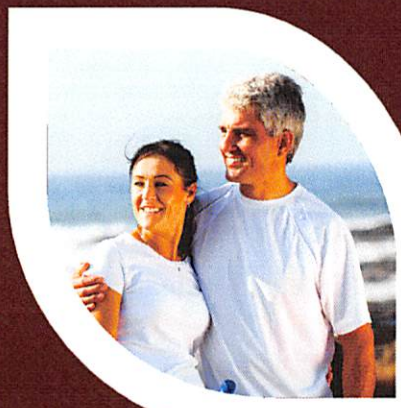
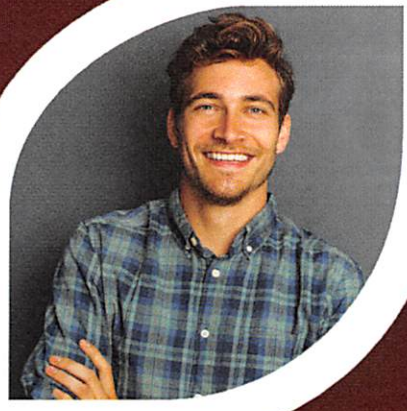
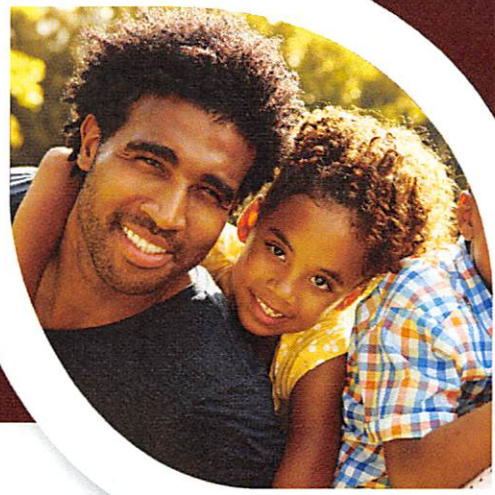
FOR YOUR BENEFIT







HAMILTON COUNTY SCHOOL DISTRICT

October 2018 - September 2019

AT HAMILTON COUNTY SCHOOL DISTRICT, your health and happiness are important to us

That's why we're so committed to making sure you get the benefits package that's right for both you and your family. Our package combines the peace of mind that comes with excellent medical care with competitive prices.

Annual Enrollment is your chance to ensure that your benefits package is right for you. Medical coverage, dental care, even financial wellbeing programs built around you and created to keep you in great shape, physically and financially.

Please take the time to read through this booklet and understand all the options available to you. Taken together, we think we've created a benefit package that gives you outstanding support, whether you're at work, at home or even on vacation.

What's here?

Medical Waiver Credit (Plan A)

If you choose not to enroll in medical insurance through Hamilton County Schools, you may enroll in employee only dental coverage and long-term disability insurance **at no cost to you**.

This credit does not exempt you from the ACA Individual Coverage mandate requiring most individuals to have health insurance.

ENROLLMENT GUIDELINES

Know **when** you can change your coverage

Nancy just got hired!

As a new hire, Nancy has 30 days to enroll for benefits that become effective on the first of the month following 60 days of employment. Coverage will be in effect until **September 30, 2019**.

Juan and his wife just had a baby!

Having a baby is a **qualifying life event**, so Juan must contact Payroll Specialist/Department within **30 days** of birth to add his baby.

During Annual Enrollment

Each Annual Enrollment, **all eligible employees** may elect new coverage in effect **October 1 through September 30**.

*Other **qualifying events** include marriage or divorce, adopting a child, custody status change of a child, a change in Medicare or Medicaid eligibility, or a change in your or your spouse's work affecting benefits eligibility.*

Know **who** you can add to your plans

You may cover:

- Your legal spouse
- Your natural, adopted, foster, step children and children in your custody due to a court order until:
  - **MEDICAL**: the end of the calendar year when they reach **age 26.**
    Extended coverage to age 30 may be available, please contact Payroll Specialist/Department for details.
  - **DENTAL & VISION**: the end of the calendar year when they reach **age 26** if unmarried
  - **CHILD LIFE INSURANCE**: from live birth through age 20 (through age 24 if a registered student in full time attendance at an accredited educational institution)

*If you have an **adult child** who became **disabled** before age 26, please contact Payroll Specialist/Department for information on adding them to medical and dental insurance.*

Know **how** to choose your coverage

Online Enrollment

Log into www.HRconnection.com to complete your enrollment and access your benefits information year round.

