Warren Consolidated Schools

Your Benefits Guide

WEA

Welcome to Open Enrollment 2018!

Important Medicare Information

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage. Please see page 10 for details.

What's Inside	

Contacts

Have Questions? Get Answers!

Provider	Benefit	Contact Information	
MESSA	Medical	General info / finding a provider	(800) 336-0013 www.messa.org
Health Equity	Health Savings Account	General Info and service questions	(877) 218-3432 www.healthequity.com
Delta Dental	Dental	General info / finding a provider	(800) 482-8915 www.deltadentalmi.com
Vision Service Plan (VSP)	Vision	General info / finding a provider	(800) 877-7195 www.vsp.com
Employee Benefit Concepts	Flexible Spending Account (Dependent care only)	Claim and service questions	(248) 855-8040 www.employeebenefitconcepts.com
MESSA	Basic Life ($50,000)	Claim and service questions	(800) 336-0013 www.messa.org
UNUM	Basic Life (amount over $50,000)	Claim and service questions	800) 275-8686 www.unum.com
MESSA	LTD Disability	Claim and service questions	(800) 336-0013 www.messa.org
Care's Work Life Solutions	Employee Assistance Program	Work/Life Issues	(866) 888-1555 www.caresworklifesolutions.com
WCS	All Benefits	Ann Marie Tocco	(586) 698-4108 ext. 64120 atocco@wcskids.net

Annual Open Enrollment

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period will run from November 6, 2017 through November 17, 2017. This is when you review your benefit choices and decide what plans you want to be covered by in the coming year. Which benefit plans are right for you and your family? The choices you make are important. To help guide you in your decisions, we are providing this Guide. This is an opportunity to make medical, dental, vision or life insurance election changes. This is also the open enrollment for the Dependent Care Flexible Spending Account and Health Savings Account.

2018 PLAN CHANGES!

1. There are now five healthcare benefit options to choose from.
   - Option #1: MESSA PAK A Plan/ABC Plan 1 (Medical / Delta Dental / VSP Vision / Life / LTD). Includes 3-Tier Rx plan, 0% co-insurance and pre-funded HSA contribution. (Same plan that employees are enrolled in now, except replacing current Rx plan with 3-Tier Rx plan).
   - Option #2: MESSA PAK A Plan/ABC Plan 1 (Medical / Delta Dental / VSP Vision / Life / LTD). Includes 3-Tier Rx plan, 0% co-insurance and without pre-funded HSA contribution.
   - Option #3: MESSA PAK C Plan/ABC Plan 1 (Medical / Delta Dental / VSP Vision / Life / LTD). Includes 3-Tier Rx plan, 20% co-insurance, and pre-funded HSA contribution.
   - Option #4: MESSA PAK C Plan/ABC Plan 1 (Medical / Delta Dental / VSP Vision / Life / LTD). Includes 3-Tier Rx plan, 20% co-insurance, and without pre-funded HSA contribution.
   - Option #5: MESSA PAK B Plan (Delta Dental / VSP Vision / Life / LTD)
2. The IRS has increased the minimum deductible requirement for Qualified High Deductible Health plans effective January 1, 2018 to $1,350 single / $2,700 family.
3. Warren Consolidated Schools will continue to make a contribution into your Health Savings Account equal to the annual deductible of $1,350 single / $2,700 family effective January 1, 2018.
4. Effective September 1, 2017 the “Over $50,000” Basic Life/AD&D is administered by UNUM.

WHAT YOU NEED TO DO

1. **All employees will remain enrolled in the ABC Plan 1, 0% co-insurance with the prefunded HSA unless you request a change. Your MESSA deductions will automatically be set up to be taken over 14, 17 or 19 pays depending on if you receive 21 pays (paid only during the school year), 24 pays (for year-round teachers) or 26 pays (paid through the summer), unless you request a change during open enrollment.** If you want to change your medical, dental, or vision you need to notify Ann Marie Tocco in the HR Benefits Department for the appropriate forms by **Friday, November 17th.** Benefit changes will take effect January 1, 2018. Remember, the option you choose now is the plan you will be covered by until our next open enrollment period, unless you have a Qualified Status Event (see page 4).
2. If you wish to contribute additional monies to your Health Savings Account you must return the 2018 Employee Voluntary HSA payroll deduction form. **New HSA Payroll Deduction forms are required each plan year.**
3. If you wish to enroll in the Dependent Care Flexible Spending Plan you may do so by returning the 2018 *Flexible Spending Account Election Form* to the HR Benefits Department. **New Dependent Care forms are required each plan year.**
4. If you have received correspondence from MESSA requesting dependent social security numbers either via email or mail, please respond. This information is required by the medical carriers as a result of Health Care Reform. If dependent social security numbers are not provided to MESSA, you may be subject to questions or penalties from the IRS.

