Health Insurance During Employment

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1. Are employers required to provide health insurance to their employees?

   No. Employers are not required by law to provide health and welfare benefits to employees. Many employers (especially large employers) do however provide insurance to employees, usually through a group plan. In a group insurance plan, the people who belong to the group (for example, all of the workers at a particular job) are entitled to the benefits that the insurance plan provides, such as paying for hospitalizations or physician care and reimbursements for prescription medicines.

   Exception: In selected cities, where local governments have enacted living wage ordinances, if an employee is working for a government employer or an employer that has a contract relationship with the city or county, the employee may be entitled to employer-paid health benefits or an increase in hourly wage so that the employee can independently obtain health insurance. San Francisco's Health Care Security Ordinance ("HCSO") requires employers who have at least 20 employees to pay a certain amount of money on the health care of their employees, either through paying the employees' health care premiums, contributing to the employees' health benefit flexible spending account or reimbursing fees incurred by employee who received direct health services. To be covered by the HCSO, an employee must have worked for his/her employer for 90 calendar days and must work at least 10 hours per week in San Francisco.

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2. If an employer voluntarily provides health insurance benefits, are there any laws that cover those benefits?

   The Employee Retirement Income Security Act of 1974 (ERISA) governs employer-provided health benefits if an employer voluntarily provides insurance to employees. Under ERISA, employers must provide a Summary Plan Description (SPD) to employees who participate in the plan. The SPD is usually a small pamphlet or other document that explains what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits become "vested" (or guaranteed), when and in what form benefits are paid, and how to file a claim for benefits. The employer must provide the SPD to the employee free of charge within 90 days after an employee becomes a plan participant or within 120 days after the plan is established. If the plan changes, the employer must inform the employee through a revised SPD or in a separate document called a Summary of Material Modifications that must be provided to the employee free of charge.

   Health and welfare benefits provided by employers are exempt from ERISA's minimum participation, vesting, benefit-accrual and minimum funding requirements that apply to employer-provided pension benefits.

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3. If my employer voluntarily provides health insurance benefits, is it obligated to provide benefits to all employees?

   No. An employer is free to cover some, as opposed to all, of its employees. For example, salespersons can be excluded from an insurance plan while administrators are covered.

   Exception: If an employee is entitled to participate in an employer-provided health benefits plan under ERISA, an employer may not wrongfully deny participation. (For example, an employer cannot deny health insurance benefits to workers based on their national origin.) To qualify, an individual must be classified as an employee, not a temporary worker or independent contractor and must be eligible to receive benefits according to the terms of the plan.

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4. Is my employer required to provide medical benefits to my spouse, domestic partner or dependent children?

   Much like employers are not required by law to provide health and welfare benefits to employees, they are equally not required to provide those benefits to spouses, domestic partners or dependent children. If, however, an employer voluntarily provides spousal benefits through an

insurance provider or health maintenance organizations (HMO's), the employer must also provide those same benefits to registered domestic partners of the covered employees. That's because AB 2208 requires equal treatment of spouses and registered domestic partners in all aspects of insurance coverage. (The terms and the extent of coverage, as well as the application process, must therefore be identical, too.)

Note: AB 2208 applies to insurance providers and HMO's who supply insurance to an employer's employees, but does not apply to employers who self-insure, who are not required to provide equal domestic partner coverage to their employees.

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5. Once I am receiving benefits, can my employer terminate them?

Yes. An employer may at any time amend the terms of an existing plan, including termination of the plan. Additionally, an employer may reduce or terminate health benefits of retired former employees who become eligible for Medicare Benefits without violating the Age Discrimination in Employment Act.

Exception: An employer may not terminate, suspend, discipline, discriminate, or take any adverse action against the employee for exercising his or her rights under a plan or ERISA, or for giving information or testimony in an investigation or proceeding relating to ERISA.

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6. If I file a claim for health benefits under a plan provided by my employer and it is denied, what can I do?

If you believe that there has been a violation of the plan (e.g., benefits were not paid according to the plan), you may bring an ERISA claim against your employer through an internal administrative claims process that is described in the SPD.

Additionally, a person also may appeal to the Secretary of Labor of the Department of labor for certain ERISA claims. The Department of Labor however, only assists claimants informally for non-ERISA based claims.

If you are unsure if your claim is non-ERISA based and whether you should bring a claim through the internal process or through the Department of Labor, you can refer to your SPD, which explains the administrative resources available to participants in the plan.

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7. Do I qualify for health insurance after I lose my job? What about my family?

Unless you work for the government or a church, and as long as you are employed by a business with two or more employees, you are a "covered employee" and eligible to continue your group health coverage. There is no requirement that you work for your employer for a certain amount of time. Your employer must also offer you a COBRA extension even if you are also covered by another policy, such as a spouse's policy through his or her job. (See our Fact Sheet titled Health Insurance After Employment: COBRA for more information).

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For further information about your employment rights, contact the Workers' Rights Clinic.

Disclaimer

This Fact Sheet is intended to provide accurate, general information regarding legal rights relating to employment in California. Yet because laws and legal procedures are subject to frequent change and differing interpretations, the Legal Aid Society–Employment Law Center cannot ensure the information in this Fact Sheet is current nor be responsible for any use to which it is put. Do not rely on this information without consulting an attorney or the appropriate agency about your rights in your particular situation.