2017

EHN | EMPLOYERS HEALTH NETWORK

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PHARMACY BENEFIT MANAGEMENT

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BENEFITS GUIDE

2017

Benefits Overview

Employers Health Network Holdings is proud to offer a comprehensive benefits package to eligible, full time employees who work 30 hours or more per week. The compete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (Medical), and there are benefits provided at no cost to you (Basic Term Life and Long-Term Disability). In addition, there are voluntary benefits available to you through affordable payroll deductions.

Benefit Plans Offered

- Medical
- Dental
- Vision
- Basic Term Life Insurance
- Voluntary Term Life Insurance
- Voluntary Short-Term Disability
- Long-Term Disability

Eligibility

You and your dependents are eligible for benefits on the first of the month following 60 days of employment.

Listed below are eligible dependents:

1. Your legal spouse
2. Children to age 26 including but not limited to:
    - Biological children of our legal spouse (step-children), provided such child resides in your household for at least 180 days per calendar year.
    - Legally adopted children or children placed in your home prior to adoption.
    - Any child you are required to provide medical benefits subject to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

Elections made now will remain in effect until the next open enrollment unless you or your family members experience a qualifying even. **You must contact Human Resources within 30 days of the qualifying event.**

What is a Qualifying Event?

One of the stipulations of tax advantage plans is that coverage must remain in force until the beginning of the new plan year unless there is a qualifying event or change in family status.

A qualifying event or family status change may include:

- Birth or adoption of a child, marriage or divorce, death of spouse, change in spouse employment, loss or gain or spouse or dependent's medical coverage through another employer.

As a cafeteria plan participant, when you experience a status change, you must notify the Benefits Department and provide the required documentation within 31 days of the event to ensure coverage.

Unless you have a qualifying event, you cannot make changes to your benefits until next open enrollment period.

Pre-Tax Enrollment Considerations

Employees electing medical, dental, or vision should be aware that these are pre-tax benefits; whereby, all employee-paid contributions are deducted from pre-tax earnings. When insurance premiums are deducted on pretax basis, your take home pay is increased because your premium payments are subtracted from your gross pay before taxes are applied. Pre-tax deductions also lower your taxable income for the year by the amount of the total payroll deduction for insurance premiums.

How to Make a Change:

NOW is the time to make changes to your current coverage or elect to participate!

During Open Enrollment (**November 25 – December 5, 2018**), you can add/drop current coverage or add/drop dependents. If you choose to waive coverage, you are required to electronically sign a waiver.

During Open Enrollment, you will be able to access the enrollment materials in your Employee Self-Service Portal of iSolved (Benefits Enrollment).

You MUST have made your elections/changes/revisions to your Benefits before end of day Wednesday, December 5, 2018 to have or waive coverage.

Failure to do so could result in no coverage for all of 2019.

Once you have made your elections, please print or save your confirmation page

iSolved®

Medical Benefits

Administered by Health Plans, Inc.

	EHNH High Deductible Plan	
	In Network	**Out of Network**
Annual Deductible	$5,000 Single $10,000 Family	$10,000 Single $20,000 Family
Annual Out-of-Pocket Maximum (includes deductible)	$6,750 Single $13,500 Family	$13,500 Single $27,000 Family
Coinsurance	100% after deductible	40% after deductible
DOCTOR'S OFFICE		
Primary Care Office Visit	100% after deductible	40% after deductible
Specialist Office Visit	100% after deductible	40% after deductible
Wellness Care	Covered 100% deductible waived	40% after deductible
PRESCRIPTION DRUGS		
Deductible	**Medical Deductible Applies +**	
Preventative	100% - deductible waived	
Tier 1	$10 Copay after deductible	
Tier 2 – Brand Preferred – Variable Copay	$45 Copay after deductible	
Tier 3 – Brand Non-Preferred – Variable Copay	20% minimum of $100	
Specialty Tier 1	20% minimum of $150	
Specialty Tier 2 – Variable Copay	Maximum Coupon Amount	
HOSPITAL SERVICES		
Urgent Care	100% after deductible	
Emergency Room	Deductible + $300 Copay	
Hospital Services	100% after deductible	40% after deductible
Outpatient Surgery	100% after deductible	40% after deductible
MENTAL HEALTH/ SUBSTANCE ABUSE SERVICES		
Inpatient Services	100% after deductible	40% after deductible
Outpatient Services	100% after deductible	40% after deductible

Employee Health Premiums

The company pays 90% towards the EHNH High Deductible Health Plan (HDHP).

	Employee Monthly
Employee Only	$38.74
Employee & Spouse	$77.48
Employee & Spouse*	$277.48
Employee & Child(ren)	$71.67
Employee & Family	$110.40
Employee & Family*	$310.40

Spousal Surcharge

An annual spousal surcharge of $200 per month (prorated over a per-pay-period basis) will be added to your 2019 medical premiums if:

- Your spouse has medical coverage available through another employer
- Your spouse waives coverage through their employer; and
- You elect to cover your spouse under our medical plan

You will need to certify whether your spouse has other employer-sponsored medical coverage. This does not apply if your spouse or domestic partner is also an EHNH employee or if they are covered under Medicare.

