Classified Management Retirees

Retiree Benefits Guide

2021 - 2022

Think Benefits

Think Benefits.

Dear Valued Retiree:

Buena Park School District takes pride in offering a comprehensive and competitive benefit program to all eligible past employees.

This brochure highlights all plans that are available to you and your dependents for the 2021-2022 plan year.

Thank you again for your past work with BPSD!

Sincerely,

Your Human Resources Department

The benefits in this summary are effective:

October 1, 2021 - September 30, 2022

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 15-16 for more details.

Eligibility

RETIREE ELIGIBILITY

You are eligible for Buena Park School District's benefits if you retired as an active, full-time or part-time employee who was regularly scheduled to work as defined by the current Collective Bargaining Agreement on file with the Bargaining Unit and with us.

DEPENDENT ELIGIBILITY

The following dependents are eligible for coverage:

- Legal Spouse
- California Registered Domestic Partners who are members of the same sex or opposite sex (if one or both persons are over the age of 62)
- Child(ren) including biological, adopted, stepchild(ren), child(ren) of eligible Domestic Partner up to age 26, and any other child(ren) for whom you are a legal guardian (legal guardianship eligible until age 18)
- Child(ren) over age 26 if incapable of self-care and legally dependent

DEPENDENT VERIFICATION

Adding dependents is subject to eligibility verification. Please make sure to submit copies of original documents to Human Resources as SISC will need to keep them.

- Marriage Certificate and front page of tax return– Required when adding a spouse
- Birth/Hospital Certificate– Required when adding dependent child(ren)
- Court documents showing legal responsibility– Required when adding adopted children or children covered due to legal guardianship
- Birth Certificate & Physician's Certification– Required when adding children over age 26 incapable of self-support due to disability
- Social Security Numbers– Required when adding all dependents
- Copy of your Declaration of Domestic Partnership with the Secretary of State– Required when adding a domestic partner

QUALIFYING EVENTS

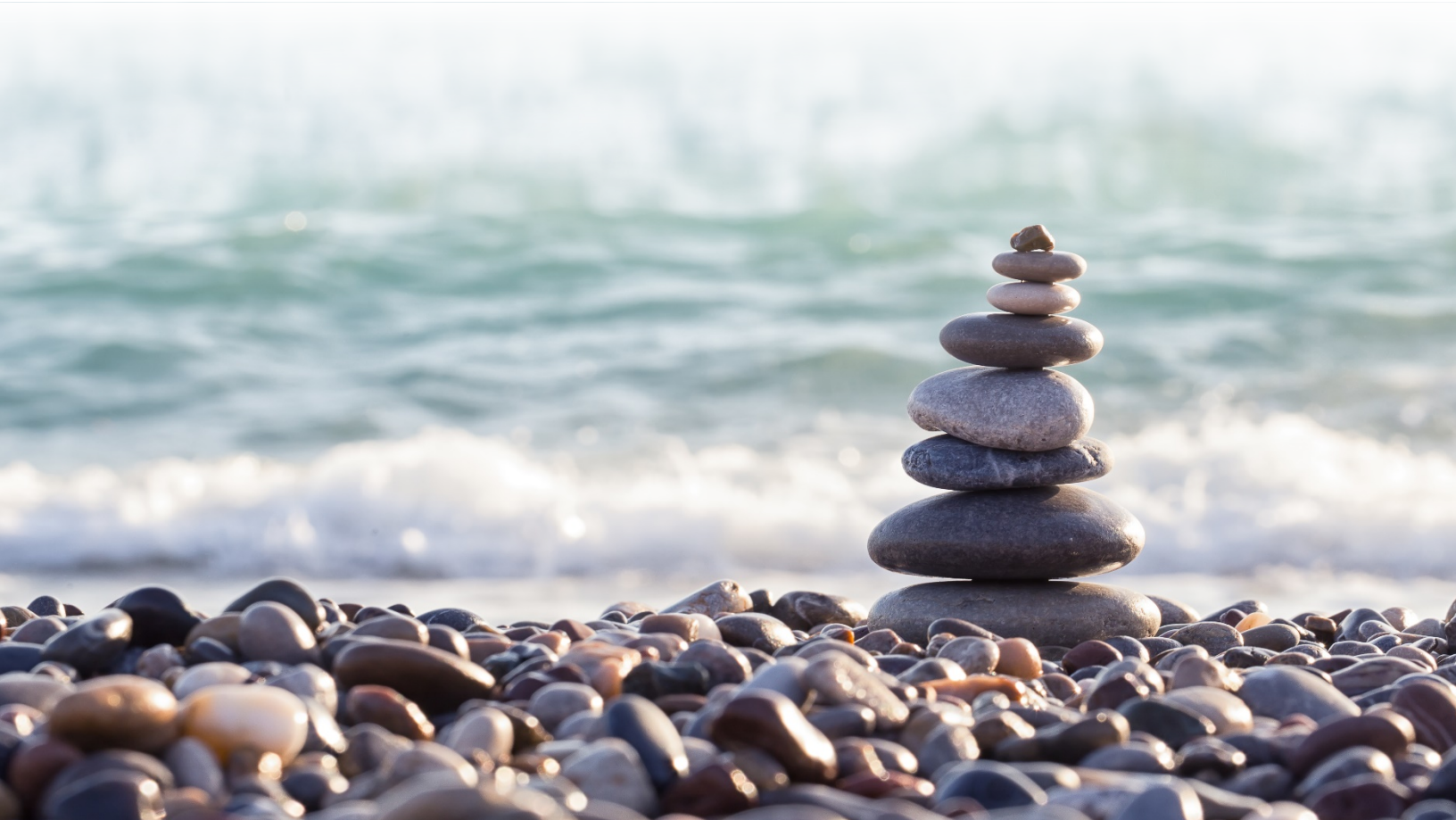
Please make sure to notify Human Resources right away if you have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 31 days to make your change.