To enroll in your benefits:

- Click "ENROLL NOW" on the Blue Bar.
- Click "**add contact**" to add a dependent or beneficiary. *You must have a beneficiary on file to complete your enrollment.*
- Confirm Personal, Dependent, and Beneficiary Information by clicking the **pencil** in the **Status** column for the "action required" contacts.
- Navigate through the plan options on the right of your screen to make your selections for each benefit. *Choose "waive" if you wish to waive coverage. You will be required to enter a waiver reason when waiving medical coverage.*
  - **Dependents**: If you wish to cover any dependents, be sure to select their names under each benefit to enroll them
- Click "**back to benefit options**" to return to the benefit list
- Click "**Confirm elections**" once you've made all of your elections, and *review your choices*. If all are correct, click "**confirm**".

WAIT! You aren't done yet!
You must *print* your Election Summary report, *sign* it, and *submit* it to Payroll Specialist/Department for your elections to be completed. *You are responsible for getting your signed Enrollment Summary to Payroll Specialist/Department.*

For year-round access to your benefit information:
Log in and choose Menu ⓘ My Information ⓘ My Benefits. In the dropdown box, select the start date of the plan year (i.e. 10/01/2018)

MEDICAL INSURANCE MADE SIMPLE

What happens when you need health care?

Be an educated health consumer

All four plans cover in-network preventive care 100%. Beyond that, your responsibility depends on the plan you choose, the services you need, and where you receive your care.

YOUR PLANS AT-A-GLANCE	05771	05360	05302	05192 /93 HSA
Networks	In- and out-of-network coverage available	In- and out-of-network coverage available	In- and out-of-network coverage available	In- and out-of-network coverage available
Deductible	$ $	$ $	$ $ $ $	$ $ $
Out-of-Pocket Maximum	$ $	$ $	$ $ $	$ $ $
How you pay for care	Mostly copays	Mix of copays and deductible then coinsurance	Mix of copays and deductible then coinsurance	Deductible then coinsurance

Know your terms!

Copay – a flat fee you pay whenever you use certain medical services, like a doctor visit.

Deductible – the dollar amount you pay before your medical insurance begins paying deductible-eligible claims.

Coinsurance – the percentage of covered medical expenses you continue to pay after you've met your deductible and before you reach your out of pocket maximum.

Provider Charges– the amount charged to pay providers such as anesthesiologists, radiologists, doctors, and pathologists who work in certain facilities. The amounts shown on page 5 are facility charges.

Out of pocket maximum – the most you will pay during the **calendar year** for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Balance billing – the amount you are billed to make up the difference between what your out-of-network provider charges and what insurance reimburses. **This amount is in addition to, and does not count toward your out-of-pocket maximum.**

Florida Blue

Group Number: **78162**
Website: **www.floridablue.com**
Phone: **1-800-352-2583**

Download Florida Blue's mobile app for claims information, to access your ID card, find a doctor, and more!

