2026
Benefit Guide

Plan Year: **January 1, 2026 – December 31, 2026**

Manheim Township
Lancaster · 1729 · County
A Healthy Community

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 15 for more details.

Manheim Township strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Benefits Guide.

This guide will outline all the different benefits Manheim Township offers, so you can identify which offerings are best for you and your family.

If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

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Enrollment and Eligibility

Who Is Eligible?

If you're a full-time employee at Manheim Township, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week.

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make regarding your benefit elections can have a significant impact on your life and finances, so it is important to weigh your options carefully.

Employees newly eligible for benefits must complete a Benefits Election Form.

If you are currently enrolled and want to make changes to your elections for January 1, 2026, such drop coverage for you are your dependents, add dependents to your coverage, or make changes in your contributions amounts to your HSA, you need to complete and submit a Benefit Election Form.

Once you have made your elections, you will not be able to make changes until the next open enrollment period unless you have a qualified change in status.

When to Enroll

Open enrollment period which begins on November 3, 2025 and runs through November 14, 2025.

All enrollment forms are due in Human Resources by November 14, 2025.

If you are a new hire and it is outside the yearly open enrollment period, the benefits you choose will become effective the first day following a 30-day waiting period from your date of hire.

How to Make Changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce, or legal separation.
- Birth or adoption of a child.
- Change in child's dependent status.
- Death of a spouse, child, or other qualified dependent.
- Change in employment status or a change in coverage under another employer sponsored plan.

What to know for 2026

PPO Medical/Rx Plans

Highmark BlueShield is the medical/prescription drug (Rx) carrier for the 2026 plan year. Your ID card will state PMHIC.

You have the choice of one medical/Rx plan option (see page 5):

QHDHP $2000/$4000

Under the QHDHP, $2000/$4000 plan all medical services and prescription drugs – with the exception of preventive care –are subject to the deductible. If you have family coverage, the entire $4000 deductible must be met before the plan begins to pay for services. However, if you enroll in the QHDHP, you will have a Health Savings Account to help cover your medical costs.

Health Savings Account

If you select the QHDHP, you will have a Health Savings Account (HSA). The money in the HSA can be used for qualified medical expenses. You can elect to contribute fund to your HSA account on a pre-tax basis. Provided you are enrolled in the QHDHP, in 2026 Manheim Township will contribute $1,000 for a single contract and $2,000 for a family contract to your HSA account *(see page 6).*

Dental

Your dental plan is offered through United Concordia Dental (*see page 7*)

Vision

You have vision coverage through Davis Vision *(see page 8).*

Medical Plan - QHDHP 2000/4000 - Highmark

The following chart is an overview of the benefits that will take effect January 1, 2026.

Highmark Blue Shield QHDHP $2000/$4000		
Services	**In-Network**	**Out-of-Network**
Plan Deductible *(per benefit period)*	$2,000 per member $4,000 per family	$2,000 per member $4,000 per family
Coinsurance	100% after deductible	80% after deductible
Office Visits	Primary - $20 Specialist - $35	80% after deductible
Retail Clinical Visits and Virtual Visits	$20 copay after deductible	80% after deductible
Telemedicine	100% after deductible	Not Covered
Inpatient Hospitalization	100% after deductible	80% after deductible
Outpatient Surgery	100% after deductible	80% after deductible
High Tech Imaging *(CT/PET scans, MRIs)*	100% after deductible	80% after deductible
Lab Services *(x-ray, blood work)*	100% after deductible	80% after deductible
Preventive Care *(Deductible does not apply)*	100%, no deductible	80% after deductible
Emergency Room *(Deductible does not apply)*	$100 copay after network deductible	
Urgent Care *(Deductible does not apply)*	$35 copay after deductible	80% after deductible
Out-of-Pocket Maximum *(includes deductible, co-pays, and coinsurance)*	$3,000 per member $6,000 per family	$6,000 per member $12,000 per family
Prescription Drugs - Generic - Preferred Brand - Non-Preferred Brand	**<u>Retail (30-day supply)</u>** Integrated with medical deductible $8 $20 $45	**<u>Mail-Order (90-day supply)</u>** Integrated with medical deductible $16 $40 $90

Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health / Substance Abuse benefit. Services are limited to those listed on the Highmark Preventive Schedule (Women's health Preventive Schedule may apply). Based on plan allowance. Providers can bill the difference between charge and plan allowance in addition to applicable deductible and coinsurance amounts. Visit limits per benefit period may apply.

Health Savings Accounts

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs).

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

- **It is portable**—The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver**—HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2026 is $4,400 for individual coverage and $8,750 for family coverage.

Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

Who can contribute?

Employee and/or Employer. Manheim Township will contribute $1,000 for single coverage or $2,000 for family coverage into your HSA in 2026. The contributions to the HSA account by Manheim Township will be made bi-annually. If an employee enrolls in the HSA mid-year, the employer will contribute a pro-rated amount.

When is my money available?

You can only use the amount of money that you have deposited into your HSA.

What happens to the money if I do not use it?

Since this is an individual savings account, you keep the money. You can use it for future medical expenses. If you terminate employment with Manheim Township, the account is yours to keep.

What can it be used for?

Out of pocket medical, dental and vision expenses (for you, your spouse, and children claimed as a tax dependent) that are incurred after the HSA was established. COBRA premiums, long-term care premiums, Medicare

Can I change the amount I'm having withheld during the year?

Yes. You can make changes at any time.

Dental Plan – United Concordia

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Manheim Township offers dental coverage through United Concordia Dental.

Type of Service	In-Network	Out-of-Network
Diagnostic & Preventive Services – *Exams, Cleanings, X-rays, Fluoride Treatment, Sealants, and Palliative Treatment*	100%	100%
Basic Services – *Basic Restorative, Simple Extractions, Space Maintainers, Endodontics, Complex Oral Surgery General Anesthesia, Repairs of: Crowns, Bridges & Dentures)*	100%	100%
Major Services – *Surgical and Nonsurgical Periodontics* *Inlays, Onlays, Crowns, Prosthetics*	100% 50%	100% 50%
Orthodontia Services *Diagnostic, Active, Retention Treatment*	50%	50%
Lifetime Orthodontic Maximum *(per person)*	$1,200	
Annual Program Deductible *(per person/ per family)*	None	
Annual Program Maximum *(per person)*	$1,500 Excludes Orthodontics	

Representative listing of covered services – certificate of coverage provides a detailed description of benefits

Dependent children covered to age 26. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee (also known as balance billing). United Concordia Dental's standard exclusions and limitation apply.

Vision Plan – Davis Vision

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Manheim Township's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Manheim Township offers Designer Vision Plan Option H through Davis Vision via PMHIC

Type of Service & Frequency	In-Network	Out-of-Network
Examination *Once every 12 months*	Covered in Full	Up to $40
Frames *Once every 12 months*	$130, plus 20% of balance	Up to $50
Eyeglass Lenses (per pair) *Once every 12 months* Single Bifocal Trifocal Lenticular	Covered in Full	 Up to $40 Up to $60 Up to $80 Up to $100
Contact Lenses (in lieu of glasses) *Once every 12 months* Daily-wear fitting and evaluation Elective contacts Visually Required	$30, plus 15% off balance	 $20 $105 $225
Lens Options Scratch-Resistant Coating Polycarbonate Lenses Anti-Reflective Coating Standard Progressives Photochromic Lenses	 $0 $0 - $30 $35 $50 $65	 $25 $66 $83 $198 $110

Mail Order Contact Lenses Replacement contacts (after initial benefit) though DavisVisionContacts.com mail-order service ensures easy convenient, purchasing online and quick, direct shipping to your door.

Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK.

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vison Care Processing Unit
P.O. Box 1525
Latham NY 12110

Basic Life Insurance

As a full-time employee, you also receive life and accidental death and dismemberment (AD&D) insurance. Manheim Township provides full-time employees with group life and AD&D and pays the full cost of this benefit.

Manheim Township pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

Short-Term Disability

Short-term-disability is offered through Manheim Township pays 100% of the premium cost.

Short-Term Disability	
When Benefits Begin	After 7 days for injury After 7 days for sickness
Percentage of Income Replaced	66.67%
Maximum Benefit	$1,350 per week
Benefit Period	12 weeks

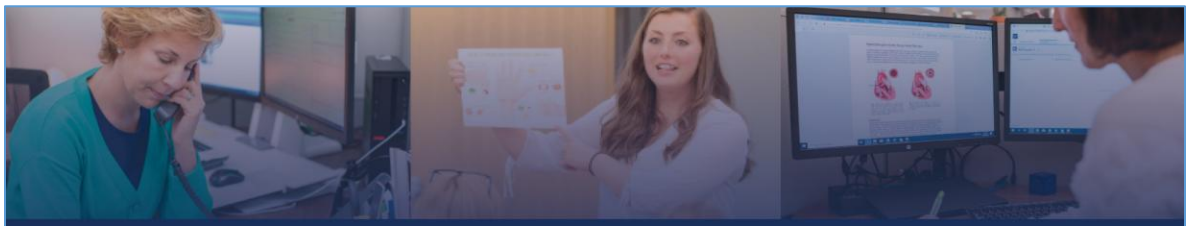
Long-Term-Disability

If you're unable to work because of a covered disability, Long-term-disability insurance replaced a portion of your income. After your claim is approved, you will receive a monthly check for your benefits to help you pay for everyday expenses like mortgage or rent, childcare and groceries.

Long-Term-Disability	
When Benefits Begin	90 Days
Percentage of Income Replaced	60%
Maximum Benefit	$5,500 per month
Benefit Period	Normal Retirement Age (or to defined period of time if disabled after age 60)

ConnectCare3

ConnectCare3 is a personal, confidential Patient Advocacy and Nurse Navigation service designed to help you and your family get the best medical care. We find the best doctors and your best treatment options. We will personally accompany patients to medical appointments. We provide compassionate assistance in navigating the healthcare system.



The ConnectCare3 Benefit

Your health and wellness partner.

What is ConnectCare3?

ConnectCare3 is a confidential benefit provided to employees and their dependents covered under the health plan at no additional cost. ConnectCare3 has no affiliation with any insurance carrier or hospital system. We aim to provide callers with positive health outcomes on their health and wellness journey.

Available Services

Patient Advocacy
The patient advocates are the first line of contact when reaching out to ConnectCare3. They also assist our clinical team with conducting research.

Nurse Navigation
The nurse navigators are available to work with patients who have received a medical diagnosis that requires a specialist. Our nurses can provide education on a diagnosis and treatments, physician options, and can help patients prepare for physician appointments.

Chronic Disease Management & Prevention
The Chronic Disease Management & Prevention team consists of registered nurses, certified health coaches, and a registered dietitian. Our team approach to preventing and managing chronic conditions provides you with access to resources and expertise all in one place.

Nutrition Education
Our registered dietitian will help patients to understand the connection between diet and health by completing a thorough nutritional assessment and providing healthy meal plans and alternatives.

Tobacco Cessation
Work one-on-one with our Tobacco Cessation coaches to achieve and maintain a tobacco-free life.

How to Enroll

Contact us at 877-223-2350 or info@connectcare3.com to enroll in our services today.

Sign Up to Receive Health & Wellness Updates

Scan the QR code to sign up to receive our health and wellness resources!

ConnectCare3®
For more information, visit connectcare3.com

EHD Member CARE Services

Connect. Advocate. Research. Educate.

Our Member CARE Associates are here to assist employees and their dependents with benefit questions and claim issues. Our goal in CARE is to Connect members with the appropriate benefit resources and health care providers, Advocate on their behalf to resolve claims issues, and provide Research and Education to members, ultimately enabling them to become better consumers of healthcare. Navigating the insurance world can be difficult. Recognizing this, we provide our clients with access to this value added services. We can help you answer some of your toughest questions and conundrums:

Do you need help understanding what is covered under your insurance plan?

Do you need help understanding how your prescription plan works?

Do you need help interpreting your Explanation of Benefits (EOB) after the insurance has made a payment or denial?

Do you need help determining what you owe to the provider of service?

For answers to these and other questions (in English or Spanish) call Member CARE Services at 1.866.298.0181.

How to Contact Your Member CARE Associate

Phone

1.866.298.0181

PLEASE HAVE YOUR 5-DIGIT CLIENT CODE READY WHEN CALLING

Client ID:

72276

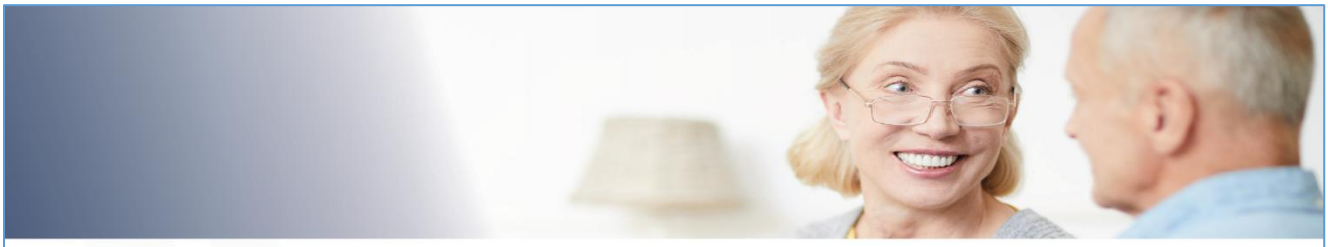
Yanira Vega

yvega@EHDInsurance.com

At EHD, we're proud of our history and our heritage, and equally proud of continuing to operate as a privately held and independent company, as we have since 1896. EHD is now one of the largest and most reputable full-service insurance brokerages in the United States. We have locations in Lancaster, Exton, Wyomissing and Pittsburgh.

