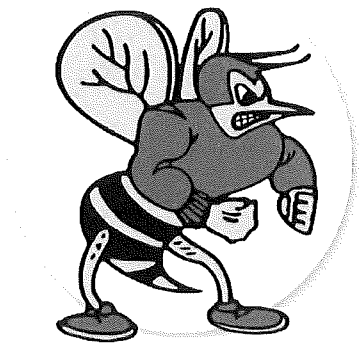
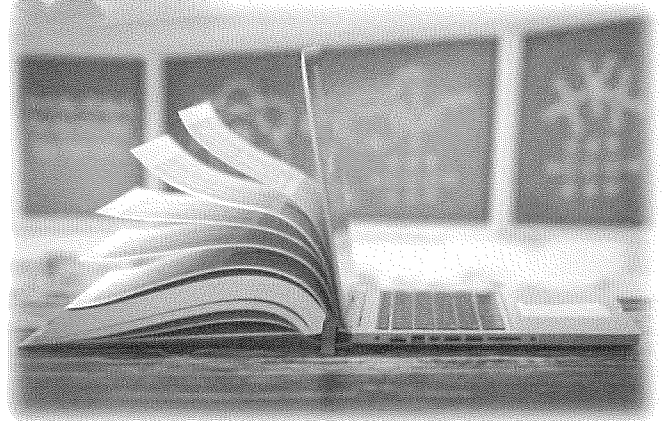


SCHOOL DISTRICT OF COLBY

2024-25 Employee Benefits Guide



School District of Colby Employee Benefits Guide Template Acknowledgement

M3 Insurance Solutions, Inc. (M3) has prepared the Employee Benefits Guide template to assist your organization in educating employees on health and welfare insurance benefits placed by M3. This template does not include all terms, coverages, exclusions, limitations, and conditions of applicable plan(s) contract language.

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We encourage you to review/edit/utilize all included content at your discretion. If necessary, please consult with your employee benefits attorney regarding program compliance.

By deleting or removing this page, you acknowledge that your organization assumes full responsibility of the content that is provided to your employee population.

Benefits Enrollment Checklist

This guide will help you get to know your benefits and your choices for the 2024-25 plan year. Be sure to learn about your options so you can make informed choices for yourself and your eligible dependents.

During Enrollment

Enroll in these plans or waive coverage:

- ☐ Medical
- ☐ Health Reimbursement Account (HRA)
- ☐ Flexible Spending Account (FSA)
- ☐ Dental
- ☐ Vision
- ☐ Voluntary Life and AD&D
- ☐ Short Term Disability
- ☐ Voluntary Accident
- ☐ Voluntary Critical Illness
- ☐ Voluntary Hospital Indemnity

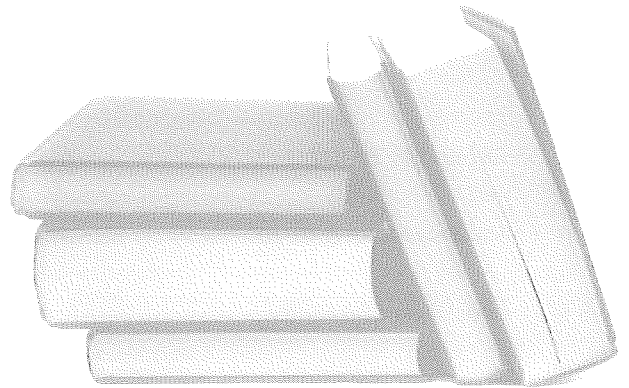


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This document is an outline of the coverage proposed by the carrier(s), based on information provided by your employer. It does not include all of the terms, coverage, exclusions, limitations and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request. The intent of this document is to provide you with general information regarding the status of and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issue. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Carrier Contacts

Coverage	Carrier	Contact
Medical	Aspirus Health Plan	866-631-5404 www.aspirushealthplan.com
Health Reimbursement Account (HRA)	Employee Benefits Corporation (EBC)	800-346-2126 www.ebcflex.com
Flexible Spending Account (FSA)	Employee Benefits Corporation (EBC)	800-346-2126 www.ebcflex.com
Dental	Delta Dental of WI	800-236-3712 www.deltadentalwi.com
Vision	DeltaVision	844-848-7090 www.deltavisionwi.com
Group Life & AD&D	The Standard	800-628-8600 www.standard.com
Voluntary Life & AD&D	The Standard	800-628-8600 www.standard.com
Short Term Disability	National Insurance Services	800-627-3660
Long Term Disability	National Insurance Services	800-627-3660
Voluntary Accident	The Standard	866-851-5505 www.standard.com
Voluntary Critical Illness	The Standard	866-851-5505 www.standard.com
Voluntary Hospital Indemnity	The Standard	866-851-5505 www.standard.com

Medical Plan

You get the most from your benefits when you take the time to learn about your options and make decisions that are best for you and your family. School District of Colby provides eligible employees access two different Health Plans administered by Aspirus Health Plan. Both plans have the same benefits:

1. Aspirus Health Plan Signature HMO Plan offers the lowest premiums and features Aspirus Health Care and affiliated providers and does not provide any coverage – outside of the network – except for emergency room services or with an approved referral from Aspirus Health Plan.
2. Aspirus Health Plan Freedom Network Point-of-Service Plan. This is a 2-Tier plan – meaning that it does provide both in and out-of-network coverage. This option features the Aspirus Health Plan Freedom Network which provides additional access to WI-based providers in addition to all of the providers in the Signature Network, but does have a higher premium cost.

