The Clarke University Employee Health Care Plan

NOTICES & DISCLOSURES

for the 2019 Plan Year

Notice of HIPAA Special Enrollment Rights

If you chose to decline 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 with 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll in this plan if coverage is lost under a Medicaid plan or CHIP, or due to a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP. In these events you must request enrollment within 60 days of the date of a determination of eligibility for premium assistance or the date the Medicaid of CHIP coverage ends.

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

Please note that in such cases enrollment is not automatic, and therefore following the enrollment process in its entirety is required, even if it does not change your election tier. So for example, you must formally enroll your newborn child onto the plan within 30 days of the date of birth *even if you already have family coverage and your premiums would not change as a result*. Failing to enroll a dependent would result in that dependent not having coverage even though the coverage for the rest of the family would continue.

Finally, please be advised that this plan reserves the right to require a *written reason for declining the offer of coverage*. When an enrollment/waiver form is provided for this purpose, a signed and dated letter waiving the coverage and specifying the specific reason for

NOTICE: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see the Notice of Creditable Coverage on Page 6 for important information!

All questions should be directed to:

Jody Pfohl
Director of Human Resoucres
(563) 588-8194
jody.pfohl@clarke.edu

declining the coverage may be accepted by the Plan Administrators.

To request special enrollment or obtain more information, contact Jody Pfohl at (563) 588-8194 or jody.pfohl@clarke.edu.

Privacy Policy Notice of Availability

Our Flexible Spending Arrangement (FSA) maintains a *HIPAA Notice of Privacy Practices* (NPP) that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Jody Pfohl at (563) 588-8194.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note that more generous lengths of stay may apply under certain state laws, when applicable. In such cases, please refer to plan documents for a description of these richer guidelines.

Women's Health and Cancer Rights Act Notice

If you are going to have (or have had) a mastectomy, you may be entitled to health care 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.

Any benefits payable will be subject to the same deductibles, coinsurance and other provisions applicable to other surgical and medical benefits provided under the plan. Please see your Summary of Benefits and Coverage (SBC) or other plan materials for your medical and surgical deductible and coinsurance information.

To request more information on WHCRA benefits, please contact Jody Pfohl at (563) 588-8194 or jody.pfohl@clarke.edu.

Michelle's Law Notice

Health plans which extend coverage to full-time students age 26 or older are required to comply with Michelle's Law, an amendment to ERISA allowing students to take up to 12 months medical leave of absence *without causing a reduction in their health care coverage and/or COBRA premium*.

This means that coverage for dependent children age 26 or older cannot be immediately terminated due to loss of student status caused by a medically necessary leave of absence protected under Michelle's Law. Instead, any such termination of coverage will not occur before the date that is the earlier of:

- 12 months (one year) after the first day of the medically necessary leave of absence, or
- The date on which such coverage would otherwise terminate under the terms of the plan (see ERISA §714(b)).

A medically necessary leave of absence generally means a leave of absence from or other change in enrollment status in a postsecondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage. Certification by a treating physician stating that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary may be requested in certain circumstances, however.

Please see plan materials for details pertaining to eligibility for full-time

students age 26 or older. Additional information about protections afforded under Michelle's Law can be found at https://www.law.cornell.edu/uscode/text/29/1185c.

Notice of Patient Protections and Selection of Providers

Designation of Primary Care Providers

If the health plan in which you are enrolled (or are enrolling) requires the designation of a primary care provider (or "PCP"), please note that you have the right to designate any primary care provider who participates in the plan's provider network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider as well as a list of the participating primary care providers, contact the plan's insurer/TPA listed on your ID Card and other plan materials.

Direct Access to Obstetrics or Gynecological Specialists

If the health plan in which you are enrolled (or are enrolling) requires referrals to see specialists, you do not need prior authorization to obtain direct access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. Please note, however, that the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals, if applicable.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan's insurer/TPA listed on your ID Card and other plan materials.

