Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
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PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either - submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Dixie County Board of County Commissioners	4. Employer Identification Number (EIN) 59-6000587	
5. Employer address 24 NE 35 Hwy Suite H	6. Employer phone number	
7. City Cross City	8. State Florida	9. ZIP code 32628
10. Who can we contact about employee health coverage at this job? Angela Crowley		
11. Phone number (if different from above) 352-498-206	12. Email address HRAdmin@dixiecounty.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  All employees. Eligible employees are:

  X Full Time Employees

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  X☐ We do offer coverage. Eligible dependents are:

  Legal Dependents

  ☐ We do not offer coverage.

X☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Important Notice from Dixie County Board of County Commissioners About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Dixie County Board of County Commissionershas determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Dixie County Board of County Commissioners coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Dixie County Board of County Commissioners coverage, be aware that you and your dependents willbe able to get this coverage back as an active employee and will not for retirees.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Dixie County Board of County Commissionersvand don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information [or call [Insert Alternative Contact] at [(XXX) XXX-XXXX]. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [Insert Name of Entity] changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

[7

Name of Entity/Sender:Dixie County Board of County Commissioners

Contact--Position/ : Angela Crowley
Phone Number: 352-498-1206

ACA Eligibility

Your Eligibility: You are eligible for health care benefits under the Plan if you are a full-time employee. For purposes of the Plan's health care benefits, a full-time employee is an employee who is employed, on average, for at least 30 hours of service per week.

Unless otherwise communicated to you by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, contract employees, part-time employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Company's payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Look-back Measurement Method for Determining Full-time Employee Status:

The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- ❑ X All employees;
- ❑ Salaried employees;
- ❑ Hourly employees;
- ❑ Employees in the following state(s):
- ❑ _____;
- ❑ • All collectively bargained employees;
- ❑ • All non-collectively bargained employees;
- ❑ All collectively bargained employees covered by the following bargaining agreement(s): _____.

The **look-back measurement method** involves ***three different periods***:

1. A ***measurement period*** is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

    a. If you are an **ongoing employee**, this measurement period is called the "***standard measurement period***." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care

benefits for the stability period that follows the standard measurement period and any administrative period.

b. If you are a **new variable hour, seasonal or part-time employee**, this measurement period is called the "***initial measurement period.***" Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

c. if you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a **full-time employee** who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

2. The ***stability period*** is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

3. An ***administrative period*** is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation. The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Patient's Bill of Rights

The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new "Patient's Bill of Rights" gives the American people the stability and flexibility they need to make informed choices about their health.
View **Key Features of the Affordable Care Act** or read a **year-by-year overview of features**.

Coverage

- **Ends Pre-Existing Condition Exclusions for Children**: Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- **Keeps Young Adults Covered:** If you are under 26, you may be eligible to be covered under your parent's health plan.
- **Ends Arbitrary Withdrawals of Insurance Coverage**: Insurers can no longer cancel your coverage just because you made an honest mistake.
- **Guarantees Your Right to Appeal**: You now have the right to ask that your plan reconsider its denial of payment.

Costs

- **Ends Lifetime Limits on Coverage:** Lifetime limits on most benefits are banned for all new health insurance plans.
- **Reviews Premium Increases**: Insurance companies must now publicly justify any unreasonable rate hikes.
- **Helps You Get the Most from Your Premium Dollars**: Your premium dollars must be spent primarily on health care – not administrative costs.

Care

- **Covers Preventive Care at No Cost to You**: You may be eligible for recommended preventive health services. No copayment.
- **Protects Your Choice of Doctors:** Choose the primary care doctor you want from your plan's network.
- **Removes Insurance Company Barriers to Emergency Services**: You can seek emergency care at a hospital outside of your health plan's network.

For More Information

- Read the Full Law
- Find detailed technical and regulatory information on the Patient's Bill of Rights.

CHIPRA

The Children's Health Insurance Program Reauthorization Act (CHIPRA) extends and expands the state Children's Health Insurance Program (CHIP). The following key provisions affect group health plans. Employers and group health plan administrators should note that some obligations were required to be complied with by April 1, 2009.

Premium Assistance Subsidy for Employer Coverage

States may elect to offer a premium assistance subsidy to help CHIP and Medicaid eligible children obtain "qualified employer-sponsored coverage". The subsidy may be provided as a reimbursement directly to the employee or as a direct payment to the employer. Employers can opt-out of direct payments.

Notice to Employees of Premium Assistance

Special Update: The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) has released an updated model notice for employers to provide information on eligibility for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP). Employers that provide coverage in states with premium assistance through Medicaid or CHIP must inform employees of potential opportunities for assistance in obtaining health coverage. The updated model notice includes information on how employees can contact their state for additional information and how to apply for premium assistance.

