NEW BRUNSWICK PUBLIC SCHOOLS

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Benefits Guide

2027

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Dear New Brunswick Public Schools Employee,

At New Brunswick Public Schools we're committed to providing benefits that support you and your family through every stage of life. This guide is designed to help you understand your options and make informed decisions about the coverage that's right for you.

As you review your benefits, consider your personal needs, your dependents, and how you typically use healthcare and other services. Choosing the right coverage can help you manage costs and get the most value from your benefits throughout the year.

What to expect in this guide:

- Overview of available benefits and coverage options
- Key plan details, including costs and coverage levels
- Resources to help you make confident decisions

Health insurance is undeniably complicated and full of terms and concepts that may be unfamiliar. Visit healthcare.gov to review the glossary of commonly used insurance terms.

If you have questions or need help along the way, support is available to guide you through your options and enrollment.

This benefit summary provides selected highlights of the employee benefits program available. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Our company reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

Help starts here

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your benefits issues such as:

- Benefits questions
- ID card requests
- Precertification support
- Claims resolution
- Prescription issues
- Provider network questions
- ...and much more!

For service that's confidential and responsive, contact:

answers@benefitsvip.com
866.286.5354
Monday - Friday,
8:30am-8:00pm (ET)

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

BenefitsVIP
Help starts here.



BenefitsVIP.com
Request member assistance and order ID cards with a click.



HealthDiscovery.org
Get vital, useful and fun health insurance and wellness facts.

Eligibility

You are eligible to enroll in benefits if you are a full-time employee regularly scheduled to work at least **30 hours per week**.

You may also cover your eligible dependents, which include:

- Your legal spouse
- Your children up to age 26, including biological, stepchildren and adopted children
- Children over age 26 who are mentally or physically disabled and dependent on you for support
- Unmarried children ages 26-31 may be eligible under the provisions of Chapter 375 (Dependent to Age 31), if certain eligibility standards are met

Enrollment

To enroll, please complete and return all required forms to Carol Chacon. If you have any questions or need assistance, Carol can be reached at 732-745-5300 x5424 or via email at carol_chacon@nbpsnj.net. Please refer to the cost sheet to calculate your share of the premium.

If you're enrolling during Open Enrollment:

- The open enrollment period typically occurs in November
- Coverage elected during open enrollment will be effective 1/1/2027

For newly hired Employees:

- Benefits begin immediately upon hire. Every new employee has ten (10) days to complete paperwork for benefits. If you do not return the paperwork, you will be force enrolled in the Educators Health Plan for you as the employee only, and you will be charged accordingly for those benefits. Once you've completed enrollment in a medical or dental plan, you'll need to submit documents that confirm dependent eligibility (such as marriage/birth certificate, federal tax return proving dependency).
- If you opt to waive coverage, you must submit proof of other coverage.

Qualified life events

Once you have made your benefit elections, changes cannot be made until the next enrollment period unless you experience a qualifying life event. Examples of qualifying life events include, but are not limited to, marriage, divorce, the birth or adoption of a child, or gaining or losing other health coverage. Documentation supporting the qualifying life event will be required before any changes can be processed.

You have 30 days from the date of the qualifying life event to request a coverage change. For most qualifying life events, coverage becomes effective on the first day of the month following receipt of the enrollment request and supporting documentation. For newborns, coverage is effective as of the date of birth.

Child between ages 26-31?

The State of NJ has enacted legislation that extends eligibility for medical coverage (not including Rx coverage) for certain dependents. Under this regulation, your dependent may be eligible to maintain coverage under your benefit plan until the dependent reaches their 31st birthday. Please note that prescription drug coverage is only available through COBRA.

There will be a cost associated with the addition of this individual to your benefit plan. This additional cost will be charged to you or your Chapter 375 Dependent. In order to maintain this coverage, you must continue to provide the required contributions for the duration of the policy. Failure to provide these funds will result in your Chapter 375 Dependent's removal from the plan.

For more information or to enroll:

- Cigna enrollees should call call Cigna directly at 800-315-6011
- Aetna enrollees should contact Carol Chacon, Benefits Coordinator at 732-745-5300 x5424

Dependents must meet the below criteria to be eligible:

- Under the age of 31;
- Unmarried;
- Without dependents of their own;
- A resident of NJ or a full-time student at an accredited school in any state or country;
- Not covered by another plan and cannot be entitled to Medicare.

We offer a variety of medical plan options through **Aetna and Cigna** to provide flexibility and choice. While all plans offer similar core benefits and coverage levels, you may select the carrier and provider network that best meets your needs and preferences. Please refer to the cost sheet to calculate your share of the premium.

