2024 Open Enrollment

Helping you make informed choices
about your employee benefits.

archcare
The Continuing Care Community
of the Archdiocese of New York

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact **ArchCareBenefits@archcare.org**.

The Annual Benefit Open Enrollment period is November 13 through December 1, 2023. During this time all non-union benefit-eligible Care Members can make changes to their coverage. Coverage elected during open enrollment is effective January 1, 2024.

ArchCare is committed to offering you quality, competitive and cost-effective medical, dental, and vision programs, as well as other important benefits. We are also committed to wellness. We recognize that your benefits are extremely important to you and your family as well as a large part of your total compensation package.

Welcome to ArchCare's Annual Open Enrollment

Employees wishing to make changes to their benefit elections for the 2024 plan year will need to complete an Open Enrollment Election form.

What is considered a change?

» Adding or removing a dependent(s) from coverage

» Waiving coverage

» Switching medical plans

Flexible Spending Accounts

Flexible Spending Accounts (FSA's) do not automatically renew from year to year. **If you want a Medical and/or Dependent Care FSA in 2024, you MUST make an election during Open Enrollment** (even if you had an FSA in 2023).

What if I have questions about enrollment or benefits?

Please contact archcarebenefits@archcare.org

Eligibility

All Non-Union Care Members working at least 20 hours per week and their qualified dependents (legally married spouses and dependent children under age 26) are eligible to be covered by group health insurance program.

For dependent enrollment, Care Member must provide marriage certificate for spouse and birth certificate(s) for child(ren).

For additional information regarding open enrollment, please contact **ArchCareBenefits@archcare.org**

Change of Family Status

You should carefully consider your Open Enrollment decisions because your elections remain in effect for the plan year (January 1, 2024 through December 31, 2024). After you enroll, the only time you may make changes to your benefits program during the plan year is if you experience a qualifying life event.

A qualifying life event as defined by the IRS includes: marriage, divorce, or legal separation, birth or adoption of a child, death of a dependent, start or end of your spouse's employment and insurance coverage, your dependent becomes ineligible for coverage, becoming eligible for Medicare or Medicaid during the plan year.

Medical Insurance

Administered by Emblem

ArchCare offers a choice of three medical plans through Emblem Health. All non-union, regular full-time and part-time benefit eligible Care Members are eligible to enroll in ArchCare's health insurance plan. Coverage is available to Care Members and their eligible dependents. Coverage elected during open enrollment is effective January 1, 2024.

	EPO1	PPO2		EPO3
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Deductible	$750 Individual / $2,250 Family	N/A	$750 Individual / $2,250 Family	$4,000 Individual / $8,000 Family
Coinsurance	100%	90%	70%	100%
Out-of-Pocket Maximum	N/A	$1,500 Individual / $4,500 Family	$3,500 Individual / $10,500 Family	N/A
Routine Physical Exams	Covered in full	Covered in full	Deductible & coinsurance applies	Covered in full
Primary Office Visit (Pediatricians, Internists, Family Practitioners)	$35 per visit	$25 per visit	Deductible & coinsurance applies	$35 per visit
Specialist Visit	$50 per visit	$25 per visit	Deductible & coinsurance applies	$50 per visit
Well-Child Care	Covered in full	Covered in full	Deductible & coinsurance applies	Covered in full
Outpatient Day Surgery	$50 – office setting; Covered in full after deductible – surgical facility	$25 – office setting; Covered at 90% – surgical facility	Deductible & coinsurance applies	Covered in full after deductible
Urgent Care	$35 adult visit	$25 adult visit	30% coinsurance, after deductible	$35 adult visit
Emergency Room Care	No charge after deductible	$100 copay	$100 copay	No charge, after deductible
Imaging (CT / PET Scans, MRIs)	No charge after deductible	10% coinsurance, after deductible	30% coinsurance, after deductible	No charge, after deductible
Hospitalization	No charge after deductible	10% coinsurance, after $750 copay	30% coinsurance, after $1,000 copay	No charge, after deductible
Rehabilitation Services 48 visits per calendar year	Inpatient: No charge after deductible Outpatient: $50 adult visit	$25 adult visit	30% coinsurance, after deductible	Inpatient: No charge after deductible Outpatient: $50 adult visit

http://www.emblemhealth.com/Find-a-Doctor.aspx

Click Search by Network or Plan Choose the Bridge Network

ConsumerMedical

ArchCare will continue to offer ConsumerMedical, at no cost to employees and their eligible dependents who are enrolled in an ArchCare medical plan.

ConsumerMedical is your Medical Ally for confidential, one-on-one support to help you and your family make informed decisions about any medical condition, such as cancer, low back pain, asthma, osteoarthritis, high blood pressure, insomnia, diabetes and stress, to name a few.

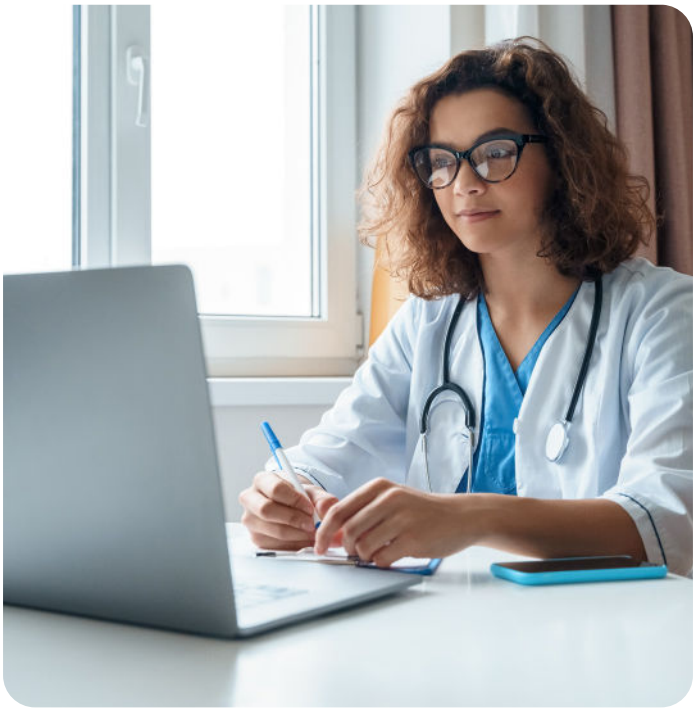
Free expert medical guidance for any condition

- Support to help you better understand your medical condition and treatment options
- Answers to your questions (or guidance if you're not sure what to ask)
- Recommendations for top-rated specialists and hospitals
- Help getting a second opinion when you need one

Has your doctor recommended surgery?

ConsumerMedical will help you understand the risks and benefits before you decide. If you're considering low back surgery, hip or knee replacement or a hysterectomy, you could receive a $400 gift card for participating at least 30 days before your scheduled surgery! *

*To be eligible for gift card, contact ConsumerMedical at least 30 days before scheduled date for one of the surgeries listed above to engage and complete survey. Gift card is provided by ConsumerMedical – recipient is responsible for any applicable taxes. Call for more details.



CALL CONSUMERMEDICAL!

888.361.3944

Monday - Friday,

9 a.m. - 9 p.m.

Eastern

www.myconsumermedical.com

Enter ArchCare in the company code field.

Prescription Drug Coverage – Caremark

	Retail Program	Mail Service Program
When:	For immediate medicine needs or short-term medicines	For maintenance or long-term medicines
Where:	You can use your prescription benefit at more than 62,000 Caremark retail pharmacies nationwide, including 20,000 independent pharmacies. Go to **www.caremark.com** to locate a pharmacy in your area.	Simply mail your original prescription along with the mail service order form to Caremark. Your medicine will be sent directly to your home.
Cost:	$15 – Generic Medicine $40 – Brand Name Medicine on drug list* $80 – Brand Name Medicine not on drug list*	$30 – Generic Medicine $80 – Brand Name Medicine on drug list* $160 – Brand Name Medicine not on drug list*
Supply:	30-day supply	90-day supply
Refill Cap:	Copays double after the third fill	None

This is just a brief outline of the benefits offered. For additional information contact **ArchCareBenefits@archcare.org**.

Flexible Spending Accounts (FSA)

ArchCare offers a Flexible Spending Account program through Benefit Resources that allows eligible Care Members to use pre-tax dollars to pay for qualified out-of-pocket medical expenses and dependent care expenses. All non-union full-time and part-time benefit eligible Care Members are eligible to enroll in the FSA plan during open enrollment.

- You decide how much money you want to set aside from each paycheck before taxes are deducted.
- This lowers your taxable income and reduces the amount of tax you pay for the year.
- The money you set aside is there for you to use to pay for eligible health and dependent care expenses as allowed by the IRS Code 502.
- If you do not use the money, you will lose the money per IRS Regulations.

The maximum contributions to the FSA plans are:

- Medical FSA: $3,050 for calendar year 2024
- Dependent Care FSA: $5,000 for calendar year 2024

Dental Insurance

Administered by MetLife

ArchCare offers a dental plan through MetLife. With the MetLife Dental Plan, eligible Care Members will have access to MetLife's expansive national network of dentists. All non-union full-time and part-time benefit eligible Care Members are eligible to enroll in the dental insurance plan. Coverage is available to Care Members and their eligible dependents. Coverage elected during open enrollment is effective January 1, 2024.

		DPPO	
		In-Network	Out-of-Network
Per Calendar Year Deductible		$50 Individual / $150 Family	
Calendar Year Coverage Maximum		$2,250 per person	$2,250 per person
TYPE A – PREVENTIVE SERVICES (DEDUCTIBLE WAIVED)			
Periodic Oral Exam	1 in 6 months	100%	100%
X-Rays	Frequency dependent upon type of X-Ray	100%	100%
Teeth Cleaning	1 in 6 months	100%	100%
Fluoride Treatments	Once per calendar year for members under age 19	100%	100%
TYPE B – BASIC RESTORATIVE CARE			
Fillings		100%	100%
Oral Surgery		100%	100%
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	100%	100%
Root Canal Treatment	Once per tooth per 24 months	100%	100%
Periodontics	Periodontal scaling and root planning once per quadrant every 24 months Periodontal surgery once per quadrant, every 36 months	100%	100%
TYPE C – MAJOR RESTORATIVE CARE			
Simple Extractions		80%	80%
Crown, Denture, and Bridge Repair / Recementations		80%	80%
Implants		80%	80%
Bridges and Dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. Dentures and bridgework replacement: one every 10 years. Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.	80%	80%
Crowns / Inlays / Onlays	Replacement once every 10 years	80%	80%
Orthodontics	Available to covered dependents up to age 26. Covered at 50% to a separate lifetime maximum of $2,000.		
Dependent Eligibility	Eligible dependents are covered up to age 26.		

Vision Insurance

Administered by VSP

ArchCare offers a vision plan through VSP. Under the VSP Signature Plan, you will have access to VSP's national network of doctors and vision care providers. All non-union full-time and part-time benefit eligible Care Members are eligible to enroll in the dental insurance plan. Coverage is available to Care Members and their eligible dependents. Coverage elected during open enrollment is effective January 1, 2024.

	Vision Plan		
	Your Coverage from a VSP Doctor	**In-Network Member Cost**	**Out-of-Network Reimbursement**
WellVision Exam (every calendar year)	» Focuses on your eyes and overall wellness	$0	Up to $50
Frames (every calender year)	» $150 Allowance for a wide selection of frames » $170 Allowance for featured frame brands » Costco / Walmart equivalent frame allowance ($80) » 20% off balance over your allowance	$0	Up to $70
Lenses (every calendar year)	» Single vision, lined bifocal, and lined trifocal lenses » Polycarbonate lenses for dependent children	$0 copay	Up to $50 / $75 / $100
Lens Enhancements (every calendar year)	» Standard progressive lenses » Premium progressive lenses » Custom progressive lenses » Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Up to $75
Contacts – instead of glasses (every calender year)	» $150 allowance for contacts; copay does not apply » Contact lens exam (fitting and evaluation)	Up to $60	Up to $105
Essential Medical Eye Care	» Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	N/A
Extra Savings	» 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% from any VSP doctor within 12 months of your last WellVision Exam. » No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam » Laser Vision Correction – average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Cost of Coverage

Contributions for Medical, Prescription, Dental and Vision (pre-tax):

2024 Wellness Plan Contributions Per Bi-weekly Pay Period

Salary Level	Coverage	Option 1 Choice Plan – EPO	Option 2 Choice Plus Plan – PPO	Option 3 Choice Plan – EPO
Under $44,000	Single	$57.75	$58.56	$12.79
	Care Member + 1	$114.21	$113.67	$15.68
	Family	$174.01	$176.00	$18.87
$44,001–$66,000	Single	$68.19	$70.40	$13.57
	Care Member + 1	$134.99	$137.20	$17.24
	Family	$204.65	$210.74	$21.18
$66,001–$100,000	Single	$85.59	$82.22	$14.88
	Care Member + 1	$169.61	$160.74	$19.84
	Family	$252.52	$245.46	$24.78
$100,001–$160,000	Single	$92.56	$88.14	$15.41
	Care Member + 1	$183.46	$172.51	$20.89
	Family	$276.19	$262.81	$26.56
$160,001+	Single	$103.00	$97.01	$16.19
	Care Member + 1	$204.25	$190.15	$22.45
	Family	$306.84	$288.86	$28.86

2024 Non-Wellness Plan Contributions Per Bi-weekly Pay Period

Salary Level	Coverage	Option 1 Choice Plan – EPO	Option 2 Choice Plus Plan – PPO	Option 3 Choice Plan – EPO
Under $44,000	Single	$107.13	$107.94	$62.17
	Care Member + 1	$163.59	$163.05	$65.06
	Family	$223.39	$225.38	$68.26
$44,001–$66,000	Single	$117.57	$119.78	$62.95
	Care Member + 1	$184.37	$186.58	$66.62
	Family	$254.03	$260.12	$70.56
$66,001–$100,000	Single	$134.97	$131.60	$64.26
	Care Member + 1	$218.99	$210.12	$69.22
	Family	$301.90	$294.84	$74.16
$100,001–$160,000	Single	$141.94	$137.52	$64.79
	Care Member + 1	$232.84	$221.89	$70.27
	Family	$325.57	$312.19	$75.94
$160,001+	Single	$152.38	$146.39	$65.57
	Care Member + 1	$253.63	$239.53	$71.83
	Family	$356.22	$338.24	$78.24

Dental Contributions

There is no contribution required for dental plan coverage if you are enrolled in the medical plan.

If you are waiving Medical coverage and would like to enroll in Dental and Vision coverage, you will pay the amounts listed below.

Per Bi-Weekly Pay Period	
Single:	$5.00
EE + 1:	$15.00
Family:	$25.00

Telemedicine

What is it?	Why use it?	What can I use it for?
» Unlimited access to doctors (24/7/365) • Phone:**800.835.2362** • Virtual Visit: **https://www.teladoc.com** » Mobile App: Teladoc » U.S. Board Certified Physicians » No copays, deductibles or per call charges	» When you need care now » Easy and convenient to use » Saves you time and money	» Sinus problems » Cold and flu symptoms » Bronchitis » Allergies » Short term prescription refills » Care when you're away from home » If you're considering the ER or urgent care for a non-emergency

Wellness Program

Our goal of supporting your efforts to make healthy decisions through a focus on Awareness, Prevention, and Action remains the same.

Employees will still accumulate points to earn "Wellness" contributions. Complete wellness challenges in any order, one / two at a time, or all at once. It's your choice.

New employer well-being challenges will be offered for 2024. You can also earn points by tracking your fitness activities. Visit the ArchCare wellness portal to access the full list of WellRight activities.