The employer CHIP notice must be provided annually before the start of each plan year. An employer may provide the notice applicable to the state in which an employee resides concurrent with the furnishing of:

- Materials notifying the employee of health plan eligibility;
- Materials provided to the employee in connection with an open season or election process conducted under the plan; or
- The summary plan description.

To download the updated CHIP model notice, please click on the link below.

- Model Employer CHIP Notice

Disclosure to States

Plan administrators of group health plans are required to disclose information about the plan to State Medicaid and CHIP programs upon request. The Departments of Labor and Health and Human Services are required to develop a model disclosure form for plan administrators.
Before enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), employees and their dependents who became eligible for employment-based group health plan coverage, but did not enroll when first given the opportunity, had no guaranteed right under Federal law to join the group health plan if their circumstances changed at a later time. Even if the plan offered an annual open enrollment period, the individual would not only have to wait until that period, but enrollment during that period could be considered a “late enrollment” subject to a higher premium or restricted benefits.

Special Enrollment

CHIPRA provides that group health plans and health insurance issuers must permit employees and their dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

1. Losing eligibility for coverage under a State Medicaid or CHIP program, or
2. Becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage, or within 60 days of being determined to be eligible for premium assistance.
For more information and guidance regarding CHIPRA, click here.

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

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

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

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

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

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 July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Declaración de la Ley de Reducción de Trámites

Según la Ley de Reducción de Trámites de 1995 (Ley Pública 104-13) (PRA, por sus siglas en inglés), no es obligatorio que ninguna persona responda a una recopilación de información, a menos que dicha recopilación tenga un número de control válido de la Oficina de Administración y Presupuesto (OMB, por sus siglas en inglés). El Departamento advierte que una agencia federal no puede llevar a cabo ni patrocinar una recopilación de información, a menos que la OMB la apruebe en virtud de la ley PRA y esta tenga un número de control actualmente válido de la oficina mencionada. El público no tiene la obligación de responder a una recopilación de información, a menos que esta tenga un número de control actualmente válido de la OMB. Consulte la Sección 3507 del Título 44 del Código de Estados Unidos (USC). Además, sin perjuicio de ninguna otra disposición legal, ninguna persona quedará sujeta a sanciones por no cumplir con una recopilación de información, si dicha recopilación no tiene un número de control actualmente válido de la OMB. Consulte la Sección 3512 del Título 44 del Código de Estados Unidos (USC).

Se estima que el tiempo necesario para realizar esta recopilación de información es, en promedio, de aproximadamente siete minutos por persona. Se anima a los interesados a que envíen sus comentarios con respecto al tiempo estimado o a cualquier otro aspecto de esta recopilación de información, como sugerencias para reducir este tiempo, a la dependencia correspondiente del Ministerio de Trabajo de EE. UU., a la siguiente dirección: 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. También pueden enviar un correo electrónico a ebsa.opr@dol.gov y hacer referencia al número de control de la OMB 1210-0137.

Número de Control de OMB 1210-0137 (caduca el 31/12/2016)

ERISA Special Enrollment

2590.701-6 Special enrollment periods.
(a) ***Special enrollment for certain individuals who lose coverage—***
(1) ***In general.*** A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 2590.701-2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.
(2) ***Individuals eligible for special enrollment—***
(i) ***When employee loses coverage.*** A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—
(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;
(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.
(ii) ***When dependent loses coverage—***
(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—
(*1*) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(*2*) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(*3*) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

Special Enrollment under HIPAA

Under HIPAA, certain events that happen to employees or their dependents trigger a right to "special enroll" in your employer-sponsored group health plan. Special enrollment generally means that the employee or dependent will have 30 days from the date of the event to request coverage in your group health plan, **regardless of your open enrollment period**. Special enrollment rights under HIPAA arise out of:

- The loss of **other** health coverage; or an employer terminating contributions toward health coverage; and
- A person becoming a new dependent through
    - Marriage;
    - Birth;
    - Adoption; or
    - Placement for adoption

Loss of Other Health Coverage

When one of your employees, or a dependent of an employee, loses **other** health coverage, a special enrollment opportunity in your group health plan may be triggered.
To have a special enrollment opportunity as a result of losing other health coverage:

- The employee or dependent must have had other health coverage when he or she previously declined coverage under your group health plan.
- If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted.
- If the other coverage was not COBRA continuation coverage, special enrollment can be requested when the individual **loses eligibility** for the other coverage.

Events Related to Losing Health Coverage

Some examples of events that cause an individual to lose eligibility for health coverage include:

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan because of age, work, or school status;
- Death of the employee covered by the plan;
- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals;
- An individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

Termination of Employer Contributions

If an employer terminates all contributions to a group health plan, but individuals have the option to continue coverage and pay 100% of the cost themselves, these individuals have a special enrollment right because the employer has terminated contributions. Thus, if all employer contributions have ended, individuals covered under the plan would have a special enrollment right, regardless of their option to continue coverage under the plan by paying the full cost of coverage.