General Notice of COBRA Continuation Coverage Rights

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the

Plan because of the following qualifying events:

- Death of your spouse;
- 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 of the following qualifying events:

- Death of parent-employee;
- 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 continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- 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).

For all 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 the person listed at the front of this booklet.

How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights can be directed to Jody Pfohl at (563) 588-8194 or jody.pfohl@clarke.edu. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa.

For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Notice of Creditable Coverage

We have determined that the prescription drug coverage provided under the Clarke University Employee Health Care Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage" as defined by the Medicare Modernization Act (MMA).

Why This is Important

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, *when you finally do enroll* **you may be subject to a late enrollment penalty** added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases *based on the number of full, uncovered months* during which you went without either Medicare Part D or else without "creditable" prescription drug coverage from another source (such as ours).

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from Oct. 15 through Dec. 7 of each year, as well during what is known as a "Medicare Special Enrollment Period" (which is triggered by certain qualifying events, such as the loss of employer/union-sponsored group health coverage). **Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available**. Finally, please be cautioned that even if you elect our coverage you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before enrolling in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to Jody Pfohl at (563) 588-8194 or jody.pfohl@clarke.edu.

Marketplace (exchange) Notice PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the ACA Health Insurance Marketplace (the "exchange") and employment based health coverage offered.

What is the Government-run Health Insurance Marketplace (exchange)?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage occurs on an annual basis, and Special enrollment Periods are available throughout the year to those with a qualifying life event such as marriage, divorce, birth or adoption of a child, loss of a job and other events.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium and a reduction in plan cost-sharing if your employer a) does not offer coverage to you at all or b) does not offer coverage that meets certain standards. Specifically, if your cost for SELF-ONLY coverage on a plan offered to you by your employer is more than 9.5% of your household income for the year (plus all applicable adjustments for inflation), OR if the coverage your employer provides does not meet the "Minimum Value (MV) Standard" set by the Affordable Care Act, you may be eligible for a tax credit. [1]

Note: There may be some disadvantages if you purchase a health plan through the Marketplace instead of accepting coverage offered by your employer. First, current regulations generally prohibit employers from contributing funds toward non-group health premiums. This means that you will lose any employer premium contributions that would have otherwise been payable. Second, the costs paid toward employer-offered health coverage are generally excluded from income for Federal and State income tax purposes. However, payments for coverage through the Marketplace are made on an AFTER-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please check your coverage materials or contact Jody Pfohl at (563) 588-8194 or jody.pfohl@clarke.edu.

The Marketplace or a licensed insurance broker can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** to find more information.

[1] *An employer-sponsored health plan meets the "Minimum Value (MV) Standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs and meets other requirements.*

PART B: General Information

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		5. Employer Identification Number
Clarke University		42-0680408
5. Employer address		6. Employer phone number
1550 Clarke Drive		(563) 588-8194
7. City.	8. State	5. Zip code
Dubuque	IA	52001
10. Who can we contact about employee health coverage at this job?		
Jody Pfohl		
11. Phone number (if different from above)	12. Email address	
(563) 588-8194	jody.pfohl@clarke.edu	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

All employees we deem eligible for health coverage under the plan's eligibility rules. Generally speaking, coverage is offered to full-time employees working at least 30, but other criteria may apply based on employment class and other facts and circumstances.

With respect to dependents:

All eligible spouses and dependents under the age of 26, as well as others who meet specified criteria (e.g. those who meet full-time student and disabled dependent definitions). Please contact the individual listed in Box 10 (above) with any questions.

☑ If checked, this coverage meets the minimum value standard and the cost of this coverage is intended to be affordable under one of the §4980H Affordability Safe Harbors.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. You may need to get information from your employer, about their coverage, in order to find out if you qualify for a tax credit to lower your monthly premiums.

Notice of Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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 August 10, 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/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm 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: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.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: https://dwss.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 August 10, 2017, 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.

(expires 12/31/2019)