ABC Company

Benefits Plan Overview 2016

Welcome

ABC Company takes pride in offering a comprehensive and competitive benefits package to its employees. ABC Company, through all of its benefit partners, offers you a benefit program that allows choice and flexibility. Through this program you can choose the benefits that are best for you and your family.

Please take the time to review all of the plan options available to you prior to making your selections. Consider each benefit and choose the benefits package that will best meet your and your family's needs throughout the year.

Options selected during open enrollment remain in place for the full plan year. Options selected upon hire remain in place through the end of the plan year in which you are hired.

ABC Company reserves the right to modify, amend, suspend or terminate any plan at any time, and for any reason without prior notification. You will be notified of any changes to these plans and how they affect your benefits, if at all. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make explanations of the plans in this brochure as accurate as possible. However, should there be a discrepancy between this brochure and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written description in the insurance contracts will always govern.

The Internal Revenue Service *(IRS)* states that eligible employees may only make elections to the plan once a year at open enrollment. Medical, Dental, and Vision benefit choices are binding through April 30th of each year. The following circumstances are the ONLY reasons you may change your benefits during the year:

Marriage	***Death of a Spouse***
Divorce	***Death of a Dependent***
Birth & Adoption	***Loss of Dependent Status***
Loss of Spouse's job where coverage is maintained through a spouse's plan	

These special circumstances, often referred to as life event changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform the Employee Benefits Center within 30 days of the event to avoid lapse in coverage. All other changes are deferred to open enrollment.

Medical Benefits

ABC Company has partnered with CBIZ, our broker, to provide you and your family a broad access to high-quality healthcare providers both regionally and nationwide. ABC Company is offering one High Deductible Health plan. The plan is a Point Of Service Open Access plan that works with the Health Savings Account (HSA). This plan is administered by Cigna and had a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalization. Depending upon the type of service, whether it be a routine office visit, a trip to the emergency room, or any other medical service under the plan, your medical plan shares the cost of care with you in different ways.

Please see the summary on Page 2 for specific plan details. ABC Company shares the cost with their employees.

INSIDE THIS ISSUE:

This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents, the language of the official plan document shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by ABC Company.

Medical Benefits Description

	Cigna Level Funding– Single Plan Option POS H.S.A. Open Access Plus OAP	
	In-Network	**Out-of-Network**
Deductible:		
Single	$1,400	$2,800
Family	$2,800	$5,600
Out of Pocket Maximum:		
Single	$2,800	$5,600
Family	$5,600	$11,200
Coinsurance:	100%	70%
Office Visits:		
Preventive Care	Covered 100%	30% of AB
Primary Care Physician	Deductible, then $30 copay	Deductible, then 30% of AB
Specialist	Deductible, then $30 copay	Deductible, then 30% of AB
Urgent Care	Deductible, then $75 copay	Deductible, then 30% of AB
Lab and x-ray (free standing)	No Charge after Deductible	Deductible, then 30% of AB
Diagnostic Services	Deductible, then $30 copay	Deductible, then 30% of AB
Vision	Not Included	Not Included
Hospitalization:		
Inpatient	No Charge after Deductible	Deductible, then 30% of AB
Outpatient	No Charge after Deductible	Deductible, then 30% of AB
Emergency Room (Waived if admitted)	Deductible, then $300 / visit	
Miscellaneous:		
Primary Physician	No Referral required	N/A
Physician Network	CIGNA	N/A
Lifetime Maximum	Unlimited	
Prescription Drugs:	Integrated Medical & Pharmacy Deductible	
Generic / Tier 1	$10 Copay after Deductible	
Brand / Formulary or Tier 2	$25 Copay after Deductible	
Brand / Non-Formulary or Tier 3	$45 Copay after Deductible	
Mail Order (90-day supply)	2 x copay after Deductible	

Employee Contributions	
Per Pay (26 Pays)	**Medical (CIGNA)**
Employee	$27.63
Employee & Spouse	$190.29
Employee & child(ren)	$136.00
Family	$247.27

DENTAL BENEFITS

Good Dental health is important to your overall well being. At the same time, we all need different levels of dental treatment. The Dominion Dental plan provides affordable coverage based on the type of services obtained – **Preventive, Basic or Major** – whether or not you obtain services from a network or out-of-network provider.

Under this plan, you may obtain covered services from any dentist. However, if an out-of-network provider is used, reimbursement is based on Dominion's usual and customary reasonable charge. Employees who use dentists or dental specialists that are part of Dominion's Provider Network *(participating Dental Provider)* will see reduced or eliminated out-of-pocket expenses.

A complete provider directory can be accessed online at www.domiondental.com.

