Chase Brexton Health Care

Because everyone's health matters.

Benefits Plan Overview 2017

WELCOME

The following pages offer a highlight of Chase Brexton Health Care's 2017 benefit programs. We are excited to announce that these programs provide you and your family access to high-quality healthcare and an array of additional benefits. It is important that you take the time to review all of the plan options available to you. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet you and your family's needs throughout the year.

The benefit plans described in this brochure will be in place Jan 1, 2017 through December 31, 2017.

Chase Brexton encourages you to take the time to read and understand the full array of benefits offered so that you may take full advantage of all of these programs.

The Internal Revenue Service (IRS) states that the eligible employees may only make elections to the plan at time of hire and once a year at open enrollment. Medical and dental benefit choices are binding through Dec 31st of each year. The following circumstances are some 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 Human Resources within 31 days of the event to avoid lapse in coverage. All other changes are deferred to open enrollment.

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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 these materials 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 benefit may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by Chase Brexton Health Care. These documents are available on the HR intranet.

Medical & Rx Benefits

Chase Brexton offers Associates a choice of three PPO medical plans through United HealthCare: HMO, Point of Service, and a High Deductible Health Plan with a Health Savings Account (HDHP/HSA Plan).

The medical options cover a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalizations. Please refer to the summary below for specific details on each medical plan option. www.uhc.com

Associates are eligible for medical benefits on the first of the month coinciding with or following their date of hire.

Benefits Description	Optimum Choice GOLD	Choice Plus SILVER		Choice Plus HSA H.D.H.P w/H.S.A. BRONZE	
	In-Network	*In-Network*	*Out-Of-Network*	*In-Network*	*Out-Of-Network*
Deductible Individual Family	None	$1,500 $3,000	$2,500 $5,000	$2,600[1] $5,200[1]	$2,700[1] $5,400[1]
Out-Of-Pocket Maximum Individual Family	$1,500 $3,000	$3,000 $6,000	$4,000 $8,000	$4,000 $8,000	$4,000 $8,000
Coinsurance	0%	20%	40% after Ded	20%	40% after Ded
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Office Visit	No Charge	0%	20% after Ded	No Charge	20%, after Ded
Primary Office Visit	$30 Copay	$30 Copay	20% after Ded	20% after Ded	40% after Ded
Specialist Services	$40 Copay	$40 Copay	20% after Ded	20% after Ded	40% after Ded
Urgent Care	$75 Copay	$75 Copay	20% after Ded	20% after Ded	20% after Ded
Emergency Room	$150 Copay	$150 Copay	$150 Copay	20% after Ded	20% after Ded
Inpatient Hospital Services	$500/visit	20% after Ded	40% after Ded	20% after Ded	40% after Ded
Outpatient Surgery	$100 Copay	20% after Ded	40% after Ded	20% after Ded	40% after Ded
X-Ray and Lab & Pathology Services	No Charge	No Charge	20% after Ded	20% after Ded	40% after Ded
Imaging Services Routine Radiology/Diagnostic MRI/MRA, CT, PET Scans	$100 Copay	$150 Copay	20% after Ded	20% after Ded	40% after Ded
Routine Mammography	No Charge	No Charge	20% after Ded	No Charge	20% after Ded
Durable Medical Equipment	No Charge	20% after Ded	40% after Ded	20% after Ded	40% after Ded
Prescription Drug ***(including oral contraceptives)*** Tier 1 Tier 2 Tier 3 Mail Order (90 Day Supply)	$10 Copay $35 Copay $60 Copay $25/$87.50/$150	$10 Copay $35 Copay $60 Copay $25/$87.50/$150	$10 Copay $35 Copay $60 Copay $25/$87.50/$150	Deductible then: $10 Copay $35 Copay $60 Copay $25/$87.50/$150	Deductible then: $10 Copay $35 Copay $60 Copay $25/$87.50/$150

Note[1]: *Single deductible and out-of-network maximum apply when an individual is enrolled without dependents. Family deductible*

***Note:** *Dependents to age 26 may be covered under your medical plan regardless of student status.*

***Should there be any discrepancies between the above summary and the actual plan contract(s), the Plan contract(s) supersedes this summary.*

Medical High Deductible Health Plan

The premiums for the High Deductible Health Plan (“HDHP”) 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. You will be responsible for your healthcare expenses, other than preventative/wellness expenses,[1] up to the amount of the deductible.[2]

A Health Savings Account (“HSA”) is a type of savings account that allows you to save for medical expenses on a tax-free basis. 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" rule. Any money you put into this account belongs to you.

The HDHP, together with the HSA, represents a different approach to healthcare. 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 biweekly 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.

If you choose this plan, you will receive the benefit of United HealthCare's negotiated discounts when you use participating providers. Once the annual deductible has been met, your coverage will be more like the insurance under our more traditional plans, the Core and Preferred, and larger medical expenses are generally covered in full.

The maximum contribution to an HSA for calendar year 2017 is $3,400/Individual or $6,750/Family. Participants age 55 or older can make “catch-up” contributions. The 2017 catch-up contribution is $1,000.

[1]Under this plan, as long as you receive service from an United Health Care participating provider, your preventative office visits will be subject to a $0 co-pay. Refer to the Preventive Flyer for specifics and frequencies.

[2]Associates who use out-of-network benefits should be aware that out-of-network costs are tracked separately and are subject to a different deductible . Out-Of-Network Costs may exceed out-of-network maximums due to balancing billing from out-of-network providers. Associates who use out-of-network benefits should contact HR before choosing a plan to discuss

Who Is Eligible to Open a Health Savings Account?

Medical Plan Coverage	You must be enrolled in the HDHP through Chase Brexton and open an account with Optum Bank
No Other Coverage	You may not have any other health plan coverage and that would include any type of medical spending account (FSA) except a *limited 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.

Vision Benefits

We offer Vision insurance through United HealthCare to include both in-network and out-of-network benefits. Annual vision benefits include one vision exam, frames and discounted lenses. To locate a par-

Vision Benefits Description	United HealthCare		
	Frequency	*In-Network Benefits*	*Out-of-Network Reimbursement*
Comprehensive Eye Exam	Every 12 months	$10 copay	Up to $40
A complete pair pf eyeglass lenses or covered-in -full contact lenses after copay	Every 12 months	$25 copay	
Frames • Single vision, lined bifolcal, lined trifocal or lined lenticular lenses (other lens options available at a discounted rate) • Standard scratch coating	Every 14 Months Every 12 months Covered in full	$130 allowance Covered in full Covered in full	Up to $45
Lens Options	See benefit summary for details		
Elective Contact Lenses • Contact lenses that fall outside the covered in full selection (copay does not apply)	Every 12 months	$125 allowance	Up to $125
Additional Materials	20% off		

Assurant Dental Benefits

Good dental health is important to your overall well-being. At the same time, we all need different levels of dental treatment. Assurant's PPO dental plan provides affordable coverage based on the type of services obtained – Preventative, Basic, Major or Child Orthodontics.

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

A complete provider directory can be accessed online at www.assuranthealth.com (Dental PPO/PDN with PPOII network).

Dental Benefits Description	Assurant	
	In-Network	*Out-of-Network*
Deductible Individual Family	$50 $50	$50 $50
Preventive Services[1] Oral Exams, Full Mouth X-Rays, Fluoride Treatments, Sealants, Teeth Cleaning[1], Periodontal Maintenance	90%	90%
Basic Services Fillings, Endodontics-Root Canal, Periodontics, Oral Surgery, General Anesthesia, Pulp Capping	Deductible then 10%	Deductible then 20%
Major Services Inlays & Onlays, Crowns, Dentures, Bridges	Deductible then 40%	Deductible then 50%
Orthodontic Services (Children only—Appliance Must be Placed Prior to Age 20)	50% *($1,500 life-time maximum)*	50% *($1,500 life-time maximum)*
Annual Maximum	$1,500/*Per Year*	

Note[1]:*Teeth Cleaning in preventive services will be covered at 100% if done by a Chase Brexton dentist.*
Out of network benefits are subject to reasonable and customary charges.. Balance billing may apply.

Disability Benefits

Your disability benefits provide you with a source of income in the event that you are not able to work due to an accident, illness or injury. Chase Brexton provides Short-Term and Long-Term Disability Benefits to all eligible Associates at no cost to the Associate.