You have the freedom to receive care from any licensed provider. However, you generally pay less when you receive care from doctors, hospitals and other health care facilities that participate in the Aspirus Health Plan network that you select. Find a participating health care provider in your area by going to:

<https://p1.aspirushealthplan.com/find-a-doctor/>

For emergency room services, benefits always pay at the “in-network” level regardless of whether the hospital is considered in-network or not. Refer to the Summary Plan Descriptions (SPDs) or Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

- All full-time employees

And Your...

- Spouses
- Biological children, stepchildren, legally adopted children (effective from the placement date for adoption), and foster children up to age 26.

Terms To Know

Deductible

The amount **you pay** out of your pocket each year **before the plan begins** sharing costs for most services. Payments to in-network and out-of-network providers count toward your annual deductible and annual out-of-pocket maximum.

Copay

The dollar amount you must pay for certain covered services. Payments count toward your annual out-of-pocket maximum but not toward your deductible.

Out-of-Pocket Maximum

The most you'll have to pay out of your pocket in a calendar year for covered services.

Coinsurance

The cost share between you and the plan after you meet the calendar year deductible. In other words, after you meet your deductible, you share any remaining covered expenses with the plan. The plan covers the percentage of the expense shown.

Medical Plan Highlights

Aspirus Health Plan Network: Signature		HMO HDHP \$2,000/\$4,000 DEDUCTIBLE In-Network Coverage Only
Deductible		
Single		\$2,000
Family		\$4,000
Out-of-Pocket Maximum		
Single		\$2,000
Family		\$4,000
Coinsurance		100%
Physician Services		
Routine / Preventive Care		<i>Select Services Are FREE</i>
Office Visit		Deductible, then 0%
Specialist		Deductible, then 0%
Hospital Services		
Inpatient		Deductible, then 0%
Outpatient		Deductible, then 0%
Walk-in Clinics Urgent Care ER		
Urgent Care		Deductible, then 0%
Emergency Care		Deductible, then 0%
Prescription Drugs		Retail – 30 Day Supply
Generic		\$10
Brand		\$30
Non-Preferred		\$60
Specialty		25% to \$250

* **Selecting a Provider:** Using a Network provider maximizes your benefits. You can find a Network provider by clicking on Find a Doctor at <https://p1.aspirushealthplan.com/find-a-doctor/>. If you go to a provider outside this Network, you will likely have higher out-of-pocket costs. For more information, please see Reimbursement Notifications for Non-Network Providers and/or view your Certificate at www.aspirushealthplan.com.

Refer to the Summary Plan Descriptions (SPDs) or Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

Monthly Premiums	Employer Cost	Employee Cost
Employee	\$878.82	\$119.84
Family	\$1,994.92	\$272.04

Medical Plan Highlights (continued)

Aspirus Health Plan Network: Freedom	POS HDHP \$2,000/\$4,000 DEDUCTIBLE	
	In-Network	Out-of-Network
Deductible		
Single	\$2,000	\$4,000
Family	\$4,000	\$8,000
Out-of-Pocket Maximum		
Single	\$2,000	\$6,000
Family	\$4,000	\$12,000
Coinsurance	100%	80%
Physician Services		
Routine / Preventive Care	<i>Select Services Are FREE</i>	Deductible, then 20%
Primary Care Physician	Deductible, then 0%	Deductible, then 20%
Specialist	Deductible, then 0%	Deductible, then 20%
Hospital Services		
Inpatient	Deductible, then 0%	Deductible, then 20%
Outpatient	Deductible, then 0%	Deductible, then 20%
Urgent Care	Deductible, then 0%	Deductible, then 20%
Emergency Room (ER)	Deductible, then 0%	Deductible, then 20%
Prescription Drugs	Retail – 30 Day Supply	
Generic	\$10	N/A
Brand	\$30	N/A
Non-Preferred	\$60	N/A
Specialty	25% up to \$250	N/A

* **Selecting a Provider:** Using a Network provider maximizes your benefits. You can find a Network provider by clicking on Find a Doctor at <https://p1.aspirushealthplan.com/find-a-doctor/>. If you go to a provider outside this Network, you will likely have higher out-of-pocket costs. For more information, please see Reimbursement Notifications for Non-Network Providers and/or view your Certificate at www.aspirushealthplan.com.

Refer to the Summary Plan Descriptions (SPDs) or Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

Monthly Premiums	Employer Cost	Employee Cost
Employee	\$1,028.22	\$140.21
Family	\$2,334.06	\$318.28

Health Reimbursement Account (HRA) – Signature Plan

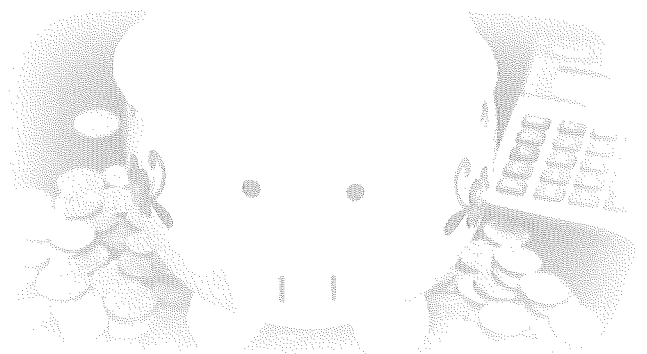
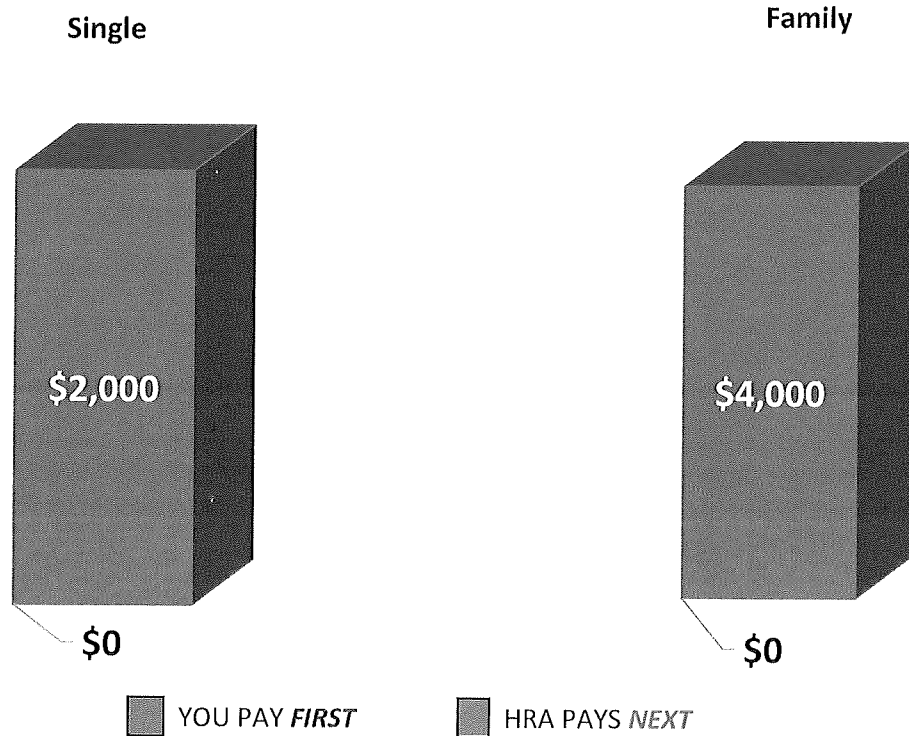
How does a Health Reimbursement Account work?

Employees are required to cover the *FIRST*

- \$0 for single coverage
- \$0 for family coverage

Health Reimbursement Account (HRA) covers the *NEXT*

- \$2,000 for single coverage
- \$4,000 for family coverage



Health Reimbursement Account (HRA) – Freedom Plan

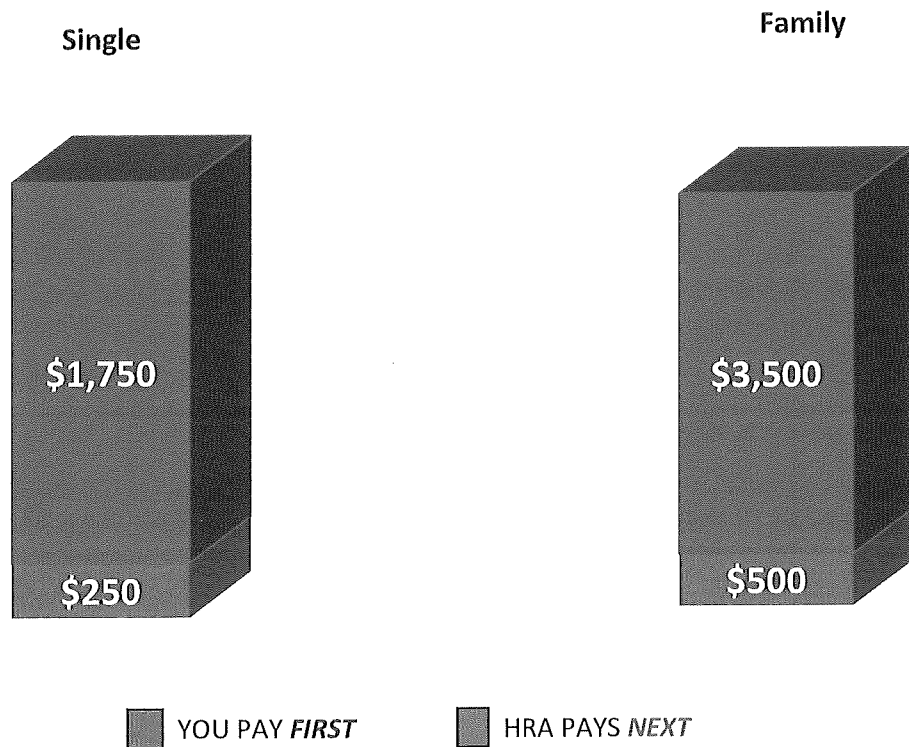
How does a Health Reimbursement Account work?

Employees are required to cover the *FIRST*

- \$250 for single coverage
- \$500 for family coverage

Health Reimbursement Account (HRA) covers the *NEXT*

- \$1,750 for single coverage
- \$3,500 for family coverage



Flexible Spending Account (FSA)

With an FSA, you can set aside tax-free money to pay for eligible medical and dependent care expenses. When you participate in an FSA, you decide how much you want to contribute each plan year (Sept 1 through August 31). The money you contribute is deducted from your pay before taxes are taken out. ***This lowers your taxable income, which means lower taxes for you!*** However, you must use the amounts in your account by year-end or lose the balance.