Cost of Coverage

	Medical			Dental	
	Kaiser Traditional HMO	Anthem HMO	Anthem PPO	DeltaCare HMO	Delta Dental PPO
Retiree Only	$0.00	$0.00	$0.00	$66.38	$145.06
Retiree + 1 Dependent	$706.80	$880.80	$949.60	$66.38	$145.06
Retiree + Family	$1,227.60	$1,530.00	$1,652.40	$66.38	$145.06

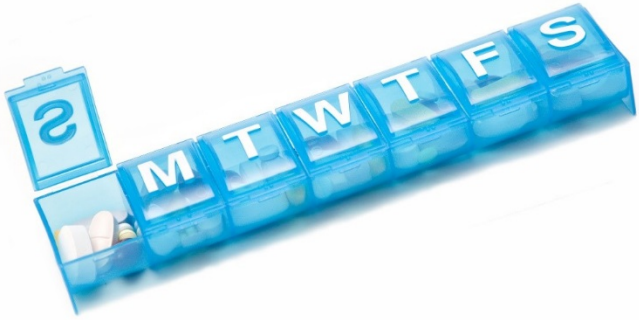


Prescription Drug Savings

ARE PRESCRIPTION DRUG COSTS BREAKING YOUR BUDGET?

A little research before you go to the pharmacy could result in huge savings.

	Insider Tip	Rx Expert
	Your medical plan includes prescription drug coverage. You pay a different amount depending on the "tier" or class of drug.	GENERIC drugs are always the least expensive. Get in the habit of asking your doctor or pharmacist if there's a generic alternative.
	A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.	If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan's preferred drug list.
	A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan's website or app.	SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like goodrx.com or lowestmed.com.
	SPECIAL HANDLING REQUIRED? Your plan may require preauthorization (plan approval) or step therapy (trying certain drugs before others). Specialty drugs such as injectables may need to be purchased from a certain provider.	Talk with your doctor about your course of treatment and confirm whether your plan requires any special procedures.



Is it Preventive or Diagnostic

You benefit both financially and health-wise when you get annual checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's fully covered in-network.

But did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

Preventive care services	Diagnostic services
• Help you stay healthy by checking for disease before you have symptoms or feel sick	• Check for disease after you have symptoms or because of a known health issue
• Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions	• Can also include physical exams, lab tests and prescriptions
• 100% covered when delivered by an in-network provider	• You pay your share of the cost

PREVENTIVE: At Don's annual checkup, his doctor orders a blood sugar test to screen for diabetes, even though Don does not have symptoms.

DIAGNOSTIC: Grace's doctor orders a blood sugar test because she complains of increased thirst, frequent urination, weight loss, and fatigue—all symptoms of diabetes.

PREVENTIVE: As part of her well woman exam, Vanessa receives a mammogram to make sure there have been no changes since last time.

DIAGNOSTIC: Darla visits her doctor because she found a lump. Her doctor schedules a mammogram and a biopsy to check for cancer.