	Dominion (Formerly DentaQuest) Dental	
	In-network	**Out-of-network**
Annual Maximum (Calendar Year) *(per covered individual)*	$1,500	
Deductible (Calendar Year)		
- Individual	$50	
- Family	$150	
Preventive (Class I) *Diagnostic and Preventive Services*	100%	100%
Basic (Class II) *Basic Restorative, Simple Extractions, Prosthetic Maintenance, General Anesthesia for Covered Surgical Procedures, Palliative Emergency Dental Care*	80%	80%
EPO (Class III) *Endodontics, Periodontics, Oral Surgery*	50%	50%
Major (Class III) *Major Restorative, Endosteal Implants*	50%	50%
Orthodontia (Class IV) *(eligible to age 19)*	OrthoSelect or 50% up to $1,000 lifetime maximum	

Employee Contributions	
Per Pay (26 Pays)	**Dental (Dominion)**
Employee	$12.95
Employee & Spouse	$29.00
Employee & Child(ren)	$30.95
Family	$42.99

VISION BENEFITS

All full-time, regular employees are eligible to sign up for vision coverage, which allows participants to get an examination annually and lenses, frames, and contact lenses *(in lieu of frames & lenses)* every 12 months.

Participants have the option of receiving care from a network or out-of-network provider; however, if you use a non-network provider you will incur higher out-of-pocket expenses. www.avesis.com

	Avesis Vision	
	In-network	**Out-of-network**
Copayments		
Examination	$10 Copay	$35 allowance
Materials - lenses and frames	$25 Copay	see schedule below
Frequency of Service		
Vision Exam	12 Months	
Lenses, Frames, Contact Lenses*	12 Months	
Lenses (pair)		
Standard Single Vision	$25 Copay	Up to $25 Allowance
Standard Bifocal	$25 Copay	Up to $40 Allowance
Standard Trifocal	$25 Copay	Up to $50 Allowance
Standard Lenticular	$25 Copay	Up to $80 Allowance
Standard Progressive	Up to $50 allowance plus 20% off retail	Up to $40 Allowance
Frames	Up to $50 Allowance, retail of $100 to $150	Up to $45 Allowance
Contact Lenses	Elective - Up to $130 Allowance; Covered in Full if Medically Necessary	Up to $130 Allowance; $250 if Med. Necessary
Lasik Surgery	Provider discount up to 25% plus $150 allowance (lifetime benefit)	Reimbursed up to $150 (lifetime benefit)

Employee Contributions	
Per Pay (26 Pays)	**Vision**
Employee	$3.45
Employee + One	$6.04
Family	$8.98

Health Savings Account (HSA)

Employees have the option to open an HSA account when enrolling into a High Deductible HSA plan option. The premiums for the High Deductible Health Plan are significantly lower than the premiums for the other plans. The premium cost for this plan is less because, as its name suggests, there is a higher deductible that employees must meet before the plan begins to pay eligible expenses. You will be responsible for your health care expenses, other than preventative/wellness expenses, up to the amount of the deductible.

A Health Savings Account ("HSA") is a type of savings account that allows you to save for medical expenses on a tax-free basis. An HSA is like a 401k plan for medical expenses; a tax-favored savings account established by you. The savings in your HSA are immediately available to you to pay for qualified medical expenses not covered by insurance. You may also choose to contribute to an HSA and save the funds for medical expenses in the future. Unlike flexible spending accounts (FSAs), HSA funds are not subject to a "use it or lose it" policy. Any money you put into this account belongs to you.

The HDHP, together with the HSA, represents a different approach to health care. The plan concept, however, is simple:

- Carry a low cost, high deductible health plan instead of a higher priced plan with a lower deductible. Your weekly payroll contribution for insurance premium is less than the other plans.
- Contribute funds to your HSA on a pre-tax basis to use for medical expenses.
- Withdraw funds on a tax-free basis, at your option, to pay routine medical bills. What you don't use from the account each year (the excess savings less costs) stays in your savings account and continues to grow on a tax-favored basis to supplement your retirement.

Who is eligible to open a Health Savings Account

Medical Plan Coverage	You must be enrolled in the HDHP through ABC Company
No Other Coverage	You may not have any other health plan coverage and that would include a medical spending Account (FSA). Those covered by a spouse's plan *(that is not a HDHP plan)*. Medicare, Medicaid or Tricare are also not eligible to have a health savings account.
Other Benefits	You may not have received any Veterans Administration benefits in the last three months.
Dependent Status	You may not be claimed as a dependent on another person's tax return.

How it Works

Basic Life and Accidental Death & Dismemberment

ABC Company offers its employees basic life insurance and AD&D coverage through CIGNA at **no cost** to you. Eligible employees receive Basic Life Insurance equal to one times your salary up to $50,000. Accidental Death and Dismemberment Insurance provides a benefit equal to your basic life insurance in the event of death or dismemberment resulting from a covered accident. At age 70, the benefit begins to reduce. Please see plan summary for more details.