Important Information

Any forms you complete in the future requesting dependent social security numbers need to be completed in its entirety.

5. If you wish to enroll in the employee paid Supplemental Life or Survivor Income Benefit you will need to complete a MESSA application (only available to those enrolled in the MESSA medical plan or if you elect the $5,000 group term life insurance).
6. If you have received correspondence from MESSA requesting dependent social security numbers either via email or mail, please respond. This information is required by the medical carriers as a result of Health Care Reform. If dependent social security numbers are not provided to MESSA, you may be subject to questions or penalties from the IRS. Any forms you complete in the future requesting dependent social security numbers need to be completed in its entirety.
7. This is also the time to add or drop dependents from your coverage. If enrolling a spouse or child(ren), you must also submit the following:

Legal Spouse:

Both of the following documents -

- marriage certificate
- first page of your most recent tax return Form 1040 (you may black out financial and social security
- information), if spouse files separately, the first page of the most recently filed tax return of your spouse

Same Sex Domestic Partner (applicable tax rules apply):

- Signed and notarized Other Qualified Adult Affidavit

Children Under Age 26 (Eligible for medical/dental/vision until the end of the calendar year they turn 26):

Any **one** of the following documents -

- birth certificate or adoption paperwork, or
- first page of your most recent tax return Form 1040 (you may black out financial and social security information), or
- Qualified Medical Child Support Order (QMCSO), or
- court paperwork for legal guardianship

Disabled Children:

Both of the following documents -

- The required documentation noted above for those under age 19, and
- Documentation verifying a permanent disability that began before the child otherwise would have lost eligibility

MAKING MID-YEAR CHANGES

You may only change your benefit elections during the plan year if you have a qualified change in status as defined by the Internal Revenue Code, and as allowed by the underlying health benefit plan. Change in status events include:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order.
- Marriage, legal separation, annulment, or divorce.
- Death of a dependent.
- A change in your home address if it causes you to lose eligibility for coverage.
- A change in employment status if it affects eligibility under the plan.

Important Information cont.

- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

The IRS requires that the change you make be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. Or if your spouse's employment terminates and s/he loses medical coverage through their employer, you may add your spouse to your medical coverage. Remember that you need to request the change within 31 days of the event.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the HR Benefits Department.

The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities.

- The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify the HR Benefits Department within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this Guide.

BENEFIT ENROLLMENT COMMUNICATIONS DISCLOSURE

This Benefit Guide contains a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. The District reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes, and the law itself as the governing documents.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

Do you know that your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call MESSA for more information.

Important Information cont.

HIPAA PRIVACY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the HR Benefits Department.

HEALTH SAVINGS ACCOUNT (HSA) ELIGIBILITY

Federal law governing tax-free savings accounts restricts who is eligible to have a tax-free health savings account (HSA). The law also defined the "qualified medical expenses" that can be covered or reimbursed from an HSA. Additionally, there are restrictions on which family members an account holder can spend HSA dollars to cover or reimburse for their qualified medical expenses. In order to qualify to have an HSA and make tax-free contributions to it, an employee:

- Must be covered by an HSA-qualified high deductible plan (MESSA ABC plans are HSA-qualified).
- Cannot be a Canadian resident that is enrolled in the Canadian Healthcare System.
- Cannot be claimed as a dependent on someone else's tax return.
- Cannot be covered by another person's health plan if the other person's plan is not HSA qualified.
- Can still be eligible for an HSA if his/her spouse has a non-HSA qualified health plan, provided the employee is not covered by the spouse's plan.
- Cannot be enrolled in any part of Medicare or Medicaid.
- Cannot have utilized VA benefits in the three months leading up to enrollment in the HSA plan.
- Generally cannot make contributions to an HSA if he/she has a medical Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA) that reimburses qualified medical expenses (even if the employee is covered by a high deductible health plan).

