made by the Affordable Care Act and to encourage appropriately designed, consumer-protective wellness programs in group health coverage. These regulations are effective for plan years starting on or after January 1st, 2014.

The regulations divide wellness programs into three categories:

- "Participatory" Programs are those that either do not provide a reward or do not include any conditions for obtaining a reward that are based on an individual satisfying a standard that is related to a health factor. For example, a program that reimburses employees for all or part of the cost of membership in a fitness center or a program that provides a reward to employees for attending a monthly, no-cost health education seminar.
- "Activity-only" programs are those in which an individual is required to perform or complete an activity related to a health factor in order to obtain a reward. Activity-only wellness programs do not require an individual to attain or maintain a specific health outcome. Examples of activity-only wellness programs include walking, diet, or exercise programs.
- "Outcome-based" programs are those in which an individual must attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward.

Protecting Consumers

In order to protect consumers from unfair practices, the regulations require activity-based and outcome-based wellness programs to follow certain rules, including:

1. Individual employees must have the opportunity to qualify for the reward annually;
2. The reward cannot exceed 30% of the total cost of health-care coverage (with an additional 20% available for programs designed to reduce tobacco use);
3. The program must be reasonably designed to promote health or prevent disease;
4. The full reward must be uniformly available, requiring reasonable alternatives that provides employees identical benefits as the original program; and
5. The employer must provide adequate notice of the plan, its alternatives, and the available benefits.

ANTI-DISCRIMINATION PROVISIONS

Several provisions of the Affordable Care Act prohibit discrimination including:

SEC. 2704. Prohibition of Preexisting Condition Exclusions or Other Discrimination Based On Health Status

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

SEC. 2701. Fair Health Insurance Premiums

The premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market may vary with respect to the particular plan or coverage involved only by:

- whether such plan or coverage covers an individual or family;
- geographic area;
- age (limitations apply); and
- tobacco use (limitations apply).

SEC. 2705. Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status
(2) Medical condition (including both physical and mental illnesses)
(3) Claims experience
(4) Receipt of health care
(5) Medical history
(6) Genetic information
(7) Evidence of insurability (including conditions arising out of acts of domestic violence)
(8) Disability
(9) Any other health status-related factor determined appropriate by the Secretary

SEC. 2706. Non-Discrimination in Health Care

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. This section shall not require that a group health plan and health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.

A group health plan, a health insurance issuer, or the Secretary may establish varying reimbursement rates based on quality or performance measures.

SEC. 1557. Nondiscrimination

In 2016, the Department of Health and Human Services (HHS) issued its "Nondiscrimination in Health Programs and Activities" final rule to clarify and expand discrimination protections under section 1557 of the ACA. Under this final rule, individuals are now protected in health care against discrimination on the basis of:

- Race
- Color
- National Origin
- Age
- Disability
- Sex and Gender Identity

90-DAY WAITING PERIOD LIMITATION

For plan years beginning on or after January 1st, 2014, individuals who are eligible for employer-provided health coverage will not have to wait more than 90 days to begin coverage. On June 25th, 2014, the IRS, EOL, and HHS published final regulations which allow an orientation period not exceeding 30 days prior to the start of the 90-day waiting period, effective for plan years beginning on or after January 1st, 2015.

Employees with Variable Hours Each Week

If a group health plan conditions eligibility on an employee regularly working a specified number of hours per period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time), the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition, which may include a measurement period that is consistent with the time frame permitted for such determinations.

SUMMARY OF BENEFITS AND COVERAGE AND UNIFORMED GLOSSARY

Under the Affordable Care Act, health insurers and group health plans are required to provide Americans who have private insurance with clear, consistent, and comparable information about their health plan benefits and coverage. Specifically, the regulations ensure consumers have access to two forms that will help them understand and evaluate their health insurance choices. The forms include:

- An easy-to-understand summary of benefits and coverage (SBC)
- A uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "copayment"

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan.

Plans and issuers are also required to provide notice of modification in any of the terms of the plan or coverage involved that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage.

Coverage Examples

This summary of benefits and coverage will include a standardized health plan comparison tool for consumers called "coverage examples," much like the Nutrition Facts label required for packaged foods. The coverage examples would illustrate how a health insurance policy or plan would cover care for common benefits scenarios. Using clear standards and guidelines provided by the Center for Consumer Information and Insurance Oversight (CCIIO), plans and issuers will simulate claims processing for each scenario so consumers can see an illustration of the coverage they get for their premium dollar under a plan. The examples will help consumers see how valuable the health plan will be at times when they may need the coverage.

Uniform Glossary of Terms

Under the Affordable Care Act, consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "copayment." To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor (DOL) will also post the glossary on the new health care reform website, www.HealthCare.gov and www.dol.gov/ebsa/healthreform.

If recipients don't speak English, they should be entitled to receive the SBC and uniform glossary in their native language upon request.

MARKETPLACES AND 4 WAYS TO APPLY FOR COVERAGE

There are four basic ways to apply for health coverage through the Marketplace:

- **Apply online.** Visit HealthCare.gov to get started.
- **Apply by phone.** Call 1-800-318-2596 to apply for a health insurance plan and enroll over the phone (TTY: 1-855-889-4325).
- **Apply in person.** Visit a trained counselor in your community to get information and apply in person. Find help in your area at LocalHelp.HealthCare.gov.
- **Apply by mail.** Complete a paper application and mail it in. You can download the paper application form and instructions from HealthCare.gov.

The Affordable Care Act (ACA)

HEALTH INSURANCE MARKETPLACE NOTICE

You May Be Eligible to Shop for Coverage at the Marketplace

Beginning January 1, 2014, individuals and employees of small businesses have access to affordable coverage through a new competitive private health insurance market – the Health Insurance Marketplace.

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Open enrollment for health insurance coverage through the Marketplace began October 1st, 2013. Section 1512 of the Affordable Care Act (ACA) creates a new Fair Labor Standards Act (FLSA) section 18B requiring a notice to employees of coverage options available through the Marketplace.

Background

Section 18B of the FLSA, as added by section 1512 of the Affordable Care Act, generally provides that, in accordance with regulations promulgated by the Secretary of Labor, an applicable employer must provide each employee at the time of hiring (or with respect to current employees, not later than October 1st, 2013), a written notice:

1. Informing the employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;
2. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code if the employee purchases a qualified health plan through the Marketplace; and
3. If the employee purchases a qualified health plan through the Marketplace, that the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer. All or a portion of such contribution may be excludable from income for federal income tax purposes.

What Is the Marketplace?

The Marketplace is a way to find health coverage that fits your budget and meets your needs. With one application, you can see all your options and enroll.

When you use the Health Insurance Marketplace, you'll fill out an application and find out if you can get lower costs on your monthly premiums for private insurance plans. You'll find out if you qualify for lower out-of-pocket costs.

The Marketplace will also tell you if you qualify for free or low-cost coverage available through Medicaid or the Children's Health Insurance Program (CHIP).

Open enrollment occurs between November 1 and January 15. Coverage began January 1st, 2014.

The Health Insurance Marketplace is sometimes known as the health insurance "exchange."

If your state does not operate a Health Insurance Exchange, you can visit HealthCare.gov to seek further information and check eligibility – even apply for insurance.

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) EXCLUSION LIMITED

Health Flexible Spending Accounts (FSAs) are benefit plans that employers can sponsor to allow their employees to be reimbursed on a tax-favored basis for certain medical expenses that are not covered by the employer's major medical plan. Generally, employees decide before the beginning of the plan year how much money they want to contribute to the FSA. Throughout the year, they can draw from this account for qualified medical expenses that are not covered by their employer's main health plan. This can include copays, deductibles, and various medical services and products – from dental and vision care to eyeglasses and hearing aids

Under the Affordable Care Act, beginning with calendar year 2023, the maximum amount an employee can exclude from income for contributions to a flexible spending account is limited to $3,050. That limit is per person so both the employee and their spouse can each set aside $3,050, where applicable. The new limit is based only on the calendar year regardless of the plan year of the plan.

