IBEW/AECA FAMILY HEALTH

IBEW LOCAL 613 & CONTRIBUTING EMPLOYERS FAMILY HEALTH PLAN
501 Pulliam St SW • Suite 444 • Atlanta, Georgia 30312
1.800.922.1613 • www.nebainc.com

IT'S TIME TO ENROLL!

DURING ANNUAL ENROLLMENT EACH YEAR, IT IS IMPORTANT THAT YOU:

- ➔ **UPDATE** the Fund with your current information, including address, email, phone numbers and marital status;
- ➔ **CHOOSE** between the Cigna or Kaiser benefit options *(only available if you reside in a zip code that is within the Plan's "Kaiser Service Area." See page 3 for more details)*; and
- ➔ **ENROLL** the dependents that you want to have covered under your benefits for the upcoming year.

REMEMBER: YOU MUST COMPLETE ENROLLMENT IN ORDER FOR YOUR DEPENDENTS TO HAVE COVERAGE IN 2024

WHEN	October 16, 2023 through December 1, 2023
WHERE	Enroll online* at: www.nebainc.com
NEED HELP?	Contact the Fund Office at 1-800-922-1613

*If you would prefer to complete a paper enrollment, contact the Fund Office at 1-800-922-1613.

ALL PARTICIPANTS MUST COMPLETE THE ENROLLMENT BY DEC 1st

YOUR ONLINE ENROLLMENT APPLICATION CAN BE ACCESSED RIGHT INSIDE YOUR MEMBER PORTAL – JUST A SINGLE SIGN ON TO ENROLL AND VIEW INFORMATION ON YOUR BENEFITS, WORK HISTORY AND MORE!

ENROLLMENT IS FAST AND EASY – Much of the information will be pre-populated for you, but please review to make sure it is still correct!

➡ LOG-ON	to www.nebainc.com
➡ CLICK	on the Member Login link at the top of the page.
➡ LOG-IN	to your member portal with your email and password. If you need to create a log-in, click on "Create Account." To create an account, you will need an email address, your name, social security number, date of birth and home zip code.
➡ CLICK	on the Enrollment link in your dashboard and from the Welcome Page, then click on ● January 1, 2024 – December 31, 2024 New! to get started.
➡ VERIFY	that the information we have for you on file is correct - you can also add or remove dependents as needed to confirm who you want to enroll for benefits for 2023.
➡ CHOOSE	your Bundle Election (if you live in a zip code where you can choose between the Cigna or Kaiser plans click on the comparison of coverage options to see which plan is best for you) and your Coverage Type (Employee Only, Employee & Child(ren), Employee & Spouse, or Employee & Family)
➡ UPDATE	your named beneficiaries for your pension and life insurance. If you have updated your beneficiaries since 1/1/22, the portal will show your current beneficiaries.
➡ ANSWER	a question about your spouse's employment status. **A spouse who has access to but is not enrolled in coverage through their own employer will not be eligible for coverage under the Family Health Plan.**
➡ GO GREEN	by registering for electronic consent to receive certain plan disclosures via email instead of paper.
➡ REVIEW	your enrollment information – go back and edit as necessary.
➡ SUBMIT	your completed enrollment – you're done!

Step-by-step instructions for completing the enrollment process can be found under the "Enrollment" Icon **when you log into your member portal** and are also available on IBEW Local 613's website at **www.ibew613.org** under "News".

If you fail to complete enrollment, you will be defaulted to Employee Only coverage for 2024 – this means your dependents will not be eligible for benefits effective January 1, 2024 unless you complete your enrollment and you select to cover them.

ALL PARTICIPANTS MUST COMPLETE THE ENROLLMENT BY DEC 1st

SUMMARIES OF BENEFITS AND COVERAGE (SBCs): Included with this notice is a copy of the SBC for the Cigna Open Access Plus benefit ("OAP") option and, if you reside in the Kaiser Service Area, a copy of the SBC for the Kaiser HMO benefit option. These documents provide important information to help you make your benefit decisions for the upcoming year. If you reside in the Kaiser Service Area, we have also included a side-by-side comparison of the basic benefit provisions of both the Cigna and Kaiser options.