EHDInsurance.com | +1-800-544-7292

EHD Medicare Services



If you're nearing retirement age, or are over 65 and still working, you may have questions about healthcare when you retire including Medicare. EHD can help.

Our Senior Services Consultant specializes in helping you navigate:

- Original Medicare
- Medicare Supplements (Medigap Plans)
- Medicare Advantage Plans
- Part D Prescription Drug Plan

If you've reached the place in your life where decisions about Medicare are imminent, it may be a comfort to know that EHD offers the following services to our clients at no cost:

- Meeting with Individual Clients or Employer Groups
- Explaining the Medicare Process, including the proper enrollment time
- Compare your current coverage with Medicare
- Assist with enrolling in Medicare
- Review options for Supplemental Coverage, Advantage Plans, and Drug Coverage
- Assist in the enrollment process with Carriers
- Continuous client service

If these are of interest to you, or you have questions, do not hesitate to contact our Senior Services Consultant today!

All your questions. Answered.

FOR SPECIFIC MEDICARE BILLING QUESTIONS:
CALL MEDICARE
1-800-633-4227

FOR QUESTIONS ABOUT PART A OR PART B COVERAGE:
CALL SOCIAL SECURITY AT
1-800-772-1213

Bonnie Whalen
Senior Services Consultant
bwhalen@ehdinsurance.com
(800) 544-7292 X 4262
1857 William Penn Way
Lancaster, PA 17601

"We see EHD as a very valuable asset in our effort to do business. The EHD staff has been a great group to work with and we look forward to a productive future together."
— President, MANUFACTURER

EHDInsurance.com | +1-800-544-7292

Contact Information

In addition to your Manheim Township HR Team, here is a list of providers that can assist you with questions regarding your benefits, claims, etc.

Benefit plan	Provider	Telephone	Website
Medical/Rx	Highmark Blue Shield	888-767-7014	www.highmark.com
Dental	United Concordia	800-332-0366	www.unitedconcordia.com
Vision	Davis Vision	877-923-2847, Client Code:4964	www.davisvision.com
Life/Disability	OneAmerica	800-249-6269	www.oneamerica.com
ConnectCare3 Patient Advocacy	ConnectCare3	877-223-2350	www.connectcare3.com
Member CARE Services	EHD	1-866-298-0181 **Client ID:** 72276	**EMAIL:** YVega@ehdinsurance.com
Medicare Questions?	EHD/Bonnie Whalen	717-394-5681 Ext. 4262	**EMAIL:** BWhalen@ehdinsurance.com

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.

Required Notices

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends; or after the employer stops contributing towards the other coverage.

You may be able to enroll yourself and your dependents in this plan if you or your dependents become eligible for Medicaid and SCHIP coverage. However, you must request enrollment within 60 days after it is determined that you or your dependents are eligible for Medicaid or SCHIP coverage.

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call your Plan Administrator for more information:

Highmark Blue Shield 800-345-3806

Notice of available privacy practices

Manheim Township (the "Plan") provides health benefits to eligible employees and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about Plan participants in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a notice of privacy practices, which describes the ways that the Plan uses and discloses PHI. To receive a copy of the Plan's notice of privacy practices you should contact your employer's Privacy Official, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach this contact person at: 717-569-6408, ext. 1134.

Newborns' and Mother's Health Protection Act

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

Important Notice from Manheim Township About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Manheim Township and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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. Manheim Township has determined that the prescription drug coverage offered by the Manheim Township group health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your Manheim Township coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your Manheim Township prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with Manheim Township 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 prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the 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 November 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 Manheim Township changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2026
Name of Entity/Sender:	Manheim Township
Contact--Position/Office:	Maribel Fernandez
Address:	1840 Municipal Drive Lancaster PA 17601
Phone Number:	(717) 569-6408 ext. 1134
Email Address:	mfernandez@manheimtownship.org
Carrier Phone Number:	Highmark Blue Shield 800-345-3806

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

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

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

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

Important: Please be advised that this information is not a guarantee of benefits. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the plan at the time services are rendered.

LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: https://medicaid.ncdhhs.gov/ 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: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

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PENNSYLVANIA – Medicaid & CHIP	VIRGINIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Important: Please be advised that this information is not a guarantee of benefits. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the plan at the time services are rendered.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

EMERGENCY SERVICES

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When Balance Billing isn't Allowed, you also have these Protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.