DATE: **OCTOBER 31, 2017**

TO: **CITY OF SANTA ROSA RETIREES**

FROM: **DOMINIQUE KURIHARA, RISK MANAGER**

SUBJECT: **2018 RETIREE HEALTH PLAN AND RATES**

We are pleased to announce that this year's Open Enrollment period is **now open and will continue through November 20, 2017**. This is your once-a-year opportunity to change your Retiree medical plan, if you wish to do so. **IF YOU DON'T HAVE ANY CHANGES, YOU DON'T NEED TO DO ANYTHING.**

Please refer to the attached Health Summary Comparison sheet to compare the City's Kaiser HMO plan and the City's EPO & PPO plans. As you will see, there are no changes in co-pays and/or deductibles from 2017 to 2018 plan year. The date for any changes to your medical plan will go into effect on **January 1, 2018**. Should you choose to change from your current Retiree medical plan, enclosed are the following documents for your information and use:

- A Health Plan Comparison sheet comparing all three (3) available plans;
- A cost sheet that covers the 2018 rates for each plan;
- An enrollment form to complete, date, sign and return should you choose to change plans; and
- 2018 Annual Notices.

Please return the enrollment form by mail or in person by no later than **Monday, November 20, 2017** to:

City of Santa Rosa
Attn: Human Resources Department
100 Santa Rosa Ave., Room 1
Santa Rosa, CA 95404

You will receive new payment coupons directly from Employee Benefit Services (EBS) by mid December 2017. For additional questions, please contact Michelle Capella at (707) 543-3062.

Encls.

City of Santa Rosa
Health Plan Comparison

NAME OF PLAN	Kaiser HMO	City PPO		City EPO
	Network Only	Participating Provider	Non-Participating Provider	Participating Provider Only
Employee Portion of Premium	12.5%	15.0%		20%**
Type of Plan/Service Area	HMO / Limited Service Area	Preferred Provider Organization / Any Service Area		Exclusive Provider Organization / California only
Access to Specialists	Must have PCP/ may refer yourself to some specialists within Kaiser	Can choose directly		Provider Referral or Self Referral
Network	Only when referred by Kaiser	BlueCross Prudent Buyer PPO	Available at higher cost	BlueCross Prudent Buyer PPO
Lifetime Maximum	Unlimited	Unlimited		Unlimited
Pre-existing Condition Exclusion	No	No		No
Calendar Year Deductible - Individual	None	$300		None
Calendar Year Deductible - Family	None	$900 (3 per family)		None
Calendar Year Out-of-Pocket Maximum Per Person *	$1,500	$1,800	None	$1,500
Out of Pocket Maximum Per Family *	$3,000	$3,900	None	$3,500 2-Party / $4,500 Family
Prescription Drug Benefit	KAISER	EXPRESS SCRIPTS		EXPRESS SCRIPTS
	Tier 1 / Tier2	Tier 1 / Tier2 / Tier 3	Tier 1 / Tier2 / Tier 3	Tier 1 / Tier2 / Tier 3
Pharmacy Out-of-Pocket Maximum	None	$4,800/$9,300	None	$5,100/$8,700
Retail Participating Pharmacy (30 day supply)	$10 generic 50% co-payment for drugs to treat sexual dysfunction	$5 generic/$20 brand/$50 non-formulary Brand $20 plus difference in cost over generic if generic readily available. Medically necessary only. 50% co-payment for drugs to treat sexual dysfunction		$10 generic/$25 brand/$55 non-formulary Brand $25 plus difference in cost over generic if generic readily available. Medically necessary only. 50% co-payment for drugs to treat sexual dysfunction
Mail Order 90 days	$10 generic 50% co-payment for drugs to treat sexual dysfunction	$10 / $35 / $85	Not Covered	$20 / $45 / $95 50% co-payment for drugs to treat sexual dysfunction
NOTE	N/A	All percentages are based on allowances under plan benefit - provider has agreed to accept allowable charge.	All percentages are of usual and customary charges - any charges above that are the responsibility of the employee.	N/A
Preventive Care: ob/gyn w/pap, mammograms, colonoscopy (PPO/EPO), prostate screenings, and physicals PER SCHEDULE. Well baby and prenatal visits.	$0 co-pay per visit (well-baby, prenatal)	$0 copay per visit/ 100% other (per schedule)	40%	$0 copay
Physician Office Visits (for everything except preventive services) - mental health is paid the same as physical health	$20 co-pay	$20 copay	40%	$25 co-payment per visit
Lab & X-Ray (Diagnostic)	No Copay	20%	40%	$25 copay
Emergency Services	$75 co-payment per visit (Waived if admitted)	$75 per visit for ER (Waived if admitted)	40%	$75 per visit for ER (Waived if admitted)
Ambulance	$50 per trip	20%	40%	$50 per trip
In Patient Hospital Services (includes room & board) and Physician Services	$100 per admission	20% for up to 120 days	40%	$250 per admission