The $3,050 limit applies only to salary reduction contributions under a health care FSA and does not limit the amount allowed for reimbursement under an FSA for dependent care assistance or adoption care assistance. Likewise, it also doesn't apply to salary reduction or any other contributions to a health savings account (HSA) or to amounts made available by an employer under a health reimbursement arrangement (HRA).

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The Affordable Care Act (ACA)

Key Provisions *(Coverage of Preventative Services)*

In March 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA aka "health care reform" or "Obamacare"), into law. The ACA is intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs. It provides a number of mechanisms — including mandates, subsidies, and tax credits — to employers and individuals to increase the coverage rate and health insurance affordability.

Individual Shared Responsibility

The Individual Shared Responsibility provision of the law applies to the self-employed and requires that each individual, beginning in January 2014, have basic health insurance coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing a federal income tax return starting in 2015. Individuals will not have to make a payment under these rules if coverage is unaffordable, you spend less than three consecutive months without coverage, or you qualify for an exemption for several other reasons, including hardship and religious beliefs.

Health Insurance Marketplaces

Also known as the "Health Insurance Marketplace," the Affordable Insurance Exchange is a new, transparent, competitive insurance marketplace where individuals and small businesses can purchase affordable and qualified health benefit plans. The Marketplace for small employers, known as the Small Business Health Options Program (SHOP), and the Individual Marketplace for consumers and those who are self-employed, opened in all states in 2014.

Essential Health Benefits

The Affordable Care Act ensures that health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include services within at least ten core categories, among them emergency services; maternity and newborn care; prescription drugs; and preventive and wellness services.

Premium Tax Credits for Consumers & Self-Employed Individuals

Consumers and self-employed individuals may be eligible for a tax credit that can be used right away to lower the monthly health plan premiums. Individuals who qualify can take the premium tax credit in the form of advance payments to lower their monthly health plan premiums starting in 2014, which can help make insurance more affordable. The value of the tax credit an individual is eligible for depends on how much income they or their family expects to earn.

Tax Credits for Small Businesses

The ACA enacted Section 45R of the Internal Revenue Code, which contains provisions for tax credits available to certain small businesses that offer health insurance coverage to their employees. Effective June 20th, 2014, the IRS published final regulations that affect small employers that may be eligible for any taxable year in the credit period. The final regulations define an eligible small employer as an employer with no more than 25 full-time equivalent employees (FTEs), whose employees have average annual wages of no more than $50,000 per FTE, and that has a qualifying arrangement where the employer pays a uniform percentage (not less than 50 percent) of the premium costs offered by the employer to its employees through a Small Business Health Options Program (SHOP) Exchange.

Timeline

The Affordable Care Act contains numerous provisions that took effect at various times between 2010 and 2018. The following timeline are the highlights of provisions that have previously passed.

2017

- **February 28**: Large employers must report and verify the offer of affordable and adequate coverage to the IRS by February 28 (March 31 if submitted electronically)

2016

- **January 1**: Employer Shared Responsibility mandate begins for businesses with 50 to 99 employees
- **March 31**: Large employers must report and verify the offer of affordable and adequate coverage to the IRS by March 31 (June 30 if submitted electronically)

2015

- **January 1**: Employer Shared Responsibility mandate begins for businesses with 100 or more employees
- Health insurance exchanges become available for larger employers (those with 50-100 employees)

2014

- **January 1**: Coverage begins in the Health Insurance Marketplace
- Coverage for pre-existing conditions
- Medicaid expansion
- No more yearly limits on coverage
- Expanded small business tax credit

2010-2013

- **October 1, 2013**: Open enrollment in the Health Insurance Marketplace begins
- **October 1, 2013**: Employers are required to notify employees of the existence and functioning of Health Insurance Marketplaces
- New preventive services for women
- Plan participants have a right to Summary of Benefits and Coverage in order to make informed decisions about their healthcare options
- Prescription drug discounts for seniors
- Free Medicare preventive services for seniors

CONTINUED >>>

90-DAY WAITING PERIOD LIMITATION

For plan years beginning on or after January 1st, 2014, individuals who are eligible for employer-provided health coverage will not have to wait more than 90 days to begin coverage. On June 25th, 2014, the IRS, DOL, and HHS published final regulations which allow an orientation period not exceeding 30 days prior to the start of the 90-day waiting period, effective for plan years beginning on or after January 1st, 2015.

Orientation Period Defined

The orientation period is a time period used by the employer and employee to evaluate whether the employment situation is satisfactory for each party. The duration of the orientation period cannot exceed one month, and is measured by adding one calendar month to the employee's start date and then subtracting one calendar day. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2.

Waiting Period Defined

A group health plan and a health insurance issuer offering group coverage may not use a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. For this purpose, being eligible for coverage means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms).

Furthermore, if, under the terms of a plan, an employee may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, the 90-day waiting period limitation is considered satisfied. Accordingly, a plan or issuer will not be considered to have violated the rule merely because employees take additional time to elect coverage.

Employees with Variable Hours Each Week

If a group health plan conditions eligibility on an employee regularly working a specified number of hours per period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time), the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition, which may include a measurement period that is consistent with the time frame permitted for such determinations.

WELLNESS PROGRAMS

The Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. The Departments of Health and Human Services, Labor, and the Treasury have jointly released regulations on wellness programs to reflect the changes to existing wellness provisions made by the Affordable Care Act and to encourage appropriately designed, consumer-protective wellness programs in group health coverage. These regulations are effective for plan years starting on or after January 1st, 2014.

The regulations divide wellness programs into three categories:

- "Participatory" Programs are those that either do not provide a reward or do not include any conditions for obtaining a reward that are based on an individual satisfying a standard that is related to a health factor. For example, a program that reimburses employees for all or part of the cost of membership in a fitness center or a program that provides a reward to employees for attending a monthly, no-cost health education seminar.
- "Activity-only" programs are those in which an individual is required to perform or complete an activity related to a health factor in order to obtain a reward. Activity-only wellness programs do not require an individual to attain or maintain a specific health outcome. Examples of activity-only wellness programs include walking, diet, or exercise programs.
- "Outcome-based" programs are those in which an individual must attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward.

Protecting Consumers

In order to protect consumers from unfair practices, the regulations require activity-based and outcome-based wellness programs to follow certain rules, including:

1. Individual employees must have the opportunity to qualify for the reward annually;
2. The reward cannot exceed 30% of the total cost of health-care coverage (with an additional 20% available for programs designed to reduce tobacco use);
3. The program must be reasonably designed to promote health or prevent disease;
4. The full reward must be uniformly available, requiring reasonable alternatives that provides employees identical benefits as the original program; and
5. The employer must provide adequate notice of the plan, its alternatives, and the available benefits.

CONTINUED >>>

ANTI-DISCRIMINATION PROVISIONS

Several provisions of the Affordable Care Act prohibit discrimination including:

SEC. 2716. Prohibition of Discrimination Based On Salary

The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

This does not prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly-situated employees with a higher hourly or annual compensation.

SEC. 2704. Prohibition of Preexisting Condition Exclusions or Other Discrimination Based On Health Status

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

SEC. 2701. Fair Health Insurance Premiums

The premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market may vary with respect to the particular plan or coverage involved only by:

- whether such plan or coverage covers an individual or family;
- geographic area;
- age (limitations apply); and
- tobacco use (limitations apply).

SEC. 2705. Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status

(2) Medical condition (including both physical and mental illnesses)

(3) Claims experience

(4) Receipt of health care

(5) Medical history

(6) Genetic information

(7) Evidence of insurability (including conditions arising out of acts of domestic violence)

(8) Disability

(9) Any other health status-related factor determined appropriate by the Secretary

SEC. 2706. Non-Discrimination in Health Care

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. This section shall not require that a group health plan and health insurance issuer to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.

A group health plan, a health insurance issuer, or the Secretary may establish varying reimbursement rates based on quality or performance measures.

SEC. 1557. Nondiscrimination

In 2016, the Department of Health and Human Services (HHS) issued its "Nondiscrimination in Health Programs and Activities" final rule to clarify and expand discrimination protections under section 1557 of the ACA. Under this final rule, individuals are now protected in health care against discrimination on the basis of:

- Race
- Color
- National Origin
- Age
- Disability
- Sex and Gender Identity

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The Affordable Care Act (ACA)

WHISTLEBLOWER NOTICE

The Affordable Care Act (ACA) contains various provisions to make health insurance more affordable and accountable to consumers. To further these goals, the Affordable Care Act's section 1558 provides protection to employees against retaliation by an employer for reporting alleged violations of Title I of the Act or for receiving a health insurance tax credit or cost sharing reductions as a result of participating in a Health Insurance Exchange, or Marketplace.

Title I includes a range of insurance company accountability requirements, such as the prohibition of lifetime limits on coverage or exclusions due to pre-existing conditions. Title I also includes requirements for certain employers.

An employer may not discharge or in any manner retaliate against an employee because he or she:

- provided information relating to any violation of Title I of the ACA, or any act that he or she reasonably believed to be a violation of Title I of the ACA to the employer, the federal government, or a state attorney general;
- testified, assisted, or participated in a proceeding concerning a violation of Title I of the ACA, or is about to do so; or
- objected to or refused to participate in any activity that he or she reasonably believed to be in violation of Title I of the ACA.

In addition, an employer may not discharge or in any manner retaliate against an employee because he or she received a credit under section 36B of the Internal Revenue Code of 1986 or a cost-sharing reduction under section 1402 of the ACA.

If an employer takes retaliatory action against an employee because he or she engaged in any of these protected activities, the employee can file a complaint with the Occupational Safety and Health Administration (OSHA), the agency charged with whistleblower law enforcement.

Unfavorable Employment Actions

An employer may be found to have violated the ACA if the employee's protected activity was a contributing factor in the employer's decision to take unfavorable employment action against the employee. Such actions may include:

- Firing or laying off
- Blacklisting
- Demoting
- Denying overtime or promotion
- Disciplining
- Denying benefits
- Failure to hire or rehire
- Intimidation
- Making threats
- Reassignment affecting prospects for promotion
- Reducing pay or hours

Deadline for Filing Complaints

Complaints must be filed within 180 days after an alleged violation of the ACA occurs. An employee, or representative of an employee, who believes that he or she has been retaliated against in violation of the ACA should file a complaint with OSHA.

MARKETPLACES AND 4 WAYS TO APPLY FOR COVERAGE

There are four basic ways to apply for health coverage through the Marketplace:

- **Apply online.** Visit HealthCare.gov to get started.
- **Apply by phone.** Call 1-800-318-2596 to apply for a health insurance plan and enroll over the phone (TTY: 1-855-889-4325).
- **Apply in person.** Visit a trained counselor in your community to get information and apply in person. Find help in your area at LocalHelp.HealthCare.gov.
- **Apply by mail.** Complete a paper application and mail it in. You can download the paper application form and instructions from HealthCare.gov.

CONTINUED >>>

The Affordable Care Act (ACA)

SUMMARY OF BENEFITS AND COVERAGE AND UNIFORMED GLOSSARY

Under the Affordable Care Act, health insurers and group health plans are required to provide Americans who have private insurance with clear, consistent, and comparable information about their health plan benefits and coverage. Specifically, the regulations ensure consumers have access to two forms that will help them understand and evaluate their health insurance choices. The forms include:

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Plans and issuers are also required to provide notice of modification in any of the terms of the plan or coverage involved that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage.

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Uniform Glossary of Terms

Under the Affordable Care Act, consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "copayment." To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor (DOL) will also post the glossary on the new health care reform website, www.HealthCare.gov and www.dol.gov/ebsa/healthreform.

If recipients don't speak English, they should be entitled to receive the SBC and uniform glossary in their native language upon request.

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

Employers with group health plans must notify employees residing in any of the 38 states listed below of their eligibility for state Medicaid assistance and/or state child health plan assistance under the Children's Health Insurance Program Reauthorization Act, or CHIPRA.

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)**.

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 January 31, 2024. Contact your State for further information on eligibility –

ALABAMA—Medicaid
Website: http://www.myalhipp.com
Phone: 1-855-692-5447

ALASKA—Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS—Medicaid
Website: http://www.myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA—Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO—Health First Colorado (Colorado's Medicaid Program) & **Child Health Plan Plus (CHP+)**
Health First Colorado Website: https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA—Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA—Medicaid
GA HIPP Website: https://medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/children-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA—Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other—Medicaid
Website: https://www.in.gov/medicaid
Phone 1-800-457-4584

IOWA—Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS—Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY—Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA—Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline)
or 1-855-618-5488 (LaHIPP)

MAINE—Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=e n_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS—Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA—Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI—Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA—Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

NEBRASKA—Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA—Medicaid
Medicaid Website: http://dhcfp.nv.gov Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY—Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK—Medicaid
Website: https://www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA—Medicaid
Website: https://medicaid.ncdhhs.gov Phone: 919-855-4100

NORTH DAKOTA—Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA—Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON—Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS—Medicaid
Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT—Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA—Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON—Medicaid
Website: https://www.hca.wa.gov Phone: 1-800-562-3022

WEST VIRGINIA—Medicaid and CHIP
Website: https://dhhr.wv.gov/bms http://mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN—Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING—Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Telephone: 1-800-251-1269

To see if any more States have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, you can 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.

OMB Control Number 1210-0137

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

Employers with group health plans must notify employees residing in any of the 38 states listed below of their eligibility for state Medicaid assistance and/or state child health plan assistance under the Children's Health Insurance Program Reauthorization Act, or CHIPRA.

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).

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 January 31, 2024. Contact your State for further information on eligibility –

ALABAMA—Medicaid
Website: http://www.myalhipp.com
Phone: 1-855-692-5447

ALASKA—Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS—Medicaid
Website: http://www.myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA—Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322 Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO—Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA—Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA—Medicaid
GA HIPP Website: https://medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA—Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other—Medicaid
Website: https://www.in.gov/medicaid
Phone 1-800-457-4584

IOWA—Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS—Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY—Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA—Medicaid
Website: www.medicaid.la.gov
or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline)
or 1-855-618-5488 (LaHIPP)

MAINE—Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=e n_US
Phone: 1-800-442-6003 TTY: Maine relay 711

CONTINUED >>>

Children's Health Insurance Program (CHIP)

Continued

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS—Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA—Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI—Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA—Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA—Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA—Medicaid
Medicaid Website: http://dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid
Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY—Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK—Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA—Medicaid
Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA—Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA—Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON—Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347,
or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS—Medicaid
Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT—Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427

VIRGINIA—Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON—Medicaid
Website: https://www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA—Medicaid and CHIP
Website: https://dhhr.wv.gov/bms
http://mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN—Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING—Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Telephone: 1-800-251-1269

To see if any more States have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, you can 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

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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.

OMB Control Number 1210-0137

Employee Information

Understanding Your Health Care Options

There are many different types of health benefit plans. The more informed you are, the better your health-care decisions will be. Ask your Human Resources (HR) Manager to provide information to help you match your needs and preferences with the available plans.

Review the Benefits Available
Do the plans offered cover preventive care, well-baby care, vision, or dental care? Are there deductibles? How are pre-existing conditions handled? Answers to these questions can help determine the out-of-pocket expenses you may face. Matching your needs and those of your family members will result in the best possible benefits.

Affordable Care Act
Under the Affordable Care Act (ACA), you may have additional health coverage options through the Health Insurance Marketplace (or "Marketplace"). As of January 1st, 2014, the Marketplace can be used to buy coverage, determine your eligibility to lower your monthly premiums, and to find out what your premium, deductibles, and out-of-pocket costs were before you make a decision to enroll. Beginning October 1st, 2013, all employers subject to the Fair Labor Standards Act (FLSA) were required to provide a notice informing all employees of the Health Insurance Marketplace. Ask your HR manager for your copy of the notice if you joined after this date.