Available on the App Store

GET IT ON Google Play

YOUR MEDICAL COVERAGE

IN-NETWORK COVERAGE

	05771	05360	05302	05192/93 HSA
CALENDAR YEAR DEDUCTIBLE	$1,500 per person $4,500 family maximum	$1,500 per person $4,500 family maximum	$5,000 per person $10,000 family maximum	$2,500 single coverage $5,000 family coverage
COINSURANCE *(your share)*	20%	20%	30%	20%
OUT-OF-POCKET MAXIMUM	$4,500 per person $9,000 family maximum	$5,000 per person $10,000 family maximum	$6,350 per person $12,700 family maximum	$5,800 | $11,600 *($6,850 max per person)*
PREVENTIVE CARE	Covered 100%	Covered 100%	Covered 100%	Covered 100%
PRIMARY CARE VISIT	$30	$25	$30	Deductible then 20%
SPECIALIST VISIT	$55	$50	$55	Deductible then 20%
LAB AND X-RAY	**Lab**: $0 **X-Ray**: $50	**Lab**: $0 **X-Ray**: $50	**Lab**: $0 **X-Ray**: DED then 30%	**Lab**: Deductible **X-Ray**: DED then 20%
IMAGING (MRI / CT)	$250	$450	Deductible then 30%	Deductible then 20%
URGENT CARE CENTER	$60	$55	$60	Deductible then 20%
EMERGENCY ROOM	$250	Deductible then 20%	$300	Deductible then 20%
INPATIENT HOSPITAL	Deductible then 20%	Deductible then 20%	Deductible then 30%	Deductible then 20%
OUTPATIENT HOSPITAL	Deductible then 20%	Deductible then 20%	Deductible then 30%	Deductible then 20%
AMBULATORY SURGERY	$200	Deductible then 20%	Deductible then 30%	Deductible then 20%
PRESCRIPTION DRUG COVERAGE				
RETAIL	$10 / $60 / $100	$10 / 20% / NC	$10 / 20% / NC	DED then $10 / $50 / $80
MAIL ORDER	$25 / $150 / $250	$25 / 20% / NC	$25 / 20% / NC	DED then $25 / $125 / $200

OUT-OF-NETWORK COVERAGE

CALENDAR YEAR DEDUCTIBLE	$4,500 per person $13,500 family maximum	$3,000 per person $9,000 family maximum	$10,000 per person $30,000 family maximum	$5,000 single coverage $10,000 family coverage
COINSURANCE *(your share)*	50% after deductible	40% after deductible	50% after deductible	40% after deductible
OUT-OF-POCKET MAXIMUM	$9,000 per person $18,000 family maximum	$8,000 per person $16,000 family maximum	$20,000 per person $40,000 family maximum	$11,600 single coverage $23,200 family coverage

Out-of-Network coverage is subject to **balance billing** (see page 4)

HEALTH SAVINGS ACCOUNT (HSA)

The HSA is a great way to handle any medical expenses not covered by your medical insurance. You make regular contributions to your account through payroll – and the contributions are tax free.

AND THAT'S NOT ALL:

- You own the account, even if you change plans or jobs;
- Your contributions are tax-free to pay for medical, prescription, dental and vision expenses;
- There are federal, state and FICA tax savings;
- Your funds roll over from year to year;
- Any withdrawal for qualified medical expenses is tax-free.

HOW YOUR HSA WORKS

Once you enroll in the 05192/93 plan, we will complete the account setup steps to open your HSA And once it's open, you can begin making contributions.

	IF YOU CHOOSE INDIVIDUAL COVERAGE	IF YOU CHOOSE FAMILY COVERAGE
2018 Annual Maximum Contribution *(from all sources)*	**$3,450**	**$6,900**

Contribution maximums assume 12 months of coverage in the 05192/93 plan, and are pro-rated on a monthly basis for coverage lasting less than 12 months.

AGE 55 OR OLDER?

You may contribute an extra **$1,000** per year in catch-up contributions. Contribution maximums based on 2018 IRS limits and are pro-rated on a monthly basis for coverage lasting less than 12 months. As of the publication date of this benefit guide, the 2019 IRS limits: Individual $3,500/ Family $7,000.

Brad has an individual HSA

He saves directly from his paycheck into his HSA

$2,340 ($97.50 per paycheck)

No income tax is applied

$2,340
Tax-free money to cover medical expenses

Angie doesn't have an HSA

She saves for medical expenses directly from her paycheck

$2,340 ($97.50 per paycheck)

- $585 (25% federal income tax)

$1,755
Post-tax money to cover medical expenses

It's good to know your funds are available as soon as they are deposited and you can use your money in two ways:

1. **Pay** for out-of-pocket costs if you receive medical, prescription, dental, or vision care
2. **Leave** the money in your account so it will carry over from year-to-year and grow tax-free

However, please remember that you'll need to enroll in the 05192/93 plan to join our HSA. Also, you can't contribute to an HSA if you're in another medical plan (including Medicare or TRICARE) or are a dependent on someone else's tax return. In these cases, you can still enroll in the HDHP plan, but you'll need to opt out of the HSA.

Florida Blue

Group Number: **78162**
Website: **www.floridablue.com**
Phone: **1-800-352-2583**

Download Florida Blue's mobile app for claims information, to access your ID card, find a doctor, and more!

Available on the App Store

GET IT ON Google Play

DENTAL INSURANCE

Dental care that makes you smile

Our Humana dental PPO plan allows you to visit any licensed dentist you like -- but choose a Humana PPO dentist and you'll make the most of your plan. *For ID cards: Login to www.humana.com and register by clicking "Sign In", or download the Humana App on the App Store or Google Play With a Humana PPO dentist, you'll enjoy:

QUALITY ASSURANCE
PPO Dentists are monitored for proper licensing, cleanliness, and safety.

NO BALANCE BILLING
You won't be charged more than the contracted rate.

NO PRE-PAYMENT
You'll pay only your portion of the bill - Humana pays your dentist directly.

LOWER PRICES
Through reduced fees

ID Cards **login to www.humana.com and register by clicking [Sign In] or Dowload the Humana App from the App Store or Google Play.**

Benefits and Covered Services	Dental PPO Plan
Plan Year Deductible - *waived for Type 1 Care and Orthodontia*	$50 per person | $150 per family
Plan Year Benefit Maximum *(excluding Type 1 Care)*	$2,500 per person
In-Network Care	
Type 1: Preventive Care	100% Covered
Type 2: Basic Care (fillings, extractions)	Deductible then 20%
Type 3: Major Care (crowns, dentures)	Deductible then 50%
Type 4: Child Orthodontic Care *(to age 18)*	50% *($1,000 lifetime maximum benefit)*
Out-of-Network Care	
Type 1: Preventive Care	100% Covered *(plus balance billing)*
Type 2: Basic Care (fillings, extractions)	Deductible then 20% *(plus balance billing)*
Type 3: Major Care (crowns, dentures)	Deductible then 50% *(plus balance billing)*
Type 4: Child Orthodontic Care *(to age 18)*	50% *($1,000 lifetime maximum benefit)*

GOOD TO KNOW: EXTENDED MAXIMUM BENEFIT!

If your expenses exceed the maximum annual benefit during the **plan year (October through September)**, you will receive a 30% discount on any additional services (excluding orthodontia) for the remainder of the year.

Reminder: your deductible and maximum benefits accrue from October through September each year.

Humana

Group Number: **663874**
Website: **www.humana.com**
Phone: **1-800-233-4013**

VISION INSURANCE

Focus on your vision

Keep your eyes healthy and your vision sharp with comprehensive vision coverage offered through Humana. All services except frames are available once every 12 months; frames are available once every 24 months.

		In-Network	Out-of-Network
COPAYS	Eye Examination	$10 Copay	Up to $30 reimbursement
	Materials	$15 Copay	N/A
EYE GLASSES	Lenses - Single	Covered after copay	Up to $25 reimbursement
	Lenses - Bifocal	Covered after copay	Up to $40 reimbursement
	Lenses - Trifocal	Covered after copay	Up to $60 reimbursement
	Frames - after copay	$130 allowance (20% off balance)	Up to $65 reimbursement
CONTACT LENSES	Elective Contact Lenses ⓘ	$130 allowance	Up to $104 reimbursement
	Medically Necessary Contacts	Covered 100%	Up to $200 reimbursement

ⓘ Elective contact lenses are available in lieu of glasses (lenses and/or frames). You are not eligible for glasses for 12 months after you receive elective contacts, and vice-versa.

Diabetic? Your vision plan includes enhanced diabetic care to include exams, scanning laser, and retinal imaging at no cost to you when you use an in-network provider.

Humana

Group Number: **663874**
Website: **www.humanavisioncare.com**
Phone: **1-866-537-0229**

YOUR COST FOR COVERAGE

Your Semi-Monthly Cost for Coverage

We do our very best to get the most competitive prices while getting you the best possible coverage. These premiums are the amount you pay for your insurance each paycheck. Remember that they come out before taxes, lowering your taxable income.

Medical Plan Premiums	05771	05360	05302	05192 /93
Employee Only	$173.29	$129.74	$53.37	$80.65
Employee + Spouse	$658.01	$554.36	$372.59	$283.62
Employee + Child(ren)	$468.34	$388.20	$247.68	$178.89
Employee + Family	$917.93	$782.05	$543.76	$427.13

Dental Plan Premiums	WITH HCSD MEDICAL INSURANCE	PLAN A - FOR EMPLOYEES WHO WAIVE HCSD MEDICAL INSURANCE
Employee Only	$24.85	$0.00
Employee + Spouse	$40.08	$15.23
Employee + Child(ren)	$38.19	$13.34
Employee + Family	$49.65	$24.80

Vision Plan Premiums	VISION PLAN
Employee Only	$0.00
Employee + Spouse	$3.35
Employee + Child(ren)	$3.02
Employee + Family	$6.66

LIFE AND DISABILITY INSURANCE

Life Insurance

Basic Life Insurance

If you're a full-time employee, we'll provide you with free Basic Life and Accidental Death and Dismemberment (AD&D) insurance in the amount of $20,000 through The Standard. AD&D coverage is designed to pay a benefit if you pass away due to an accident, and may pay a partial benefit if an accident causes a loss of certain functions. The amount of your benefit begins to reduce by 50% beginning at age 70. See the policy for coverage and age reduction details.

Supplemental Life Insurance

You have the opportunity to elect and purchase additional life insurance for yourself, your spouse, and your dependent child(ren) through The Standard. AD&D coverage equal to the amount you elect is automatically included. Your cost for coverage depends on your age and the amount of coverage you elect, and is available on HRconnection.

Feature	For you	For your spouse	For your child(ren)
Available increments	$10,000	$5,000	Flat $10,000
Coverage maximum	$300,000	$150,000	$10,000
Medical question limit ⓘ	$120,000	$30,000	$10,000

ⓘ As a newly eligible employee, you may elect up to the medical question limit with no medical questions required. Any requests to enroll or increase coverage after the first opportunity will be subject to medical questions.

Long-Term Disability Insurance

All full-time active employees are eligible to participate in our long-term disability plan through The Standard.

After **180 days** of inability to work, the plan pays 60% of your pre-disability base income to a maximum of $6,000 per month. Payments may continue for up to two years if you are not able to perform the duties of your own occupation, or until age 65 if you are not able to perform the duties of any occupation. If you become disabled after age 65, benefit payments depend on your age.

Your cost for coverage depends on your income and is available on HRconnection. **If you declined medical insurance with Hamilton County School District, long-term disability insurance is included in Plan A coverage at no cost to you.**

ANNUAL NOTICES AND DISCLOSURES

This section contains important information about your benefits and rights. Please read the following pages carefully and contact Payroll Specialist/Department with any questions you have.

HIPAA 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.

To request special enrollment or obtain more information, contact your Benefits or HR Administrator.

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, 2018. Contact your State for more information on eligibility.

State Contact Information is available at the end of this notice.

Section 111 – Effective January 1, 2009 Group Health Plans are required by the Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. This mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help to establish who pays first. The mandate requires Group Health Plans to collect additional information such as social security numbers for all enrollees, including dependents aged six months or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

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.

Newborns' and Mothers' Health Act - Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection – If your group health plan requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the group health plan will make one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

STATE CONTACT INFORMATION:

Alabama Medicaid	**Website:** http://myalhipp.com/ **Phone:** 1-855-692-5447
Alaska Medicaid	**Website:** http://health.hss.state.ak.us/dpa/programs/Medicaid/ **Phone (Outside of Anchorage)**: 1-888-318-8890 **Phone (Anchorage)**: 907-269-6529
Colorado Medicaid	**Medicaid Website:** http://www.colorado.gov/hcpf **Medicaid Phone:** 1-800-221-3943
Florida Medicaid	**Website:** http://flmedicaidtplrecovery.com/hipp/ **Phone:** 1-877-357-3268
Georgia Medicaid	**Website:** http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) **Phone:** 404-656-4507
Indiana Medicaid	Healthy Indiana Plan for low-income adults 19-64: **Website:** http://www.hip.in.gov | **Phone:** 1-877-438-4479 All other Medicaid: **Website:** http://www.indianamedicaid.com | Phone 1-800-403-0864
Iowa Medicaid	**Website:** http://www.dhs.state.ia.us/hipp/ **Phone:** 1-888-346-9562
Kansas Medicaid	**Website:** http://www.kdheks.gov/hcf/ **Phone:** 1-785-296-3512
Kentucky Medicaid	**Website:** http://chfs.ky.gov/dms/default.htm **Phone:** 1-800-635-2570
Louisiana Medicaid	**Website:** http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 **Phone:** 1-888-695-2447
Maine Medicaid	**Website:** http://www.maine.gov/dhhs/ofi/public-assistance/index.html **Phone:** 1-800-442-6003 **TTY**: Maine relay 711
Massachusetts Medicaid & CHIP	**Website:** http://www.mass.gov/MassHealth **Phone:** 1-800-462-1120
Minnesota Medicaid	**Website:** http://mn.gov/dhs/ma/ **Phone:** 1-800-657-3739
Missouri Medicaid	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
Montana Medicaid	**Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084
Nebraska Medicaid	**Website:** http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx **Phone:** 1-855-632-7633
Nevada Medicaid	**Website:** http://dwss.nv.gov/ **Phone:** 1-800-992-0900
New Hampshire Medicaid	**Website:** http://www.dhhs.nh.gov/oii/documents/hippapp.pdf **Phone:** 603-271-5218
New Jersey Medicaid & CHIP	**Website**: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ **Medicaid Phone:** 609-631-2392 **Website**: http://www.njfamilycare.org/index.html **CHIP Phone**: 1-800-701-0710

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

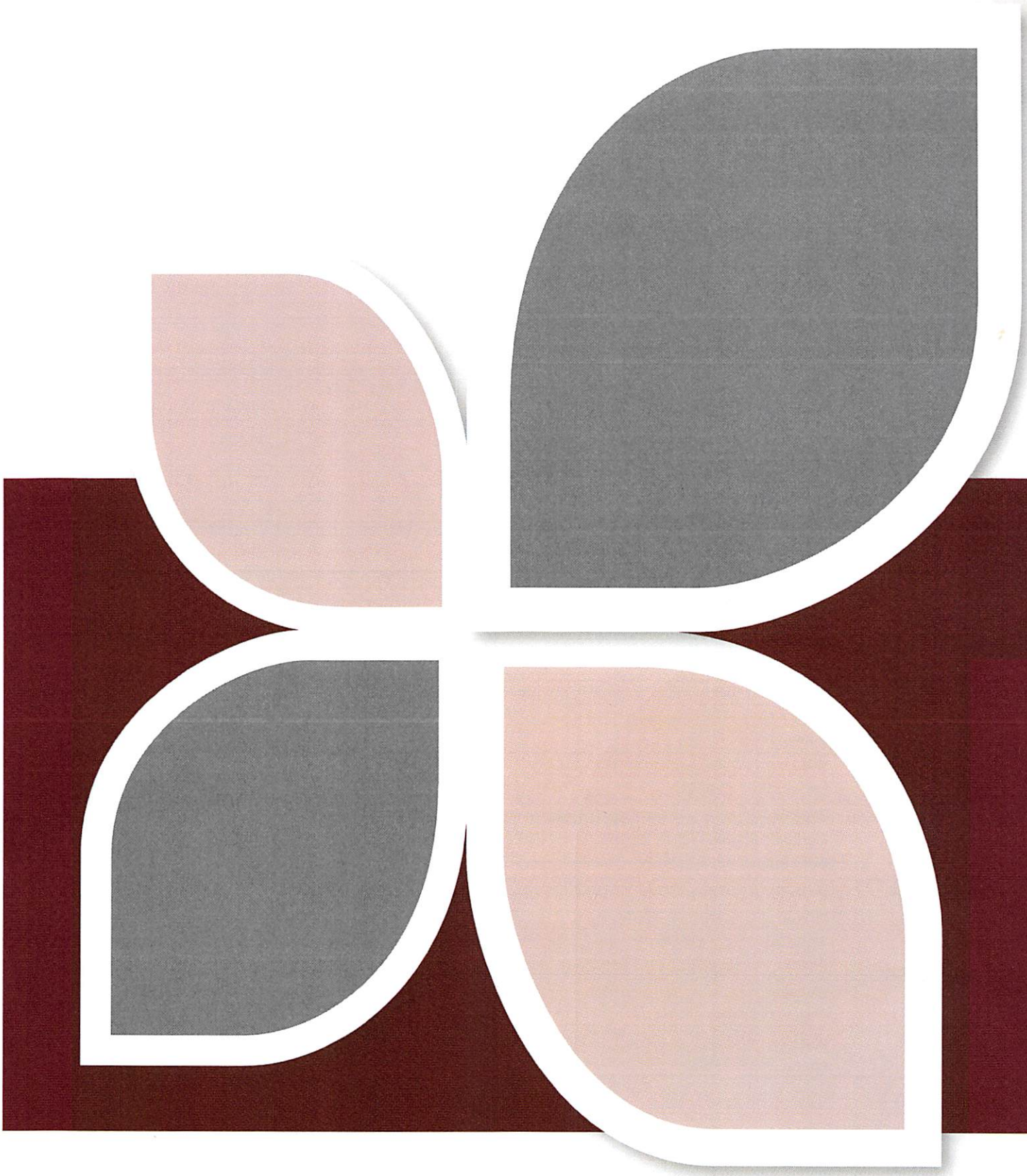
STATE CONTACT INFORMATION (continued):