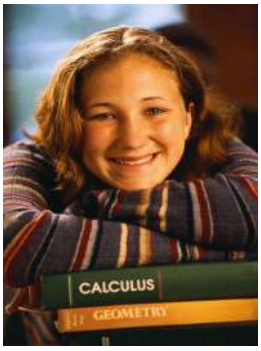
MEDICARE AND HEALTH SAVINGS ACCOUNT (HSA) ELIGIBILITY

Medicare eligibility alone does not disqualify you from contributing, or receiving employer contributions to an HSA. If you are actively employed and are not receiving Social Security, you will not be automatically enrolled in Medicare. When you receive Social Security you are automatically enrolled in Medicare Part A at age 65. You cannot decline the automatic enrollment in the hopes of participating in an HSA. **NOTE:** Although no further funds can be contributed to your HSA once you are enrolled in Medicare, any funds that remain in your HSA can still be used to pay for eligible medical expenses on a tax-advantaged basis.

Active employees who turn age 65 during the course of a tax year could be subject to IRS imposed interest/penalties should the employee choose to begin receiving Social Security benefits when they turn age 65 (which automatically enrolls you in Medicare Part A). According to Health Equity, our H.S.A. Plan Administrator, if you choose to begin receiving Social Security when you turn age 65, you are only able to have pro-rated contributions made to your H.S.A. account through the month prior to your 65th birthday. If you will be turning age 65 in 2018, you will be receiving a personalized letter from the HR Benefits Office indicating what your pro-rated contribution maximum can be.

***For additional information please see the MESSA Health Savings Account Eligibility document located on the WCS website under Departments-Human Resources-Benefit Plan Information.**

Dental Plan



WCS provides superior dental coverage to eligible employees. The dental plan is administered by Delta Dental. The Delta dental plan year is July through June.

Here are some key features of our Delta Dental plan:

- Coverage for preventive and basic services, like cleanings, x-rays, and fillings; and coverage for major services, are all subject to a certain coinsurance.
- Services are subject to an annual maximum benefit.
- Coverage for orthodontia services to a lifetime maximum per person with no age limit.
- With this plan, you may receive care from any dentist you choose and still enjoy coverage, however you will have lower out-of-pocket costs if you use a Delta Dental dentist because these network dentists have agreed to a reduced fee for dental services, so you pay less in coinsurance.
- A Delta Dental dentist cannot "balance bill" you for more than your coinsurance because the fee schedule has already been agreed to.

Dental cards are not provided. Please advise your provider that your dental plan is administered by Delta Dental of Michigan and your provider will verify benefits with your social security number.

*For a Provider Directory or to see if there is a network dentist near you, visit the **www.deltadentalmi.com** website or **www.messa.org.**

Vision Plan

The District sponsors an excellent vision program to eligible employees. The vision plan is administered by Vision Service Plan (VSP) and is now underwritten by Blue Cross Blue Shield so you may present your MESSA medical card when seeking vision services. The VSP Vision plan year is July through June.

If you use an in-network provider, most services are generally paid at 100%. Some services have dollar limitations, though, so review the VSP materials for details. If you receive services in-network, the provider will bill VSP directly and receive their payment from VSP. You don't have to do anything!

You still have the option of receiving care from a non-VSP provider. If you do, you will be paid according to your currently negotiated benefit levels and you will also need to file a claim and wait for reimbursement.

*For a Provider Directory or to see if there is a network provider near you, visit the **www.vsp.com** website or **www.messa.org.**

Life Benefits

WEA members are enrolled in a District-paid Life Insurance program that is insured by MESSA and UNUM.

The WEA life insurance benefit plan options are either a Board paid flat $50,000 or one and one-half times your salary up to a maximum of $200,000. If you chose the one and one-half times your salary option, the first $50,000 will be insured by MESSA and the benefit amount above the $50,000 with be insured through UNUM. This coverage helps to provide WEA members with financial protection for their families.

If you are currently enrolled in the flat $50,000 benefit and wish to increase it to the Increment of Income benefit, you will be required to submit an Evidence of Insurability Form to UNUM for approval.

The IRS requires the value of employer-provided group term life coverage over $50,000 to be taxed. The taxable value of this life insurance coverage is called "imputed income". It does not include accidental death and dismemberment coverage.