Who is Eligible for Coverage?
Some plans will cover not only the employee, but also family members. Assess who can be covered and the costs associated with each option. Ask questions such as, at what age are dependents no longer covered? Are spouses who work full time eligible for coverage? Are domestic partners eligible for coverage?

Research HMO vs. PPO
Find out if your plan offers a choice of HMO or PPO and analyze which one best fits your situation. With a Health Maintenance Organization (HMO), you will need to receive most or all of your health care from a network provider (PCP). You are required to select a primary care physician, who will provide all your basic healthcare services and, when needed, refer you to a specialist. There are minimal co-payments required under HMOs.

A Preferred Provider Organization (PPO) is a health plan that has contracts with a network of "preferred" providers from which you can choose. You do not need to select a PCP and you do not need referrals to see other providers in the network. While there is more flexibility with which doctors you can see, co-payments for services are generally more than that for an HMO.

Verify That Your Doctors Participate in the Plan
If you have specific doctors that you prefer or specialists that provide treatment, ask to see your health-care providers Physician Directory to see if your doctor is covered under the plan. This information may assist in deciding whether or not to choose an HMO or PPO. In the case of an HMO, it will be necessary to choose a doctor as your PCP.

Flex Spending Options May Help Cover Costs
Some companies offer Flex Benefits which acts as an expense account to help cover costs for qualified medical expenses or child or dependent care. Money is automatically set aside from your salary and is not taxed, saving you up to 40%. Expenses can be paid with a benefit debit card or money can be refunded with a check or direct deposit.

Assess Your Benefit Coverage as Your Family Status Changes
Marriage, divorce, childbirth or adoption, or the death of a spouse are life events that may signal a need to change your health benefits. You, your spouse, and dependent children may be eligible for a special enrollment period under provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Be Aware That Changing Jobs and Other Life Events Can Affect Your Health Benefits
Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you, your covered spouse, and your dependent children may be eligible to purchase extended health coverage under your employer's plan if you lose your job, change employers, get divorced, or upon the occurrence of other events. Federal COBRA law applies to most employers with 20 or more workers and requires your plan to notify you of your rights. Employers in states with "mini-COBRA" laws (affecting those with less than 20 workers) must also provide such notice. Most plans require eligible individuals to make their COBRA election within 60 days of the plan's notice.

If you're changing jobs, HIPAA generally limits pre-existing condition exclusions to a maximum of 12 months (18 months for late enrollees). HIPAA also requires this maximum period to be reduced by the length of time you had prior creditable coverage. You should receive a certificate documenting your prior creditable coverage from your old plan when coverage ends.

Look for Wellness Programs
More and more employers are establishing wellness programs that encourage employees to work out, stop smoking, and generally adopt healthier lifestyles. HIPAA encourages group health plans to adopt wellness programs but also includes protections for employees and dependents from impermissible discrimination based on a health factor. These programs often provide rewards such as cost savings as well as promoting good health.

Read Your Plan's Summary Plan Description (SPD) ... It's a Wealth of Information
Your health plan administrator should provide a copy of its SPD. It outlines your benefits and your legal rights under the Employee Retirement Income Security Act (ERISA), the federal law that protects your health benefits. It should contain information about the coverage of dependents, what services will require a co-pay, and the circumstances under which your employer can change or terminate a health benefits plan. Save the SPD and all other health plan brochures and documents, along with memos or correspondence from your employer relating to health benefits.

Plan for Retirement
Before you retire, find out what health benefits, if any, extend to you and your spouse during your retirement years. Consult with your employer's human resources office, your union, the plan administrator, and check your SPD. Make sure there is no conflicting information among these sources about the benefits you will receive or the circumstances under which they can change or be eliminated. With this information in hand, you can make other important choices, like finding out if you are eligible for Medicare and Medigap insurance coverage.

Know How to File an Appeal if Your Health Benefits Claim is Denied
Understand how your plan handles grievances and where to make appeals of the plan's decisions. Keep records and copies of correspondence. Check your health benefits package and your SPD to determine who is responsible for handling problems with benefit claims. Contact the Employee Benefits Security Administration (EBSA) for customer service assistance if you are unable to obtain a response to your complaint.