Employees hired on or after July 1, 2020 may choose from two medical plan options:

- The Garden State Plan (GSP) offers a limited New Jersey-based network; there is no coverage available outside of the state of New Jersey, except in emergency situations. You may see any doctor in the network without a referral.
- The Educators Health Plan (EHP) provides nationwide access and allows you the freedom to see any doctor in the network without a referral. All out-of-network reimbursements are subject to reasonable & customary allowances as determined by the carrier.

Employees hired before July 1, 2020 may choose from four medical plan options:

You may choose from the options described above or enroll in a Point of Service (POS) plan

- The Aetna POS plan offers predictable copays for most in-network services. You may see any doctor in the network without a referral.
- Under the Cigna POS plan, you may pay a copay or be responsible for any applicable deductible and coinsurance, depending on the in-network service received. You must choose a Primary Care Physician (PCP), and referrals are required to see specialists.

Member portal

Register via aetna.com or mycigna.com or through the mobile app. The portal provides convenient access to a variety of tools and resources to help you manage your healthcare benefits. You can search for in-network providers, review your benefit information, estimate out-of-pocket costs for medical services based on your location and procedure, view Explanation of Benefits (EOB) statements, and access electronic ID cards whenever you need them. The portal is a valuable resource for understanding and making the most of your health plan.

ID cards

Cigna does not issue physical ID cards. You may access electronic cards via mycigna.com. Aetna cards should be received within ten business days after your application is processed.

Lab network

The preferred lab network is LabCorp or Quest.

Your prescription drug coverage is included as part of your medical plan. Prescription coverage for all plans is provided by Cigna. The tables on the medical plan pages outline your specific costs based on the type of medication and how it's filled, which will determine what you pay for prescriptions.

Visit mycigna.com to review the Prescription Drug List (Value) to determine which tier applies and confirm if any drug management programs apply. Some medications require prior authorization (PA) before they're covered by the plan. If a PA is needed, your doctor must provide additional information for the insurance company to review before coverage can be approved. If notified that a PA is required, contact your doctor's office as soon as possible, as the review process may take several days.

Most plans group medications into tiers:

- **Generic medications**: lower-cost options that offer the same effectiveness as brand-name drugs
- **Preferred brand-name medications**: covered at a higher cost than generics
- **Non-preferred or specialty medications:** typically the highest cost, depending on the medication

You can fill prescriptions at participating retail pharmacies or, for certain medications, through mail-order services. Mail-order may offer added convenience and cost savings for ongoing prescriptions.

To help manage your costs:

- Ask your provider if a generic or preferred option is available
- Use in-network pharmacies
- Consider mail-order for maintenance medications
- Visit goodrx.com and/or the manufacturer website for cost saving programs

Note for GSP & EHP enrollees:

For brand-name drugs with generic equivalents available, the plan will pay the cost of the generic equivalent. Members who choose to fill the prescription with the brand-name drug will be responsible for the difference in the cost of the prescription. Specialty drugs must be filled via Accredo (Cigna's Home Delivery specialty pharmacy vendor).

Note for POS enrollees:

For specified maintenance medications, you must obtain a 90-day prescription (filled at a retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the entire cost of the prescription. Specialty drugs must be filled via Accredo (Cigna's Home Delivery specialty pharmacy vendor).

	Aetna Garden State Plan *(NJ Only Access)* **Designated NJ Providers**	Aetna or Cigna Educators Health Plan *(National Access)* **In-Network**
Annual Deductible Calendar year	$0 Individual $0 Family	$0 Individual $0 Family
Annual Out-of-Pocket Max	$500 Individual $1,000 Family	$500 Individual $1,000 Family
Physicians Services		
Primary Care	$10 copay	$10 copay
Specialist Visit	$15 copay	$15 copay
Preventive Care	Covered in full, no deductible	Covered in full, no deductible
Hospital Services		
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%
Outpatient Surgery	Plan pays 100%	Plan pays 100%
Tests		
Advanced Imaging	Plan pays 100%	Plan pays 100%
Lab	Plan pays 100%	Plan pays 100%
Urgent / Emergency Care Visits		
Urgent Care	$15 copay	$15 copay
Emergency Room	$125 copay	$125 copay
Prescriptions (Retail 30-day supply) - Cigna administers Rx for all plans		
Generic	$5 copay	$5 copay
Brand w/ no generic available	$10 copay	$10 copay
Brand w/ generic available	Member pays difference	Member pays difference
Vision Services		
Eye Exam	$15 copay / 12 months	$15 copay / 12 months
Hardware	Not Covered	Not Covered
	Non Designated NJ Providers	**Out-of-Network**
Annual Deductible Calendar year	$350 Individual $700 Family	$350 Individual $700 Family
Coinsurance	Plan pays 70% after deductible	Plan pays 70% after deductible
Annual Out-of-Pocket Max	$2,000 Individual $5,000 Family	$2,000 Individual $5,000 Family

Certain services may require prior authorization. See the detailed benefit summary or contact BenefitsVIP for more information.