***If your spouse has access to ACA compliant coverage through his/her employer and chooses not to enroll, the premium is reflected above. You will be required to provide documentation of coverage during enrollment in this plan.**

Your Medical Network

All employees that reside **outside** of South Carolina and Florida will access the **Cigna** network nationwide.

All employees that reside in South Carolina and Florida will access the EHN network where available. Network coverage for emergency medical services and for dependents residing outside of South Carolina and Florida will be provided by MultiPlan Network nationwide.

Glossary of Terms

Preventive Care – In-network preventive care is covered at 100% without cost share. Preventive Care may include routine annual physicals, OB/GYN exams, scheduled child well exams & immunizations.

Copays – Office visits copays cover the expense of your office visit, excluding any additional services such as lab work, x-ray and more.

Coinsurance – Once you meet your deductible, the plan pays a certain percentage of the claim. The percentage will depend on which plan you are enrolled in and where the services are provided.

Out-of-Pocket Maximums – This is the maximum amount per year that you and your family may pay out before the plan pays 100% of eligible claims.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a companion feature to the EHNH High Deductible Plan and is administered through Optum Financial Services (Optum). The HSA is an important key to your cost savings. In order to have an HSA, you must enroll in the EHNH High Deductible Plan. An HSA allows you to contribute pre-tax dollars that can be used to pay certain out-of-pocket health care costs, such as deductibles and coinsurance. You choose how much you wish to contribute (subject to applicable limits).

Your HSA has some big advantages that benefit you! These include:

- No use-it-or-lose-it requirement. Your account balance can grow over time to cover future expenses, since any unused funds in your account roll over from year-to-year.
- You may invest part of your account balance for longer term growth using a combination of investment funds, once your account balance is at least $2,000.
- You own the account if you leave EHNH or its subsidiaries.

You are not allowed to use your HSA to cover eligible medical expenses incurred before your account is established. Also, your HSA will not reimburse expenses greater than your account balance. However, as contributions go into your account, they can be withdrawn to cover any eligible expenses that were incurred after your account was established.

IRS Regulations

- You cannot be covered by any other medical plan, entitled to Medicare benefits or be eligible to be claimed as a dependent on another person's tax return.
- Expenses of domestic partners and their dependents are not eligible for reimbursement unless they qualify as your tax dependents.
- See Publication 502 at www.IRS.gov for eligible expenses.
- For proof of expense eligibility, save receipts.

Dental Benefits

Administered by Reliance Standard

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Employers Health Network Holdings dental benefit plan. Dental is available through payroll deductions.

	High Plan Option
Annual Deductible	$50 Individual $150 Family
Annual Benefit Maximum	$1,500
Orthodontia Lifetime Maximum	$1,000
Preventive Services Oral exams (2 per year), Bitewing x-rays (1 per year), routine cleanings (2 per year), fluoride treatments (to age 13)	100%
Basic Services Sealants (to age 13), Fillings, Simple extractions,	80%
Major Services Surgical extractions, oral surgery, Anesthesia, Endodontics, Periodontics, Bridges, Dentures, Crowns	50%
Orthodontia* *12 month waiting period*	50%

Orthodontics coverage is limited to dependent children

	Employee Monthly
Employee Only	$31.46
Employee & Spouse	$62.92
Employee & Child(ren)	$63.50
Employee & Family	$97.88

Vision Benefits

Administered by Reliance Standard

The Employers Health Network Holdings Vision Program is most beneficial when participants make use of an In-Network Vision Center. Members may also utilize the provider of their choice and receive the benefits outlined in the chart below.

Covered Services	Frequency	Copayment	Options and Retail Value
Eye Exam	12 months	$10	In-network
Eyeglass Frames	24 months	$25	Up to $130 Retail allowance
Eyeglass Lenses	12 months	$25	Single, Bifocal, Trifocal and Lenticular
Contact Lenses (in lieu of Eyeglass Frames & Lenses)	12 months	$130 Allowance $25 Copay	Non-Selection Lenses Medically Necessary Contacts

	Employee Monthly
Employee Only	$5.41
Employee + Spouse	$10.28
Employee + Child(ren)	$12.01
Employee + Family	$16.93

Life Insurance

Administered by Reliance Standard

Employers Health Network Holdings provides a $50,000 term life / accidental death and dismemberment policy (after eligibility waiting period of up to 30 days) and long-term disability coverage (6 month waiting period) at no cost to you. (Age Reductions apply at age 65)

You may purchase additional term life and accidental death and dismemberment (AD&D) insurance coverage. You may also purchase life and AD&D insurance for your spouse & children (to age 26), if you purchase additional coverage for yourself. You are guaranteed coverage (refer to the benefit summary below) without answering medical questions, if you enroll when you are first eligible. Age reductions apply and premium is based on the employee's age for employee and spousal insurance.

Employee:
$10,000 increments to a maximum of $500,000
Guarantee issue amount: $50,000

Spouse:
$10,000 increments to a maximum of $500,000 or 100% of employee amount
Guarantee issue amount: $10,000

Customized rate sheets will be available to employees.