REMEMBER: The benefit options you choose during Open Enrollment will be permanent for 2024 unless you experience a qualifying life event that triggers a special enrollment period.

- If you select the Kaiser HMO option during Open Enrollment, but then move outside of the Kaiser Service Area, you will be permitted a special enrollment period in order to choose the Cigna option.
- If you decline enrollment for one or more of your dependents because they have access to other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your dependents' other coverage.) However, you must request enrollment within 30-days after your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents (both the new dependents and any other dependents you had not enrolled). However, you must request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption.
- If you decline coverage for a dependent because that dependent was covered under Medicaid or the State Children's Health Insurance Program ("SCHIP"), you may be able to enroll your dependents in this plan if your dependent is no longer eligible for Medicaid or SCHIP. You may also be able to enroll your dependents in this plan if a dependent becomes eligible for premium assistance under Medicaid or SCHIP. However, you must request enrollment within 60-days of the loss of eligibility for Medicaid or SCHIP or the date the dependent becomes eligible for premium assistance.

To request a special enrollment period or to obtain more information about your special enrollment rights, contact the Fund Office at 1-800-922-1613.

KAISER HMO SERVICE AREA: Participants who reside in a zip code that is included in the Plan's "Kaiser Service Area" have the choice of participating in the Cigna Open Access Plus or the Kaiser HMO plan of benefits. This choice can only be made during enrollment and will be permanent for the full benefit year – except for those participants who choose the HMO and subsequently move out of the Kaiser Service Area. The Kaiser Service Area includes specific zip codes in the following Georgia counties: Barrow, Bartow, Butts, Carroll, Cherokee, Clarke, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Madison, Meriwether, Newton, Oconee, Oglethorpe, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton. If you have a question about a specific zip code, please contact the Fund Office at 1-800-922-1613. The Kaiser HMO option has a lower deductible and lower copays for certain medical services. However, in order to receive the enhanced benefits, the HMO uses a smaller provider network, with many services being provided only through the Kaiser Medical Centers. We encourage you to research your benefit options to determine which works best for you and your family. *Please note that completion of enrollment is not a guarantee of eligibility for benefits. For questions regarding eligibility, please refer to your Summary Plan Description or contact the Fund Office at 1-800-922-1613.*

ALL PARTICIPANTS MUST COMPLETE THE ENROLLMENT BY DEC 1st

HIGHLIGHT COMPARISON OF 2024 FAMILY HEALTH PLAN COVERAGE OPTIONS

COVERAGE UNDER BOTH OPTIONS IS FOR IN-NETWORK PROVIDERS ONLY (plus Non-Network Emergency Services)

	CIGNA OAP	KAISER HMO
NETWORK UTILIZED	CIGNA OPEN ACCESS PLUS	KAISER PERMANENTE HMO
IF YOU NEED TO SEE THE DOCTOR	Calendar Year Deductible does not apply	
Primary Care	You pay $35	You pay $20
Specialist	You pay $45	You pay $35
Mental Health	You pay $35	You pay $20
Virtual Visit/Telemedicine	You pay $35	You pay $0
WHEN YOU RECEIVE PREVENTIVE CARE	Calendar Year Deductible does not apply	
ACA Preventive Care Services	You pay $0	You pay $0
IF YOU NEED A PRESCRIPTION DRUGS		
ACA PREVENTIVE CARE DRUGS	You pay $0, no deductible	You pay $0, no deductible
PRESCRIPTION DEDUCTIBLE	$25 per individual per calendar year	None
RETAIL (30-day supply)	After deductible:	If filled at Kaiser Facility:
Tier 1: Generic	You pay $10	You pay $10
Tier 2: Preferred Brand	You pay greater of $25 or 25%	You pay $25
Tier 3: Non-Preferred Brand	You pay greater of $25 or 25%	Not covered
HOME DELIVERY (90-day supply)		
Tier 1: Generic	You pay $30	You pay $20
Tier 2: Preferred Brand	You pay greater of $75 or 25%	You pay $50
Tier 3: Non-Preferred Brand	You pay greater of $75 or 25%	Not covered
SPECIALTY (30-day supply)		
Specialty Medications	You pay greater of $25 or 25%	You pay $25
IF YOU NEED OTHER MEDICAL SERVICES		
CALENDAR YEAR DEDUCTIBLE (CYD)		
Individual	$750	$250
Family	$2,500	$750
MAXIMUM OUT-OF-POCKET		
Individual	$6,350	$6,350
Family	$12,700	$12,700
EMERGENCY CARE		
Emergency Room	You pay $100, then 30% after CYD	You pay $100, then 30% after CYD
Transportation	You pay 30% after CYD	You pay 30% after CYD
Urgent Care	You pay 30% after CYD	You pay 30% after CYD
OTHER SERVICES		
In-Network	You pay 30% after CYD	You pay 30% after CYD
Non-Network	Not covered	Not covered
VISION BENEFITS		
Adult Benefit		
Annual Exam	Reimbursed at 100%, up to $200 maximum every 24 months	You pay $0
Hardware		$200 credit every 2 years
Pediatric Benefit (under age 19)		
Annual Exam	You pay $0	You pay $0
Hardware	You pay $0 for one set of standard lenses (or standard contact lenses per year). Frames are covered in full up to $100 every 24 months.	$200 credit every 2 years

CURRENT DENTAL BENEFITS WILL STILL BE PROVIDED THROUGH CIGNA FOR <u>BOTH</u> COVERAGE OPTIONS

The above comparison just highlights basic benefits and is not intended to fully describe all benefit coverages.

IBEW LOCAL 613 AND CONTRIBUTING EMPLOYERS FAMILY HEALTH FUND

501 Pulliam St SW, Suite 444 ● Atlanta, GA 30312
2010 N.W. 150th Avenue, Suite 200 ● Pembroke Pines, FL 33028
1.800.922.1613 ● Fax 678.705.0205

EMPLOYER SPONSORED HEALTH COVERAGE VERIFICATION

****ONLY TO BE COMPLETED IF SPOUSE IS EMPLOYED – SECTIONS 3 & 4 MUST BE COMPLETED BY THE EMPLOYER ****

*The IBEW Local 613 and Contributing Employers Family Health Plan does not provide coverage to spouses whose employers offer group health benefits unless the spouse is actually enrolled in his/her employer-sponsored health plan. In order to be covered under the Family Health Plan, the spouse must have this form **completed by his/her employer** in full and submit it to the Plan. The employer may be contacted to verify the information shown herein.*

1. EMPLOYEE (SPOUSE'S) INFORMATION

Spouse First Name		**Middle Initial**		**Last Name**	
613 Participant First Name		**Middle Initial**		**Last Name**	
Address				**Phone Number**	

2. SPOUSE'S EMPLOYER INFORMATION

Name of Employer - *Please insert "Not employed" if your spouse* is unemployed						
Employer Address						
	City		**State**		**Zip**	

3. SPOUSE'S GROUP HEALTH INFORMATION (To be completed by Employer - see back of page for instructions)

Does this Employer offer Health Benefits? *	☐ **YES**	☐ **NO**
If so: Is the person named above as Spouse eligible for such medical coverage? *Please note that "eligible" means that coverage has been offered and does not require that the Spouse has elected to enroll in such coverage.*	☐ **YES**	☐ **NO**
Is the person named above as Spouse enrolled in such medical coverage?	☐ **YES**	☐ **NO**
If not enrolled: Does the amount that the Spouse would have to pay as an employee co-premium for self-only coverage exceed 9% of the Spouse's gross wages?	☐ **YES**	☐ **NO**

If the Spouse's employer does offer employer-sponsored medical coverage, but the Spouse is not eligible for such coverage, please provide a brief description of why he/she is not eligible (i.e., waiting period, works in ineligible job position or status). If the reason is due to a waiting period, please provide the first date on which the employee would be eligible for such coverage.

Description of why not eligible:

**This includes benefit plans for which there is an employee premium or payroll deduction, but does not include coverage where 100% of the premium is paid by the employee, with no employer contribution.*

4. EMPLOYER SIGNATURE – *by signing below, the Employer certifies that the information shown in Section 3 is true and correct.*

Employer Signature		**Date**	
Employer Name		**Title**	
Telephone Number		**Email**	

****PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR ADDITIONAL INFORMATION****

You may return your form by one of the following methods: Mail: 501 Pulliam St SW, Suite 444 Atlanta, GA 30312, Fax: 678-705-0205 or you may securely upload your document by visiting www.nebainc.com. Email responses should be sent to 613enrollment@nebainc.com.

EMPLOYER INSTRUCTIONS FOR COMPLETING THE SPOUSE'S GROUP HEALTH INFORMATION SECTION

Your accurate responses to the questions contained in this affidavit are important to determining your employee's coverage for benefits under the Family Health Fund. Incorrect information may result in the Spouse being responsible for repayment of benefits provided. If you have any questions on how to complete this form, please contact the Fund Office at 1-800-922-1613 for assistance.

Does this Employer offer Health Benefits?

- **Answer "YES" if** your company offers a group health benefit program that provides coverage for medical services and the employee co-premium (the amount the employee has to pay towards the cost of the coverage) is less than 100% of the total cost of the coverage.
- **Answer "NO" if** your company does not offer a group health benefit program or if the employee must pay 100% of the cost of the coverage under your group health benefit program.

If so: Is the person named above as Spouse eligible for such medical coverage?

IMPORTANT NOTE: "Eligible" does not mean that the person is actually "Enrolled" or participating in the group health plan. It just means that he/she had the opportunity to enroll by satisfying the plan's eligibility requirements (such as being in a covered job position, completing a waiting period, etc.).

- **Answer "YES" if** the Spouse (your employee) was OFFERED the chance to enroll in your group health benefit program for the current period, even if the Spouse chose not to enroll.
- **Answer "NO" if** the Spouse did not qualify for the opportunity to enroll in your group health benefit program for the current period for a reason other than the Spouse declining such enrollment.

Is the person named above as Spouse enrolled in such medical coverage?

- **Answer "YES" if** the Spouse (your employee) is enrolled in your group health plan for the current period.
- **Answer "NO" if** the Spouse is not enrolled for benefits under your group health plan for the current period.

If not enrolled: Is the amount that the Spouse would have to pay as employee co-premium for self-only coverage exceed 9% of the Spouse's gross wages?

If you offer more than one benefit plan option, the 9% should be measured off of the self-only co-premium for the lowest costing option.

- **Answer "YES" if** the amount of employee co-premium that the Spouse (your employee) would have to pay to participate in self-only coverage for your group health plan's lowest benefit option would exceed 9% of the employee's gross wages. For example, if the employee's gross wages average $1,625 per month and the employee co-premium for self-only coverage is $150 per month, $150 is greater than 9% of $1,625.
- **Answer "NO" if** the co-premium for self-only coverage for your group health plan's lowest benefit option is less than 9% of the employee's gross wages. For example, if the employee's gross wages average $1,625 per month and the employee co-premium for self-only coverage is $100 per month, $100 is less than 9% of $1,625.

If the Spouse's employer does offer employer-sponsored medical coverage, but the Spouse is not eligible for such coverage, please provide a brief description of why he/she is not eligible (i.e., waiting period, works in ineligible job position or status). If the reason is due to a waiting period, please provide the first date on which the employee would be eligible for such coverage.

Provide a short description of why the Spouse (your employee) did not satisfy the eligibility rules for coverage under your group health plan for the current period. Common reasons are: new employee waiting period, working in part-time status, or working in non-covered position.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-CIGNA24. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https:/healthcare.gov/sbc-glossary or call 1-800-922-1613 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750**/individual; **$2,500**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, prescription drugs, physician office visits, dental or vision services except those covered under major medical are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$100**/visit for Emergency room services; **$25**/individual for prescription drugs; **$50**/individual for pediatric dental.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,350**/individual, **$12,700**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, dental or vision services except those covered under major medical or deemed to be essential pediatric oral/vision services, benefit reductions for failure to obtain preauthorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.myCigna.com or call 1-800-CIGNA24	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check

Important Questions	Answers	Why This Matters:
		with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit. Deductible does not apply	Not covered	Copay applies only to professional service charge. Other charges incurred during visit are subject to deductible and coinsurance.
	Specialist visit	$45 copay/visit. Deductible does not apply	Not covered	Copay applies only to professional service charge. Other charges incurred during visit are subject to deductible and coinsurance.
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered except as required under federal law	Preauthorization is required for genetic testing. No coverage if you fail to obtain preauthorization. Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered except as required under federal law	Preauthorization is required. No coverage if you fail to obtain preauthorization. Certain services received from non-network providers while at an in-network facility may be covered as in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.myCigna.com**	Generic drugs	$25 deductible, then Retail: $10 copay/script Home Delivery: $30 copay/ script Overall deductible does not apply.	Not covered	Covers up to 34-day supply at Retail and up to 90-day supply at Home Delivery. All Specialty drug fills are limits to 30-day supply. Only 1 Specialty fill allowed at Retail, then subsequent fills must be through Home Delivery. Drugs designated as ACA preventive care are available at no charge, including contraceptives. If a brand name is requested when there is a generic equivalent available, you will be required to pay the generic copay plus the difference in cost between the brand name and the generic. Coverage for certain drugs may require preauthorization, be subject to a quantity limit, and/or be subject to a step therapy program.
	Brand name drugs (Preferred and Non-Preferred)	$25 deductible, then Retail: Greater of $25 copay/script or 25% coinsurance Home Delivery: Greater of $75 copay/script or 25% coinsurance Overall deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Preauthorization is required for certain outpatient surgical procedures Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	30% coinsurance	Not covered except as required under federal law	
If you need immediate medical attention	Emergency room care	$100 deductible, then 30% coinsurance	Covered as in-network	$100 deductible/visit waived if admitted to hospital from emergency room
	Emergency medical transportation	30% coinsurance	Covered as in-network	None
	Urgent care	30% coinsurance	Not Covered except as required under federal law	Emergency services provided at a non-network Urgent Care center licensed to operate as a freestanding emergency department may be covered as in-network

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	Preauthorization is required Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Physician/surgeon fees	30% coinsurance	Not Covered except as required under federal law	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit. Deductible does not apply. 30% coinsurance/ other outpatient services	Not Covered	Charges related to substance abuse services are not covered. Preauthorization is required for inpatient services and certain outpatient services
	Inpatient services	30% coinsurance	Not Covered except as required under federal law	Charges related to substance abuse services are not covered. Preauthorization is required for inpatient services and certain outpatient services Certain services received from non-network providers while at an in-network facility may be covered as in-network.
If you are pregnant	Office visits	30% coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and deductible may apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage for dependent child pregnancy, except for certain preventive services. Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Childbirth/delivery professional services	30% coinsurance	Not Covered except as required under federal law	
	Childbirth/delivery facility services	30% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	Coverage is limited to 16 hours/day. Preauthorization is required
	Rehabilitation services	30% coinsurance	Not Covered	Preauthorization is required for speech therapy
	Habilitation services	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	30% coinsurance	Not Covered	Preauthorization is required for admission to skilled nursing facility
	Durable medical equipment	30% coinsurance	Not Covered	Preauthorization is required
	Hospice services	30% coinsurance	Not Covered	Preauthorization is required for admission to hospice facility
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	No Charge Deductible does not apply.	Limited to one exam/year.
	Children's glasses	No Charge. Deductible does not apply.	No Charge Deductible does not apply.	Limited to one set of lenses/year. Coverage for frames limited to $100 every 24 months.
	Children's dental check-up	No Charge. Deductible does not apply.	No Charge Deductible does not apply.	Limited to 1 exam/6 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Habilitation services
- Hearing aids
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Pregnancy of dependent child, except for preventive services mandated by law.
- Private duty nursing
- Routine foot care
- Substance abuse services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care, limited to $10/visit maximum payment and 26 visits/year
- Dental care (adult), limited to $100/year
- Routine eye care (Adult), limited to $200/24 months

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-CIGNA24 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-CIGNA24
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-CIGNA24
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-CIGNA24
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-CIGNA24

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$775
Copayments	$0
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,335**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$700
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$875
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,575**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.kp.org/plandocuments or call 1-888-865-5813 (TTY: 711. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https:/healthcare.gov/sbc-glossary or call 1-800-922-1613 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250**/individual; **$750**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, prescription drugs, physician office visits, dental or vision services except those covered under major medical are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$50**/individual for pediatric dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,350**/individual, **$12,700**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, dental services except those covered under HMO medical benefits, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-888-865-5813 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit. Deductible does not apply	Not covered	Copay applies only to professional service charge. Other charges incurred during visit are subject to deductible and coinsurance.
	Specialist visit	$35 copay/visit. Deductible does not apply	Not covered	Copay applies only to professional service charge. Other charges incurred during visit are subject to deductible and coinsurance.
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.kp.org**	Generic drugs	At Kaiser: $10 copay/script At Network Pharmacy: $20 copay/script At Home Delivery: $20 copay/script Deductible does not apply	Not Covered	Covers up to 30-day supply at retail; 31-90 day supply at mail order. Network Pharmacies limited to one-time fill, refills must be through Kaiser. No charge for contraceptives or certain other preventive medications (subject to formulary guidelines).
	Preferred brand name drugs	At Kaiser: $25 copay/script At Network Pharmacy: $35 copay/script At Home Delivery: $50 copay/script Deductible does not apply	Not Covered	Covers up to 30-day supply at retail; 31-90 day supply at mail order. Network Pharmacies limited to one-time fill, refills must be through Kaiser.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
	Non-preferred brand name drugs	Not Covered	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Physician/surgeon fees	30% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$100 copay, then 30% coinsurance	Covered as in-network	$100 copay/visit waived if admitted to hospital from emergency room
	Emergency medical transportation	30% coinsurance	Covered as in-network	None
	Urgent care	30% coinsurance	Not Covered	Non-Plan provider urgent care covered only if you are temporarily outside of Kaiser service area or for emergency services provided at urgent care center licensed to operate as a freestanding emergency department.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	Certain services received from non-network providers while at an in-network facility may be covered as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral health: $20 copay/visit (individual) $10 copay/visit (group) Deductible does not apply. Substance abuse: Not Covered	Not Covered	Charges related to substance abuse services are not covered.
	Inpatient services	Mental/Behavioral health: 30% coinsurance Substance abuse: Not Covered	Not Covered	Charges related to substance abuse services are not covered. Certain services received from non-network providers while at an in-network facility may be covered as in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge. Deductible does not apply.	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Coverage is limited to 1 Postnatal visit. Depending on the type of services, copayment, coinsurance and deductible may apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not Covered	Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Childbirth/delivery facility services	30% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	Private duty nursing not covered.
	Rehabilitation services	30% coinsurance	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	30% coinsurance	Not Covered	None
	Durable medical equipment	30% coinsurance	Not Covered	Coverage is limited to items on DME formulary.
	Hospice services	30% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge, Deductible does not apply	Not Covered	Refractive exam provided to children up to age 19.
	Children's glasses	No Charge. Deductible does not apply	Not Covered	Limited to $200 credit every 2 years for glasses.
	Children's dental check-up	No Charge. Deductible does not apply	No Charge Deductible does not apply.	Coverage provided through Cigna. Limited to 1 exam/6 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Hearing aids (adult)
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Substance abuse services
- Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care, limited to 26 vistis/year
- Dental care (adult), limited to $100/year
- Hearing aids (under age 19 only): limited to $3,000/ear every 48 months)
- Routine eye care (Adult), limited to $200 credit/2 years

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agency in the chart below:

Your Grievance and Appeals Rights

Kaiser Permanente Member Services	1-888-865-5813 (TTY: 711) or www.kp.org/memberservices
Cigna Healthcare (for dental benefits only)	1-800-CIGNA24 (244-6224) or www.myCigna.com
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Georgia Department of Insurance (for Kaiser HMO benefits only)	1-800-656-2298 or www.oci.ga.gov/

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-865-5813 (TTY: 711)
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-865-5813 (TTY: 711)
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-888-865-5813 (TTY: 711)
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-865-5813 (TTY: 711)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$3,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,020**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$250
Copayments	$200
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Women's Health and Cancer Rights Act

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 (800) 922-1613.

HIPAA Privacy Notice

The Plan is required to take reasonable steps to ensure the privacy of your personally identifiable health information in accordance with the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related federal regulations. The Plan adopted a Notice of Privacy Practices describing how health information about you may be used and disclosed by the Plan and other parties as permitted under HIPAA and the federal regulations and how you can get access to this information. For additional information, you may request a copy of the Privacy Notice by submitting a written request to the Fund Office.

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 January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)