	Aetna POS *(National Access)*	Cigna POS *(National Access)*
	In-Network	**In-Network**
Annual Deductible Calendar year	$0 Individual $0 Family	$250 Individual $500 Family
Annual Out-of-Pocket Max	$1,500 Individual $3,000 Family	$1,000 Individual $2,000 Family
Physicians Services		
Primary Care	$10 copay	$15 copay
Specialist Visit	$20 copay	$35 copay
Preventive Care	Covered in full, no deductible	Covered in full, no deductible
Hospital Services		
Inpatient Hospitalization	Plan pays 100%	Plan pays 100% after deductible
Outpatient Surgery	Plan pays 100%	Plan pays 100% after deductible
Tests		
Advanced Imaging	Plan pays 100%	Plan pays 100% after deductible
Lab	Plan pays 100%	Plan pays 100%
Urgent / Emergency Care Visits		
Urgent Care	$25 copay	$25 copay
Emergency Room	$25 copay	$50 copay
Prescriptions (Retail 30-day supply) - Cigna administers Rx for all plans		
Tier 1: Generic	$10 copay	$10 copay
Tier 2: Preferred Brand	$20 copay	$20 copay
Tier 3: Non-Preferred Brand	$40 copay	$40 copay
Vision Services		
Eye Exam	Covered in full / 12 months	$5 copay / 12 months
Hardware	$70 reimbursement / 24 months	$20-75 reimbursement / 12 months
	Out-of-Network	**Out-of-Network**
Annual Deductible Calendar year	$5,000 Individual $15,000 Family	$500 Individual $1,000 Family
Coinsurance	Plan pays 50% after deductible	Plan pays 80% after deductible
Annual Out-of-Pocket Max	$10,000 Individual $30,000 Family	$1,000 Individual $2,000 Family

Certain services may require prior authorization. See the detailed benefit summary or contact BenefitsVIP for more information.

How much you pay depends on the care you receive and how you use your plan. Staying in-network is one of the easiest ways to manage your costs. Providers in the network have negotiated rates, which typically means lower out-of-pocket expenses.

As a reminder, the Garden State Plan (GSP) offers a limited New Jersey-based network; there is no coverage available outside of the state of New Jersey, except in emergency situations.

Aetna Enrollees

- **Garden State Plan**: To receive the highest benefit level, members in all counties (except Ocean, Monmouth and Cape May) may choose providers in the Aetna Whole Health New Jersey Open Access Managed Choice network; For Members in Ocean, Monmouth and Cape May, you may choose providers in the Savings Plus New Jersey Open Access Managed Choice network
- **Educators Health Plan**: To receive the highest benefit level, select providers in the Managed Choice POS Open Access network
- **POS**: To receive the highest benefit level, select providers in the Managed Choice POS Open Access network

Cigna Enrollees

- **Educators Health Plan**: To receive the highest benefit level, select providers in the Open Access Plus network
- **POS**: To receive the highest benefit level, select providers in the Seamless Metro NY network

Find in-network providers

To find in-network providers or view your plan details, visit aetna.com or mycigna.com.

Before receiving care, it's a good idea to review your plan details and confirm whether services require prior approval.

Telemedicine

Virtual care gives you access to a licensed provider by phone or video—so you can get care without going to a doctor's office. It's a convenient option for everyday health needs, whether you're at home, at work, or traveling.

What's covered

Virtual care can be used for a range of non-emergency conditions, including:

- Cold, flu, and sinus symptoms
- Allergies and minor infections
- Skin conditions and rashes
- Prescription refills and general medical questions

Access care

Visit aetna.com or mycigna.com or the mobile app to register and access telemedicine and virtual care services by phone or video.

Keep in mind

Virtual care is not appropriate for emergencies. If you're experiencing a medical emergency, call 911 or go to the nearest emergency room.

Choose the Right Care

When you need medical care, understanding your options and choosing the most appropriate level of care is important for both your health and your wallet. Seeking care in the right setting can help you receive timely treatment while avoiding unnecessary costs and delays.