Short-Term Disability (STD):

Your STD benefit equals 60% of your weekly base earnings to a maximum benefit of $2,500 per week. This benefit takes effect after a 14-day waiting period that begins at the start of an absence due to an accident or illness. The benefit duration is 24 weeks.

Long-Term Disability (LTD):

Your LTD benefit equals 60% of your monthly base earnings to a maximum benefit of $10,000 per month. This benefit takes effect when your STD coverage ends.

www.thehartford.com

Basic Life and Accidental Death & Dismemberment Insurance

Chase Brexton provides eligible associates with Basic Life Insurance in an amount equal to your annual base salary to a maximum of $100,000. Accidental Death and Dismemberment Insurance pays a benefit that varies with the type of loss or accident. These benefits are paid for by Chase Brexton and provided by The Hartford. www.thehartford.com

Supplemental Life Insurance

Employees have the option to purchase additional life insurance for themselves and for their dependents. In addition to completing the on-line enrollment process, you may need to complete an Evidence of Insurability Form if you wish to purchase or change your additional life insurance plan. Your premium may change if you have moved to a different age category. www.thehartford.com

Group Accident Insurance

(Available during Open Enrollment Only)

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious, like an injury from a car accident. Your plan can pay you a benefit for an emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage for your spouse and dependent children.

Group Critical Illness Insurance

(**Available during Open Enrollment Only**)

What's a critical illness? Some common examples are heart attack, stroke, and cancer. But this coverage also includes serious conditions like permanent paralysis—the kind of injury that can happen to a healthy person in a car or skiing accident, for example. The medical treatment for these conditions can be very expensive. Critical illness insurance can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. You decide how to spend it. You can use this coverage more than once for different conditions, but

Flexible Spending Accounts *(FSA)*

Chase Brexton allows you to defer a portion of your pay through payroll deduction into Flexible Spending Accounts (FSAs). The money that goes into an FSA is deducted on a pre-tax basis, which means it is taken from your pay before Federal and Social Security taxes are calculated. Because you do not pay income taxes on money that goes into your FSA, you decrease your taxable income.

It is important that you carefully estimate the expenses that you intend to pay from your FSA. If you do not use all of the money in your accounts by the end of the plan year, Federal law requires you to forfeit any unused balances. You may rollover up to $500. You have up to three months after the plan year ends to submit qualified expenses for reimbursement incurred during the prior year.

Employee account reports are available on-line: https://myplans.cbiz.com or 800-815-3023, Option 4.

Medical FSA:

You may deposit up to **$2,550** per plan year into your Medical FSA to cover you and your dependents during the plan year. Eligible expenses include, but are not limited to: deductibles, co-payments and co-insurance payments, uninsured dental expenses, vision care expenses and hearing expenses. Remember, over-the-counter medications are no longer eligible unless they are submitted with a doctor's letter of medical necessity and prescription. **Please note; if you participate in the HSA Bronze plan then you may not participate in the Chase Brexton Medical FSA.**

Dependent Care FSA:

You may deposit up to **$5,000** per plan year into Dependent Care FSA. Eligible expenses include payments to day care centers, preschool costs, before and after school care and elder dependent care.

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.

NON-MEDICAL

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or CHIP.

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 (410)-545-4481 X 2623.

IMPORTANT NOTICE FROM CHASE BREXTON 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 Chase Brexton 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. Chase Brexton has determined that the prescription drug coverage offered by Aetna 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 **Chase Brexton** 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 **Chase Brexton** coverage, be aware that you and your dependents may 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 **Chase Brexton** 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 **Chase Brexton** 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).

Date:	**October 15,2016**
Name of Entity/Sender:	**Chase Brexton Services, Inc.**
Contact--Position/Office:	**HR Department- Lindsey Brown**
Phone:	**(410)-545-4481 X 2623**

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, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	KENTUCKY – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ALASKA – Medicaid	**LOUISIANA – 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: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
ARKANSAS – Medicaid	**MAINE – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
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: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739
GEORGIA – Medicaid	**MISSOURI – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on 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**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – 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://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	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
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/ default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
RHODE ISLAND – Medicaid	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
SOUTH CAROLINA – Medicaid	
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	

To see if any other states have added a premium assistance program since July 31, 2016, 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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