PREVENTIVE: Aki's doctor orders lab work during his annual physical, including a cholesterol check.

DIAGNOSTIC: Hector was diagnosed with high cholesterol two years ago. He has blood tests twice a year to check his cholesterol levels and make sure his medication is the right dose.

If you're unsure why a test was ordered, ask your doctor. And don't forget to schedule your preventive care visits. Many people use a key date like their birthday or anniversary as a reminder to make their appointments each year.

Know Where To Go

ER or Urgent Care

The emergency room shouldn't be your first choice unless there's a true emergency.

Consider Urgent Care For...	Go to the Emergency Room For...
Symptoms, pain or conditions that require quick medical attention but do not require hospital care, such as:	Serious or life threatening conditions that require immediate treatment that you can get only at a hospital such as:
-Earache	-Chest pain or severe abdominal pain
-Sore throat	-Trouble breathing
-Rashes	-Loss of consciousness
-Broken fingers or toes	-Severe bleeding that can't be stopped
-Flu	-Large broken bones
-Fever up to 104 degrees	-Major injuries from a car crash, fall or other accident
	-Fever above 104 degrees

Other non-emergency care options

Our medical plans offer plenty of options when you need care or advice, but it's not an emergency:

Plan	Call a nurse 24/7	Find doctor/urgent care
Anthem Blue Cross Medical HMO / PPO	(800) 977-0027	(800) 825-5541
Kaiser Permanente Medical HMO	(800) 464-4000	(800) 464-4000
MDLive 24/7 Physician Line	(888) 632-2738	

Medical

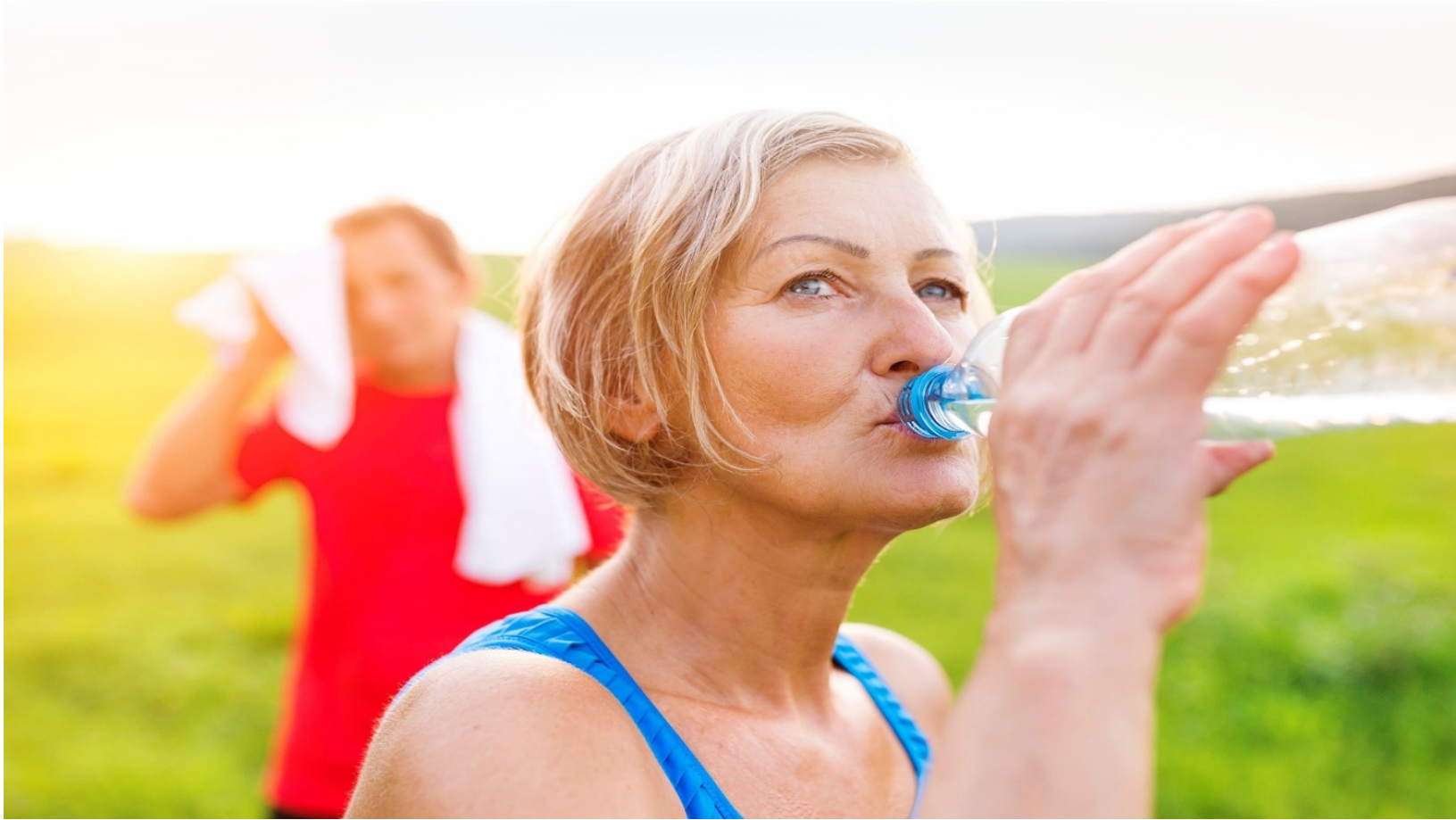
Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