YOU MUST COMPLETE THE RELIANCE STANDARD ENROLLMENT FORM IN ORDER TO ENROLL IN VOLUNTARY LIFE INSURANCE. IF YOU WISH TO ELECT COVERAGE OVER THE GUARANTEED ISSUE AMOUNT, YOU MUST ALSO COMPLETE THE EVIDENCE OF INSURABILITY (EOI) FORM. MAKE SURE YOU LIST ALL DEPENDENTS YOU WISH TO COVER AS WELL AS SELECT YOUR BENEFICIARIES.

Disability Insurance

Administered by Reliance Standard

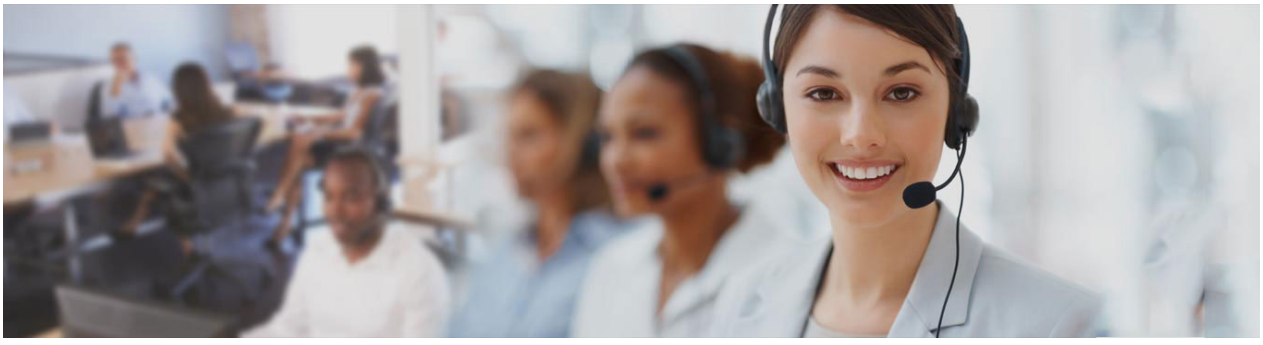
Should you become unable to work due to illness or accident, Disability Insurance can replace a portion of your income. Employers Health Network Holdings offers a Long-Term Disability package at no cost to you. Short-Term Disability is available to you at this time through payroll deductions.

	Short Term Disability	Long Term Disability
Benefits Begin	If you become disabled, there is an elimination period before benefits are payable. Your benefits will begin paying: • On the 15th day for Accident • On the 15th day for Illness (3 months pre-existing limitation)	If you become disabled, there is an elimination period before benefits are payable. Your benefits will begin paying: • On the 91st day for Accident • On the 91st day for Illness (3 months pre-existing limitation)
Paid Benefit Amount	60% of your weekly, before – tax earnings, not to exceed $1,000 Weekly	60% of your weekly, before – tax earnings, not to exceed $2,000 Weekly
Maximum Benefit	Benefits are available for up to 11 Weeks	Benefits are available for up to Normal Social Security Retirement Age
Employee Contribution	Paid by Employee **Customized Rate Sheets Available*	Paid by Employer

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

BENEFIT	CARRIER/CONTACT	PHONE	WEBSITE
Medical	Health Plans, Inc. (HPI)	1-800-532-7575	www.healthplansinc.com
Dental, Vision, Life, Disability	Reliance Standard	1-800-351-7500	www.rsli.com
Health Savings Account (HSA)	Optum Bank	1-800-791-9361	www.optumbank.com
EHNH Human Resources and Benefits Department	Matt Lowrey Sarah Burkhalter	matt.lowrey@ehnhllc.com sarah.burkhalter@southernscripts.net	



Annual Notices & Disclosures

Important Notice from Employers Health Network Holdings About Your Prescription Drug Coverage and Medicare

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30-day after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

HIPAA Privacy Notice - Protecting Your Health Information Privacy Rights

Employers Health Network is committed to the privacy of your health information. The administrators of the Employers Health Network insurance plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

Women's Health and Cancer Rights Act Initial Notification

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 states 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 physician 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 the plan. Therefore, your deductible and coinsurance apply as according to your employer-sponsored medical insurance plan.

If you would like more information on WHCRA benefits, please contact Human Resources.

Important Notice from Employers Health Network About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Employers Health Network and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Employers Health Network Holdings, LLC has determined that the prescription drug coverage offered by EHNH High Deductible Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from your Employee Benefit Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Employers Health Network coverage will be affected. See plan SPD for more information about your prescription drug coverage provisions/options.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Employers Health Network and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Employers Health Network Holdings, LLC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 11/19/2018
Name of Entity/Sender: Employers Health Network Holdings, LLC
Contact: Matt Lowrey
Phone Number: 318-214-4764

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, 2017. Contact your State for more information on eligibility:

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, 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 12/31/2019)

NOTES

This document is an outline of the coverage proposed by our carriers, based on information provided. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

This benefit summary prepared by: