



Benefit Connection

2016-2017 Open Enrollment
Town of Payson

Your 2016–2017 Open Enrollment Period is April 18 to May 31, 2016.

The Time Is Here!

The Arizona Public Employers Health Pool (APEHP) open enrollment period is the designated time each year during which you can: (1) make changes to your existing coverage; and (2) elect or change coverage for your spouse, domestic partner, and/or dependents. If you anticipate that your or your family’s health needs will be changing, now is the time to take action.

- **Review this guide** thoroughly to see what’s new, and refresh your knowledge of the different benefit plans.
- **Share this guide** with your family. The amount you pay each month depends on whom you elect to enroll. You may choose the appropriate level of coverage: for yourself, yourself and your spouse or domestic partner, yourself and your children, or your entire family. See “Who is Eligible to Enroll?” on page 2.
- **Attend an open enrollment meeting** to ask questions and obtain answers regarding 2016–2017 benefits.
- **Learn about** the variety of health-related programs available. Depending on your employer, you may not be eligible to receive all of the benefits outlined in this guide.
- **Complete and submit an enrollment form** if you plan to make changes to your elections. Please refer to your employer’s benefits office for the due date for your open enrollment form(s) changes.
 - If you do not submit an enrollment form, you will continue with the same benefits and coverages you had during the 2015–2016 plan year.
 - You **MUST** reenroll each year to participate in a health savings account (HSA).

Read this guide carefully. If you do not intend to make any changes to your benefits, you do not need to fill out any new forms. New forms are required, however, if your employer offers certain benefits and you are planning to:

- drop coverage or change plans,
- participate in a health savings account (HSA),
- add or remove a dependent, spouse, or domestic partner,
- elect or cancel voluntary vision benefits,
- enroll in voluntary life insurance for the first time,
- elect or cancel dental benefits,
- increase or change your voluntary life insurance,
- change life insurance beneficiaries, or
- opt out of the insurance plan.

NOTE: *This open enrollment guide is intended only as a brief description of your plan benefits. It attempts to describe important details and changes to the plans in a clear, simple, and concise manner. If there is a conflict between this guide and the wording of plan documents, the plan documents will govern. APEHP retains the right to change, modify, suspend, interpret, or cancel some or all of the benefits or services at any time.*

Open Enrollment Basics

Get Ready to Enroll

If you want to make changes to your benefit elections, you will need to complete and submit your enrollment form(s) as follows:

- Select a medical program option. (To decline coverage, you must complete the portion of the enrollment form that indicates your desire to opt out of coverage through APEHP.)
- Decide on the tier of coverage you want, depending on who will be covered. If you are adding a lawfully married spouse, you will need to provide a certified marriage certificate. If you are adding a domestic partner, complete the statement of domestic partnership.

Your choices for coverage are:

- employee;
 - employee plus spouse or domestic partner;
 - employee plus child(ren); or
 - employee plus family.
- If you want to enroll in a high deductible health plan (HDHP), and you wish to contribute to a health savings account, or HSA, you need to decide how much you will contribute. Please note that you are not required to contribute to the HSA.*
 - Review and/or update your beneficiary designation form for your life insurance benefit.
 - Review and decide whether or not to elect supplemental life coverage.
 - Fill out the open enrollment form if you want to add or delete vision coverage.
 - Fill out the open enrollment form if you want to add or delete dental coverage.
 - Confirm that any dependents are still eligible to be enrolled.
 - Sign and date the enrollment form(s).

Please refer to your employer's Human Resources Department for the due date of your open enrollment form(s) changes.

* If enrolling in an HSA, you will need to complete additional forms. These will be provided during your open enrollment meeting, and should also be available from your Human Resources manager.

If you have questions about eligibility, please contact your Human Resources Department or refer to the Plan Document/Summary Plan Description (SPD).

Who is Eligible to Enroll?

Those eligible for benefits include:

- full-time employees working at least 30 hours per week;
- part-time employees working a minimum of 20 hours per week, if the employer allows part-time coverage;
- active board members or council members, as permitted by their host organizations;
- dependents of enrolled employees, including:
 - (1) lawfully married spouse;
 - (2) domestic partner;
 - (3) dependent children; up to age 26; and
 - (4) an unmarried child who is mentally or physically handicapped and dependent chiefly on the enrolled employee for support and maintenance.

NOTE: If your spouse loses coverage—due to a job loss, for example—that is considered a qualifying event, and he or she may enroll within 31 days of the event.

Helpful Tips:

- If you are expecting a baby and want APEHP coverage for your child, please remember to complete the appropriate forms within 31 days following the birth.
- Dependent children up to age 26 may be covered under a parent's plan, regardless of student or marital status.
- Participants may not be covered by more than one APEHP employer's plan for any medical, dental, vision, or life insurance benefits.

What's New for 2016–2017

There are changes being implemented for the plan year that begins July 1, 2016. Here is a brief summary of those changes. Refer to the specific sections of this guide that pertain to these subjects for more information.

- **CVS/Caremark will be your new pharmacy benefit manager.** If you utilize the mail order program, starting July 1, 2016 you will need a new prescription from your doctor to transfer to the Caremark Mail Service Pharmacy even if your current prescription has not expired.
- **Identification cards.** This year a new identification card will be issued for medical/prescription drug coverage prior to the new plan year. **Please do not destroy your current ID card until you have received the new card.**
- **Health Savings Account (HSA) contributions will increase.** The HSA maximum allowable contributions for the 2016–2017 plan year are \$3,350 for individual coverage and \$6,750 for family coverage.
- **APEHP \$1,500 HDHP with HSA medical plan out-of-pocket limit will decrease.** The in-network annual out-of-pocket limit will be \$6,550 for a family of 2 or more.
- **APEHP \$2,500 HDHP with HSA medical plan out-of-pocket limit will decrease.** The in-network annual out-of-pocket limit will be \$6,550 for a family of 2 or more.
- **Health Care Flexible Spending Account (FSA) and Dependent Care FSAs.** Not available starting July 1, 2016.