Your medical options for 2021-2022 are the following:

- **Kaiser HMO (through SISC)**
- **Anthem HMO (through SISC)**
- **Anthem PPO (through SISC)**

Plan Offerings:

An HMO plans' primary objective is to offer you and your dependents quality coverage at a lower cost. If you select the Anthem HMO, you must choose a primary care physician (PCP) and medical group who will then coordinate your care through the carrier's HMO network of physicians and hospitals, resulting in cost savings for you. Kaiser's network is a unique model as the insurance company employs hospitals, doctors, and nurses which members would receive all treatment from, except in an emergency. This "closed" system offers high quality care and benefits at a low cost relative to other insurance companies. The Anthem Blue Cross HMO, on the other hand, offers members a variety of medical groups and physicians to choose from. Even more so, PPO plans are designed to provide members with choice and flexibility. By enrolling in the Anthem PPO plan, you will have access to in-network and out-of-network coverage allowing you to see any provider of your choice (out-of-network care will lead to higher out-of-pocket costs).



Medical

	Kaiser Permanente HMO (SISC)	Anthem Blue Cross HMO (SISC)	Anthem Blue Cross PPO (SISC)	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Deductible Individual / Family	None	None	$500 / $1,000	
Annual Out-of-Pocket Max	$1,500 / $3,000	$1,000 / $2,000	$2,000 / $4,000	Unlimited
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit				
Primary Provider	$20 copay	$10 copay	$20 copay[2]	See footnote 1
Specialist	$20 copay	$10 copay	$20 copay[2]	See footnote 1
Preventive Services	No charge	No charge	No charge[2]	Not covered
Chiropractic Care	$10 copay (up to 30 visits per year combined with Acupuncture)	$10 copay (up to 30 visits per year combined with Acupuncture)	20%	Not covered
Lab and X-ray	No charge	Complex imaging: $100 copay All others: No charge	20%	Complex Imaging: All billed amounts exceeding $800/test All others: Not covered
Inpatient Hospitalization	No charge	No charge	20%	All billed amounts exceeding $600/day
Outpatient Surgery	$20 copay	No charge	20%	See footnote 1
Urgent Care	$20 copay	$10 copay (waived if admitted)	$20 copay[2]	See footnote 1
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay then 20% (copay waived if admitted)	$100 copay then 20% (copay waived if admitted)

[1]When using Non-Network PPO providers, members are responsible for any difference between the maximum allowed and actual charges, as well as any deductible and percentage copay.

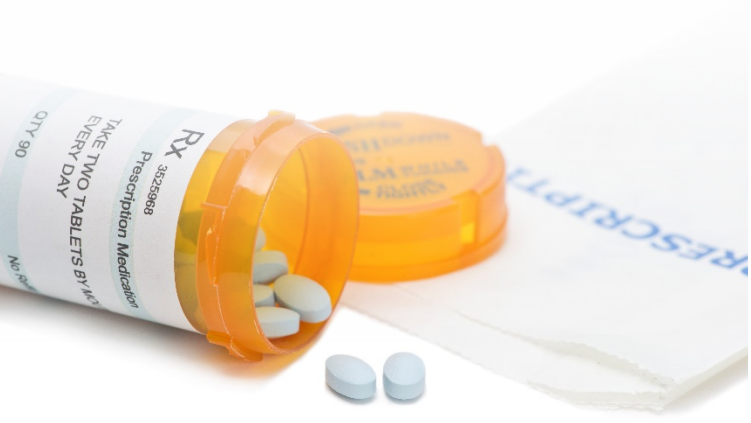
[2] Deductible waived.