Voluntary Life/AD&D, Spouse, Child

Term Life may be purchased for yourself and dependents.

Employee Life/AD&D Insurance

- Benefit Amount: Increments of $10,000, up to $500,000
- AD&D Benefit

If you purchase coverage for yourself, then you can also purchase coverage for your family.

Spouse Life/AD&D Insurance

- Benefit Amount: Increments of $5,000 up to $250,000 maximum (up to 50% of the employee amount–whichever is less)

Child Life/AD&D Insurance

- Benefit Amount: Increments of $1,000 up to $10,000
- Age Limit: 19, or age 26 if full-time student

Voluntary Life/AD&D Benefit Choices

- If you enroll in the plan, the annual enrollment period is a time when you can increase your Life coverage up to the guarantee issue maximum of $100,000 with no medical underwriting.
- If your spouse enrolls in the plan, you can increase his or her coverage at subsequent annual enrollments up to the guarantee issue maximum of $25,000 with no medical underwriting.

Disability Insurance

ABC Company' disability plans work together to help you pay your household expenses if you become disabled and cannot work. ABC Company pays 100% of the cost for both your Long Term Disability and Short Term Disability plans.

Short Term Disability: This benefit is 60% of your annual earnings up to $1,500 per week. Short Term Disability benefits begin on the 15th day of illness.

Long Term Disability: This benefit is 50% of your annual earnings up to a maximum of $7,500 per month. Long Term Disability benefits begin after the 90th day of illness.

Retirement/401(k) Savings Plan

ABC Company has established a qualified retirement plan that offers employees the opportunity to make regular contributions, through salary reduction, into the plan. Employees may contribute to the regular 401(k) plan with pre-tax contributions or to the 401(k) ROTH plan with after-tax contributions. Eligibility must be full-time, 21 years of age and following 3 consecutive months of service.

The maximum contribution for 2016 is $18,000 with a $6,000 catch-up provision for employees age 50 and over. Contributions cannot exceed the pre-determined annual IRS limits. Participants may modify salary deferral elections on the first day of each month.

Contact Human Resources for additional information.

HEALTH ADVOCATE

HealthAdvocate
Always at your side

Health Advocate is an employee-paid benefit provided to associates and their dependents through its staff of Personal Health Advocates (PHA). Members requiring assistance call a special toll-free Health Advocate telephone number (1-866-695-8622). Members talk with a PHA, who then becomes "their" Personal Health Advocate, personally helping them with their issues, problems or other needs for assistance.

Health Advocate:

- Saves members considerable time and money
- Helps members eliminate the hassles and frustrations typically encountered when dealing with the healthcare system
- Assists members in finding the best doctors, hospitals and other healthcare providers
- Handles problems and addresses issues quickly and professionally
- Protects your privacy and confidentiality
- Facilitates access to centers of medical excellence

EMPLOYEE ASSISTANCE PROGRAM

Cigna

Cigna's Life Assistance Program provides access to telephonic or in-person behavioral health assistance and online tools. The program offers coverage to both employees and their families:

- Access to telephonic counseling 24 hours a day, seven days a week from Cigna's licensed clinical and up to three, free in-person sessions with licensed behavioral health clinicians in Cigna's network
- Up to three qualified online telephonic referrals for life events
- Up to 60% Discounts on health and wellness products and services through the Health Rewards discount program
- Free monthly employee telephonic seminars
- Monthly communications for employers

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE SERVICES

Whether your travel is for business or personal reasons, worldwide emergency travel assistance program goes with you when you travel to a foreign country or just 100 miles or more from home. This program is for yourself, your spouse or your dependent children need immediate assistance anywhere in the world*

Services are available for simple to extreme travel emergencies:

- Hospital admissions guarantee
- Emergency medical evacuation
- Care if minor children
- Prescription assistance
- Transportation for a friend or family member to join the hospitalized patient.

*Employees are covered for business or personal travel, spouses and dependent children are covered for personal travel only.

COMPLIANCE NOTICES:

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers 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 vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the 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 insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 1.800.433.5768.

Important Notice 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 ABC Company 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. ABC Company has determined that the prescription drug coverage offered by Cigna 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 Cigna coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Cigna coverage, be aware that you and your dependents may not be able to get this coverage back.

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 ABC Company and 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.

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 ABC Company 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).

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, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**LOUISIANA – Medicaid**
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
ALASKA – Medicaid	**MAINE – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741
COLORADO – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
FLORIDA – Medicaid	**MINNESOTA – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739
GEORGIA – Medicaid	**MISSOURI – Medicaid**
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
INDIANA – Medicaid	**MONTANA – Medicaid**
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA – Medicaid**
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	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
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
RHODE ISLAND – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

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Notes: