



The Pet Loss Center®

HONORING THE JOURNEY

Benefits Enrollment Guide  
Plan Year: 4/1/2018 to 3/31/2019



# Open Enrollment for Your Benefits

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It's Open Enrollment- if you want to make changes to your benefits, *NOW* is the time.

What is Open Enrollment?

Open Enrollment is the one time each year you can make changes to your benefit elections.

- You can add or drop eligible dependents in your medical, dental and/or vision plans
- You can opt out of your medical, dental and/or vision plans
- You can enroll for the first time in medical, dental and/or vision plans

Elections you make during open enrollment will become effective April 1, 2018.

The Pet Loss Center offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best for you and your family.



## ***Who is Eligible?***

If you are a full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. If you enroll, you may also enroll your spouse and/or children.



## ***When to Enroll?***

Now is the time to enroll. Please submit your elections by **March 14, 2018**.

## ***How to Enroll?***

Make your benefit elections by completing the enrollment form. Once you make your elections you will not be able to change until next open enrollment.



You can only make changes during the year for qualified life events such as:

- Marriage, Divorce, Legal Separation
- Birth or Adoption of a child
- Change in child's dependent status
- Death of spouse, child or other qualified dependent
- Involuntary loss of other coverage
- Change in spouse's employment status

# Medical and Prescription Drugs

The Pet Loss Center gives you the freedom to choose between our two medical plans. Our benefits are as follows:

United Healthcare Medical Insurance		
Plan Option	Option 1	Option 2
Plan Name	5000 100% H.S.A. Plan - AE3L	3000 80% Copay Plan - AGZ4
Network Name	ChoicePlus PPO	ChoicePlus PPO
Calendar Year Deductible		
Individual	\$5,000	\$3,000
Family	\$10,000	\$6,000
Out-of-Pocket Max (per calendar yr includes deductible and copays)		
Individual	\$6,000	\$6,000
Family	\$12,000	\$12,000
Office Visits		
Preventive Care	No Charge	No Charge
Physician Visit	Plan pays 100% after you satisfy annual deductible	\$0 copay for ages <19 \$30 copay general doctor \$60 copay specialist
Telemedicine/Virtual Visits	\$49 service fee	\$25 copay virtual visits Lab & x-ray costs go toward deductible.
Other Services		
Inpatient Hospital Services	Plan pays 100% after you satisfy annual deductible	Plan pays 80% after you satisfy annual deductible
Outpatient Hospital   Facility Services	Plan pays 100% after you satisfy annual deductible	Plan pays 80% after you satisfy annual deductible
Emergency Room	Plan pays 100% after you satisfy annual deductible	Plan pays 80% after \$250 copay. If admitted, plan pays 80% after deductible.
Urgent Care	Plan pays 100% after you satisfy annual deductible	\$75 copay
Prescription Drugs		
Tier 1	\$10 - after deductible	\$10
Tier 2	\$35 - after deductible	\$35
Tier 3	\$60 - after deductible	\$60
Tier 2 Specialty	\$100 - after deductible	\$100
Tier 3 Specialty	\$300 - after deductible	\$300
Health Savings Account (2018 Maximum Contribution Allowed)		
Employee Only	\$3,450 annual maximum	N/A
Employee + 1 or more dependents	\$6,900 annual maximum	N/A
If you enroll in Option 1, The Pet Loss Center will contribute \$1,000 prorated over the year to your H.S.A.		

# Medical Insurance & Health Savings Accounts (HSA)

Both of our medical insurance options give you freedom to choose any doctor within the UHC Choice Plus network.

Option 2 is our traditional plan that offers copays for routine care and prescription drugs.

Option 1 is designed to give you more control and responsibility over your health care expenses. If you elect to enroll in Option 1, you can open a bank account, called a Health Savings Account. You can then contribute money to the account and receive an income tax deduction on your contributions.

## H.S.A Info- Did you know?

Money in an H.S.A. is yours! It is NOT use it or lose it. Money can accrue over the course of years.

H.S.A funds can only be used for an eligible medical expense.

Examples of eligible expenses are as follows: (health plan may not cover these)

Acupuncture	Alcoholism Treatment	Ambulance Services
Dental Expenses	Chiropractor	Psychiatric Care
Hospitalization	Doctor Fees	Prescription Drugs
Contact Lenses	Laboratory Fees	Surgery

You are free to spend your H.S.A. money on any eligible expense but if not covered by health insurance plan your deductible will not be reduced by those expenses.

## Annual Maximum H.S.A. Contribution

2018	Employee Only Coverage	\$3,450 annual maximum
	Employee + Dependent(s)	\$6,900 annual maximum
Catch Up Provision	For participants 55+	\$1,000+ to amounts about annually

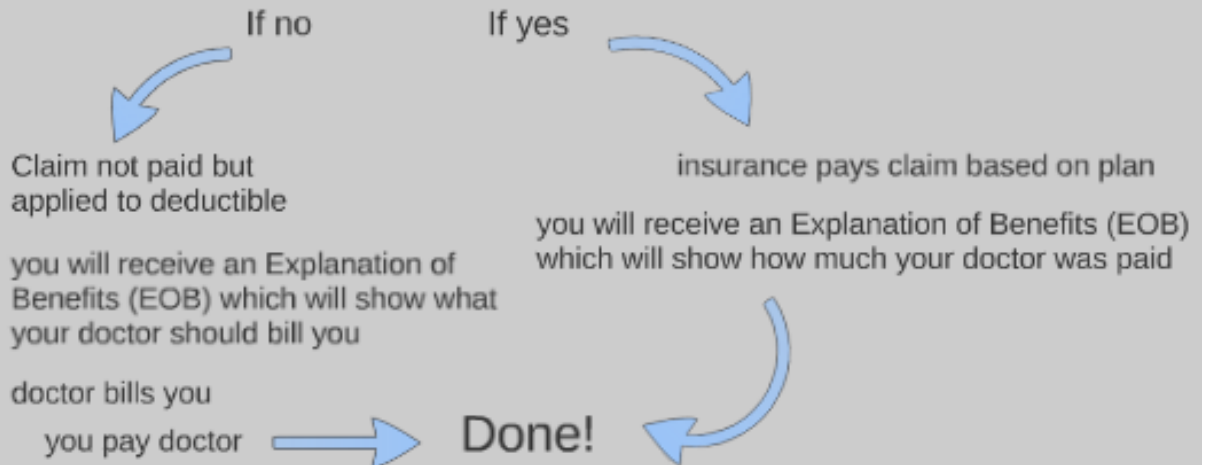
**\*Please note, if you are enrolled in Medicare the IRS states you are not eligible to open or receive contributions to a Health Savings Account.**

# Health Savings Account- Medical plan Option 1



## Steps to using your HSA and Medical Plan

- 1) open health savings account with a bank  
you will receive a debit card to use to pay eligible health expenses
- 2) When you go to a doctor or medical facility tell them you have a high deductible HSA plan  
ask them to file the claim with your insurance company
- 3) Have you met your deductible for the year?



### Did you know?

Money in an HSA is yours! It is not use it or lose it like other types of accounts.

HSA funds can only be used for eligible medical expenses, such as:

- |                 |                      |                    |
|-----------------|----------------------|--------------------|
| Acupuncture     | Alcoholism treatment | Chiropractor       |
| Dental expenses | Doctor fees          | Ambulance services |

You can spend your HSA money on any eligible expense but if the expense is not covered by your health plan those expenses won't count towards satisfying your health plan deductible.

# Dental Benefits

The Pet Loss Center plan allows you to see the dentist of your choice. However out-of-network dentists may balance bill for you amounts above the plan pays. To get the most value stay in the UHC National Options PPO 30 network. The plan benefits are described below:

Voluntary Dental Plan	
Plan	UnitedHealthcare P1211
Calendar Year Deductible- Only Applied to Basic and Major Services	
Individual	\$50
Family	\$150
Dental Type	Plan Pays and Services Covered
Preventive Services	Plan pays 100% Preventive Services include: exams, cleanings, limited x-rays, fluoride treatments, sealants, space maintainers
Basic Services	Plan pays 80% Basic Services include: fillings, general services
Major Services	<b>12 Month Waiting Period for Major Services:</b> Plan pays 50% Major Services include: root canals, periodontics, crowns, dentures, inlays, onlays, bridges, oral surgery
Annual Maximum	\$1,000 per covered person

# Vision Benefits

Our vision plan provides coverage for exams, lenses, contacts and frames. You must use a network vision provider to get benefits described below.

Our plan is described below.

Voluntary Vision Plan	
Carrier	UnitedHealthcare V1008
Plan Services	Benefits
Vision Exams	\$10 Copay
Materials (Lenses/ Frames)	\$25 Copay
Elective Contacts	\$105 Allowance
Frames	\$130 Allowance + 30% discount
Frequency	1 exam and new lenses every 12 months Frames every 24 months

# Additional Benefits

The Pet Loss Center plan also gives you the opportunity to choose options from Aflac. Some of the information is listed below:

**Aflac**

Aflac benefits pay YOU for a covered event. You can choose to use the money Aflac pays for medical bills or any other way you wish. It's your money!

Aflac options are:

Cancer Plan	Accident Plan	Hospital Plan	Critical Illness Plan
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See Aflac enrollment packet for more information.

# Important Contact Information:

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## The Pet Loss Center

Benefits and Human Resources contact:  
Kelly Box  
817-271-4847  
[kbox@humcapinc.com](mailto:kbox@humcapinc.com)

## Insurance Help

The Reaves Agency  
Account Manager: Shelly Martin  
972-348-0094  
[shelly@reavesagency.com](mailto:shelly@reavesagency.com)

Medical Carrier:  
UnitedHealthcare

Member Services: 800-357-0978

To find a doctor:  
[www.myuhc.com](http://www.myuhc.com)  
Network: Choice Plus

Dental & Vision Carrier:  
UnitedHealthcare

Member Services: 877-844-4999  
To find a dental or vision provider:  
[www.myuhc.com](http://www.myuhc.com)  
Dental Network: National Options PPO 30  
Vision Network: Click on "find a vision provider"

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### Open Enrollment Checklist:

- Review this enrollment guide and consider your benefit needs for the upcoming year.
- Enroll or decline coverage by completing the enrollment form.
- Have a great day!

**Action Required!** All eligible employees must complete a form. All elections will be locked until next open enrollment except for qualified life changes for which we are notified within 30 days.



## Annual Enrollment Notices

*Please note: This is not a legal document. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer and insurance carriers. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.*

### Enrollment Notice

#### Women's Health and Cancer Rights Act of 1998

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. Therefore, the following deductibles and coinsurance apply: Please refer to previous sections of this enrollment guide for deductible amounts.

If you would like more information on WHCRA benefits, call your HR Manager.

#### Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, your employer provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing. Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit

<http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html>.

Your plan continues to cover women's in-network preventive health care services — such as mammograms, screenings for cervical cancer, and other services — with no cost sharing as mandated by the Affordable Care Act.

#### Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

#### Special Enrollment Rights

- **After declining health coverage.** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the health plans in the future, provided that you request enrollment within 31 days after your other coverage ends.
- **New dependents.** 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, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- **Government programs.** You may be able to enroll yourself or your dependents in the health plan if:
  - Your or your dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
  - You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request enrollment 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. If you have a special enrollment event and want to enroll in health coverage, contact the Human Resources Department.

## 60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

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

## Notice of COBRA Continuation Coverage Rights

### Introduction

You are receiving this notice because you have recently become covered under a group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

#### **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. **You Must Give Notice of Some Qualifying Events For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan**

**Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.**

#### **How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

#### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

#### **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

#### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## 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](http://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](http://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](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –**

<b>ALABAMA – Medicaid</b>	<b>FLORIDA – Medicaid</b>
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	Website: <a href="http://flmedicaidprecovery.com/hipp/">http://flmedicaidprecovery.com/hipp/</a> Phone: 1-877-357-3268
<b>ALASKA – Medicaid</b>	<b>GEORGIA – Medicaid</b>
The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
<b>ARKANSAS – Medicaid</b>	<b>INDIANA – Medicaid</b>
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864
<b>COLORADO – Medicaid</b>	<b>IOWA – Medicaid</b>
Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a> Medicaid Customer Contact Center: 1-800-221-3943	Website: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562

<b>KANSAS – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-785-296-3512	Website: <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a> Phone: 603-271-5218
<b>KENTUCKY – Medicaid</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>LOUISIANA – Medicaid</b>	<b>NEW YORK – Medicaid</b>
Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a> Phone: 1-888-695-2447	Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
<b>MAINE – Medicaid</b>	<b>NORTH CAROLINA – Medicaid</b>
Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-442-6003 TTY: Maine relay 711	Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a> Phone: 919-855-4100
<b>MASSACHUSETTS – Medicaid and CHIP</b>	<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Phone: 1-800-462-1120	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
<b>MINNESOTA – Medicaid</b>	<b>OKLAHOMA – Medicaid and CHIP</b>
Website: <a href="http://mn.gov/dhs/ma/">http://mn.gov/dhs/ma/</a> Phone: 1-800-657-3739	Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742
<b>MISSOURI – Medicaid</b>	<b>OREGON – Medicaid</b>
Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075
<b>MONTANA – Medicaid</b>	<b>PENNSYLVANIA – Medicaid</b>
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP</a> P Phone: 1-800-694-3084	Website: <a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a> Phone: 1-800-692-7462
<b>NEBRASKA – Medicaid</b>	<b>RHODE ISLAND – Medicaid</b>
Website: <a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a> Phone: 1-855-632-7633	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 401-462-5300
<b>NEVADA – Medicaid</b>	<b>SOUTH CAROLINA – Medicaid</b>
Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900	Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a> Phone: 1-888-549-0820

<p align="center"><b>SOUTH DAKOTA - Medicaid</b></p> <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>	<p align="center"><b>WASHINGTON – Medicaid</b></p> <p>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a>  Phone: 1-800-562-3022 ext. 15473</p>
<p align="center"><b>TEXAS – Medicaid</b></p> <p>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a>  Phone: 1-800-440-0493</p>	<p align="center"><b>WEST VIRGINIA – Medicaid</b></p> <p>Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a>  Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p align="center"><b>UTAH – Medicaid and CHIP</b></p> <p>Website:  Medicaid: <a href="http://health.utah.gov/medicaid">http://health.utah.gov/medicaid</a>  CHIP: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a>  Phone: 1-877-543-7669</p>	<p align="center"><b>WISCONSIN – Medicaid and CHIP</b></p> <p>Website:  <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a>  Phone: 1-800-362-3002</p>
<p align="center"><b>VERMONT– Medicaid</b></p> <p>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>  Phone: 1-800-250-8427</p>	<p align="center"><b>WYOMING – Medicaid</b></p> <p>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a>  Phone: 307-777-7531</p>
<p align="center"><b>VIRGINIA – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>  Medicaid Phone: 1-800-432-5924  CHIP Website:  <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>  CHIP Phone: 1-855-242-8282</p>	

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

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

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.