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered with our Kaiser Permanente HMO (SISC), Anthem Blue Cross HMO (SISC), and Anthem Blue Cross PPO (SISC) plans.

	Kaiser Permanente HMO (SISC)	Anthem Blue Cross HMO (SISC)	Anthem Blue Cross PPO (SISC)	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Limit Individual / Family	Medical Out-of-Pocket Maximum Applies	$1,500 / $2,500	$2,500 / $3,500	N/A
Pharmacy				Members must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider.
Generic	$10 copay	Costco: No charge Other: $7 copay	Costco: No charge Other: $9 copay	
Brand	$20 copay	$25 copay	$35 copay	
Supply Limit	100 days	30 days	30 days	
Mail Order				Members must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider.
Generic	$10 copay	No charge	$0 copay	
Brand	$20 copay	$60 copay	$90 copay	
Supply Limit	100 days	90 days	90 days	



Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Your dental options for 2021-2022 are the following:

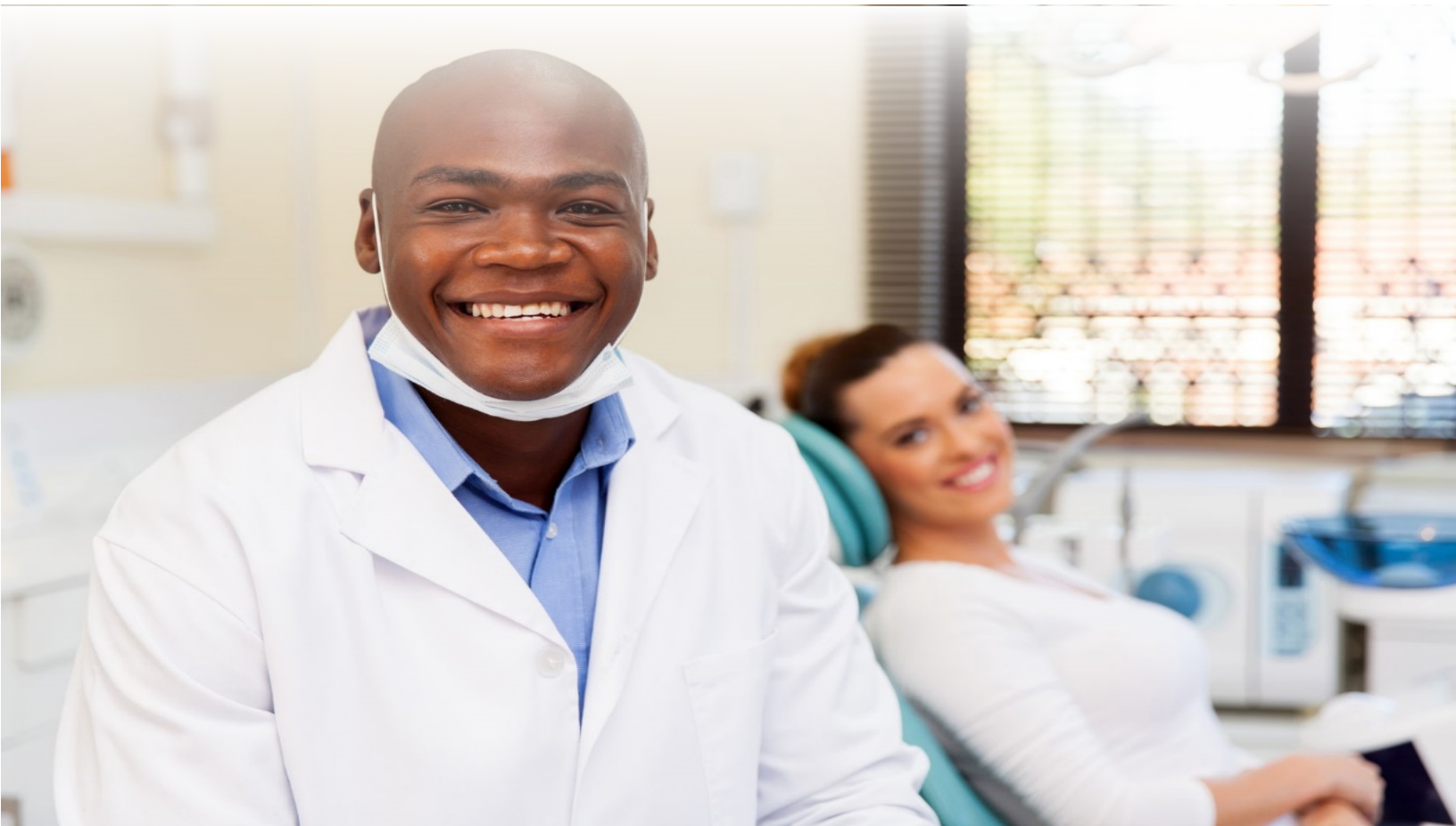
- **DeltaCare HMO**
- **Delta Dental PPO**