- Telemedicine $
- Primary Care $$
- Urgent Care $$$
- Emergency Room $$$$

A Flexible Spending Account (FSA) allows you to set aside pre-tax money to pay for eligible healthcare and dependent care expenses. Your contributions are deducted from your paycheck before taxes, helping reduce your taxable income.

You must enroll in your FSA each year to continue contributing. The plan runs on a calendar year.

Healthcare FSA

- Use it for eligible medical, dental, and vision expenses, including doctors visits, prescriptions, physical therapy, dental care, vision exams, glasses, and contacts
- You can contribute up to the IRS maximum
- A grace period is available; you have an additional 2½ months after the end of the plan year to incur eligible expenses and use any remaining FSA funds. Expenses must be incurred during the grace period to be eligible for reimbursement. Any unused funds remaining after the grace period will be forfeited in accordance with IRS rules.

Dependent Care FSA

- Use for eligible dependent care expenses, including childcare, before or after-school programs, summer day camps, or care for a dependent adult while you work
- You can contribute up to the IRS maximum
- Elect carefully: Funds must be used within the plan year and cannot be rolled over

Commuter FSA

- Use for eligible commuting expenses, including public transportation (bus, train, or subway) and qualified parking
- You can contribute up to the IRS maximum

Online Access

Register via isolvedbenefitservices.com for the member portal or through the mobile app. Through the portal, you can view your account balance and transaction history, submit and track claims, and access important alerts, notices, and communications.

Debit Card

You can use your Prepaid Benefits Card to pay your providers for eligible healthcare expenses or pay with your personal funds and submit a claim for reimbursement.

You must save all receipts from purchases. The carrier may request that you substantiate your purchases.

FSA Store

Use your FSA dollars on thousands of pre-approved eligible products.

Shop now at fsastore.com.

Dental benefits are administered by Cigna

We offer two dental plan options, allowing you to choose the coverage that best meets your needs. Please refer to the cost sheet to calculate your share of the premium.

PPO Network access

- For PPO, if you visit an in-network provider, your costs will be lower. You can choose a provider in the network (Total Cigna DPPO) via mycigna.com.
- Out-of-network benefits are typically based on the 90th percentile of charges in your area, meaning the plan pays based on what most dentists charge for a service. If your dentist charges more than that amount, you are responsible for the difference.

DMO Network access

- You must choose a Primary Care Dentist (PCD). The DMO requires members to use participating providers, as out-of-network benefits are not available. You can choose a provider in the network (Cigna Dental Care Access) via mycigna.com.

ID cards

Cigna does not issue physical ID cards. You may access electronic cards via mycigna.com.

	PPO In-Network	DMO In-Network Only
Annual Deductible Calendar Year	$0 Individual $0 Family	$0 Individual $0 Family
Annual Plan Maximum	$1,500 per individual	Per patient charge schedule
Diagnostic & Preventive	Plan pays 80%	Per patient charge schedule
Restorative	Plan pays 60%	Per patient charge schedule
Orthodontia *(Adults and dependent children)*	Plan pays 60%	Per patient charge schedule
Orthodontia Lifetime Maximum	$750 per individual	Per patient charge schedule
Out-of-Network Reimbursement Level	90th Percentile (Highest reimbursement)	In-Network Only

Certain services may require prior authorization. See the detailed benefit summary or contact BenefitsVIP for more information.

Garden State Plan and Educators Health Plan cost is based on a percentage of your salary.

To calculate your annual cost, multiply your annual salary by the percentage show below.

POS and dental cost is based on a percentage of premium.

Please refer to the POS and dental benefit cost sheet to calculate your share of the premium.

Garden State Plan	Employee Only	EE plus Spouse	EE plus Child(ren)	EE plus Family
Salary less than 40K	1.5%	1.5%	1.5%	1.65%
40,001-50,000	1.5%	1.65%	1.5%	1.95%
50,001-60,000	1.5%	1.95%	1.5%	2.2%
60,001-70,000	1.5%	2.2%	1.5%	2.5%
70,001-80,000	1.5%	2.5%	1.65%	2.75%
80,001-90,000	1.5%	2.75%	1.8%	3.0%
90,001-100,000	1.65%	3.0%	1.95%	3.3%
100,001-100,999	1.8%	3.3%	2.2%	3.3%
101,000-125,000*	1.8%	3.3%	2.2%	3.6%

Educators Health Plan	Employee Only	EE plus Spouse	EE plus Child(ren)	EE plus Family
Salary less than 40K	1.7%	2.8%	2.2%	3.3%
40,001-50,000	1.9%	3.3%	2.5%	3.9%
50,001-60,000	2.2%	3.9%	2.8%	4.4%
60,001-70,000	2.5%	4.4%	3.0%	5.0%
70,001-80,000	2.8%	5.0%	3.3%	5.5%
80,001-90,000	3.0%	5.5%	3.6%	6.0%
90,001-100,000	3.3%	6.0%	3.9%	6.6%
100,001-125,000*	3.6%	6.6%	4.4%	7.2%

*For any employee electing the GSP or EHP earning a base salary above $125,000, the maximum contribution will be based on a salary of $125,000.

POS and dental cost is based on a percentage of premium.

- To calculate your annual POS medical cost, multiply the annual cost noted below by the salary range percent below.
- To calculate your annual dental cost – multiply the annual employee only cost noted below by the salary range percent below. If you are electing dependent dental coverage, you must also add in the additional dependent cost (shown below as the additional amount per month, based on 10 months).
- POS and dental costs are subject to change each July.

Costs as of 7/1/2026	Aetna POS	Cigna POS	Dental DMO	Dental PPO
Employee Only	$25,249.80	$23,138.52	$274.68	$638.52
EE plus Spouse	$60,576.60	$50,902.92	$45.44 additional	$73.51 additional
EE plus Child(ren)	$41,235.48	$34,656.72	$21.10 additional	$28.33 additional
EE plus Family	$68,826.48	$57,903.48	$76.86 additional	$96.77 additional

Salary Range	Employee Only	EE plus Spouse	EE plus Child(ren)	EE plus Family
Salary less than 20K	4.5%	3.5%	3.5%	3.0%
20,000-24,999	5.5%	3.5%	3.5%	3.0%
25,000-29,999	7.5%	4.5%	4.5%	4.0%
30,000-34,999	10.0%	6.0%	6.0%	5.0%
35,000-39,999	11.0%	7.0%	7.0%	6.0%
40,000-44,999	12.0%	8.0%	8.0%	7.0%
45,000-49,999	14.0%	10.0%	10.0%	9.0%
50,000-54,999	20.0%	15.0%	15.0%	12.0%
55,000-59,999	23.0%	17.0%	17.0%	14.0%
60,000-64,999	27.0%	21.0%	21.0%	17.0%
65,000-69,999	29.0%	23.0%	23.0%	19.0%
70,000-74,999	32.0%	26.0%	26.0%	22.0%
75,000-79,999	33.0%	27.0%	27.0%	23.0%
80,000-84,999	34.0%	28.0%	28.0%	24.0%
85,000-89,999	34.0%	30.0%	30.0%	26.0%
90,000-94,999	34.0%	30.0%	30.0%	28.0%
95,000-99,999	35.0%	30.0%	30.0%	29.0%
100,000-109,999	35.0%	35.0%	35.0%	32.0%
110,000 and over	35.0%	35.0%	35.0%	35.0%

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)
Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)
If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SPECIAL ENROLLMENT RIGHTS CHIPRA – CHILDREN'S HEALTH INSURANCE PLAN
You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances: You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible. You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)
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 (including spouse) for up to 24 months while in the military. Even if you do not 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 for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW
Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)
GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

NO SURPRISES ACT

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible. What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service. You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://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://myarhipp.com/
Phone: 1-855-692-7447 (1-855-MyARHIPP)

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+ Website:
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/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

ILLINOIS – Medicaid
Medicaid Application Website: https://abe.illinois.gov
HIPP Hotline: 217-524-8268
HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA – Medicaid
Website: https://www.in.gov/medicaid/
Additional Information: http://www.in.gov/fssa/dfr/
Family and Social Services Administration:
Phone: 1-800-403-0864
Member Services:
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/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):
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
KCHIP Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Customer Service: 1-888-342-6207
Email: healthy@la.gov
LaHIPP Website: https://www.ldh.la.gov/lahipp
Phone: 1-877-697-6703
Email: La.HIPP@la.gov
Fax: 1-888-716-9787
Mailing Address:
100 Crescent Centre Parkway, Suite 1000
Tucker, GA 30084

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Website:
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/health-care-coverage/
Phone: 1-800-657-3672

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
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: 1-800-852-3345 ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
HIPP Website:
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

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

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
Website:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
UPP Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
FAMIS Select:
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
HIPP Programs:
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
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/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, 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. OMB Control Number 1210-0137 (expires 5/31/2029)