Contact Us

<p>Plan Administration and Employee Advocate</p>	<p>Arizona Public Employers Health Pool (APEHP) Member Services: (800) 718-8328 http://www.apehp.org/</p>
<ul style="list-style-type: none"> ▪ Eligibility ▪ Benefits Information ▪ Medical Plan Claims and Appeals ▪ COBRA Administration ▪ Precertification 	<p>AmeriBen Medical Management P.O. Box 7186 Boise, ID 83707 Member Services: (866) 955-1485 http://www.myameriben.com</p>
<p>HSA Administration</p>	<p>Health Equity 15 W. Scenic Pointe Drive, Suite 400 Draper, UT 84020 Member Services: (866) 346-5800 http://www.healthequity.net/apeshp</p>
<p>Medical Plan Provider Network</p>	<p>BlueCross BlueShield of Arizona http://www.azblue.com/ <i>BlueCross BlueShield® of Arizona (BCBSAZ), an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield outside of Arizona.</i></p>
<p>Mayo Clinic Arizona</p>	<p>Mayo Clinic Arizona Appointment office: (480) 301-1735 http://mayoclinic.org/arizona/</p>
<p>Dental Plan</p>	<p>Delta Dental P.O. Box 43026 Phoenix, AZ 85080-3026 Member Services: (800) 352-6132 http://www.deltadentalaz.com/</p>
<p>Vision Plan</p>	<p>Vision Service Plan (VSP) Member Services: (800) 877-7195 http://www.vsp.com/</p>
<p>Prescription Drugs (Retail and Mail Order)</p>	<p>CVS/Caremark Customer Care: (800) 552-8159 http://www.caremark.com</p>
<p>Employee Assistance Program (EAP)</p>	<p>EAP Preferred Member Services: (800) 327-3517, ext. 2 http://www.eappreferred.com/ User name: APEHP; Password: eappreferred</p>

Medical Options

APEHP offers a flexible benefits program that lets you choose from different preferred provider organization (PPO) medical plan options utilizing the BlueCross BlueShield of Arizona (BCBSAZ) network and/or the Mayo Clinic. Review the comparison pages for each option and contact your Human Resources Department for more information.

Comparing Your Options

Each plan option offered by your employer covers the same range of services. The plans differ, however, in terms of the copay and out-of-pocket medical costs—deductibles and coinsurance—you could incur during the plan year.



Your Annual Deductible

The annual deductible is the amount of covered medical expenses that you pay each fiscal year (from July 1 to June 30) before the plan pays any benefits. Once you meet the deductible, you pay a percentage of covered medical costs (coinsurance), and the plan pays the balance. You must meet separate deductibles for in-network and out-of-network services before the plan will pay benefits. Once your coinsurance reaches the out-of-pocket maximum for in-network services for the year, the plan pays 100% of the remaining allowed charges for the rest of the plan year. (This is not true for out-of-network services, however.) You should not be required to pay anything out-of-pocket at the point of service.

In-Network Versus Out-of-Network Services

You may use any qualified provider you choose. However, your benefits will be greater if you use in-network providers and facilities. (To find an in-network provider, visit the APEHP website at <http://www.apehp.org> and click on Employee Resources.) When you use an in-network provider, that provider agrees to accept the contracted fee as payment in full for fees and services. When you use an out-of-network provider, your coinsurance will be higher, and you may be responsible for any costs that exceed the contracted fee established within the authorized provider network.

To gain the best savings, use in-network providers. The coinsurance is 80% in-network, with a limit on your annual out-of-pocket spending.

Physician Office Visit Example:

1. You are covered under the Core Plan with employee-only coverage. You see an in-network BCBSAZ physician for treatment of an illness. At the time of service, you should not be required to pay anything.
2. The physician submits a claim to AmeriBen for \$150. AmeriBen reviews the claim and reduces it to the BCBSAZ contracted fee. Assume in this scenario that the bill is reduced to \$100.
3. Because your deductible has not yet been met for the year, you are responsible for paying the \$100 to the physician. The \$100 will be applied to your \$500 in-network deductible.
4. For the remainder of the year, you must pay \$400 in additional deductible before the plan begins paying for in-network physician services at 80 percent.
5. Once the deductible is met, you will pay 20 percent of the allowed amount, to a maximum of \$4,500 (your out-of-pocket limit).
6. When you reach the \$4,500 out-of-pocket limit (including deductible), the plan will pay 100 percent of eligible services through the end of the plan year.

Note: Your contributions to the deductible and the out-of-pocket limits reset to zero on July 1 of each plan year.

Prescription Drugs

All medical options include the prescription drug coverage listed in the 2016–2017 medical benefits table (see following benefit pages).

If you elect an HDHP, your deductible must be met before the plan pays for prescription drug benefits.

Prescription drug benefits are paid based on a formulary (called "Preferred"), which is a list of drugs that are covered under the plan. The medicines that are covered under the outpatient prescription drug benefits fall into three categories: generic, preferred brand name, and non-preferred brand name.



Prescription Drug Programs

CVS/Caremark is the pharmacy benefit manager for APEHP. Most retail pharmacies are members of the CVS/Caremark network.

