



TOLEDO AREA REGIONAL TRANSIT AUTHORITY

A photograph of a family enjoying a ride on a bicycle. A man is leaning over the back of a white and red bicycle, supporting a young girl as she pedals. A woman is crouching on the ground to the right, smiling and watching them. The background shows a large, two-story brick house with a prominent chimney, set against a warm, golden light, suggesting late afternoon or early morning. The scene is captured in a cinematic style with soft lighting and a shallow depth of field.

# 2025 PART-TIME EMPLOYEE BENEFITS GUIDE



Dear Employees,

We are pleased to offer a comprehensive benefits package that provides quality plans and programs for you and your family. We remain committed to providing you with the best plan options and tools to optimize your health, wellness, and financial security.

Open Enrollment for your benefit elections will take place from November 18th through 29th. The choices you make during this time will take effect on January 1<sup>st</sup> and will remain in place for the entire policy year. If you are making changes to your current elections, please login to ADP Workforce Now to complete your enrollment. We encourage all employees to log into their ADP Workforce Now account to double check elections, as well as to make decisions on the newest benefits made available through TARTA. Please note, if you wish to continue contributing to the FSA, you must re-elect that coverage for the new Benefit Plan Year.

To ensure you are selecting the best benefit options for you and your family, please spend some time reviewing the plan information in this guide, including the costs and coverage levels.

We look forward to a successful Open Enrollment campaign. Comprehensive information on our plans and partners are available online through Workforce Now. Please email Human Resources if you have any questions or need assistance with the enrollment process.

Sincerely,

**Laura Koprowski**  
**Chief Executive Officer**  
**Toledo Area Regional Transit Authority**



# TABLE OF CONTENTS

4	Eligibility Guidelines	10	Employee Assistance Program
5	Cost of Coverage Summary	11	Contacts
6	Medical/Rx Insurance	12	Notices
7	Health Savings Account		
8	ERChealth Smart Rewards		
9	Life & Disability Insurance		





# ELIGIBILITY

We encourage you to read the information in this benefit guide very carefully. This benefit guide provides an overview of the benefits available to you as an eligible part-time TARTA employee. It is intended only as a general summary of the various options & is not a legal document. Refer to your summary plan description & carrier certificates for final confirmation of coverage.

## Employees

### Part-Time Eligible Employees

TARTA offers a health and welfare program that provides you with coverage that helps reduce your medical expense, improve your health and well-being, and protect you while you are an active employee.

### New Hire Part-Time Employees

It is important you review the benefit information and enroll in benefits during your initial new hire period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event.

### Termination of Coverage

If employment is terminated, coverage will cancel at the end of the month. The company paid life insurance will end on the date of termination. You may elect to continue parts of your life insurance through Guardian. Please contact Guardian for details.

## Dependents

Your dependents may also be covered under the Medical, Dental, Vision and Voluntary Life and AD&D. A dependent is defined as:

- Your legal spouse
- A dependent child until the child reaches his or her 26<sup>th</sup> birthday; includes natural biological child, stepchild, legally adopted child or a child legally placed for adoption.
- Child for whom the subscriber or the subscriber's spouse is a legal guardian or as otherwise required by law, a child who is considered an alternate recipient under a qualified medical child support order
- Your dependent child who is Disabled either mentally or physically may continue beyond the day the child otherwise ceases to be a Dependent under the terms of the plan.

### Dependent Verification

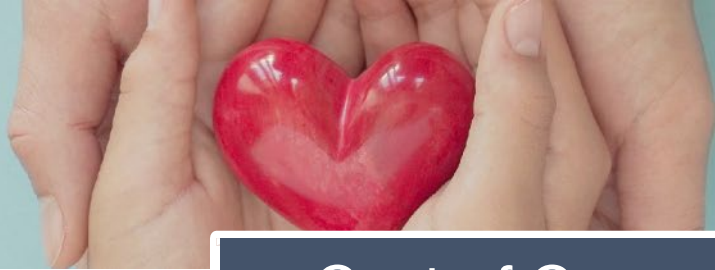
You will be asked to provide Human Resources proof of dependent eligibility, which include marriage certificate, birth certificate, affidavit of qualifying adult, placement certificate, document of guardianship, etc.

## Making Enrollment Changes during the Year

In most cases, your benefit elections remain in effect until the next Open Enrollment period. To make changes outside of the Open Enrollment period, you must incur a qualifying life event.

A qualifying event includes marriage, birth, adoption, divorce, death, loss of eligibility, change in Medicare or Medicaid eligibility, decree or court order, change in dependent eligibility status.





# Cost of Coverage Summary

## Anthem Blue Cross & Blue Shield

Elect to cover yourself and your dependents. The medical plan is offered through Anthem Blue Cross & Blue Shield and include prescription coverage.

[Find Care & Estimate Costs for Doctors Near You | Anthem.com](https://www.anthem.com)

TARTA contributes **\$350 annually** into the Health Savings Account (HSA) for enrolled employees.

WEEKLY Rates (per pay period)	Employee
MEDICAL <i>Blue Cross Blue Shield</i>	9% of weekly pay
BI-WEEKLY Rates (per pay period)	Employee
MEDICAL <i>Blue Cross Blue Shield</i>	9% of weekly pay

Enrolled members may contribute additional funds, pre-tax, directly into your Health Savings Account (HSA).

Once you've enrolled into the HSA, look out for your debit card in the mail. Your HSA debit card works the same as a regular debit card once you activate it.

- Use the HSA online bill-pay to make paying your medical bills easier.
- Log in to anthem.com or download the Sydney Health mobile app to see your HSA balance, find an in-network provider, check the costs for care, etc.

# MEDICAL/RX



## Plan Option:

### High Deductible Health Plan (HDHP)

Designed for those who prefer the predictability of set payments for doctor appointments & other medical services.

Benefits	In-Network	Out-of-Network
Deductible: Single/Family	\$4,000 / \$8,000	\$8,000 / \$16,000
Annual Out-of-Pocket Maximum	\$6,600 / \$13,200	\$10,000 / \$20,000
Coinsurance <i>What you pay after your Deductible</i>	30%	50%
Primary Care Visits	30% after deductible	50% after deductible
Preventive Care	No charge	50% after deductible
Specialist Visits	30% after deductible	50% after deductible
Virtual Care: <i>Primary care/Mental Health/Specialist</i>	30% after deductible	
Inpatient Visit	30% after deductible	50% after deductible
Outpatient Services	30% after deductible	50% after deductible
Facility Fee <i>(i.e., hospital, skilled nursing)</i>	30% after deductible	50% after deductible
Emergency Room	30% after deductible	Covered as In-Network
Urgent Care	30% after deductible	50% after deductible
<b>Rx Retail (30-day supply)</b>		
Generic	10% after deductible	50% after deductible
Preferred Brand	10% after deductible	50% after deductible
Non-Preferred Brand	10% after deductible	50% after deductible
Specialty	10% after deductible	50% after deductible
<b>Rx Home Delivery (90-day supply)</b>		
Generic	10% after deductible	Not covered
Preferred Brand	10% after deductible	Not covered
Non-Preferred Brand	10% after deductible	Not covered
Specialty	10% after deductible	Not covered





# HEALTH SAVINGS ACCOUNT



## Who is eligible for an HSA?

In order to be eligible to make pre-tax contributions to a Health Savings Account, individuals must:

- Be covered under an HDHP on the first day of the month that the account is established and the first day of the month in which deposits are made.
- Not also be covered under any other health plan that is not an HDHP. Certain types of limited benefit plans may be ok, such as a cancer policy, automobile policy or a fixed daily benefit policy (hospital indemnity).
- Not be entitled to benefits under Medicare.
- Not be claimed as a dependent on another person’s tax return.

## HSA Contribution Limits

Annual Contribution Rules	2025 Limit: \$4,300 for individuals & \$8,550 for families
Catch-Up Contribution	Those 55 years of age or higher, but not entitled to Medicare benefits, can fund an additional \$1,000/year!
Amount of Funding	Contributions above the annual limit are subject to income taxes and a penalty

## Eligible Expenses

For a complete listing of eligible expenses can be found at the IRS website & Publication 502.

- |                            |                         |                            |
|----------------------------|-------------------------|----------------------------|
| ▪ Ambulance                | ▪ Eyeglasses            | ▪ Drug Addiction Therapy   |
| ▪ Blood Tests              | ▪ Hearing Aides         | ▪ Spinal Fluid Test        |
| ▪ Braces                   | ▪ Insulin Treatments    | ▪ Splints                  |
| ▪ Contact Lenses           | ▪ Lab Tests             | ▪ Sterilization            |
| ▪ Chiropractic Visits      | ▪ Oral Surgery          | ▪ Therapy Equipment        |
| ▪ Crutches                 | ▪ Prenatal Care         | ▪ Vaccines                 |
| ▪ Dental Treatments/X-Rays | ▪ Prescription Drugs    | ▪ Vitamins (if prescribed) |
| ▪ Dentures                 | ▪ Psychologist Services | ▪ Wheelchairs              |
| ▪ Dermatologist Visits     | ▪ Psychiatrist Services | ▪ X-Rays                   |



# ERChealth



## Smart Rewards

When an employee enrolls in the medical plan offered through Anthem BCBS, members are enrolled in the ERChealth program. Members are eligible to earn \$300 max per enrolled employee. You can earn these rewards by completing the following:

<p align="center"><b>Annual Well Exam or Annual Well Woman Exam</b></p> <p align="center">\$100 per plan year</p> <p align="center">Completing an annual well exam or well woman exam is an essential step in understanding your health and building an ongoing relationship with your primary care physician.</p>	
<p><b>Preventive Cancer Screenings</b></p> <p>\$50 per plan year</p> <p>Get rewarded for completing one of the following preventive cancer screenings: mammogram, colorectal screening, prostate screening, and skin cancer screening.</p>	<p><b>ConditionCare</b></p> <p>\$100 per plan year</p> <p>If you're dealing with a chronic condition like asthma or diabetes, you can get one-on-one help from a health care professional to help you manage your health and reach your goals.</p>
<p><b>Steps Tracking</b></p> <p>\$25 per month</p> <p>Employees and spouses can earn up to \$25 per month for meeting a minimum of 240,000 steps. Keep track manually or by linking a wearable device or app.</p>	<p><b>Building Healthy Families</b></p> <p>\$75 per plan year</p> <p>Work with a Family Care Coach who provides personalized support to help you navigate your family's unique journey.</p>
<p><b>Health Assessment</b></p> <p>\$50 per plan year</p> <p>Receive a reward for completing your Health Assessment by answering questions about your overall health, medical history, diet, and exercise.</p>	<p><b>Well-being Coach</b></p> <p>\$100 per plan year</p> <p>A live health coach motivates and supports you through making meaningful changes towards quitting smoking or weight management.</p>





## LIFE & DISABILITY



### Basic Life Insurance

We know you want to protect your loved ones in case of life's uncertainties. Guardian offers Basic Term Life Insurance and Accidental Death & Dismemberment (AD&D) coverage at no cost to you. You may purchase additional, supplemental coverage to increase your coverage amounts.

Protection from life's unexpected events, provided by TARTA at no cost to you!

At no cost to you, Basic Term Life Insurance gives you:

- Coverage of \$10,000
- AD&D coverage as part of your life insurance
- The ability to convert to an individual policy if you leave
- Portability allows you to take the coverage with you if you terminate employment.
- Possible waiver of premiums if you become disabled
- Possible accelerated death benefit if you are diagnosed with a terminal disease
- No age reduction schedule

#### Actively at Work Requirement for Life Insurance:

You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

Don't forget to designate a beneficiary for employee life insurance.



# HOSPITAL INDEMNITY



**IMPORTANT: This is a fixed indemnity policy, NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

**Looking for comprehensive health insurance?**

- **Visit [HealthCare.gov](http://HealthCare.gov)** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](http://naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

### Why do I need a Hospital Indemnity plan?

Hospital indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on your recovery.

*MONTHLY Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Hospital Indemnity Plan	\$20.85	\$41.46	\$33.98	\$54.59

\*See Rate Page for bi-weekly and weekly per pay cost



## Why do I need an Accident plan?

When you, your spouse or child has a covered off-the-job accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs. While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, childcare, deductibles and copays...or any way you see fit.

Injury	Cash Payment
Accidental Death	EE: \$25,000 Spouse: \$12,500 Child: \$5,000
Hospital Admission	\$1,000 ICU: \$2,000
Hospital Confinement	\$250/day – up to 1 year
Fracture	Schedule up to \$6,000
Ambulance	Ground: \$200 Air: \$1,000
Emergency Room	\$200
Dislocations	Schedule up to \$5,000
Coma	\$10,000
Concussion	\$200

The Accident plan includes a **Wellness benefit** that will pay **\$75** for receiving Preventive Care

*MONTHLY Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Accident Plan	\$13.75	\$23.20	\$24.52	\$33.97

\*See Rate Page for bi-weekly and weekly per pay cost





# CRITICAL ILLNESS



## Why do I need a Critical Illness plan?

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels. Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness.

<h3>Features &amp; Plan Provisions</h3>	<ul style="list-style-type: none"> <li>Coverage is available to all family members: spouses up to 100% of the face amount elected by the employee; children up to 25%</li> <li>Elect \$10,000, \$20,000, or \$30,000 in coverage</li> <li>Guarantee Issue for employee &amp; spouse is \$30,000 (no medical questions asked)</li> <li>Includes an <b>annual Wellness benefit that pays you \$100 per person per year</b> for many common preventive screenings</li> </ul>
---	---

Provides a large, lump sum benefit to help you bounce back when you suffer a major health event. The Critical Illness benefit pays cash, on top of any other medical, disability or supplemental plan.

### Covered Conditions:

- Heart Attack (Myocardial Infarction)
- Stroke
- Cancer
- Renal Failure
- Carcinoma in Situ
- Coronary Artery Bypass Surgery
- Alzheimer's Disease
- Multiple Sclerosis
- Parkinson's Disease

### Childhood Conditions:

- Cerebral Palsy
- Cleft Lip/Palate
- Club Foot
- Cystic Fibrosis
- Down's Syndrome
- Muscular Dystrophy
- Spina Bifida
- Type I Diabetes

[\\*See Guardian summary for full listing of covered conditions](#)

*MONTHLY Rates	<30	30-39	40-49	50-59	60-69	70+
\$10,000	\$5.20	\$8.30	\$15.10	\$28.80	\$48.10	\$75.60
\$20,000	\$10.40	\$16.60	\$30.20	\$57.60	\$96.20	\$151.20
\$30,000	\$15.60	\$24.90	\$45.30	\$86.40	\$144.30	\$226.80

\*Spouse coverage premium is based on Employee age; Child cost is included with employee election

**\*See Rate Page for bi-weekly and weekly per pay cost**



# CANCER



## Why do I need Cancer coverage?

No one is ever prepared in life for a cancer diagnosis. Unfortunately, cancer touches almost everyone at some point in their lives and everyone's story is unique – especially when it comes to treatment. Cancer coverage helps offset the costs of treatments and keeps you focused on your recovery, not your finances.

### Features & Plan Provisions

- Coverage is available to all family members: Employee, Spouse and Child(ren).
- The coverage pays \$2,500 upon initial diagnosis.
- The benefit waiting period is 30 days after your effective date during which the initial diagnosis benefits will not be payable.
- The benefit will pay based on each specific service or treatment received from your cancer diagnosis. For example: radiation therapy, bone marrow/stem cell, home health care, immunotherapy, reconstructive surgery, and more.
- Includes an **annual Wellness benefit that pays you \$50 per person per year** for many common preventive screenings

*MONTHLY Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Cancer Plan	\$24.26	\$48.06	\$26.94	\$50.74

\*See Rate Page for bi-weekly and weekly per pay cost

# SUPPLEMENTAL RATES



ACCIDENT	Employee Only	Family
Weekly	\$3.17	\$7.84
Bi-Weekly	\$6.35	\$15.68

HOSPITAL	Employee Only	Family
Weekly	\$4.81	\$12.60
Bi-Weekly	\$9.62	\$25.19

CRITICAL ILLNESS			
<i>Per thousand Unit Rate</i>			
Attained Age	Employee	Spouse	Child(ren)
25	\$0.52	\$0.52	Included in EE Election
35	\$0.83	\$0.83	
45	\$1.51	\$1.51	
55	\$2.88	\$2.88	
65	\$4.81	\$4.81	

CANCER	Employee Only	Family
Weekly	\$5.60	\$11.71
Bi-Weekly	\$11.20	\$23.42





# EMPLOYEE ASSISTANCE PROGRAM



We all need a little support now and then.

The Employee Assistance Program (EAP) provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- Consultative services are available to provide direct support and assistance.
- Work/life assistance that can help you save money and balance commitments.
- Access legal and financial assistance and resources – including WillPrep Services

Uprise Health EAP can offer help with:

## Education

- Admissions testing & procedures
- Adult re-entry programs
- College planning
- Financial aid resources

## Lifestyle & Fitness Management

- Anxiety & depression
- Divorce & separation
- Drugs & alcohol

## Dependent Care & Caregiving

- Adoption assistance
- Before/after school programs
- Elder care

## Working Smarter

- Career development
- Effective managing
- Relocation

## Legal & Financial

- Basic tax planning
- Credit & collections
- Debt counseling
- Home buying

COMPLETELY CONFIDENTIAL

1-800-386-7055

[Uprise Health Member Portal](#)

Access Code: worklife

24-hour crisis help available

Regular Office Hours: Monday – Friday 6:00am – 5:00pm PST

# CONTACTS

Benefit	Administrator	Contact Information
Medical/Rx	Anthem BCBS ERC Policy# L09804	<a href="http://www.anthem.com">www.anthem.com</a>
Dental	Anthem Policy# L09804	<a href="http://www.anthem.com">www.anthem.com</a> (833) 639-1634
Vision	Anthem - Blue View Vision Policy# L09804	<a href="http://www.anthem.com">www.anthem.com</a> (866) 723-0515
Basic Life/AD&D Voluntary Life/AD&D	Guardian Group#: 00059382	<a href="http://www.guardianlife.com">www.guardianlife.com</a> (888) 600-1600
Accident Cancer Critical Illness Hospital	Guardian Group#: 00059382	<a href="http://www.guardianlife.com">www.guardianlife.com</a> (888) 600-1600
Employee Assistance Program (EAP)	Guardian Access Code: worklife	<a href="http://www.worklife.uprisehealth.com">www.worklife.uprisehealth.com</a> (800) 386-7055

## TARTA Human Resources

Mary Lambert	Human Resources Manager - Benefits	<a href="mailto:mlambert@tarta.com">mlambert@tarta.com</a> Office - (419) 245-5216 Cell - (734) 777-6032
--------------	---------------------------------------	--

# Toledo Area Regional Transit Authority 2025 OPEN ENROLLMENT & PLAN PARTICIPANT NOTICES

-----  
**ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!**

## Notice of Creditable Coverage

Your prescription drug coverage provided under Toledo Area Regional Transit Authority's Anthem BCBS plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

---

### Why This is Important

---

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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. Toledo Area Regional Transit Authority has determined that the prescription drug coverage offered by the Anthem BCBS plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>th</sup> through December 7<sup>th</sup>. However, if you lose your current creditable coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Toledo Area Regional Transit Authority coverage may or may not be affected as well as dependent coverage. Additional guidance is available at <https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/> which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.



**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 Toledo Area Regional Transit Authority 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 Toledo Area Regional Transit Authority changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Mary Lambert – HR Manager  
Address: 1127 W. Central Avenue, Toledo, OH 43697-0792  
Phone Number: 419-245-5216

**For More Information Regarding 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:

1. Visit [www.medicare.gov](http://www.medicare.gov)
2. 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
3. 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](http://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).**

## HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, “protected health information” (PHI). For information to be considered “PHI”, it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual’s “protected health information” (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual’s PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.



## Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

**Treatment Purposes.** The Health Plan may disclose PHI to a health care provider for the health care provider’s treatment purposes. For example, if an individual’s Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual’s PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual’s medical condition, prior diagnoses and treatment, and prognosis.

**Payment Purposes.** The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

**Health Care Operations.** The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and

improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

**To a Business Associate of the Health Plan.** The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

**To the Health Plan Sponsor.** The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

**Required by Law or Requested as Part of a Regulatory or Legal Proceeding.** The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

**Public Health Activities or to Avert a Serious Threat to Health or Safety.** The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

**Law Enforcement or Specific Government Functions.** The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

### **An Individual's Rights Regarding PHI**

An individual has the following rights with respect to their PHI:

**Right to Inspect and Copy PHI.** An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.



**Right to Request Restrictions.** An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

**Right to Receive Confidential Communications of PHI.** An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

**Right to Request an Amendment.** An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

**Right to Accounting of Disclosures.** An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

**Breach Notification.** An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

*Optional if covered entity engages in underwriting* **Genetic Information** An individual's genetic information will not be used for underwriting except for long term care plans.

**Right to Paper Copy.** An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

#### **The Health Plan's Responsibilities Regarding an Individual's PHI**

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

**Department of Health and Human Services  
The Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20210**

---

## **HIPAA Plan Special Enrollment Notice**

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

In addition, if you have a new dependent, as a result of your 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, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

---

## **Genetics Information Notice**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

---

## **Mental Health/Substance Use Disorder Parity**

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

---

## **Newborns and New Mothers Care Disclosure**

This Plan generally does not, consistent with applicable 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, consistent with that same Federal law, this Plan 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, this Plan does not, in accordance with Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

---

## **Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice**

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

---

## **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](http://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](http://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](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a> HIBI Customer Service: 1-855-692-6442	Website: <a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, Press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a> Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> <a href="http://www.in.gov/fssa/dfr/">http://www.in.gov/fssa/dfr/</a> Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: <a href="#">Iowa Medicaid   Health &amp; Human Services</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="#">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="#">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a> HIPP Phone: 1-888-346-9562	Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> 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: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a> KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a> Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a>	Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a> Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-977-6740 TTY: Maine relay 711	Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a> Phone: 1-800-862-4840 TTY: 711 Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a>
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a> Phone: 1-800-657-3672	Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084 Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a>	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900	Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>            Phone: 1-800-356-1561            CHIP Premium Assistance Phone: 609-631-2392            CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>            CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>            Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>            Phone: 919-855-4100</p>	<p>Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>            Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
<p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>            Phone: 1-888-365-3742</p>	<p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>            Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a>            Phone: 1-800-692-7462            CHIP Website: <a href="http://www.pa.gov/childrens-health-insurance-program">Children's Health Insurance Program (CHIP) (pa.gov)</a>            CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>            Phone: 1-855-697-4347, or            401-462-0311 (Direct Rlte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>            Phone: 1-888-549-0820</p>	<p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>            Phone: 1-888-828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: <a href="http://www.texas.gov/health-insurance-premium-payment-program">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a>            Phone: 1-800-440-0493</p>	<p>Utah's Premium Partnership for Health Insurance (UPP)            Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a>            Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a>            Phone: 1-888-222-2542            Adult Expansion Website:  <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a>            Utah Medicaid Buyout Program Website:  <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a>            CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a></p>

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: <a href="https://www.vermont.gov/health/hipp">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427	Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022	Website: <a href="https://dhr.wv.gov/bms/">https://dhr.wv.gov/bms/</a> <a href="http://mywvhpp.com/">http://mywvhpp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

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

U.S. Department of Labor Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)  
 1-877-267-2323, Menu Option 4, Ext. 61565



STAY  
CONNECTED.

**TARMA**

**TAKING YOU PLACES**

Don't forget to elect  
benefits through ADP



Your benefit information  
at your fingertips! Your  
benefit information  
at your fingertips!

- Complete benefit overviews and summaries
- Access to online enrollment
- Carrier contacts
- Mobile-friendly