30 Days to Request Special Enrollment

If a plan must offer special enrollment due to a loss of eligibility or termination of employer contributions, the plan must provide at least 30 days for the employee or dependent to request coverage after the loss of other coverage or termination of employer contributions.
In addition, the resulting coverage must be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

New Dependent

A special enrollment opportunity may also be triggered when a person becomes a new dependent through marriage, birth, adoption or placement for adoption.
For each triggering event, a special enrollee may not be treated as a late enrollee. Therefore, the maximum pre-existing condition exclusion period that may be applied to a special enrollee is 12 months, and the 12 months are reduced by the special enrollee's prior creditable coverage.

Person Becoming a New Dependent- 30 Days to Request Special Enrollment

If a special enrollment opportunity is available, the individual must request special enrollment within 30 days of the marriage, birth, adoption or placement for adoption that triggered the special enrollment opportunity.

- In the case of marriage, enrollment is required to be effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan.
- In the case of birth, adoption or placement for adoption, enrollment is required to be effective not later than the date of such birth, adoption or placement for adoption.

No Pre-Existing Conditions for Children Acquiring Coverage Through Special Enrollment

A newborn, adopted child under 18 or child under 18 placed for adoption cannot be subjected to a pre-existing condition exclusion period if the child is enrolled within 30 days of birth, adoption or placement for adoption and has no subsequent significant break in coverage.

Requirement to Disclose Individuals' Special Enrollment Rights

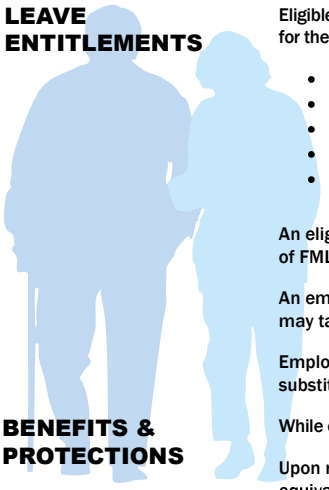
A description of special enrollment rights must be provided to employees at the time or before they are offered the opportunity to enroll in the group health plan. **Special enrollment notice may be provided in the summary plan description (SPD)** if the SPD is provided to the employee at the time or before the employee is initially offered the opportunity to enroll in the plan. If the SPD is provided at a later time, the special enrollment notice should be provided separately (for example, as part of the application for coverage).

Plans that qualify as "excepted benefits" do not have to offer special enrollment.

Please note that employees or dependents must be given 60 days to request enrollment if they lose Medicaid or Children's Health Insurance Program (CHIP, formerly known as the State Children's Health Insurance Program or SCHIP) coverage by losing eligibility or becoming eligible for Medicaid or CHIP assistance with group health plan premiums. See the CHIPRA compliance activity for more information.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

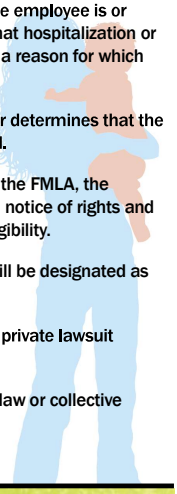
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

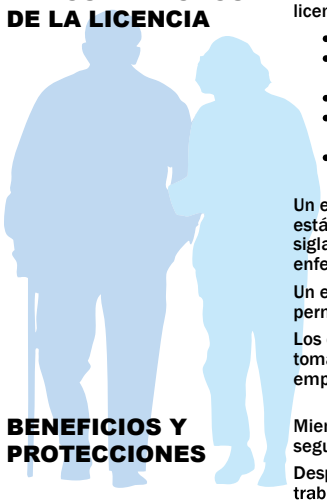
www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

DERECHOS DEL EMPLEADO
SEGÚN LA LEY DE AUSENCIA FAMILIAR Y MÉDICA

DIVISIÓN DE HORAS Y SALARIOS DEL DEPARTAMENTO DE EE. UU.



DE LOS DERECHOS DE LA LICENCIA

Los empleados elegibles que trabajan para un empleador sujeto a esta ley pueden tomarse hasta 12 semanas de licencia sin sueldo sin perder su empleo por las siguientes razones:

- El nacimiento de un hijo o la colocación de un hijo en adopción o en hogar de crianza;
- Para establecer lazos afectivos con un niño (la licencia debe ser tomada dentro del primer año del nacimiento o la colocación del niño);
- Para cuidar al cónyuge del empleado, al hijo, o al padre que tenga un problema de salud serio que califique;
- Debido a un problema de salud serio del mismo empleado que califique y que resulte en que el empleado no pueda realizar su trabajo;
- Por exigencias que califiquen relacionadas con el despliegue de un miembro de las fuerzas armadas que sea cónyuge del empleado, hijo o padre.