Cover Your Mental Health
Many health care plans include an Employee Assistance Program (EAP) which offers employees confidential care with a mental health professional should the need arise. In most cases, this benefit extends to an employee's family members as well.

Employee Information

Understanding Your Health Care Options

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Review the Benefits Available

Do the plans offered cover preventive care, well-baby care, vision, or dental care? Are there deductibles? How are pre-existing conditions handled? Answers to these questions can help determine the out-of-pocket expenses you may face. Matching your needs and those of your family members will result in the best possible benefits.

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If you have specific doctors that you prefer or specialists that provide treatment, ask to see your health-care provider's Physician Directory to see if your doctor is covered under the plan. This information may assist in deciding whether or not to choose an HMO or PPO. In the case of an HMO, it will be necessary to choose a doctor as your PCP.

Flex Spending Options May Help Cover Costs

Some companies offer Flex Benefits which acts as an expense account to help cover costs for qualified medical expenses or child or dependent care. Money is automatically set aside from your salary and is not taxed, saving you up to 40%. Expenses can be paid with a benefit debit card or money can be refunded with a check or direct deposit.

CONTINUED >>>

Employee Health Insurance Information

Assess Your Benefit Coverage as Your Family Status Changes

Marriage, divorce, childbirth or adoption, or the death of a spouse are life events that may signal a need to change your health benefits. You, your spouse, and dependent children may be eligible for a special enrollment period under provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Be Aware That Changing Jobs and Other Life Events Can Affect Your Health Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you, your covered spouse, and your dependent children may be eligible to purchase extended health coverage under your employer's plan if you lose your job, change employers, get divorced, or upon the occurrence of other events. Federal COBRA law applies to most employers with 20 or more workers and requires your plan to notify you of your rights. Employers in states with "mini-COBRA" laws (affecting those with less than 20 workers) must also provide such notice. Most plans require eligible individuals to make their COBRA election within 30 days of the plan's notice.

If you're changing jobs, HIPAA generally limits pre-existing condition exclusions to a maximum of 12 months (18 months for late enrollees). HIPAA also requires this maximum period to be reduced by the length of time you had prior creditable coverage. You should receive a certificate documenting your prior creditable coverage from your old plan when coverage ends.

Look for Wellness Programs

More and more employers are establishing wellness programs that encourage employees to work out, stop smoking, and generally adopt healthier lifestyles. HIPAA encourages group health plans to adopt wellness programs but also includes protections for employees and dependents from impermissible discrimination based on a health factor. These programs often provide rewards such as cost savings as well as promoting good health.

Read Your Plan's Summary Plan Description (SPD) … It's a Wealth of Information

Your health plan administrator should provide a copy of its SPD. It outlines your benefits and your legal rights under the Employee Retirement Income Security Act (ERISA), the federal law that protects your health benefits. It should contain information about the coverage of dependents, what services will require a co-pay, and the circumstances under which your employer can change or terminate a health benefits plan. Save the SPD and all other heath plan brochures and documents, along with memos or correspondence from your employer relating to health benefits.

Plan for Retirement

Before you retire, find out what health benefits, if any, extend to you and your spouse during your retirement years. Consult with your employer's human resources office, your union, the plan administrator, and check your SPD. Make sure there is no conflicting information among these sources about the benefits you will receive or the circumstances under which they can change or be eliminated. With this information in hand, you can make other important choices, like finding out if you are eligible for Medicare and Medigap insurance coverage.

Know How to File an Appeal if Your Health Benefits Claim is Denied

Understand how your plan handles grievances and where to make appeals of the plan's decisions. Keep records and copies of correspondence. Check your health benefits package and your SPD to determine who is responsible for handling problems with benefit claims. Contact the Employee Benefits Security Administration (EBSA) for customer service assistance if you are unable to obtain a response to your complaint.

Cover Your Mental Health

Many health care plans include an Employee Assistance Program (EAP) which offers employees confidential care with a mental health professional should the need arise. In most cases, this benefit extends to an employee's family members as well.