NAME OF PLAN	Kaiser HMO	City PPO		City EPO
	Network Only	Participating Provider	Non-Participating Provider	Participating Provider Only
Out Patient Surgery Hospital	$20 per procedure	20%	40%	$250 per visit
Skilled Nursing Facility	No Charge - up to 100 days per plan year	20% Up to 60 days per confinement	40% Up to 60 days per confinement	$250 per admission- 100 days maximum per calendar year
Home Health Care	No Charge - up to 100 visits	20% Up to 60 days per year	20% Up to 60 days per year	No charge for the first 30 days $25 co-pay starting with 31st calendar day after 1st visit (up to 60 days per year)
Physical, Speech and Occupational Therapy	$20 co-payment per visit for short-term physical, speech and occupational when prescribed by a Kaiser physician and when significant improvement is expected within 2 months	20%	40%	Inpatient or Outpatient - $25 copay
Maternity Coverage	%0 co-payment for prenatal visits $100 hospital charge	Prenatal - $0 office visit co-pay hospitalization - 20% / 80%[1]	40%	$0 co-payment for prenatal visits $250 hospital admission co-payment
Family Planning /infertility	$20 co-payment per visit (diagnosis & limited treatment per schedule)	Not Covered	Not Covered	Not Covered
Transgender Services (See Benefits Summary for a description of the services covered)	Covered (co-payments dependent on service provided, i.e., office visit $20; hospital in-patient = $100 per visit)	Not Covered	Not Covered	Not Covered
Chiropractic/Acupuncture	Not Covered (Discounts Available)	20% Up to 20 visits per year for combined servicess.	40% Up to 20 visits per year for combined services.	Not Covered
Vision	$20 co-pay per visit including routine eye exam (Eyeware not included)	20% Disease and accident only	40% Disease and accident only	$25 co-pay Disease and Accident Only
Retiree Conversion	Yes (California only)	Yes		Yes (California only)
*OOP Max Includes	Medical Copays only - NOT RX	Med Copays & Coinsurance In Network	Out of network excluded from OOP Max	Medical Copays only

***Transgender Services covered under Kaiser Plan Only

Retiree Health Plan Rates January 1, 2018 to December 31, 2018		
CITY PPO	**RATE LEVEL**	**CITY- PPO**
Retiree Under 65 (Non Medicare)	Single	**$1,159**
Retiree & Spouse Both Non Medicare	Double	**$2,266**
Retiree (All Non Medicare)	Family	**$3,003**
Retiree Over 65 w/Medicare	Single	**$805**
Retiree & Spouse Both Over 65 w/Medicare	Double	**$1,674**
Retiree & Spouse 1 with Medicare, 1 without	Double	**$1,964**
Retiree (1 with Medicare 2 Without)	Family	**$2,701**
Retiree (2 with Medicare 1 Without)	Family	**$2,411**
For rates for more than two dependents, see HR		
CITY EPO		**CITY EPO**
Retiree Under 65 (Non Medicare)	Single	**$1,332**
Retiree & Spouse Both Under 65 (both Non Medicare)	Double	**$2,756**
Retiree (All Non Medicare)	Family	**$3,664**
Retiree Over 65 w/Medicare	Single	**$865**
Retiree & Spouse Both Over 65 w/Medicare	Double	**$1,722**
Retiree & Spouse 1 with Medicare, 1 without	Double	**$2,197**
Retiree (1 with Medicare 2 Without)	Family	**$3,105**
Retiree (2 with Medicare 1 Without)	Family	**$2,630**
KAISER		**KAISER**
Retiree Under 65	Single	**$1,127.00**
Retiree Under 65 w 1 dep	Double	**$2,293.00**
Retiree & 2 or more dependents	Family	**$3,203.00**
Retiree Over 65 - Senior Advantage (SA)	Single	**$323.00**
Retiree & Spouse Both w Medicare	Double	**$631.00**
Retiree & Spouse Both w/Medicare + 1 dep Non Medicare	Family	**$1,541.00**
Retiree under, spouse with Medicare (SA)	Double	**$1,450.00**
Retiree under, spouse w/Medicare w/child	Family	**$2,399.00**
Retiree with Medicare, Dependent non Medicare	Double	**$1,450.00**
Retiree with Medicare, 2 Dep non Medicare	Family	**$2,399.00**
*Retiree under 65 - Single: Same cost as active EE on Kaiser Plan w/ single coverage		

City of Santa Rosa

☐ Plan Change
☐ Delete Dependant
☐ Other_____

CITY OF SANTA ROSA
RETIREE HEALTH PLAN CHANGE SHEET

Effective Date: _____
Event Date: _____

Employee Name (Last, First, Middle)	**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Legally Separated** ☐ **Divorced** ☐ **State Domestic Partner**