Plan Offerings:

The DeltaCare HMO dental plan has one of the largest prepaid dental networks in California. This plan offers the convenience of scheduled copays for specific procedures and eliminates deductibles or annual maximums. The dental PPO plan is designed so you can choose from an extensive network of Delta Dental Dentists or any other provider of your choice. However, by using one of the Delta Dental providers, you will reduce your out-of-pocket costs.

Tip: Delta Dental offers many resources to help you manage your eligibility and billing information. At deltadentalins.com/enrollees you will have access to the following:

✓Provider finder	✓View benefits	✓View claims
✓Cost estimator	✓View/ Print ID cards	✓View eligibility



Dental

	DeltaCare HMO	Delta Dental PPO	
	Copay Amounts	**In-Network**	**Out-Of-Network**
Annual Deductible	None	None	$100 / member
Annual Maximum	None	$5,000/ member	$2,000 / member
Preventative Care			
Exams	$0	100%	100%
Cleaning	$0	100%	100%
Full Mouth X-rays	$0	100%	100%
Fluoride Treatment	$0	100%	100%
Sealants	$0	100%	100%
Basic Care			
Amalgam Fillings	100% covered	100%	80%
Endodontics			
• Anterior Root Canal	$40	100%	80%
• Bicuspid Root Canal	$80	100%	80%
• Molar Root Canal	$120	100%	80%
Periodontics			
• Gingivectomy / Quadrant	$20 - $100	100%	80%
Oral Surgery			
• Simple Extraction	100% covered	100%	80%
• Impaction	$45- $65	100%	80%
Major Care			
Crowns	$45 - $75	80%	50%
Bridges	$105 - $160	80%	50%
Complete Denture	$95	80%	50%
Orthodontic Services			
Child (up to age 19) / Adult	$1,600 / $1,800	50% / 50%	
Lifetime Maximum	None	$3,000	

For Assistance

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Group #
Medical HMO	Kaiser Permanente	(800) 464-4000	www.kp.org	231877
Medical HMO	Anthem Blue Cross	(800) 825-5541	www.anthem.com/ca/sisc	57AMT
Medical PPO	Anthem Blue Cross	(800) 825-5541	www.anthem.com/ca/sisc	40777
Dental DHMO	Delta Dental	(800) 422-4234	www.deltadentalins.com	7041-1401
Dental DPPO	Delta Dental	(800) 765-6003	www.deltadentalins.com	7041-1401
Buena Park School District Benefits	Amanda Smith	(714) 994-9237	asmith@bpsd.us	N/A

Important Plan Notices and Documents

NOTICE OF AVAILABILITY OF HIPAA 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.

NOTICE OF CHOICE OF PROVIDERS

The Anthem HMO plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, Anthem will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carriers directly.

THE 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.

SUMMARY OF BENEFITS & COVERAGE

As a past employee, the health benefits provided by Buena Park School District represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Buena Park School District offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Buena Park School District are available through our website.

Access it at www.bpsd.k12.ca.us/ (click on "District Office," then click on "Human Resources" to access).

NEWBORNS' AND MOTHERS' HEALTH PROTECTIONS 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 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.

Important Plan Notices and Documents

MEDICARE PART D NOTICE

Important Notice from Buena Park School District 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 Buena Park School District 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. Buena Park School District has determined that the prescription drug coverage offered by Kaiser and Anthem 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 through 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 do decide to join a Medicare drug plan and drop your current Buena Park School District prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Buena Park School District 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 This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. 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 Buena Park School District changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

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

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

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

Date:	October 2021
Name of entity:	Buena Park School District
Contact:	Amanda Smith
Address:	6885 Orangethorpe Avenue, Buena Park, CA 90620
Phone number:	(714) 994-9237

Important Plan Notices and Documents

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: 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 Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739 or 1-651-431-2670	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/ healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://myhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ 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, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2021)

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