Un empleado elegible que es cónyuge, hijo, padre o familiar más cercano del miembro de las fuerzas armadas que está cubierto, puede tomarse hasta 26 semanas de licencia bajo la Ley de Ausencia Familiar y Médica (FMLA, por sus siglas en inglés) en un periodo de 12 meses para cuidar al miembro de las fuerzas armadas que tenga una lesión o enfermedad seria.

Un empleado no tiene que tomarse la licencia de una sola vez. Cuando es medicamente necesario o de otra manera permitido, los empleados pueden tomarse la licencia de forma intermitente o en una jornada reducida.

Los empleados pueden elegir, o un empleador puede exigir, el uso de licencias pagadas acumuladas mientras se toman la licencia bajo la FMLA. Si un empleado sustituye la licencia pagada acumulada por la licencia bajo la FMLA, el empleado tiene que respetar las políticas de pago de licencias normales del empleador.

BENEFICIOS Y PROTECCIONES

Mientras los empleados estén de licencia bajo la FMLA, los empleadores tienen que continuar con la cobertura del seguro de salud como si los empleados no estuvieran de licencia.

Después de regresar de la licencia bajo la FMLA, a la mayoría de los empleados se les tiene que restablecer el mismo trabajo o uno casi idéntico, con el pago, los beneficios y otros términos y otras condiciones de empleo equivalentes.

Un empleador no puede interferir con los derechos de la FMLA de un individuo o tomar represalias contra alguien por usar o tratar de usar la licencia bajo la FMLA, oponerse a cualquier práctica ilegal hecha por la FMLA, o estar involucrado en un procedimiento según o relacionado con la FMLA.

REQUISITOS DE ELEGIBILIDAD

Un empleado que trabaja para un empleador cubierto tiene que cumplir con tres criterios para poder ser elegible para una licencia bajo la FMLA. El empleado tiene que:

- Haber trabajado para el empleador por lo menos 12 meses;
- Tener por lo menos 1,250 horas de servicio en los 12 meses previos a tomar la licencia*; y
- Trabajar en el lugar donde el empleador tiene al menos 50 empleados dentro de 75 millas del lugar de trabajo del empleado.

*Requisitos especiales de “horas de servicio” se aplican a empleados de una tripulación de una aerolínea.

PEDIDO DE LA LICENCIA

En general, los empleados tienen que pedir la licencia necesaria bajo la FMLA con 30 días de anticipación. Si no es posible avisar con 30 días de anticipación, un empleado tiene que notificar al empleador lo más pronto posible y, generalmente, seguir los procedimientos usuales del empleador.

Los empleados no tienen que informar un diagnóstico médico, pero tienen que proporcionar información suficiente para que el empleador pueda determinar si la ausencia califica bajo la protección de la FMLA. La información suficiente podría incluir informarle al empleador que el empleado está o estará incapacitado para realizar sus funciones laborales, que un miembro de la familia no puede realizar las actividades diarias, o que una hospitalización o un tratamiento médico es necesario. Los empleados tienen que informar al empleador si la necesidad de la ausencia es por una razón por la cual la licencia bajo la FMLA fue previamente tomada o certificada.

Los empleadores pueden exigir un certificado o una recertificación periódica que respalde la necesitad de la licencia. Si el empleado determina que la certificación está incompleta, tiene que proporcionar un aviso por escrito indicando qué información adicional se requiere.

RESPONSABILIDADES DEL EMPLEADOR

Una vez que el empleador tome conocimiento que la necesidad de la ausencia del empleado es por una razón que puede calificar bajo la FMLA, el empleador tiene que notificar al empleado si él o ella es elegible para una licencia bajo FMLA y, si es elegible, también tiene que proporcionar un aviso de los derechos y las responsabilidades según la FMLA. Si el empleado no es elegible, el empleador tiene que brindar una razón por la cual no es elegible.

Los empleadores tienen que notificar a sus empleados si la ausencia será designada como licencia bajo la FMLA, y de ser así, cuánta ausencia será designada como licencia bajo la FMLA.

CUMPLIMIENTO

Los empleados pueden presentar un reclamo ante el Departamento de Los empleados Los Los empleados pueden presentar un reclamo ante el Departamento de Trabajo de EE. UU., la División de Horas y Salarios, o pueden presentar una demanda privada contra un empleador.

La FMLA no afecta a ninguna ley federal o estatal que prohíba la discriminación ni sustituye a ninguna ley estatal o local o convenio colectivo de negociación que proporcione mayores derechos de ausencias familiares o médicas.

Para información adicional o para presentar un reclamo:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

Departamento de Trabajo de los EE.UU. | División de Horas y Salarios

WHD DIVISIÓN DE HORAS Y SALARIOS

WH1420 SPA REV 04/16

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—October 2008