School District of Colby offers three types of FSAs administered by Employee Benefits Corporation

Standard Health Care FSA

You can use this FSA to pay any qualified health care expense, including copays and deductibles, dental care and vision care. You may only enroll in one Health Care FSA per plan year – the Standard or the Limited.

Limited Health Care FSA

The expenses that are reimbursed by this FSA are limited to dental and vision care expenses in the plan year only. You're eligible if you're enrolled in the High Deductible Health Plan Option; use the Limited Health Care FSA along with a Health Savings Account (HSA) and maximize your tax savings!

Grace Period

Your Standard or Limited Health Care FSA options include a grace period, which extends your plan year by 2 months and 15 days. This allows you to continue to incur eligible expenses for payment from your Health Care FSA – Standard or Limited until November 15 and submit them for reimbursement. Please refer to Health Care FSA - Standard Details in your BESTflex Plan Summary Plan Description (SPD) for more information.

Standard & Limited Health Care FSA Contribution Limits

School District of Colby follows the indexed contribution limits set for this type of account by the Internal Revenue Service (IRS). The contribution limits for both the Standard Health Care FSA and Limited Health Care FSA work on an individual employee/financial representative basis. The individual maximum is \$3,200. However, if you and your spouse are both eligible for the same employer's FSA, you can each contribute separately to have your own \$3,200 cap.

Dependent Care FSA

The Dependent Care FSA covers the eligible day care expenses for your tax-qualified dependent(s). This can include a tax-qualified dependent under the age of 13 or an elderly parent or spouse who is physically or mentally incapable of self-care and lives with the account owner.

Unmarried individuals and married couples who file a joint tax return can contribute up to a maximum of \$5,000 per year. Individuals who are married and file taxes separately can contribute up to a maximum of \$2,500. You cannot contribute more than you or your spouse earned in income for the year. ***If you're enrolling during the year, you may not be eligible to make the maximum contribution to your FSAs. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 502 for more information.***

Dental Plan Highlights

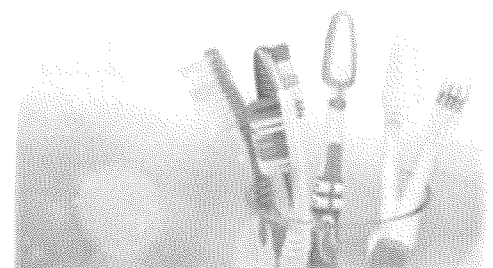
Healthy teeth and gums are an important part of maintaining your overall health. That's why School District of Colby offers a dental plan administered by Delta Dental of WI.

Delta Dental of WI		PPO / Premier
Individual Annual Maximum		\$1,000
Deductible		
Employee Only		\$0
Family		\$0
Preventive Care Services		
Exams		100%
Cleanings		100%
Fluoride Treatments		100%
X-Rays		100%
Space Maintainers		80%
Sealants		100%
Emergency Treatment to Relieve Pain <i>(Deductible Applies)</i>		100%
Basic Restorative Services		
Fillings		80%
Endodontics – Surgical / Non-Surgical		80%
Periodontics – Surgical / Non-Surgical		80%
Extractions – Surgical / Non-Surgical and other oral surgery <i>(Deductible Applies)</i>		80%
Major Restorative Services		
Crowns, Inlays, Onlays		50%
Bridges and Dentures		0%
Repairs and Adjustments to Bridges and Dentures		80%
Implants		0%
Orthodontic Services		
Coinsurance		50%
Individual Lifetime Maximum		\$1,500
Dependents Eligible to Age		19
Full-Time Students Eligible to Age		19

Dependent Eligibility

Dependents are eligible through the end of the month in which they attain age 26; except as noted for orthodontics

Monthly Premiums	Employer Cost	Employee Cost
Employee	\$32.20	\$8.05
Family	\$93.53	\$23.38



Vision Plan Highlights

Your eyes provide doctors with a clear picture of your overall health. A comprehensive eye exam can identify serious medical problems such as high blood pressure, diabetes, heart disease and much more. That's why School District of Colby provides vision care administered by DeltaVision through Delta Dental.

DeltaVision	IN-NETWORK	OUT-OF-NETWORK
Frequency		
Vision Exam		Once per 12 months
Frame		Once per 24 months
Lenses		Once per 12 months
Contact Lenses		Once per 12 months
	NETWORK BENEFIT	NON-NETWORK
Annual Vision Exam	\$20	\$35
Contact Lens (<i>fit and follow-up</i>)		
Standard Lens	Member pays up to \$55	\$0
Premium Lens	10% off retail	\$0
Allowance Summary		
Frames	\$150, then 20% off balance	\$75
Conventional Contacts	\$150, then 15% off balance	\$120
Disposable Contacts	\$150	\$120
Laser Vision Correction	15% off retail or 5% off promo price	None

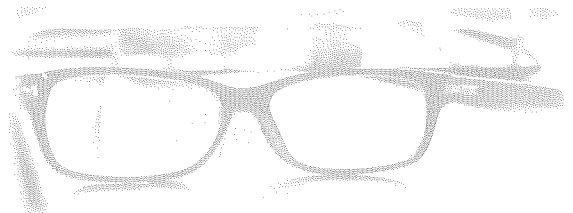
Additional In-Network Discounts

- 20% discount on items not covered by the plan at network providers. This discount may not be combined with any other discounts or promotional offers. This discount does not apply to an EyeMed® provider's professional services (i.e. exams) or contact lenses. Retail prices may vary by location.
- 40% discount on complete eyeglass purchases after your plan benefits have been fully used (includes prescription sunglasses).
- 15% discount on conventional contact lenses after your plan benefits have been fully used.
- Members can purchase eyeglasses online and apply their in-network eyeglass benefits at www.glasses.com.
- Members can purchase contact lenses online and apply their in-network contact lenses benefits at www.contactsdirect.com.

Dependent Eligibility

Dependents are eligible until they reach age 26

Monthly Premiums	Employee Cost
Employee	\$5.22
Employee + Spouse	\$10.44
Employee + Child(ren)	\$10.66
Family	\$15.88



Protection Plans

Group Term Life and Accidental Death & Dismemberment (AD&D)

Life Insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump payment if you pass away while employed by the School District of Colby. As an eligible employee, you are covered for Group Term Life and AD&D insurance at no cost to you.

School District of Colby offers a Group Term Life Insurance benefit of \$25,000 plus accidental death and dismemberment insurance coverage. Specific details of the plan are covered in the Plan Certificate.

The Standard Plan Highlights

Premium	School District of Colby pays this premium at 100%
Amount of Life Insurance Benefit	\$25,000 Employee Benefit
Amount of AD&D Benefit	Equal to term life

Voluntary Life Insurance

In addition to the Basic Term Life and AD&D insurance, you have the option to purchase Supplemental Life Insurance coverage for you and your eligible family members. Please see a representative from HR with any questions.

The Standard Plan Highlights

Employee Coverage (\$10,000 increments)	Employee – minimum benefit \$10,000, maximum benefit \$500,000, Guarantee issue is \$150,000
Spouse Coverage (\$5,000 increments)	Spouse – minimum benefit \$5,000, maximum benefit \$250,000, Guarantee Issue is \$30,000
Child Coverage (\$1,000 increments)	Child-minimum benefit is \$1,000, maximum benefit is \$10,000

Employee Premiums

AD&D rate of \$0.02 is included

Age	Employee Per \$1,000	Spouse Per \$1,000
00-24	\$.07	\$.07
25-29	\$.08	\$.08
30-34	\$.10	\$.10
35-39	\$.11	\$.11
40-44	\$.12	\$.12
45-49	\$.17	\$.17
50-54	\$.25	\$.25
55-59	\$.45	\$.45
60-64	\$.68	\$.68
65-69	\$1.29	\$1.29
70-74	\$2.08	\$2.08

for a full listing of weekly premiums, please contact HR

Child Premiums

Voluntary Term Life and AD&D	\$.23 per \$1,000
Voluntary Term Life Only	\$.03 per \$1,000

Protection Plans

Short Term Disability (STD)

School District of Colby's Short Term Disability plan is administered by National Insurance Administration (NIS) and paid for by the employee. This benefit pays a weekly percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to sickness or injury.

NIS	Benefit Highlights
Premium	Employee Paid
Weekly Benefit	\$147, \$175, \$224, \$273, \$301, \$357, \$420, \$462, \$504
Sickness Benefit Begins On	3 Days
Accident Benefit Begins On	0 Days
Maximum Benefit Duration	60 consecutive calendar days

Employee Premium	
Weekly Benefit	Rate per Month
\$147	\$10.08
\$175	\$11.76
\$224	\$15.10
\$273	\$18.48
\$301	\$20.16
\$357	\$24.08
\$420	\$28.00
\$462	\$30.80
\$504	\$33.60

Long Term Disability (LTD)

School District of Colby's Long Term Disability plan is administered by National Insurance Administration (NIS) and paid for by the District. This benefit pays a monthly percentage of your salary if you become disabled and are unable to work for an extended period of time.

NIS	Benefit Highlights
Premium	Employer Paid
Monthly Benefit	90 % to \$10,500
Elimination Period	30 Working Days
Maximum Benefit Duration	To Age 65, or 3 years and 6 months, if longer

NOTE: Both the STD and LTD include pre-existing condition limitations. Please review the plan summaries for more details. Earnings for STD and LTD benefits are based on your base annual earnings and do not include other income such as bonuses and commissions.



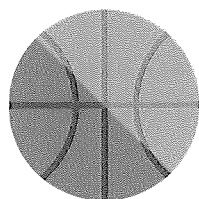
Accident Insurance

Having an accident doesn't just hurt you — it can also damage your finances. Your medical insurance will cover some of the expenses, but you'll be left to foot the bills for your copays and deductible. Those can add up fast, especially if you're unable to work while you recover. That's where Group Accident insurance comes in: It helps protect your bank account from the out-of-pocket expenses that can come with an injury — whether you're coping with a broken arm or recovering from a serious car accident.

You can get a **Health Maintenance Screening Benefit of \$50 each year** just for going to the doctor for a covered wellness exam, such as a stress test or lipid panel — a routine preventive visit that typically costs you nothing under your medical insurance.

