

The UnityPoint Rural Health Alliance Benefits Plan

NOTICES & DISCLOSURES

for the 2021 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 within 30 days after you 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 or 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 7** for important information!

All questions should be directed to:

Carrie Turnquist
Executive Director of Human Resources
(712) 213-8607
hr@bvrmc.org

declining the coverage may be accepted by the Plan Administrators.

To request special enrollment or obtain more information, contact Carrie Turnquist at (712) 213-8607 or hr@bvrmc.org.

Privacy Policy Notice of Availability

Buena Vista Regional Medical Center's 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 Carrie Turnquist at (712) 213-8607. It is also available for download at in the Employee Area of the BVRMC.org website.

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 Carrie Turnquist at (712) 213-8607 or hr@bvrmc.org.

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*.

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/us-code/text/29/1185c>.

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.

Can I enroll in Medicare instead of COBRA after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first

eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights can be directed to Carrie Turnquist at (712) 213-8607 or hr@bvrnc.org. 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.

Employee Rights Under the Family and Medical Leave Act (FMLA)

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee

unable to perform the employee's job;

- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any

practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

**Special "hours of service" requirements apply to airline flight crew employees.*

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible

for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage

and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint, call (866) 4-USWAGE (866-487-9243; TTY 877-889-5627) or go to www.dol.gov/whd.

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 UnityPoint Rural Health Alliance Benefits 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](https://www.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 Carrie Turnquist at (712) 213-8607 or hr@bvrmc.org.

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 from Medicaid in paying for your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – 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>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website:

https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_c ont.aspx

Phone: 916-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:

<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711

CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program

(HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurancebuy-program>

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:

<https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp>

Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

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: <https://www.in.gov/medicaid/>

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

<https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366

Hawki Website:

<http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

Website:

<http://www.kdheks.gov/hcf/default.htm>

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)

Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIP.PPROGRAM@ky.gov

KCHIP Website: <https://kidshhealth.ky.gov/Pages/index.aspx>

Phone: 1-877-524-4718

Kentucky Medicaid Website:

<https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or

www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740.

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:

<http://www.mass.gov/eohhs/gov/departments/masshealth/>

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website:
<https://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website:
<https://www.dhhs.nh.gov/oii/hipp.htm>
Phone: 603-271-5218
HIPP program toll free number: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
<http://www.state.nj.us/human-services/dmahs/clients/medicaid/>
Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid & CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 855-697-4347, or 401-462-0311 (Direct RItE Share Line)

SOUTH CAROLINA - Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS - Medicaid

Website: <http://gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website:
<http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:
<https://www.coverva.org/hipp/>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website:
<https://health.wyo.gov/healthcare-fin/medicaid/programs-andeligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, 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