

2025

BENEFITS

Guide



Anchor Bay Schools

Administration



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The details in this booklet are intended as an easy to read summary and provide only a general overview of the plan. It is not intended to be a contract. Additional limitations and exclusions may apply. If there is a discrepancy between this booklet and the applicable plan documents, the plan documents will prevail.



A guide to your MESSA benefits

2025 open enrollment is November 1st, 2024 to November 18th, 2024.

Dear Anchor Bay Schools member:

The open enrollment period is your opportunity to review and update your health benefits selections for the coming year. It's important for you to understand the benefits available to you, so you can make the best decisions for you and your family.

This benefit guide provides an overview of your MESSA benefit options. Please review it carefully before making your benefit selections.

Once you're ready, you can log in to your MyMESSA account at messa.org to access the online benefits website. After open enrollment closes on November 18th, 2024, you cannot change your benefit selections until the next open enrollment period.¹

Any changes you make will become effective 1/1/2024.

If you have any questions, call MESSA's Member Service Center at 800-336-0013. We're here to help!

Access the online benefits website by logging in to your MyMESSA account at messa.org to:

Review your current enrollment.

Make any benefit selection changes.

Submit benefit selection by November 18th, 2024.

¹Allowances are made for "qualifying events," such as marriage, birth, your spouse's losing coverage from another insurer, or other limited instances.

MESSA In-Network Plan Comparison - Effective 1/1/2025
Anchor Bay Schools - 004A Administration

	MESSA ABC Plan 2 \$2,000/\$4,000 HSA 0% 5-Tier Rx	MESSA ABC Plan 2 \$2,000/\$4,000 HSA 20% 5-Tier Rx	MESSA Balance+ \$1,650/\$3,300 HSA 20% MESSA Balance+ Rx
In-Network Cost Share After Deductible			
Deductible	\$2,000/\$4,000	\$2,000/\$4,000	\$1,650/\$3,300
Coinsurance	0%	20%	20%
Teladoc 24/7 care for minor illnesses, injuries and mental health	0%	20%	\$10
Teladoc Health virtual primary care	0%	20%	\$25
Office visit	0%	20%	\$25
Specialist visit	0%	20%	\$50
Urgent care	0%	20%	\$50
Emergency room	0%	20%	\$200
Total out-of-pocket maximum	\$4,000/\$8,000	\$5,000/\$8,300	\$4,050/\$8,100
Certain Benefit Differences (cost share is applied after deductible is met)			
Chiropractic manipulations	38 visits per calendar year, including therapeutic massage; 100% after ded.	38 visits per calendar year, including therapeutic massage; 80% after ded.	12 visits combined per calendar year; \$25 copay applies
Osteopathic manipulations	38 visits per calendar year; 100% after ded.	38 visits per calendar year; 80% after ded.	
Outpatient physical, occupational and speech therapy	60 visits combined per calendar year; 100% after ded.	60 visits combined per calendar year; 80% after ded.	30 visits combined per calendar year, including therapeutic massage by an approved provider (excludes massage therapist); 80% after ded.
Bariatric surgery	100% after ded.	80% after ded.	Not covered
Acupuncture	100% after ded.	80% after ded.	Not covered
Hearing aids	100% up to a max. benefit after ded.	80% up to a max. benefit after ded.	Not covered

MESSA In-Network Plan Comparison - Effective 1/1/2025
Anchor Bay Schools - 004A Administration

	MESSA ABC Plan 2 \$2,000/\$4,000 HSA 0% 5-Tier Rx	MESSA ABC Plan 2 \$2,000/\$4,000 HSA 20% 5-Tier Rx	MESSA Balance+ \$1,650/\$3,300 HSA 20% MESSA Balance+ Rx
Prescription Drugs	5-Tier Rx (after deductible)	5-Tier Rx (after deductible)	MESSA Balance+ Rx (after deductible)
Up to a 34-day supply			
Generic	Free or \$10	Free or \$10	Free or \$10
Preferred brand	\$40	\$40	\$40
Nonpreferred brand	\$80	\$80	\$80
Preferred specialty (generic specialty and brand specialty)	20% coinsurance (\$0 min - \$150 max)	20% coinsurance (\$0 min - \$150 max)	20% coinsurance (\$0 min - \$150 max)
Nonpreferred specialty	20% coinsurance (\$0 min - \$300 max)	20% coinsurance (\$0 min - \$300 max)	20% coinsurance (\$0 min - \$300 max)
90-day supply			
Generic, Preferred brand, Nonpreferred brand	3x 1-month supply; Retail or mail order	3x 1-month supply; Retail or mail order	3x 1-month supply; Retail or mail order
Additional Information			
Free preventive drug list(s)	ACA Free Preventive list and MESSA Expanded Free Preventive list. These are FREE before deductible.	ACA Free Preventive list and MESSA Expanded Free Preventive list. These are FREE before deductible.	ACA Free Preventive list and MESSA Expanded Free Preventive list. These are FREE before deductible.
Supplemental Plans	Not included	Not included	Included: MESSA's Accident, Critical Illness and Hospital Indemnity plans

