2019 Benefits Summary

June 1, 2019 – May 31, 2020

MARSH & McLENNAN AGENCY

CAROLINA THERAPY SERVICES

Insurance Contacts

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Human Resources.

MEDICAL
Medcost
Network: Medcost
800-824-7406
www.medcost.com

DENTAL
Ameritas
Network: PPO
800-487-5553
www.ameritasgroup.com

VISION
Ameritas
Network: VSP Choice
800-877-7195
Benefit Info : www.vsp.com
Find a Provider: www.ameritas.com/member

LIFE, AD&D, DISABILITY & CRITICAL ILLNESS
Reliance Standard
800-351-4357
www.reliancestandard.com

TELADOC
800.835.2362
www.teladoc.com

FLEXIBLE SPENDING ACCOUNT
Flores & Associates
877-555-5555
www.flores247.com

iBENEFITS APP& WEB PORTAL
iBENEFITS
Company Login Code: CTS2019
www.ibenefitsapp.com/carolina-therapy-services/
For Android or iPhone users

Your dedicated benefits advocates:
Marsh & McLennan Agency
Employee Benefits Services
855-313-1075
ebservices@marshmma.com

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

WHO IS ELIGIBLE?

If you are a full-time employee working 30 or more hours per week, you are eligible to enroll in the benefits described in this guide following first of the month following 30 days of service. Eligible dependents include your legally married spouse who does not have access to other employer coverage and dependent children. Dependent children are eligible for medical, dental, and vision coverage up to age 26. For child voluntary life coverage, children who are between 19 and 26 must be enrolled as a full-time student.

HOW TO ENROLL

Each person must login to Employee Navigator to confirm their Open Enrollment elections. Even if you do not make any changes for the upcoming year, you must login to confirm your enrollment. Go to www.ibenefitsapp.com/carolina-therapy-services/ and enter your Company Login Code: **CTS2019.** You will then select the Employee Navigator Login Instructions section. Then select the NEW EMPLOYEES section and follow the link to register on the Employee Navigator site. You will use the same Company Login Code: CTS2019 to register on this site. More detailed instructions can be found in the back of this booklet and on the iBenefits site.

WHEN TO ENROLL

The open enrollment period runs from May 15, 2019 through May 21, 2019. The benefits you elect during open enrollment will be effective from June 1, 2019 through May 31, 2019. If you are enrolling as a new hire, outside of the open enrollment period, benefits are effective first of the month after 30 days after your date of hire.

WHEN YOU CAN MAKE CHANGES

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan.

YOUR COST

Medical

Medcost

EMPLOYEE SEMI-MONTHLY DEDUCTIONS			
Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
$41.25	238.75	211.25	$461.25

Dental

Ameritas

EMPLOYEE SEMI-MONTHLY DEDUCTIONS			
Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
$5.47	$19.65	$25.97	$40.15

Vision

Ameritas

EMPLOYEE SEMI-MONTHLY DEDUCTIONS			
Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
$4.24	$9.08	$7.34	$12.18

Costs for short and long term disability depend on your income. Costs for these benefits can be found within the Employee Navigator system. Please refer to the Reliance Standard Benefit Overview for further details regarding the cost of coverage for the accident and critical illness plan.

Pre-Tax Advantage: Section 125 Plan

Your share of medical, dental, vision, and FSA payroll deductions are taken on a pre-tax basis through an IRS Section 125 Plan. However, due to Section 125 Plan rules, you may only make changes in your payroll deductions at the annual Open Enrollment or at the time of a Qualifying Event such as marriage, divorce, birth of a child, loss of insurance, or court order. Any Qualifying Event must be reported to Human Resources within 30 days of the event. If there has not been a Qualifying Event, you may not make any changes to your payroll deductions until the next Open Enrollment period. These are Internal Revenue Service rules and there can be no exceptions. Contact Human Resources for more information.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

Medical and Prescription Drugs

Medcost

Carolina Therapy Services offers medical coverage through Medcost. One plan option is offered. Please review the Summary of Benefits and Coverage on the Employee Benefit Center (EBC).