Here's how it works:

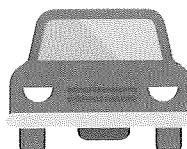
In the event of a covered accident, your Accident insurance will pay a benefit directly to you. You can use this money wherever you need it most — whether that's to help with your deductible, copays and other medical bills, or your daily expenses while you recover.



Let's say your teenage daughter gets injured during tryouts for her school basketball team and goes to urgent care for treatment. Diagnosis: dislocated elbow and fracture of the forearm and wrist. Although surgery isn't necessary, she will need follow-up appointments and physical therapy.

BENEFITS PAID TO YOU

Urgent Care Visit.....	\$50
X-ray.....	\$50
Dislocated Elbow.....	\$800
Arm Fracture.....	\$550
Wrist Fracture.....	\$550
Physician Follow-up Appointment.....	\$50
Physical Therapy Appointment (2 visits).....	\$100
SUBTOTAL.....	\$2,150
Youth Organized Sports Benefit (25% of subtotal).....	\$538
Total paid directly to you.....	\$2,688



Imagine that you survive a serious car accident. After a trip to the ER, you stay in the hospital for several days while you recover. In the weeks following the accident, you have a follow-up appointment at a clinic in another city and physical therapy.

BENEFITS PAID TO YOU

Ambulance.....	\$300
Emergency Room Visit.....	\$150
CAT Scan.....	\$200
Hospital Admission Benefit	\$1,000
5-Day Hospital Confinement (\$200 per day).....	\$1,000
Right Leg Fracture.....	\$4,000
Knee Cap Fracture.....	\$1,100
Pelvis Fracture.....	\$2,400
Physician Follow-up Appointment.....	\$50
Physical Therapy Appointment.....	\$50
SUBTOTAL.....	\$10,250
Automobile Accident Benefit.....	\$500
Transportation Benefit.....	\$150
Lodging (4 days).....	\$700
Total paid directly to you.....	\$11,600

Monthly Premium	
Enhanced - Plan 1	
Employee	\$8.06
Employee and Spouse	\$12.82
Employee and Child(ren)	\$15.25
Employee and Family	\$23.94



Accident Insurance Schedule of Benefits

These are actual benefits you could receive in the event of a covered accident. Benefits are paid once per covered accident unless otherwise noted:

Emergency Care Benefits	
Ambulance — Ground	\$300
Emergency Room Visit	\$150
Urgent Care Visit	\$50
Initial Care Visit (not payable if Urgent Care or Emergency Room Visit Benefit is payable)	\$50
Emergency Dental Care — Crown	\$200
Emergency Dental Care — Extraction	\$100
X-ray	\$50
Major Diagnostic Exam (ex: CT scan, MRI, EEG)	\$200
Transfusion Blood, Plasma or Platelets	\$300

Surgical Benefits	
Surgical Procedures	\$150-\$1,500
Surgical Repairs	\$750

Specific Injury Benefits	
Burns	\$200-\$10,000
Coma	\$7,500
Concussion	\$150
Eye Injury	\$200
Lacerations	\$75-\$500
Skin Graft	25% of the burns benefit
Fractures	\$100-\$8,000
Dislocations	\$150-\$5,000
Paralysis (percent of accidental death benefit)	15-50%

Hospital Benefits	
Hospital Admission (once per covered accident)	\$1,000
Daily Hospital Confinement (maximum 365 days per covered accident)	\$200
Critical Care Unit Admission* (once per covered accident)	\$750
Daily Critical Care Unit Confinement* (maximum 15 days per covered accident)	\$200
Daily Rehabilitation Facility (maximum 90 days per covered accident)	\$100
* Payable in addition to any Hospital Admission and/or Daily Hospital Confinement Benefit you may be eligible to receive.	

Follow-Up Care	
Medical Appliance (e.g., wheelchair, cane or brace)	\$100
Prosthesis (once per covered accident)	\$500 \$1,000 (two or more)
Physician Follow-up (up to 2 days)	\$50
Therapy Services (up to 3 days)	\$50

Additional Benefits	
Lodging (per day, up to 30 days per Accident)	\$175
Transportation (per round trip) (per day, up to 30 days per Accident)	\$150
Health Maintenance Screening Benefit (once per calendar year)	\$50
Youth Organized Sports Benefit	25%
Automobile Accident Benefit	\$500

Health Screening Benefit:

Get a Cash Benefit Each Year for Covered Wellness Exams

Regular checkups are important for the things you depend on — especially your health. You and your covered dependents will receive a cash benefit each calendar year when completing any one of the tests included, such as novel infectious disease testing (including COVID-19), lipid panel, mammography, colonoscopy, and many more. It's all part of the Health Maintenance Screening Benefit that comes with your group insurance from Standard Insurance Company.



Critical Illness Insurance

You may have medical insurance. But that doesn't mean you're covered for all of the expenses resulting from a serious illness that you probably haven't budgeted for — things like copays, deductibles, loss of income, childcare and travel expenses. Group Critical Illness insurance helps fill the gap caused by these out-of-pocket costs, creating a financial safety net for you and your family.

You can get a **Health Maintenance Screening Benefit of \$50 each year** just for going to the doctor for a covered wellness exam, such as a stress test or lipid panel — a routine preventive visit that typically costs you nothing under your medical insurance.

Here's how it works:

John has \$15,000 of Critical Illness insurance coverage. He makes an appointment with his doctor after feeling off for the past few weeks.