New York Medicaid	**Website:** http://www.nyhealth.gov/health_care/Medicaid/ **Phone:** 1-800-541-2831
North Carolina Medicaid	**Website:** http://www.ncdhhs.gov/dma **Phone:** 919-855-4100
North Dakota Medicaid	**Website:** http://www.nd.gov/dhs/services/medicalserv/Medicaid **Phone:** 1-844-854-4825
Oklahoma Medicaid & CHIP	**Website:** http://www.insureoklahoma.org **Phone:** 1-888-365-3742
Oregon Medicaid	**Website:** http://www.oregonhealthykids.gov | www.hijossaludablesoregon.gov **Phone:** 1-800-699-9075
Pennsylvania Medicaid	**Website:** http://www.dhs.pa.gov/hipp **Phone:** 1-800-692-7462
Rhode Island Medicaid	**Website:** www.ohhs.ri.gov **Phone:** 401-462-5300
South Carolina Medicaid	**Website:** http://www.scdhhs.gov **Phone:** 1-888-549-0820
South Dakota Medicaid	**Website:** http://dss.sd.gov **Phone:** 1-888-828-0059
Texas Medicaid	**Website:** https://www.gethipptexas.com/ **Phone:** 1-800-440-0493
Utah Medicaid & CHIP	**Medicaid Website:** http://health.utah.gov/medicaid **CHIP Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669
Vermont Medicaid	**Website:** http://www.greenmountaincare.org/ **Phone:** 1-800-250-8427
Virginia Medicaid & CHIP	**Website:** http://www.coverva.org/programs_premium_assistance.cfm **Medicaid Phone:** 1-800-432-5924 **CHIP Phone:** 1-855-242-8282
Washington Medicaid	**Website:** http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx **Phone:** 1-800-562-3022 ext. 15473
West Virginia Medicaid	**Website:** http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx **Phone:** 1-877-598-5820, HMS Third Party Liability
Wisconsin Medicaid	**Website:** http://www.badgercareplus.org/pubs/p-10095.htm **Phone:** 1-800-362-3002
Wyoming Medicaid	**Website:** https://wyequalitycare.acs-inc.com/ **Phone:** 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2018 or for more information on special enrollment rights, you can contact either:

U. S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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



HAMILTON COUNTY SCHOOL DISTRICT

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2018 - 2019

Arthur J. Gallagher & Co.

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