Services	PPO Plan You Pay:
Deductible (Plan Year) **- Individual** **- Family**	$2,000 $4,000 Embedded*
Out-of-Pocket Max **- Individual** **- Family**	$6,000 $12,000 Embedded**
Primary Care Visit	$30 copay
Specialist Visit	$70 copay
Hospitalization, MRI, CAT, PET	$250 per Admin Deductible, then Deductible, then 20%
Emergency Room **Urgent Care**	Deductible then 30% $75 copay
Out-of-Network **Deductible** **Coinsurance** **Out-of-Pocket Maximum**	$4,000 Individual / $8,000 Family 50% after deductible $12,000 Individual / $24,000 Family
Prescription Drugs **- Tier 1** **- Tier 2** **- Tier 3**	$10 copay $85 copay $100 copay

*Embedded Deductible: All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

**Embedded Out-of-Pocket Maximum: All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Teladoc

Teladoc provides members with on-demand, 24/7 phone/video/online access to US based, licensed physicians. You and your family members can connect instantly with their network of physicians for information, advice, and treatment including prescription medication when appropriate. For more information, please contact Teladoc at 800.835.2362 or go to www.teladoc.com. This benefit is available to all employees and their families enrolled in the company's sponsored medical coverage. **This benefit is paid 100% by CTS with no with no employee fee for services.**

Dental

Ameritas

Benefits	In Network	Out of Network
Preventive Services Exams, cleanings, x-rays	Covered at 100%	Covered at 100%
Deductible (Plan Year) Applies to basic and major services only	$50 Individual / $150 Family	$50 Individual / $150 Family
Basic Services Fillings, simple extractions	Covered at 80%	Covered at 80%
Major Services Oral surgery, crowns	Covered at 50%	Covered at 50%
Orthodontia (for children up to age 19)	Covered at 50% up to a lifetime maximum of $1,000	Covered at 50% up to a lifetime maximum of $1,000
Annual Maximum (Plan Year)	$1,500 annual maximum	$1,500 annual maximum
Late Entrant Waiting Period (Late Entrant means you are enrolling outside of your new hire waiting period without a qualifying event)	Basic: 12 Months Major: 12 Months Ortho: 12 Months	Basic: 12 Months Major: 12 Months Ortho: 12 Months

This plan allows you to seek treatment from the dentist of your choice; however, by seeing a dentist that participates within the PPO network, you will not be balanced billed for charges that are considered over reasonable and customary for your area. Please refer to your plan document for frequency and limitations.

Vision

Ameritas

The chart below provides information related to the vision plan available. Please refer to your plan document for information regarding out of network benefits.

Benefits	In Network
Exam	$10 copay
Standard Frames	$130 allowance
Standard Lenses	$25 copay
Contact Lenses (Conventional)	$130 allowance + 15% off remaining balance
Frequency of Services **Exams** **Frames** **Lenses OR Contacts**	 12 months 24 months 12 months

Flexible Spending Account (FSA) Flores

Medical Flexible Spending (FSA):
Allows you the opportunity to defer pre-tax dollars into a Flexible Spending Account (FSA) in order to pay for eligible medical, dental, and vision expenses. In 2019, you may defer up to $1,200 into your medical FSA. FSA funds are designated as "use it or lose it." At the end of the plan year, you will no longer have access to funds remaining in your FSA. All claims for FSA must be filed within 75 days of the end of the plan year.

Dependent Care Spending Account (DCSA):
Allows you to set aside up to $5,000 ($2,500 if married and filing separately) to cover child or adult day care, summer camp (excluding overnight camp), and after school care for working parents. The IRS rules state that if you don't use the money in your account by the end of the plan year, you forfeit any remaining amount in your account. The DCSA will reimburse your eligible expenses up to the amount that is in your account at the time your claim is received.

To obtain a complete list of eligible and ineligible expenses for FSAs, go to www.irs.gov/publications/p502.

Disability Income Benefits Reliance Standard

Employees may elect to purchase short and long term disability coverage through the convenience of payroll deduction. If you experience an illness or injury (non-work related for STD) that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

	Short Term Disability	Long Term Disability
Benefits Begin	15th day accident/illness	After 90 days
Benefits Duration*	11 weeks	SSNRA
Standard Maternity Benefits Duration	6 weeks vaginal delivery 8 weeks c-section	N/A
Percentage of Income Replaced	60% of weekly income	60% of monthly income
Maximum Benefit	$1,000 weekly	$5,000 monthly
Pre-Existing Condition Limitation	If you are treated or diagnosed with a condition within 3 months of your effective date, that condition will not be covered until you have been enrolled for 12 months.	If you are treated or diagnosed with a condition within 3 months of your effective date, that condition will not be covered until you have been enrolled for 12 months.
Evidence of Insurability Requirement	Yes	Yes

*Benefits duration includes the waiting period and is subject to medical necessity.

Short Term Disability Premium Calculation	Long Term Disability Premium Calculation
60% x Weekly Earnings = Volume	Annual Income / 12 = Monthly Income
(RATE) .65 x (VOLUME) / 10 = Monthly Premium	(RATE) .80 x Monthly Income / 100 = Monthly Premium
Monthly Premium x 12 / 24 = Payroll Deduction	Monthly Premium x 12 / 24 = Payroll Deduction

Basic Life Insurance

Reliance Standard

Your company provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance according to your class status and pays the full cost of this benefit. Benefits begin reducing at age 70. Contact Human Resources to update your beneficiary information.

Voluntary Life Insurance

Reliance Standard

Employees may elect to purchase additional life insurance on themselves or their dependents through the convenience of payroll deduction. If you elect when first eligible, you may elect coverage up to the Guaranteed Issue amount without having to answer any medical questions. Employee and spouse benefits reduce by 50% at employee age 70; employee and spouse rates are based on employee age. To be eligible for coverage you must be actively at work.

Guaranteed Issue	Employee: $175,000 Spouse: $20,000 Dependent Child: $10,000
Employee Coverage	You may elect coverage in $50,000 increments up to a maximum of 5x your annual earnings or $500,000.
Spouse Coverage	You may elect coverage for your spouse in $10,000 increments up to 2.5X the employee's annual salary, not to exceed 50% of employee's amount (Max -- $250K).
Child Coverage	You may elect coverage for your dependent child(ren) up to a maximum of $10,000. ($250 – 14 Days to 6 Months)

Voluntary AD&D Insurance

Reliance Standard

Voluntary Accidental Death & Dismemberment benefit with Reliance Standard provides additional protection for policy holder or beneficiaries in the event of an accidental death or dismemberment of the policy holder. Employee and spouse benefits reduce by 50% at employee age 75 and an additional 25% at age 80; employee and spouse rates are based on employee age. To be eligible for coverage you must be actively at work.

Employee Coverage	You may elect coverage in $10,000 increments up to a maximum of 10x your annual earnings or $500,000.
Spouse Coverage	You may elect coverage up to 50% of employee amount with no child(ren) covered. If child(ren) are also to be covered you may election up 40% of employee amount.
Child Coverage	You may elect up to 10% of employee amount if spouse is covered. If the coverage is employee and child(ren) only you can elect up to 15% of employee amount.

Critical Illness Insurance

Reliance Standard

CTS offers group critical illness insurance that can help protect your finances from the expense of a serious health problem, such as cancer, stroke or heart attack. If you elect, you will have a flat lump-sum benefit that's paid directly to you at the first diagnosis of a covered condition. You can use the benefit any way you choose. If you elect coverage on yourself, you can also buy coverage for your spouse in amounts up to100% of employee's coverage. In addition, children are allowed to elect up to 25% of the employee's election. **There is also a $50 wellness incentive per year for each insured person for having your annual physical.** See the Schedule of Benefits for a full list of covered conditions.

Guaranteed Issue	Employee: $30,000 Spouse: $30,000 Dependent Child: $12,500
Employee Coverage	You may elect coverage in $1,000 increments from $5,000 up to a maximum of $50,000
Spouse Coverage	You may elect coverage in $1,000 increments from $5,000 up to a maximum of $50,000; spouse election cannot exceed 100% of employee election.
Child Coverage	You may elect coverage for your dependent child(ren) in increments of $1,000 not to exceed 25% of employee election up to a maximum of $12,500.

Benefit Amount	Age 0-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70-74	Age 75-79
$5,000	$1.08	$1.60	$2.05	$3.08	$4.75	$6.98	$9.28	$12.90	$18.43	$23.53	$31.65
$10,000	$2.15	$3.20	$4.10	$6.15	$9.50	$13.95	$18.55	$25.80	$36.85	$47.05	$63.30
$15,000	$3.23	$4.80	$6.15	$9.23	$14.25	$20.93	$27.83	$38.70	$55.28	$70.58	$94.95
$20,000	$4.30	$6.40	$8.20	$12.30	$19.00	$27.90	$37.10	$51.60	$73.70	$94.10	$126.60
$25,000	$5.38	$8.00	$10.25	$15.38	$23.75	$34.88	$46.38	$64.50	$92.13	$117.63	$158.25
$30,000	$6.45	$9.60	$12.30	$18.45	$28.50	$41.85	$55.65	$77.40	$110.55	$141.15	$189.90
$35,000	$7.53	$11.20	$14.35	$21.53	$33.25	$48.83	$64.93	$90.30	$128.98	$164.68	$221.55
$40,000	$8.60	$12.80	$16.40	$24.60	$38.00	$55.80	$74.20	$103.20	$147.40	$188.20	$253.20
$45,000	$9.68	$14.40	$18.45	$27.68	$42.75	$62.78	$83.48	$116.10	$165.83	$211.73	$284.85
$50,000	$10.75	$16.00	$20.50	$30.75	$47.50	$69.75	$92.75	$129.00	$184.25	$235.25	$316.50

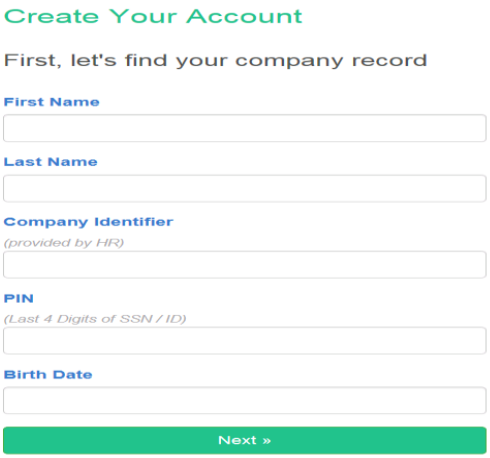
How to Enroll in your Benefits:

Employee Navigator Login Instructions

Please visit:

https://www.employeenavigator.com/Benefits/Login/Registration.aspx

1. Click on the green “Log In” button on the top right corner, then select “Register as a New User” and complete the fields noted below, using the Company Identifier – CTS2019
2. Click “Next”

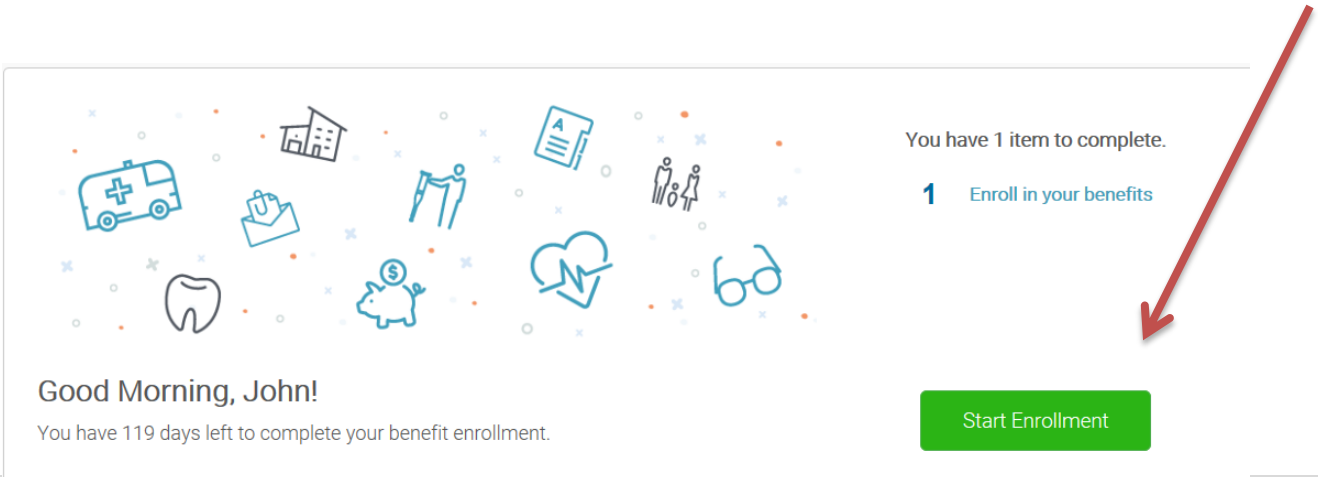


You will then be asked to create a username and password. Please make your password something you will remember but private as *this site will contain confidential employee information.*

Once you have created your login, you will be taken through a wizard that will help navigate you through the enrollment process.

So let’s begin….

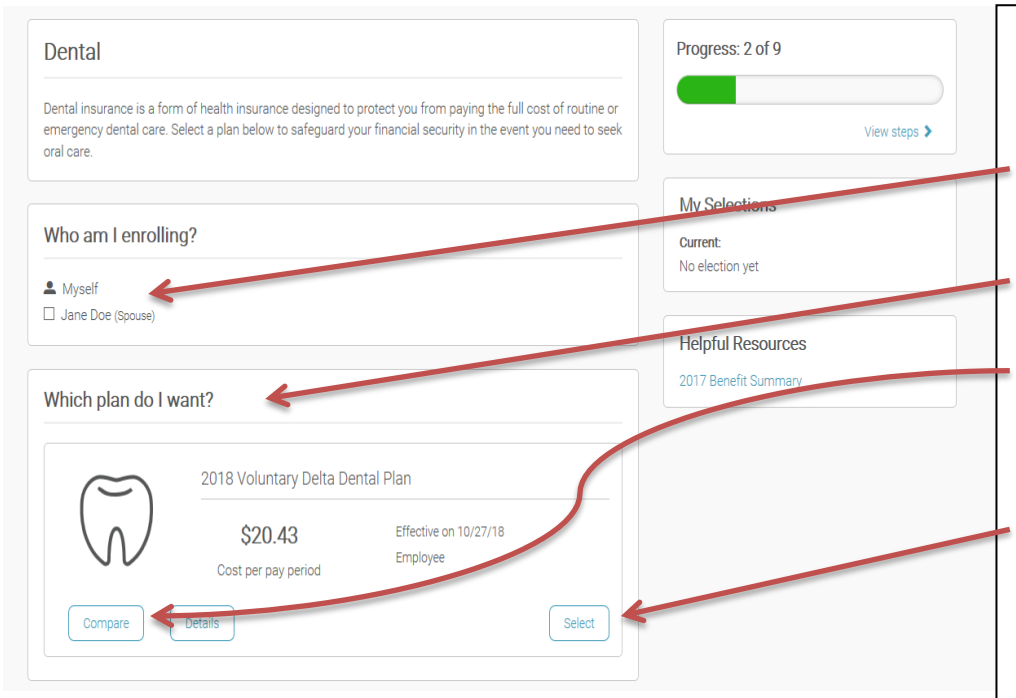
The first thing you will see is the welcome screen, example shown below. You will click the “Start Enrollment” Icon:



Next you will see a page to welcome you to your enrollment process. Click “Get Started”.

Complete any missing data on the first page where you will see your employee information. Be sure to click this button at the bottom of the screen if you have made any changes:

If you do not have any changes, click Save to go to the next screen which is “Dependent Information” and add your dependents there. Be sure to click the “Save & Continue” button once you are done adding dependents. If you do not have dependents to add, click “Save”.



This is the next page you will see. Simply complete the information to enroll or waive coverage you wish to elect for you and your dependents.

Who am I enrolling? *You will need to select your dependents on each line of coverage you are enrolling them on.*

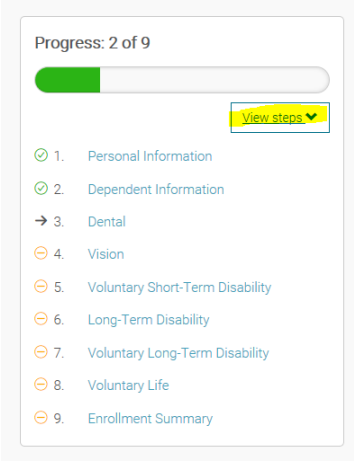
Which plan do I want (if you have more than one to choose from).

You can also click on the “compare” icon to show the plan(s) and cost for all tier levels…

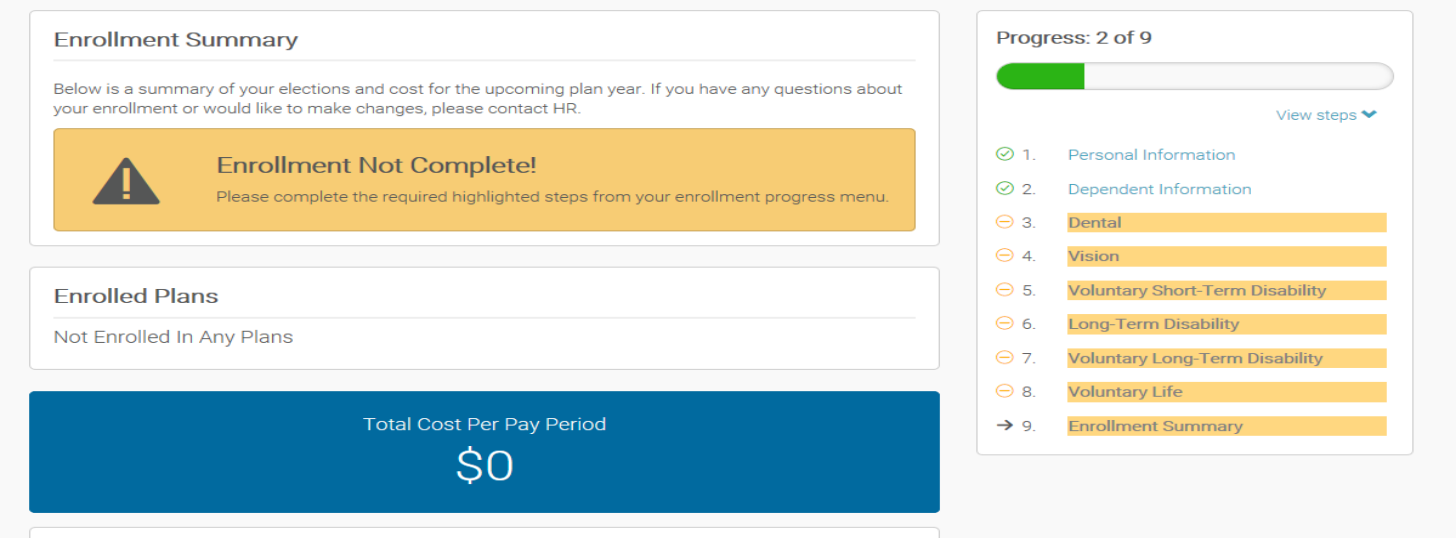
And the “details” icon to provide a brief benefits overview.

You will do this the same for each line of coverage available to you during this enrollment process.

If you need to go back during any step of the enrollment process, click on the “View Steps” under the Progress Bar and a drop down will appear. Simply click on that benefit to go that screen.

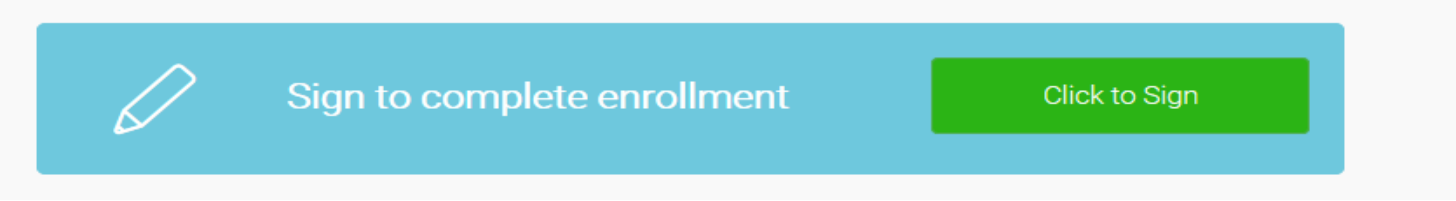


At the end, you will be able to view all elections and the cost for each line and you can print a copy for your records. If you have missed any steps, you will be notified which items need to be completed:



Be sure to always select "SAVE & CONTINUE" for any modifications that you make.

Once you have made elections for all benefits, you will ask to electronically sign and you will click the green "Click here to sign" button which will complete your enrollment process!



If you have any questions, please call Marsh & McLennan's Employee Benefit Services at 855-313-1075 or via email at ebservices@marshmma.com.

MARSH & McLENNAN AGENCY

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For details of deductibles and coinsurance applicable to these benefits, refer to your benefits summary booklet.

If you would like more information on WHCRA benefits, contact your Plan Administrator.

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your plan administrator for more information.

Newborns' and Mothers Health Protection Act Enrollment 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice from Carolina Therapy Services 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 Carolina Therapy Services 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. Carolina Therapy Services has determined that the prescription drug coverage offered by Medcost 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 15 through December 7.

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 current plan coverage will not be affected. You can keep your existing coverage or join a Medicare drug plan as a supplement to, or in lieu of, your coverage under Carolina Therapy Services plan.

If you do decide to join a Medicare drug plan and drop your current plan's coverage, be aware that you and your dependents may not be able to get this coverage back until Carolina Therapy Services next annual open enrollment (or if you experience a special enrollment event).

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 Carolina Therapy Services 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. **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 Carolina Therapy Services 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:	May 15, 2019
Name of Entity/Sender:	Carolina Therapy Services
Contact--Position/Office:	Chastity Strickland; HR Manager
Address:	111 South Railroad Avenue Dunn, NC 28334
Phone Number:	910-892-0027

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 July 31, 2018. 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: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://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: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, 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

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)


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