Diagnosis: end-stage renal failure, with a good prognosis but a long road ahead. Within days of making a claim, John receives his Critical Illness insurance benefit paid directly to him. As John undergoes intensive treatment over the next few months, he can use the benefit for any purpose, including to pay for things that his medical insurance does not cover. Things like the deductible, copays, childcare, certain medications, time away from work, alternative treatments and a special diet.

COVERED CONDITIONS:

Receive 100 percent of your coverage amount for:

- Heart Attack
- Stroke
- Coma
- Paralysis
- End-Stage Renal Failure

Attained Age Monthly Premium - Premier - Plan 2

Employee						
Blended						
	18-29	30-39	40-49	50-59	60-69	70+
\$5,000	\$1.90	\$2.90	\$5.85	\$12.10	\$22.30	\$57.10
\$10,000	\$3.80	\$5.80	\$11.70	\$24.20	\$44.60	\$114.20
\$15,000	\$5.70	\$8.70	\$17.55	\$36.30	\$66.90	\$171.30
\$20,000	\$7.60	\$11.60	\$23.40	\$48.40	\$89.20	\$228.40
\$25,000	\$9.50	\$14.50	\$29.25	\$60.50	\$111.50	\$285.50
\$30,000	\$11.40	\$17.40	\$35.10	\$72.60	\$133.80	\$342.60
Spouse						
Blended						
	18-29	30-39	40-49	50-59	60-69	70+
\$5,000	\$1.90	\$2.90	\$5.85	\$12.10	\$22.30	\$57.10
\$10,000	\$3.80	\$5.80	\$11.70	\$24.20	\$44.60	\$114.20
\$15,000	\$5.70	\$8.70	\$17.55	\$36.30	\$66.90	\$171.30



Hospital Indemnity Insurance

Planned or unplanned, a trip to the hospital can be scary. It can be even more frightening to know that your medical insurance probably won't cover all your costs. Group Hospital Indemnity insurance can help cover unexpected out-of-pocket expenses such as copays, deductibles, and out-of-network charges, as well as everyday living expenses. It pays a benefit directly to you for hospital-related events, regardless of your treatment costs or other insurance coverage you might have.

A cash benefit when you need it.

Even the best budgeters can forget to set aside money for medical expenses. Hospital Indemnity insurance provides a way to cover unexpected out-of-pocket expenses when you end up in the hospital. It also allows you to: Choose how to spend your benefit. It's your money — spend it however you want, whether it's to pay for your groceries, rent or medical bills.

Take it with you. If you leave your job, you can take your coverage with you.

Receive a benefit for taking care of your health.

You can get a **Health Maintenance Screening Benefit of \$50 each year** just for going to the doctor for a covered wellness exam, such as a bone density screening or mammogram — routine preventive visits that typically cost you nothing under your medical plan.

Here's how it works:

Kim is out of town on a business trip when she experiences abdominal pain and a racing heartbeat. Diagnosis: ruptured gastric ulcer. She is rushed to the hospital, admitted and taken into surgery. She ends up being hospitalized for 10 days, three of which are in a critical care unit. Kim's husband leaves their two kids with their daycare provider and flies to be at her side. The family now faces additional costs for travel and childcare.

Hospital Indemnity Benefits	
Hospital Admission (maximum 1 per calendar year)	\$500
Hospital Confinement (max 30 days)	\$100 per day
Critical Care Unit (pays in addition to Hospital Confinement benefit – max 30 days)	\$50 per day

Monthly Premium	
HSA - Plan 2	
Employee	\$9.01
Employee and Spouse	\$15.50
Employee and Child(ren)	\$12.99
Employee and Family	\$22.92

REQUIRED FEDERAL NOTICES

The required federal notices are provided to clients as a resource. Client assumes all responsibility for any additional notices or disclosures provided along with these template notices. Client also assumes all responsibility for any and all changes made to the template notices provided to the client by M3. Clients are encouraged to consult with their own employee benefits attorney regarding program compliance.

HIPAA 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 towards 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).

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Sara Uhlig, Payroll, 715-223-+2301
suhlig@colby.k12.wi.us

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: 7/1/2024

Who will follow this notice:

This notice describes the health information practices of Employee Benefits Corporation (the "Plan") and that of any third party that receives medical information from or for us to assist us in providing your HRA & flex benefits.

Our pledge to you:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This notice is required by the Standards for Privacy of Individually Identifiable Health Information regulations (the "Rule"). This notice will tell you about the ways in which we may use or disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose medical information, as permitted by law. The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose medical information to carry out treatment, payment and health care operations or other purposes permitted or required by law.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose your medical information to School District of Colby ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The plan sponsor has amended its plan documents to protect your medical information as required by the Rule.

Treatment means the provision, coordination, or management of health care by one or more health care providers, or a health care provider and a third party

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

Payment means activities undertaken by a health plan to determine coverage responsibilities and payment obligations for the provision of health care, or activities undertaken by a health care provider, or a health plan to obtain or provide reimbursement for health care.

For example, the Plan may disclose to your provider that you are eligible for benefits.

Health Care Operations means activities directly related to the provision of health care or the processing of health information. This includes internal quality oversight review, credentialing and health care provider evaluation, underwriting, insurance rating and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits.

For example, the Plan may use medical information about you to project future benefit costs.

The Plan will disclose medical information about you when required by federal, state or local law.

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

The Plan may disclose medical information if you are a member of the armed forces and this is required by military command authorities.

The Plan may disclose medical information about you for workers' compensation or similar programs.

The Plan may disclose medical information about you for public health activities. These activities may include the following:

- to prevent or control disease, injury or disability;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

The Plan may disclose medical information to a health oversight agency for activities authorized by law.

The Plan may disclose medical information about you if you are involved in a lawsuit or a dispute and we are responding to a court or administrative order. Also, the Plan may disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

The Plan may disclose medical information about you if asked to do so by law enforcement official, such as in response to a court order, subpoena, warrant, summons or similar process;

The Plan may disclose medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure to funeral directors, as necessary to carry out their duties, is permitted.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

The Plan may not disclose psychotherapy notes (under most circumstances), may not disclose protected health information for marketing purposes, and may not make disclosures that constitute a sale of protected health information unless authorized by the individual. Other disclosures not mentioned in this notice also require authorization from the individual.

The Plan may not disclose protected health information that is genetic information under the Genetic Information Nondiscrimination Act ("GINA") for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding medical information the Plan maintains about you:

You have the right to request an inspection and a copy of your medical information contained in a "designated record set," for as long as the Plan maintains your medical information in the designated record set.

"Designated record set," means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and care or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or for health care operations and not used to make decisions about individuals is not in the designated record set.

The Plan has the right to charge a reasonable, cost-based fee for providing a copy of your medical information or summary or explanation of your medical information.

The Plan has the right to deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If you feel the medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have a right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, your request must be in writing and should be addressed to the following individual: Sara Uhlig, Payroll, 715-223-2301. All requests for amendment of your medical information must include a reason to support the requested amendment.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

You have the right to request an “accounting of disclosures,” where such disclosure was made for any purpose other than treatment, payment or health care operations. Additionally, no accounting of disclosures will be made for the following reasons:

- if the disclosure was made to the individual about his or her own medical information;
- if the disclosure was made pursuant to an authorization;
- if the disclosure was made to certain person involved in your care or payment for your care;
- if the disclosure was made prior to the compliance date of April 14, 2003.

To request an accounting of disclosures, address your request to the following individual: Sara Uhlig, Payroll, 715-223-2301 suhlig@colby.k12.wi.us

If you request more than one accounting in a 12-month period, the Plan can charge a reasonable, cost-based fee for each subsequent accounting, unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or payment for your care, such as friends or family members.

The Plan is not required to agree with your request.

You have the right to restrict certain disclosures of protected health information to a health plan where you pay out of pocket in full for the health care item or service.

To request restrictions, you must make your request in writing to the following individual: Sara Uhlig, Payroll, 715-223-2301 suhlig@colby.k12.wi.us. The request must include (a) what information you want to limit, (b) whether you want to limit the Plan’s use, disclosure or both, and (c) to whom you want the limits to apply.

You have the right to request to receive communications of your medical information from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate all such reasonable requests.

You will be required to request confidential communications of your medical information in writing. The request should be addressed to the following individual: Sara Uhlig, Payroll, suhlig@colby.k12.wi.us

You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

To obtain a paper copy of this notice, contact the following individual: Sara Uhlig, Payroll, 715-223-2301.

You have the right to be notified following a breach of unsecured protected health information.

If you believe your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: Sara Uhlig, Payroll, suhligf@colby.k12.wi.us

You may also file a complaint with the Secretary of Health and Human Services.

The Plan will not retaliate against you for filing a complaint. The Plan will only release the minimum amount of PHI necessary to complete the required task or request.

Other uses or disclosures of your medical information not covered by this notice or the laws that apply will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke the authorization at any time, providing the revocation is done in writing. You understand that the Plan is unable to take back any disclosures already made with your permission.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) 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. Please see your Summary of Benefits and Coverage (SBC) for deductible and coinsurance information.

If you would like more information on WHCRA benefits, call your Plan Administrator 866-826-9781.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with School District of Colby 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. School District of Colby has determined that the prescription drug coverage offered by Aspirus Health Plan, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage **and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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 School District of Colby coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage

If you do decide to join a Medicare drug plan and drop your current School District of Colby coverage, be aware that you and your dependents may be able to get this coverage back if you experience a qualifying event or at the next open enrollment period.

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 School District of Colby 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 School District of Colby changes. You also may request a copy of this notice at any time.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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: 07/01/2023

School District of

Colby/Sender:

Contact--Position/Office:

Address:

Phone Number:

School District of Colby

Sara Uhlig, Payroll

705 North Second Street, Colby, WI 54421

715-213-2301

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of self-only coverage under our health plan is more than a certain percentage of your household income for the year, or if our health plan does not meet the “minimum value”¹ standard set by the Affordable Care Act, you may be eligible for a tax credit. Please visit healthcare.gov for the annual affordability percentage or contact the employer identified on the following page of this notice.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION ABOUT THE MARKETPLACE?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. You can visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹

An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

MARKETPLACE COVERAGE NOTICE (continued)

INFORMATION ABOUT THE HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name: School District of Colby
Employer Identification Number (EIN): 39-1019389
Employer Address: PO Box 110 705 North Second Street Colby, WI 54421
Employer Phone Number: 715-223-2301
Who can we contact about employee health coverage at this job? Phone Number (if different from above): Sara Uhlig

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.
- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.
- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.
- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.
- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.
- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/mc/mc-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, 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 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137

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