ACA = Affordable Care Act

~ Essentials by MESSA Rx, Balance+ Rx, and 5-Tier Rx plans have several drugs and drug categories that are excluded from coverage, including, but not limited to brand-name drugs that have generic equivalents, erectile dysfunction drugs, brand-name weight loss and prenatal vitamins, and drugs that treat coughs and colds, including most antihistamines.

~ The MESSA ABC Plan 1 and Balance+ deductible is subject to change each Jan. 1 to remain HSA-compatible, per IRS rules; out-of-pocket maximums may change based on deductible amounts.

If you have any questions, please contact your MESSA Field Representative, Heather Scott, at 800-292-4910.

This comparison is provided for informational purposes only and MESSA assumes no responsibility or liability for any errors or omissions in the content. Refer to MESSA.org and the plan booklets for additional information.

MESSA ABC with 5-Tier Rx Overview



1475 Kendale Blvd. PO Box 2560
 East Lansing, Michigan 48826-2560
 517-332-2581 • 800-292-4910

- You pay the full cost of your prescriptions until your deductible is fully paid. After deductible, you are responsible for prescription copayments or coinsurance until your out-of-pocket maximum is reached.
- If the approved amount of a prescription medication is less than the copayment, you pay only the approved amount for the drug.
- Specialty medications are handled separately. Specialty drugs must be obtained by mail through Walgreens Specialty Pharmacy or select Walgreens retail pharmacies. If you obtain them from any other provider, you may be responsible for the total cost.
- The initial quantity of select specialty drugs may be limited, and your cost will be reduced accordingly. Additional fills for specialty drugs are limited to a 30-day supply.
- Your prescription plan includes a number of money-saving features, including prior authorization, step therapy and quantity limits.
- If you have 5-Tier Rx with Mandatory Mail, you must order all 90-day prescriptions and certain long-term maintenance medications through Optum Rx for home delivery.
- To order medications through Optum Rx, log in to your MyMESSA account at messa.org and select “Optum Rx home delivery” under the “Benefits” menu. You may also call MESSA at 800-336-0013 or TTY: 888-445-5614 for assistance or contact us via live chat from your MyMESSA account or through the MESSA app.

Type of medications	Up to 34-day supply	90-day supply
List of specific preventive medications in addition to those mandated by federal law are covered 100% with no deductible required.	No cost to you	No cost to you
After your deductible is met the following copayments or coinsurance apply:		
Generic drugs Members pay the lowest copay for generics, making them the most cost-effective option for treatment.	\$10 copayment	\$30 copayment
Preferred brand-name drugs Brand-name drugs are more expensive than generics.	\$40 copayment	\$120 copayment
Nonpreferred brand-name drugs Includes brand-name drugs for which there’s either a generic alternative or a more cost-effective, preferred brand-name drug available.	\$80 copayment	\$240 copayment
Preferred specialty drugs Includes generic and brand-name specialty drugs that are used to treat difficult health conditions.	20% coinsurance with a maximum of \$150 (up to 30-day supply)	Not available
Nonpreferred specialty drugs Includes nonpreferred brand-name specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are more cost-effective generic or preferred drugs available.	20% coinsurance with a maximum of \$300 (up to 30-day supply)	Not available

*Prescription types (generic, brand-name and specialty) are subject to change without notice. The initial quantity of select specialty drugs may be limited and **your cost will be reduced accordingly for the reduced initial fill**. To fill your specialty medication prescription, call Walgreens Specialty Pharmacy at 866-249-5367. Up to a 90-day supply of insulin may be obtained for the same amount as a 34-day supply from any in-network provider.*