Wellness Challenge	Point Value	Maximum Points Per Year
Custom Challenge – Meet the Coach	100	100
SayAah	100	100
Open Wide (dental visits)	50	100
Age Gage (Health Assessment)	100	100
Protect You (Flu Shot)	100	100
Healthy U (University Courses)	25	100
Good Deed (volunteering)	10	100
Right Weigh (weigh yourself monthly)	100	100
Move It: Walk 5000 Steps a Day	100	100
Personal Challenges	20	100

Requirements

250 Q1	500 Q2	750 Q3	1,000 Q4

By the end of each quarter you will need to accumulate a minimum of 250 points to qualify for the Wellness contribution (1,000 points by year end).

To access the ArchCare wellness portal:

Visit archcare.wellright.com

Health Reimbursement Account (HRA)

For Wellness participants only, you will be eligible for an employer paid HRA account to be used toward out-of-pocket medical expenses.

The funding is contingent upon successfully accumulating the quarterly wellness points by the deadline. Each quarter as you earn your points additional HRA funds will be added to your card. If you do not earn the minimum number of points per quarter, you will lose the HRA for the balance of the year and your contribution will increase. If you wish to participate in FSA with Care Member money you would sign up for that separately.

EPO OPTION 1	
HRA Quarterly:	$37.50
HRA Annually:	$150.00
PPO OPTION 2	
HRA Quarterly:	$50.00
HRA Annually:	$200.00
EPO OPTION 3	
HRA Quarterly:	$62.50
HRA Annually:	$250.00

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below.

Benefit	Administrator	Phone	Website/Email
Medical	Emblem Health	877.842.3625	www.emblemhealth.com
Prescription Drug	CVS Caremark	800.565.7091	www.caremark.com
Dental	MetLife	800.942.0854	www.metlife.com
Vision	VSP	800.877.7195	www.VSP.com
Flexible Spending Accounts	Benefit Resource, Inc	800.473.9595	www.benefitresource.com
Telemedicine	Teladoc	800.835.2362	www.teladoc.com
Wellness	WellRight	312.724.6925	www.wellright.com

Legal Notices

Women's Health & Cancer Rights Act Notice

In the case of a covered person receiving benefits in connection with a mastectomy who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- 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 at all states of the mastectomy, including lymph edemas

Deductibles, coinsurance, and copayment amounts are the same as those applied to other similarly covered medical services, such as surgery and prosthesis.

Source: The Women's Health and Cancer Rights Act of 1998

HIPAA Privacy Notice Availability

ArchCare Group Health Plan
Protecting Your Health Information Privacy Rights

The ArchCare Group Health Plan is committed to the privacy of your health information. The administrators of the ArchCare Group Health 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.

Dependent Adult Children Coverage

Coverage for adult children, married or unmarried and without respect to student or dependency status, has been extended to your dependent children under the age of 26. During open enrollment, employees are given the opportunity to re-enroll their dependents who were terminated but now meet the new eligibility rule.

Mental Health Benefit Changes

The Federal Emergency Economic Stabilization Act of 2008 went into effect for employees on January 1, 2011. This Act requires group health plans that provide physical and mental health/substance abuse disorder benefits, ensure member financial requirements and treatment limitations that apply to mental health and substance abuse disorder benefits are no more restrictive than the financial requirements and treatment limitations on physical benefits.

Consequently, deductibles, coinsurance, copays, and out-of-pocket expenses for mental health and substance abuse disorder benefits will be no more restrictive than those for medical/surgical benefits.

Also, treatment limits, such as frequency and number- of-visit limits, and coverage days will be no more restrictive than those for medical/surgical services.

The Newborns' and Mothers' Health Protection Act (NMHPA)

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 hours 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Plans may be subject to State law requirements, please refer to the Plan Summary Plan Document for details describing any applicable State law.

Uniformed Services Employment and Reemployment Rights Act

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

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 **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 **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, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPPPROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/ applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care- programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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.

This benefit guide prepared by

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