Getting the Most from Your Prescription Benefit

The following tips can help reduce the amount of money you pay for prescriptions:

- **Generic medications** are a less expensive option than brand name drugs. Before you fill a prescription, ask your doctor if you can substitute a generic drug for a brand medication.
- **Pill splitting** can help save money without sacrificing drug effectiveness or safety. Some tablets are available at double the dose and at the same or nearly the same cost as lower doses. By splitting the larger doses, you can essentially get two doses for the price of one. There are limitations, however, on the types of pills you can split. Time-release medications and medications in capsule form, for example, cannot be split. Ask your doctor and pharmacist if your medication is available in larger doses, and if it can be split to help save you money.
- **Buy medications through the mail.** Ask your doctor for a 90-day prescription for any maintenance medication (for treatment of blood pressure, arthritis, or diabetes, for example), and take advantage of the mail order (home delivery) program. You can save money on copays by getting medications through the mail, and enjoy the convenience of having them delivered directly to your home. **Note:** You will need a new prescription to start home delivery with CVS/Caremark.
- **Ask your doctor for samples.** Doctors may get free samples from pharmaceutical sales representatives. Don't be afraid to ask if samples are available when you start taking a new medication. Samples allow you to try the new medication to see if it works before you fill an ongoing prescription.
- **Shop around for your medications.** As with everything else you buy, medication prices may vary depending upon where they are purchased. Call around to different pharmacies to check their prices, and don't forget warehouse stores, which can sometimes offer better prices than traditional retail pharmacies.
- **Ask your doctor if there is an over-the-counter alternative to your prescription.** Remember that over-the-counter medications usually come in lower strengths; therefore, you should ask your doctor about appropriate dosing.

APEHP \$1,500 HDHP with HSA Medical Benefits for 2016–2017

Each medical plan option covers the same range of services. The plans differ, however, in terms of the out-of-pocket medical costs—deductibles, copays, and coinsurance—you could incur for the year, as well as the premium. The Core Plan, Copay Plan, and three HDHP options offer lower monthly premiums in exchange for higher out-of-pocket costs for deductibles and coinsurance.

Benefit Overview	\$1,500 HDHP Plan In-Network	\$1,500 HDHP Out-of-Network
Annual Deductible ⁽¹⁾	<ul style="list-style-type: none"> • \$1,500/person • \$3,000/family of 2+ 	<ul style="list-style-type: none"> • \$2,500/person • \$5,000/family of 2+
Annual Out-of-Pocket Limit ⁽²⁾	\$3,500/person; \$6,550/family of 2+	No maximum
Office Visit	Plan pays 80%	Plan pays 50%
Well Adult Care	Plan pays 100% No deductible	Plan pays 50% No deductible
Well Child Care	Plan pays 100% No deductible	Plan pays 50% No deductible
Outpatient Lab and X-ray (including MRI, PET, & CT scans)	Plan pays 80%	Plan pays 50%
Urgent Care	Plan pays 80%	Plan pays 50%
Emergency Room	Plan pays 80%	Plan pays 80%
Inpatient Hospital	Plan pays 80%	Plan pays 50%
Outpatient Hospital	Plan pays 80%	Plan pays 50%
Outpatient Behavioral Health Visits	Plan pays 80%	Plan pays 50%
Retail Prescription Drugs (30-day supply) After deductible ⁽³⁾	You pay: <ul style="list-style-type: none"> • Generic: \$10 • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90) 	
Mail Order Drugs (90-day supply) After deductible ⁽³⁾	You pay: <ul style="list-style-type: none"> • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay 	

RED are the 2016–2017 benefit changes

This plan has a non-embedded deductible and out-of-pocket limit. This means that the family deductible and out-of-pocket limit accumulates cost-sharing for any covered family member. Families enrolled in this plan will need to meet the family deductible before any reimbursement is made for eligible medical expenses (other than for preventive/wellness care).

⁽¹⁾ The deductible must be met before the HDHP plan pays benefits. All benefits are subject to the deductible, unless otherwise noted. The family deductible must be met before claims are paid for any member of the family.

⁽²⁾ The deductible applies toward the annual out-of-pocket limit on the HDHP plans.

⁽³⁾ You must meet the annual medical plan deductible before the HDHP plan pays a prescription drug benefit, with the exception of certain preventive medications and medical services not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, please contact APEHP at (800) 718-8328.

NOTE: Please see the list of maintenance medications included in your enrollment materials that qualify for the discounted fee structure.

APEHP \$2,500 HDHP with HSA Medical Benefits for 2016–2017

Each medical plan option covers the same range of services. The plans differ, however, in terms of the out-of-pocket medical costs—deductibles, copays, and coinsurance—you could incur for the year, as well as the premium. The Core Plan, Copay Plan, and three HDHP options offer lower monthly premiums in exchange for higher out-of-pocket costs for deductibles and coinsurance.

Benefit Overview	\$2,500 HDHP Plan In-Network	\$2,500 HDHP Out-of-Network
Annual Deductible ⁽¹⁾	<ul style="list-style-type: none"> • \$2,500/person • \$5,000/family of 2+ 	<ul style="list-style-type: none"> • \$5,000/person • \$10,000/family of 2+
Annual Out-of-Pocket Limit ⁽²⁾	\$3,450/person; \$6,550/family of 2+	No maximum
Office Visit	Plan pays 80%	Plan pays 50%
Well Adult Care	Plan pays 100% No deductible	Plan pays 50% No deductible
Well Child Care	Plan pays 100% No deductible	Plan pays 50% No deductible
Outpatient Lab and X-ray (including MRI, PET, & CT scans)	Plan pays 80%	Plan pays 50%
Urgent Care	Plan pays 80%	Plan pays 50%
Emergency Room	Plan pays 80%	Plan pays 80%
Inpatient Hospital	Plan pays 80%	Plan pays 50%
Outpatient Hospital	Plan pays 80%	Plan pays 50%
Outpatient Behavioral Health Visits	Plan pays 80%	Plan pays 50%
Retail Prescription Drugs (30-day supply) After deductible ⁽³⁾	You pay: <ul style="list-style-type: none"> • Generic: \$10 • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90) 	
Mail Order Drugs (90-day supply) After deductible ⁽³⁾	You pay: <ul style="list-style-type: none"> • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay 	

RED are the 2016–2017 benefit changes

This plan has a non-embedded deductible and out-of-pocket limit. This means that the family deductible and out-of-pocket limit accumulates cost-sharing for any covered family member. Families enrolled in this plan will need to meet the family deductible before any reimbursement is made for eligible medical expenses (other than for preventive/wellness care).

⁽¹⁾ The deductible must be met before the HDHP plan pays benefits. All benefits are subject to the deductible, unless otherwise noted. The family deductible must be met before claims are paid for any member of the family.

⁽²⁾ The deductible applies toward the annual out-of-pocket limit on the HDHP plans.

⁽³⁾ You must meet the annual medical plan deductible before the HDHP plan pays a prescription drug benefit, with the exception of certain preventive medications and medical services not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, please contact APEHP at (800) 718-8328.

NOTE: Please see the list of maintenance medications included in your enrollment materials that qualify for the discounted fee structure.

APEHP \$5,000 HDHP with HSA Medical Benefits for 2016–2017

Each medical plan option covers the same range of services. The plans differ, however, in terms of the out-of-pocket medical costs—deductibles, copays, and coinsurance—you could incur for the year, as well as the premium. The Core Plan, Copay Plan, and three HDHP options offer lower monthly premiums in exchange for higher out-of-pocket costs for deductibles and coinsurance.

Benefit Overview	\$5,000 HDHP Plan In-Network	\$5,000 HDHP Out-of-Network
Annual Deductible ⁽¹⁾	<ul style="list-style-type: none"> • \$5,000/person • \$10,000/family of 2+ 	<ul style="list-style-type: none"> • \$10,000/person • \$20,000/family of 2+
Annual Out-of-Pocket Limit ⁽²⁾	\$6,450/person; \$12,900/family of 2+	No maximum
Office Visit	Plan pays 80%	Plan pays 50%
Well Adult Care	Plan pays 100% No deductible	Plan pays 50% No deductible
Well Child Care	Plan pays 100% No deductible	Plan pays 50% No deductible
Outpatient Lab and X-ray (including MRI, PET, & CT scans)	Plan pays 80%	Plan pays 50%
Urgent Care	Plan pays 80%	Plan pays 50%
Emergency Room	Plan pays 80%	Plan pays 80%
Inpatient Hospital	Plan pays 80%	Plan pays 50%
Outpatient Hospital	Plan pays 80%	Plan pays 50%
Outpatient Behavioral Health Visits	Plan pays 80%	Plan pays 50%
Retail Prescription Drugs (30-day supply) After deductible ⁽³⁾	You pay: <ul style="list-style-type: none"> • Generic: \$10 • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90) 	
Mail Order Drugs (90-day supply) After deductible ⁽³⁾	You pay: <ul style="list-style-type: none"> • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay 	

RED are the 2016–2017 benefit changes

This plan has an embedded individual deductible and an embedded out-of-pocket limit. This means that although a deductible and out-of-pocket limit apply to the family as a whole, no individual will be responsible for more than his/her individual deductible before the plan pays benefits for that person, and no individual will be responsible for more than his/her individual out-of-pocket limit.

⁽¹⁾ The deductible must be met before the HDHP plan pays benefits. All benefits are subject to the deductible, unless otherwise noted.

⁽²⁾ The deductible applies toward the annual out-of-pocket limit on the HDHP plans.

⁽³⁾ You must meet the annual medical plan deductible before the HDHP plan pays a prescription drug benefit, with the exception of certain preventive medications and medical services not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, please contact APEHP at (800) 718-8328.

NOTE: Please see the list of maintenance medications included in your enrollment materials that qualify for the discounted fee structure.

Life Insurance Benefits

Basic Life and AD&D Insurance

APEHP's life insurance and accidental death and dismemberment (AD&D) insurance benefit will be provided through Reliance Standard Life Insurance. The coverage amounts are:

- \$50,000 of basic group life insurance; and
- \$50,000 of AD&D insurance.

Employees may change their beneficiary information at any time during the year. (It's a good idea to review your beneficiary designation at least once each year.) To update your beneficiary information, please contact your Human Resources Department.



Reliance Standard Voluntary Life Insurance

To supplement APEHP's employer-paid life insurance and AD&D coverage, the pool offers you the opportunity to buy voluntary life and AD&D insurance, through Reliance Standard, for yourself, your spouse/domestic partner, and your children.

If you enroll in voluntary life insurance, you are automatically enrolled in voluntary AD&D at no additional cost.

If you wish to enroll this year for additional life insurance, you must complete a medical evidence of insurability (EOI) form. EOI is also required for new participants if the amount of life insurance is in excess of the guaranteed issue amount.

Optional coverages may be purchased as follows:

Employee—in increments of \$10,000, to a maximum of \$750,000, not to exceed five times salary. Any additional amount you apply for requires an EOI (guaranteed issue amount: \$150,000). Coverage decreases starting at age 70 to 67% and 50% at age 75.

Spouse—in increments of \$10,000, and not to exceed 100% of the employee's amount. Any additional amount you apply for requires an EOI (up to \$200,000; guaranteed issue amount: \$30,000). Coverage terminates at age 70.

Child(ren)—in increments of \$5,000, not to exceed \$10,000 (no EOI required; guaranteed issue amount: \$10,000—may be elected at any time). Coverage terminates at age 26.

Voluntary Life Insurance Rate Per \$10,000 of Coverage		
Age	Employee	Spouse
<20	\$0.66	\$0.66
20–24	\$0.66	\$0.66
25–29	\$0.76	\$0.76
30–34	\$0.96	\$0.96
35–39	\$1.06	\$1.06
40–44	\$1.16	\$1.16
45–49	\$1.66	\$1.66
50–54	\$2.46	\$2.46
55–59	\$4.46	\$4.46
60–64	\$6.76	\$6.76
65–69	\$12.86	\$12.86
70+	\$26.60	Coverage ends at 70
Child		
Rate	Coverage Elections	
\$0.70	\$5,000.00	
\$1.39	\$10,000.00	

Rates for voluntary insurance are based on the employee's age and the coverage amount. Please refer to the table above and/or to your voluntary life and AD&D summary of benefits for information on costs.

Employees will automatically be the beneficiary for all spouse, domestic partner, and dependent life insurance.

Health Savings Accounts (HSAs)

A health savings account (HSA) is available only when you enroll in one of the high deductible health plan options.

HSAs are designed to allow individuals to use tax-favored contributions to pay for eligible health care expenses. Unspent HSA money at the end of the year will automatically roll over for use in future plan years.

How the HSA Works

When you elect coverage under one of the HDHP options, you will be able to establish an HSA. If you are enrolling for the first time, you will need to complete and return an additional enrollment form. Your HSA can help you pay for eligible health care expenses for you and your family, along with expenses not covered by the plan, such as your deductible. The HSA is managed by Health Equity and works like a checking account with a debit card. The funds are available to you once they are deposited into your account, and you can use your HSA debit card to make qualifying purchases. If there is not enough money in your account to cover an eligible expense, you can be reimbursed for the amount once the funds have been deposited.

Each year you wish to contribute to your HSA, you will need to complete and return a new election form. For 2016–2017, if you are an active employee, you may contribute up to \$3,350 for individual coverage, and \$6,750 for family coverage (less any contributions made by your employer) on a pre-tax basis. If you are 55 or older, you can also make an additional \$1,000 “catch-up” contribution. All money deposited into your HSA, by you and/or your employer, will earn interest just like a savings account, but on a tax-free basis. You will still be able to use the money that remains in your HSA to pay for qualified expenses even after you stop participating in an HDHP, so you can use your HSA to save for health care expenses you may experience in the future.

When You Enroll in an HDHP

If you are electing an HDHP medical option for the first time, you will need to complete an additional enrollment form in order to establish your HSA and choose the amount you wish to contribute to your account. (Check with your employer’s benefit office or attend an open enrollment meeting for more information.) In order to open an HSA and make tax-free contributions to your account, you must be HSA-eligible. IRS guidelines define an HSA-eligible individual as a person who:

- is covered under an HDHP,
- has no other health coverage (except as permitted by the IRS),
- is not enrolled in Medicare, and
- cannot be claimed as a dependent on someone else’s tax return.

Anyone can contribute to your HSA, but only your employee contributions will qualify for pre-tax savings. Once you have established your account, you can use your HSA debit card to pay for qualified expenses for you and any dependents that you claim on your tax return.

Remember, you can only withdraw funds after they are deposited into your account.



Eligible Health Care Expenses

An HSA can help you pay for certain health care expenses that are not otherwise covered by the plan, including your annual deductible. In general, eligible health care expenses include any nonreimbursable medical, dental, or vision expense that can otherwise be deducted on your individual tax return, if you itemize deductions. (Eligible deductions are described in IRS Publication 502.) Some examples include:

- copayments and coinsurance amounts;
- prescription drugs;
- vision services, including exams, eye surgery, glasses, and contact lenses;
- dental treatments;
- smoking cessation programs;
- weight-loss programs (if prescribed by your physician for a specific disease);
- chiropractic care;
- hearing aids;
- additional amounts you pay when you do not use an in-network provider (for example, amounts over the plan’s allowed amount);
- long-term care; and
- Medicare premiums (including Part A, Part B, Part D, and Medicare managed care) or employer-sponsored health coverage premiums, including premiums for post-employment COBRA coverage.

To see a complete list of allowable expenses, visit the IRS website at <http://www.irs.gov> and review Publication 502.

Health Savings Accounts (HSAs)

continued

Paying Expenses from Your HSA

When you enroll in an HDHP, you pay expenses out of your own pocket until you meet the annual deductible. Then the plan starts to pay benefits. (There are exceptions for certain preventive medications and medical services. You will find a detailed list of medications that are exempt from this rule on the Arizona Public Employers Health Pool website at <http://www.apehp.org>; or see the APEHP 2016 maintenance medications included in your enrollment packet.)

Once you enroll in an HDHP, you will receive more information on how to make HSA contributions, and on how you can access the money in your HSA to pay for eligible health care expenses. In many instances, paying for eligible expenses is as easy as using your HSA debit card. However, keep in mind that the amount available to you can never exceed the amount in your HSA at the time of withdrawal.

If you pay expenses through your HSA, you have already used pre-tax dollars, so you cannot deduct those expenses on your individual tax return. Also, if you use the money in your HSA for non-eligible expenses, that distribution will be taxed, generally with a 20% penalty.



Tax Considerations

With an HSA, you are responsible for determining whether or not an expense is eligible to be paid from your account. In addition, you cannot claim a tax deduction for any health care expense reimbursed from your HSA. To see a complete list of allowable expenses, visit the IRS website at <http://www.irs.gov> and review Publication 502. If you still have questions, contact a member services specialist by calling Health Equity at (866) 346-5800.

Five Reasons to Enroll in an HSA

- 1. Easy-to-use online access to claims and payments.** You can go online anytime to check your account balance, pay bills, or get reimbursements.
- 2. Live member services specialists available 24/7.** Get the help you need when you need it. You can get personalized assistance from a specialist anytime, day or night.
- 3. Answers that are just a phone call away.** You can rely on a live member services specialist when you need help negotiating payment schedules with a provider, finding the average costs for treatments and prescriptions within your zip code area, or simply learning safe, effective ways to save on your health care costs.
- 4. Safe, tax-free growth for your money.** Your cash deposits are FDIC-insured. In addition, you'll be earning tax-free interest. Even if you don't use all of the money in your account, your account balance will continue to grow each year, and you won't have to pay taxes on any interest earned.
- 5. No "use-it-or-lose-it" restriction.** The money in your account can be used in years when you have greater-than-expected health care expenses. Or, at retirement, you can use the money to help pay for retiree health expenses.

For more information, call the HSA administrator, Health Equity, at (866) 346-5800, or visit <http://www.healthequity.net/apehp>.

Health Savings Accounts (HSAs) *continued*

Some Important Reminders About HSAs...

To be eligible to contribute to an HSA, you may generally only have health coverage through a high deductible health plan (HDHP). Once you are enrolled in an HDHP, federal regulations place a number of restrictions on who is eligible to make contributions to an HSA during the year. Some of the more important restrictions are outlined below:

- If you have any type of Medicare coverage, neither you nor your employer may contribute to your HSA. If your spouse has Medicare but you do not, you may contribute to your HSA as individual coverage, but not family coverage.
- You and your employer may not contribute to your HSA if you are covered by another health plan (unless that other health plan is also a qualified HDHP). For example, if you are covered under your spouse's medical plan, you may only contribute to your HSA if your spouse's medical plan is also a qualified HDHP.
- Participation in other types of coverage, such as veterans' benefits, Indian Health Services, onsite clinics, Tricare, Medicaid, mini-med plans, or supplemental medical insurance may also preclude you and your employer from contributing to an HSA. If you have questions, contact the Arizona Public Employers Health Pool at (800) 718-8328.
- You and your spouse may not be enrolled in the HDHP with an HSA and also be enrolled in a Health Care Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) that reimburses for medical services. If you enroll in the HDHP with an HSA, you may not enroll in a Health Care FSA. However, you may still enroll in a Dependent Care FSA.

Examples: Here are two examples illustrating how you can use an HSA to help pay for deductibles and other qualified medical expenses:

Example One

Joe elects individual coverage in the **\$1,500 HDHP**. On July 1, he puts the maximum (set by the IRS) of \$3,350 in his HSA. Here are Joe's in-network medical expenses for 2016–2017:

Service/benefit	Amount	What's covered	HSA Balance
Annual HSA contribution			\$ 3,350
Annual physical	\$ 300	Plan pays 100% (because it's well adult care).	\$ 3,350
Hospital visit	\$ 750	HSA pays \$750. Plan does not begin to pay 80% coinsurance until deductible has been met.	\$ 2,600
Prescriptions	\$ 200	HSA pays \$200.	\$ 2,400
X-rays, MRI	\$ 2,000	HSA pays \$550. Joe has now met his \$1,500 deductible. The plan then pays 80% of the \$1,450 balance, or \$1,160; the HSA pays the remaining 20% of the balance, or \$290.	\$ 1,560

At year-end, Joe received \$3,250 in services/benefits; his HSA paid for \$1,790, and the plan paid for \$1,460. Joe has \$1,560 remaining in his HSA that rolls over in 2017–2018 plan year.

Example Two

Fred and Sally elect family coverage (for themselves and their two children) in the **\$2,500 HDHP**. The family deductible is \$5,000. On July 1, they put the maximum (set by the IRS) of \$6,750 in their HSA. Here are the family medical expenses for 2016–2017:

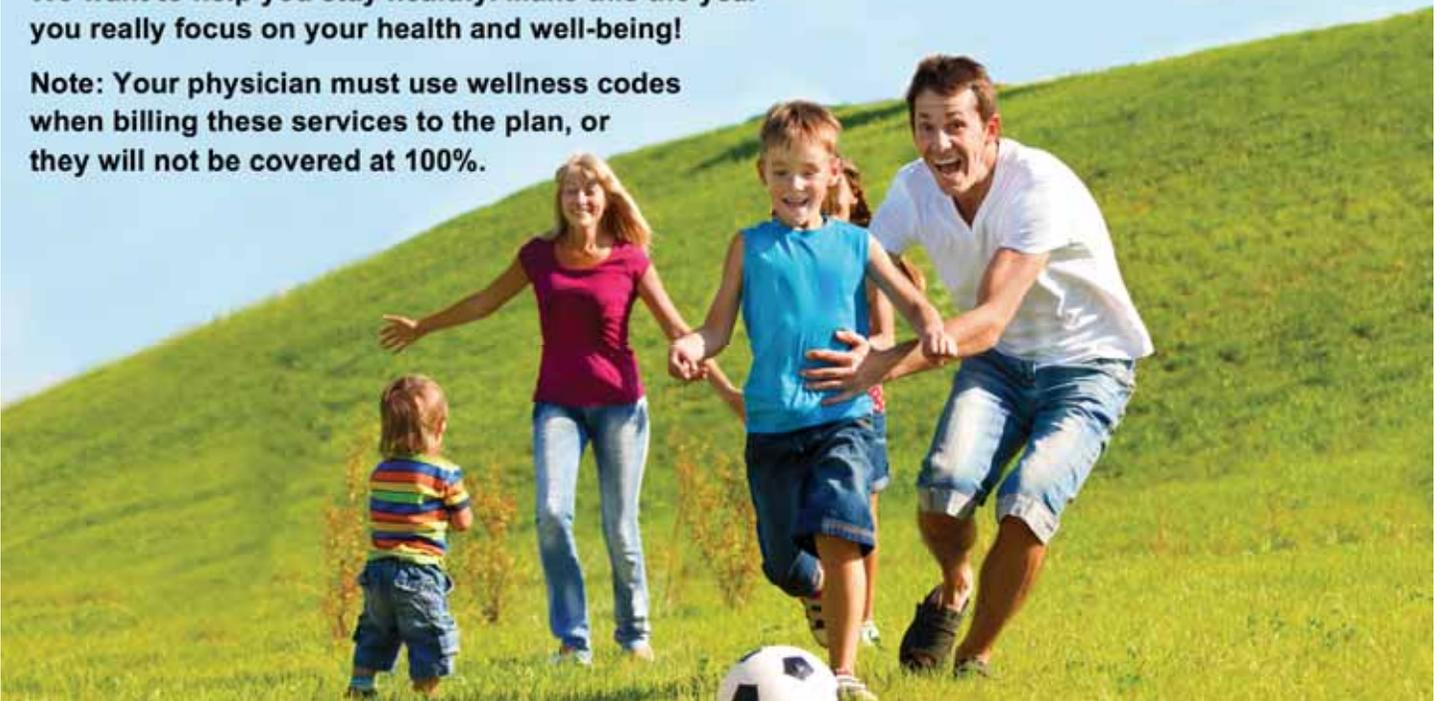
Service/benefit	Amount	What's covered	HSA Balance
Annual HSA contribution			\$ 6,750
Annual physicals	\$ 1,000	Plan pays 100% (because it's well adult and well child care).	\$ 6,750
Hospital visit	\$ 4,000	HSA pays \$4,000. Plan does not begin to pay 80% coinsurance until deductible has been met.	\$ 2,750
Prescriptions	\$ 400	HSA pays \$400.	\$ 2,350
Office visits (colds, flu)	\$ 500	HSA pays \$500. Plan does not begin to pay 80% coinsurance until deductible has been met.	\$ 1,850

At year-end, Fred and Sally received \$5,900 in services/benefits; their HSA paid for all of it (with the exception of the physical examinations, which are covered by the plan at 100%). Because they did not meet their \$5,000 family deductible, the plan's coinsurance did not apply. Fred and Sally have \$1,850 remaining in their HSA that will roll over in 2017–2018 plan year.

Wellness Benefits

We want to help you stay healthy. Make this the year you really focus on your health and well-being!

Note: Your physician must use wellness codes when billing these services to the plan, or they will not be covered at 100%.



The following medical plan benefits are covered at 100% per plan year, with no deductible, when obtained from in-network providers (out-of-network benefits are covered at 50%):

- Female adult physical exams and annual well woman exams
- Contraceptives (generic) for women
- Screening mammogram (once per year beginning at age 35)
- Prostate screenings like Prostate Specific Antigen (PSA) blood test
- Adult physical exam, expanded to cover blood pressure, weight, personal and family history, general physical exam, breast exam, testicular exam, and skin cancer exam
- Annual screening pap smear and lab work
- Cholesterol or lipid panel screening
- Screening for sexually transmitted diseases (STDs), including chlamydia, syphilis, and gonorrhea infections (annually for sexually active women ages 25 and younger, and other women at-risk)
- FOBT: Fecal Occult Blood Test, a take-home lab test (e.g., Guaiac lab test or newer Fecal Immunochemical Test (FIT) such as InSure to take home, collect specimen, and return to lab)
- Screening abdominal ultrasound (once for men ages 65 to 75 who have ever smoked)
- CDC-recommended adult immunizations for MMR, meningitis, polio, hepatitis A and B, and chickenpox (varicella)
- Blood glucose screening lab work
- Up to three visits with a dietician
- Hearing exam (also called an audiometry exam)
- HPV immunization
- Female sterilization
- Annual flu shot (influenza vaccine)
- Screening colonoscopy (Covered 100 percent in-network with no deductible. Not covered out-of-network. Payable once every 10 years starting at age 50. May be payable at a younger age, or more frequently with proof of first-degree relative with a history of colorectal cancer or familial adenomatous polyposis or hereditary familial adenomatous polyposis or hereditary non-polyposis colorectal cancer.)
- Well child exam visits and CDC-recommended immunizations
- Well child physical exam for sports
- Prenatal vitamins and certain over-the-counter drugs prescribed by a provider, payable under the prescription plan (see retail/mail order prescription drug benefit)

Employee Assistance Program (EAP)



Life isn't always easy—but you don't have to face it alone. APEHP continues to offer an employee assistance program (EAP) to help you through life's rough spots. Under the EAP, both you and your family can receive a variety of counseling services to help identify and address problems that impact your life—all at no additional cost to you.

Our partner, EAP Preferred, offers employees and their family members professional, confidential assistance. You can receive up to six counseling sessions per issue with EAP counselors who are state licensed or certified master's- or doctoral-level clinicians with years of counseling experience. In addition, many are certified employee assistance professionals with a unique understanding of the interaction between personal and workplace issues. These counselors can assist with individual, family, and employment problems, such as work-related stress, substance abuse, relationship or marital conflict, parent-child conflict, depression, anxiety, unresolved grief, and domestic violence.

Counselors can also help with referrals to doctors and to sources of legal or financial assistance.

For more information, log on to the EAP website at www.eappreferred.com and click on the link to My Life Values. Your user name is APEHP; your password is eappreferred. For an appointment or additional information, call: **(800) 327-3517, ext. 2.**

EAP Preferred offers employees and their family members:

- Free confidential counseling
- Counseling sessions near work or home
- Counselor availability, 24 x 7
- Legal counseling, financial counseling, elder/child care, and other services/assistance

Special Plan Notices

Mid-Year Changes to Your Health Care Benefit Elections

IMPORTANT: After this open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next year's open enrollment, unless you have a Special Enrollment Event or a Mid-Year Change in Status Event as outlined below:

Special Enrollment Event: 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 your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **31 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 **31 days** after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within **60 days** after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within **60 days** after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Arizona Public Employers Health Pool at (800) 718-8328.

Mid-Year Change-in-Status Event: Because the Arizona Public Employers Health Pool pre-taxes benefits, we are required to follow Internal Revenue Service (IRS) regulations regarding whether and when benefits can be changed in the middle of a plan year. The following events may allow certain changes in benefits mid-year, if permitted by the IRS:

- change in legal marital status (e.g., marriage, divorce/legal separation, death);
- change in number or status of dependents (e.g., birth, adoption, death);
- change in employee's/spouse's/dependent's employment status, work schedule, or residence that affects eligibility for benefits;
- coverage of a child due to a Qualified Medical Child Support Order (QMCSO);
- entitlement or loss of entitlement to Medicare or Medicaid;
- certain changes in the cost of coverage, composition of coverage, or curtailment of coverage of the employee's or spouse's plan; and
- changes consistent with special enrollment rights and FMLA leaves.

You must notify the plan in writing within **31 days** of the mid-year change-in-status event by contacting the Arizona Public Employers Health Pool at (800) 718-8328. The plan will determine if your change request is permitted, and if so, changes will become effective prospectively on the first day of the month following the approved change-in-status event (except for the case of newborn and adopted children, who are covered retroactively to the date of birth, adoption, or placement for adoption).

Medicare Notice of Creditable Coverage Reminder

If you or your eligible dependents are currently Medicare-eligible, or will become Medicare-eligible during the next 12 months, be sure you understand whether the prescription drug coverage that you elect through the pool is or is not creditable with (as valuable as) Medicare's prescription drug coverage.

APEHP has determined that the prescription drug coverage under the following prescription drug plan option is "creditable": Core Plan; Copay Plan; \$1,500 HDHP; \$2,500 HDHP; and \$5,000 HDHP.

If you have questions about what this means for you, review the plan's Medicare Part D Notice of Creditable Coverage, which is available from your Arizona Public Employers Health Pool representative at (800) 718-8328.

Special Plan Notices *continued*

Privacy Notice Reminder

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This plan's HIPAA privacy notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this notice when you enroll in the plan. You can get another copy of this notice from the Arizona Public Employers Health Pool representative.

Direct Access to Primary Care Provider (PCP) and OB/GYN Provider:

The medical plans offered by APEHP do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the plan may be less for the use of a non-network provider.

You also do not need prior authorization from the 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 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, contact the Arizona Public Employers Health Pool at (800) 718-8328 and ask to speak with a representative.

Important Reminder to Provide the Plan with the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of Each Enrollee in a Health Plan

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the Arizona Public Employers Health Pool at (800) 718-8328.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

You or your dependents 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.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Arizona Public Employers Health Pool at (800) 718-8328 and ask to speak with a representative.



Special Plan Notices *continued*

You Must be Qualified to Contribute to a Health Savings Account

The eligibility requirements to open and contribute to a health savings account (HSA) are mandated by the Internal Revenue Service (IRS), not by your employer. Individuals who enroll in a Health Savings Account (HSA) but are later determined to be ineligible for that account are subject to financial penalties from the IRS. **It is an individual's responsibility to ensure that he/she meets the eligibility requirements to open an HSA and to have contributions made to that HSA, as outlined below:**

- To be eligible to open an HSA and have contributions made to the HSA during the year, an individual must be covered by an HSA-qualified health plan (a HDHP) and **must not be covered by other health insurance that is not an HSA-qualified plan.** Certain types of insurance are not considered "health insurance" and will not jeopardize an individual's eligibility for an HSA, including automobile, dental, vision, disability, and long-term care insurance.
- **IMPORTANT:** Individuals enrolled in Medicare are not eligible to open an HSA or have contributions made to the HSA during the year. If you think you could become eligible for Medicare in the next 12 months, you should consider whether enrolling in the medical plan that is paired with a health savings account is a wise choice.
- You may not be claimed as a dependent on someone else's tax return.
- Individuals may not open an HSA, or have contributions made to the HSA during the year, if a spouse's health insurance, Health Care Flexible Spending Account (Health Care FSA) or health reimbursement arrangement (HRA) can pay for any of the individual's medical expenses before the HSA-qualified plan deductible is met. This means that a standard general purpose Health Care FSA may make you ineligible to open an HSA and have contributions made to the HSA during the year.

This open enrollment guide is intended only as a brief description of your plan benefits. It attempts to describe important details and changes to the plans in a clear, simple, and concise manner. If there is a conflict between this guide and the wording of plan documents, the plan documents will govern. APEHP retains the right to change, modify, suspend, interpret, or cancel some or all of the benefits or services at any time.

COBRA Coverage Reminder

In compliance with a provision of federal law referred to as COBRA continuation coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA coverage when qualifying events occur, and, as a result of the qualifying event, coverage for that qualified beneficiary ends. Qualified beneficiaries who elect COBRA continuation coverage must pay for it at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may wish to seek coverage through the Health Care Marketplace. (See <https://www.healthcare.gov/>.) In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the opportunity to elect COBRA coverage following a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after the event occurs.** The notice should be sent to the Arizona Public Employers Health Pool via first class mail, and should include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA, contact the Arizona Public Employers Health Pool at (800) 718-8328 and ask to speak with a representative.

Special Plan Notices *continued*

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 are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can 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, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, and are eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance with paying your employer health plan premiums. The following list of states is current as of January 31, 2016. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	COLORADO – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943
ALASKA – Medicaid	FLORIDA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: https://www.flmedicaidprecovery.com/ Phone: 1-877-357-3268

Special Plan Notices *continued*

GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – 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 1-800-403-0964	Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofc/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

Special Plan Notices *continued*

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dhs.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if additional states have added a premium assistance program since January 31, 2016, 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