Exemption to Imputing Income on Group Term Life Insurance in Excess of $50,000

If an employee names a charitable organization as defined under Section 170(c) of the Internal Revenue Service, as the sole beneficiary of all or part of the life insurance proceeds, imputed income will NOT be required. The charitable organization must be named beneficiary for the entire plan year. This exception also applies if the employer is the names beneficiary of the policy.

Example of Calculating Imputed Income

A 28–year old employee has $150,000 of employer-paid basic coverage. The amount of life insurance over $50,000 is divided by 1,000 and then multiplied by the applicable Table 1 rate to determine the monthly imputed income to be included on the employee's W-2. Federal and state income tax liability on this amount will depend on each employees' personal circumstances.

$150,000 total amount of employer-provided group term life insurance

$50,000 exempt amount

$100,000 / $1,000

$100 x. $0.06 Rate for 28-year old employee

$6.00 imputed (taxable) income per month

The above example would result in an annual imputed (taxable) income of $74 for a $150,000 employer-provided group term life benefit. The $72 is added as income, taxed and then removed. If this person is at a 30% tax bracket, they would have $21.60 in taxes for this benefit.

The example does not take into account any mid-year changes, such as a salary change that may result in a recalculation of the monthly imputed income amount.

Age Bracket	Table 1 Rate Per $1,000 of Benefit
Under 25	0.05
25 - 29	0.06
30 - 34	0.08
35 - 39	0.09
40 - 44	0.10
45 - 49	0.15
50 - 54	0.23
55 - 59	0.43
60 - 64	0.66
65 - 69	1.27
70 - 74	2.06

Disability Benefits

WCS also provides disability coverage to full-time WEA members. The Long Term Disability (LTD) Plan currently pays you a benefit equal to 60% of your basic earnings to a maximum monthly benefit of $7,500. Benefits are payable after 180 days of disability.

Benefits may continue until you reach age 65, or retirement whichever comes first. LTD is vital protection for you and your family. The LTD plan is insured by MESSA and paid for by the District.

Optional Life/Group Survivor Income Insurance

WEA employees are eligible to enroll in the employee paid Optional Life/Group Survivor Income Insurance (only available to those enrolled in the MESSA medical plan or if you elect the $5,000 group term life insurance). Please contact Ann Marie in the Employee Benefits Department for the applicable form/rates.

Flexible Spending Account

Dependent Care Account

The Dependent Care Account (DCA) allows you to pay (with "before tax" dollars) child and/or elder care expenses. Eligible expenses include daycare expenses you incur while you (and your spouse, if you are married) work.

As you incur eligible childcare expenses, submit a receipt to Employee Benefit Concepts—our flex claims payer. EBC will send you a check using the tax-free money from your DCA.

You enjoy a tax savings when you use the DCA because the money in the account is not subject to Federal income tax, Social Security tax (FICA), or state tax. **You may elect to contribute up to $5,000 annually or $2,500 if married and filing separately.**

If you contribute to a Dependent Care Reimbursement Account, you must file an IRS Form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care expenses.

Important Notice from Warren Consolidated Schools About Your Prescription Drug Coverage and Medicare

Notice of **Creditable** Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Warren Consolidated Schools 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. **Warren Consolidated Schools has determined that the prescription drug coverage offered by the Warren Consolidated Schools 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 through 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 Warren Consolidated Schools coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current Warren Consolidated Schools coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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 Warren Consolidated Schools 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 October to join.

Important Notice from Warren Consolidated Schools About Your Prescription Drug Coverage and Medicare - cont.

least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **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 Warren Consolidated Schools 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.

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 whether or not you are required to pay a higher premium (a penalty).

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).

Date:	November 2017
Name of Entity/Sender:	Warren Consolidated Schools
Contact—Position/Office:	Chief Operating Officer
Address:	31300 Anita Drive Warren, MI 48093
Phone Number:	(586) 825-2400

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual 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, you can 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 are not 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, 2017. You should contact your state for further information on eligibility.

ALABAMA – Medicaid
Website: www.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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA – 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

IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 1-401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://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.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022, ext.15473

WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website:https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Telephone: 1-307-777-7531

To see if any more states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Dept. of Labor, Employee Benefits Security Administration: www.dol.gov/ebsa
Phone: 1-866-444-EBSA (3272)

U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services: www.cms.hhs.gov
Phone: 1-877-267-2323, menu option 4, extension 61565