MESSA Balance+ Rx Overview



1475 Kendale Blvd., P.O. Box 2560
 East Lansing, MI 48826-2560
 517-332-2581 • 800-292-4910

The MESSA Balance+ Rx plan features an expanded free preventive prescription drug list that includes and expands upon drugs and drug categories required by federal law. Age and gender limits apply. Categories include alcohol dependence, breast cancer prevention, cholesterol, colonoscopy-related, contraceptives, fluoride preparation, blood pressure lowering, prenatal vitamins, pre-exposure prophylaxis (PrEP) for HIV, and weight loss.

Covered at no charge — no deductible, no copayment and no coinsurance.

What you pay for prescriptions from an in-network pharmacy

Types of medications	Up to 34-day supply	90-day supply
After your deductible is met the following copayments or coinsurance apply:		
Generic drugs Members pay the lowest copay for generics, making them the most cost-effective option for treatment.	\$10 copayment	\$30 copayment
Preferred brand-name drugs Brand-name drugs are more expensive than generics.	\$40 copayment	\$120 copayment
Nonpreferred brand-name drugs Includes brand-name drugs for which there's either a generic alternative or a more cost-effective, preferred brand-name drug available.	\$80 copayment	\$240 copayment
Preferred specialty drugs Includes generic and brand-name specialty drugs that are used to treat difficult health conditions.	20% coinsurance with a maximum of \$150 (up to 30-day supply)	Not available
Nonpreferred specialty drugs Includes nonpreferred brand-name specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are more cost-effective generic or preferred drugs available.	20% coinsurance with a maximum of \$300 (up to 30-day supply)	Not available
<i>Prescription types (generic, brand-name and specialty) are subject to change without notice.</i>		
<i>Up to a 90-day supply of insulin may be obtained for the same amount as a 34-day supply from an in-network provider.</i>		
<i>Specialty medications are handled separately. Specialty drugs must be obtained by mail through Walgreens Specialty Pharmacy or select Walgreens retail pharmacies. If you obtain them from any other provider, you may be responsible for the total cost. The initial quantity of select specialty drugs may be limited, and your cost will be reduced accordingly. Additional fills for specialty drugs are limited to a 30-day supply.</i>		

This is a brief overview of MESSA Balance+. For additional information, including eligibility, limitations and exclusions, please contact MESSA at 800-336-0013.



Member Service Center | 800-336-0013

Our Member Service Center is available Monday through Friday 8 a.m. to 5 p.m. Our member service specialists are experts at answering questions about your plan and helping with claims.

Your MESSA field representative | 800-292-4910

A local field representative is available to help you and your group. Your field representative can explain benefits and answer questions, attend meetings or arrange visits from other MESSA experts, including nurse educators.

Medical case management | 800-441-4626

MESSA's medical case management nurses can help members and dependents with a catastrophic injury or serious illness get access to the right care at the right time and return to their highest quality of life.

Health promotion consultant | 800-292-4910

MESSA's health promotion consultant can help you and your coworkers develop or strengthen a worksite wellness program.



Legal Notices

Privacy Practices

MESSA understands the importance of your protected health information (hereafter referred to as “PHI”) and follows strict policies in accordance with state and federal privacy laws to keep your PHI private. PHI is information about you that can reasonably be used to identify you and information that relates to your past, present, or future physical or mental health, the provision of health care or the payment of that care. Notices of the Privacy Practices for MESSA, BCBSM, NYL and VSP can be found at messa.org/privacy.

Continuation Coverage Rights Under COBRA

Introduction

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). 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, please contact your employer.

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:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;

- Your spouse's employment ends for any reason other than their 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:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than their 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?

MESSA will offer COBRA continuation coverage to qualified beneficiaries only after MESSA has been notified that a qualifying event has occurred. The employer must notify MESSA of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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 MESSA within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once MESSA 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**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify your employer 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**

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, Children's Health Insurance Program (CHIP), 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 healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation of coverage 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 medicare.gov/medicare-and-you.

Questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer.

Keep your Plan informed of address changes

To protect your family's rights, let MESSA know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send.

Notice of Special Enrollment Rights

If you are declining 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 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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.

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility; or
- You or your dependent becomes eligible for premium subsidies.

To request special enrollment or obtain more information, contact your MESSA field representative at 800-292-4910, ext. 7817.

Newborns' and Mothers' Health Protection Act Notice

Under the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), group health

plans and health insurance issuers generally may not 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).

Women's Health and Cancer Rights Act of 1998

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. If you would like more information on WHCRA benefits, contact your MESSA field representative at 800-292-4910, ext. 7817.

Michelle's Law

Notice of extended coverage to participants covered under a group health plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the

dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

Your Plan permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his/her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- Medically necessary leave of absence means a leave of absence or any other change in enrollment of a dependent child from a post-secondary educational institution that:
 - Begins while the child is suffering from a serious illness or injury
 - Is medically necessary; and
 - Causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

- If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:
 - One year after the first day of the leave of absence; or

- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle’s Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more information regarding the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits, please contact MESSA’s Member Service Center at 800-336-0013.

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. However, you may be able to buy individual insurance coverage through the Health Insurance Marketplace; for more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed in this section, 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 by calling **877-KIDS NOW (877-543-7669)** or by going online to insurekidsnow.gov to find out how to apply. If you qualify, ask if your state has a program that might help you pay the premiums or 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. **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 askebsa.dol.gov or call **866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your state for more information on eligibility.

ALABAMA — MEDICAID

Website: myalhipp.com

Phone: 855-692-5447

ALASKA — Medicaid

The AK Health Insurance Premium Payment Program

Website: myakhipp.com

Phone: 866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS — Medicaid

Website: myarhipp.com

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

CALIFORNIA — Medicaid

Health Insurance Premium Payment (HIPP)

Program website: dhcs.ca.gov/hipp

Fax: 916-440-5676

Phone: 916-445-8322

Email: hipp@dhcs.ca.gov

**COLORADO — Health First Colorado
(Colorado’s Medicaid Program) & Child
Health Plan Plus (CHP+)**

Health First Colorado website:

healthfirstcolorado.com

Health First Colorado Member Contact Center:
800-221-3943/State Relay 711

CHP+: hcpf.colorado.gov/child-health-plan-plus

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

Health Insurance Buy-In Program (HIBI):

mycohibi.com/HIBI

HIBI Customer Service: 855-692-6442

FLORIDA — Medicaid

Website: flmedicaidtplrecovery.com/

flmedicaidtplrecovery.com/hipp/index.html

Phone: 877-357-3268

GEORGIA — Medicaid

GA HIPP website: medicaid.georgia.gov/

[healthinsurance-premium-payment-program-
hipp](http://healthinsurance-premium-payment-program-hipp)

Phone: 678-564-1162, Press 1

GA CHIPRA website: medicaid.georgia.gov/

[programs/third-party-liability/childrens-
health-insurance-program-reauthorizationact-
2009-chipra](http://programs/third-party-liability/childrens-health-insurance-program-reauthorizationact-2009-chipra)

Phone: 678-564-1162, Press 2

INDIANA — Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: in.gov/medicaid/

in.gov/fssa/dfr/

Family and Social Services Administration

Phone: 800-403-0864

Member Services Phone: 800-457-4584

IOWA — Medicaid and CHIP (Hawki)

Medicaid website: [Iowa Medicaid | Health &
Human Services](http://Iowa Medicaid | Health & Human Services)

Medicaid phone: 800-338-8366

Hawki website: [Hawki - Healthy and Well Kids
in Iowa | Health & Human Services](http://Hawki - Healthy and Well Kids in Iowa | Health & Human Services)

[Hawki - Healthy and Well Kids
in Iowa | Health & Human Services](http://Hawki - Healthy and Well Kids in Iowa | Health & Human Services)

Hawki Phone: 800-257-8563

HIPP website: [Health Insurance Premium
Payment \(HIPP\) | Health & Human Services
\(iowa.gov\)](http://Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov))

[Health Insurance Premium
Payment \(HIPP\) | Health & Human Services
\(iowa.gov\)](http://Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov))

[Health Insurance Premium
Payment \(HIPP\) | Health & Human Services
\(iowa.gov\)](http://Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov))

HIPP phone: 888-346-9562

KANSAS — Medicaid

Website: kancare.ks.gov

Phone: 800-792-4884

HIPP Phone: 800-967-4660

KENTUCKY — Medicaid

Kentucky Integrated Health Insurance Premium
Payment Program (KI-HIPP) website: [chfs.ky.gov/
agencies/dms/member/Pages/kihipp.aspx](http://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx)

Phone: 855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP website: kynect.ky.gov

Phone: 877-524-4718

Kentucky Medicaid website: [chfs.ky.gov/
agencies/dms](http://chfs.ky.gov/agencies/dms)

LOUISIANA — Medicaid

Website: medicaid.la.gov

Phone: 888-342-6207 (Medicaid hotline)

Website: ldh.la.gov/lahipp

Phone: 855-618-5488 (LaHIPP)

MAINE — Medicaid

Enrollment website: [mymaineconnection.gov/
benefits/s/?language=en_US](http://mymaineconnection.gov/benefits/s/?language=en_US)

Phone: 800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium webpage:

maine.gov/dhhs/ofi/applications-forms

Phone: 800-977-6740

TTY: Maine relay 711

MASSACHUSETTS — Medicaid and CHIP

Website: mass.gov/masshealth/pa

Phone: 800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA — Medicaid

Website: mn.gov/dhs/health-care-coverage/

Phone: 800-657-3672

MISSOURI — Medicaid

Website: [dss.mo.gov/mhd/participants/pages/
hipp.htm](http://dss.mo.gov/mhd/participants/pages/hipp.htm)

Phone: 573-751-2005

MONTANA — MedicaidWebsite: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 800-694-3084

Email: HSHIPPPProgram@mt.gov**NEBRASKA — Medicaid**Website: ACCESSNebraska.ne.gov

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA — MedicaidWebsite: dhcfp.nv.gov

Phone: 800-992-0900

NEW HAMPSHIRE — MedicaidWebsite: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

Phone: 603-271-5218

Toll-free: 800-852-3345 ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov**NEW JERSEY — Medicaid and CHIP**Medicaid website: state.nj.us/humanservices/dmahs/clients/medicaid

Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: njfamilycare.org/index.html

CHIP Phone: 800-701-0710 (TTY: 711)

NEW YORK — MedicaidWebsite: health.ny.gov/health_care/medicaid

Phone: 800-541-2831

NORTH CAROLINA — MedicaidWebsite: medicaid.ncdhhs.gov

Phone: 919-855-4100

NORTH DAKOTA — MedicaidWebsite: hhs.nd.gov/healthcare

Phone: 844-854-4825

OKLAHOMA — Medicaid and CHIPWebsite: insureoklahoma.org

Phone: 888-365-3742

OREGON — MedicaidWebsites: healthcare.oregon.gov/Pages/index.aspx

Phone: 800-699-9075

PENNSYLVANIA — Medicaid and CHIPWebsite: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone: 800-692-7462

CHIP website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://Children's Health Insurance Program (CHIP) (pa.gov))

CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND — Medicaid and CHIPWebsite: eohhs.ri.gov

Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA — MedicaidWebsite: scdhhs.gov

Phone: 888-549-0820

SOUTH DAKOTA — MedicaidWebsite: dss.sd.gov

Phone: 888-828-0059

TEXAS — MedicaidWebsite: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program

Phone: 800-440-0493

UTAH — Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

Website: medicaid.utah.gov/upp/Email: upp@utah.gov

Phone: 888-222-2542

Adult Expansion Website: medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program Website:

medicaid.utah.gov/buyout-program/CHIP Website: chip.utah.gov/**VERMONT — Medicaid**Website: dvha.vermont.gov/members/medicaid/hipp-program

Phone: 800-250-8427

VIRGINIA — Medicaid and CHIP

Websites: coverva.dmas.virginia.gov/learn/premiumassistance/famis-select
coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: 800-432-5924

WASHINGTON — Medicaid

Website: hca.wa.gov
Phone: 800-562-3022

WEST VIRGINIA — Medicaid and CHIP

Website: dhhr.wv.gov/bms/mywvhpp.com/

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 855-MyWVHIPP
(855-699-8447)

WISCONSIN — Medicaid and CHIP

Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING — Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July, 31, 2024, or for more information on special enrollments rights, contact either of the following:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Website: cms.hhs.gov
Phone: 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 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