Employee Street Address	**City**	**State**	**Zip**	**Phone Number: ( )**

I ELECT/TERMINATE COVERAGE FOR:

Last	**First**	**MI**	**Action Code: Change/Delete**	**Gender**	**Relationship**	**Birth Date**	**Social Security No.**
				☐ **M** ☐ **F**	**Self**		
				☐ **M** ☐ **F**			
				☐ **M** ☐ **F**			
				☐ **M** ☐ **F**			

ELECTIONS - PLEASE CHECK APPLICABLE BOX(ES)

	Retiree Only	**Retiree + 1**	**Retiree + Family**
MEDICAL			
☐ **Kaiser Permanente** **Retiree -Group # 35908, Enrollment # 0000**	☐	☐	☐
☐ **City EPO**	☐	☐	☐
☐ **City PPO**	☐	☐	☐

ADDITIONAL HEALTH COVERAGE

Secondary/primary health coverage exists for ☐ **Self** ☐ **Spouse Only** ☐ **Spouse &Child(ren)** ☐ **Child(ren) only**

Health Carrier: _____ _____Policy no./Effective date: _____

Health Carrier: _____ _____Policy no./Effective date: _____

Authorization to obtain or release medical information explanation: The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et. Seq. of the California Civil Code. Your cooperation is being requested.

Authorization to obtain or release medical information: I hereby authorize my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim.
Initial_____

Arbitration Agreement: I agree and understand that any and all disputes, including claims relating to the delivery of services under the selected medical plan and claims of medical malpractice, (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered,) except for claims subject to ERISA, or any dispute that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or) any enrolled family member including heirs and assigns) and the insurance company providing my medical insurance (its parents, subsidiaries, or affiliates) through the above elected plan, or any Participating Physician Group/Independent Physician Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration. **Initial if you have selected the City EPO or the City PPO_____**

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

_____ _____

Signature Required for Kaiser Permanente Plan **Date**

X	Signature of witness (only required if employee signature is "X")	Date

Office Use Only **Received HR_____** **By: _____**	**ORIGINAL** **Received RM_____** **By: _____**	**Entered EBS_____** **By:_____**	**COPY** **Received PR_____** **By: _____**

2018

Annual Notices

2018

Annual Notices

Table of Contents

Medicare Part D Notice

Important Notice from CSAC Excess Insurance Authority (EIA)
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 CSAC Excess Insurance Authority's (EIA) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not 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 two 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. Your plan has determined that the prescription drug coverage offered by the EIA is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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 CSAC Excess Insurance Authority (EIA) coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under CSAC Excess Insurance Authority (EIA) is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan outside of the group Medicare plan offered by your employer, offered through the CSAC Excess Insurance Authority (EIA) prescription drug coverage, be aware that you and your dependents will lose both the medical and pharmacy coverage through the CSAC Excess Insurance Authority (EIA) and will not have an opportunity to get this coverage back once declined.

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 CSAC Excess Insurance Authority (EIA) 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) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About Your Options Under Medicare 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 CSAC Excess Insurance Authority (EIA) changes. You also may request a copy of this notice at any time.

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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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 or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2017
Name of Entity/Sender: City of Santa Rosa
Office: Human Resources
Address: 100 Santa Rosa Avenue, Room 1, Santa Rosa CA 95401
Phone Number: 707-543-3060

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights for coverage to be provided in a manner determined in consultation with the attending Physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact your health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act

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). If you would like more information on maternity benefits, call your plan administrator.

Notice of Availability of HIPPA Privacy Notice

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Human Resources Department or by contacting the insurance carriers directly.

HIPAA Notice of Special Enrollment Rights for Medical/Health Plan Coverage

If you decline enrollment in CSAC Excess Insurance Authority's (EIA) health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in CSAC Excess Insurance Authority's (EIA) health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within [30/31] days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request [medical plan OR health plan] enrollment within [30/31] days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the [30/31] day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following the qualifying event. In addition, you may enroll in CSAC Excess Insurance Authority's (EIA) medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

ACA 1557 Notice

Nondiscrimination statement for significant publications and signification communications:

CSAC Excess Insurance Authority complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Notice of Grandfathered Plan Status – CSAC Excess Insurance Authority (EIA) Plans

CSAC Excess Insurance Authority (EIA) believes that some coverage maybe "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your CSAC Excess Insurance Authority (EIA) plans may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Notice of Availability of Alternatives for Health Contingent Wellness Programs

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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:	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	
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: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medic aid/ 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://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
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://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
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 January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Services Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Rules for Benefit Changes During the Year

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes Include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change unemployment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment or ceasing to satisfy them
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

Two rules apply to making changes to your benefits during the year:

- **Any changes you make must be consistent with the change in status, AND**
- **You must make the changes within 30/31 days of the date of the event (marriage, birth, etc.) occurs (unless otherwise noted above).**

Rev. 8/04/2017