Northfield Public Schools

Universal Availability Notice

Northfield Public Schools (the "Employer") provides you with the opportunity to save for your retirement by sponsoring the Northfield Public Schools 403(b) Plan (the "Plan"). Your employer would like you to know more about your opportunity to participate and contribute to the Plan. Whether you want to enroll in the Plan or are already enrolled but wish to change your deferral amount, you can accomplish your goal by filling out a 403(b) Salary Reduction Agreement. You can obtain a copy of the agreement and information for the Plan from the Benefits Lead at 201 Orchard St S, Northfield, MN 55057, by calling 507.663.0627, or on the district's website at https://northfieldschools.org/staff/finance-forms/#.

Eligibility

All employees of the Employer who receive compensation reportable on an IRS Form W-2 are eligible to participate in the Plan.

If you are not yet enrolled in the Plan, please take a moment to review the Plan materials before enrolling. Once you are enrolled, you can review and change the amount of your contributions and your investment allocations, consistent with the terms of the Plan. The exact date your investment allocations will take effect may vary depending upon the terms of the Plan and the applicable investment arrangements.

Please be aware that the law limits the amount you may defer under this and other plans in any tax year. For 2025, the limit for deferrals is generally $23,500. You may be eligible to defer amounts in excess of $23,500 as catch-up contributions if you have at least 15 years of service with the Employer and contributed less than the annual limit for any of those years and/or if you are age 50 or over. Each participant only gets one limit for contributions to all 403(b) and 401(k) plans. So, if you are also a participant in a 403(b) or a 401(k) plan of either the Employer or another employer, your combined deferrals to that plan and to the Plan in 2025 are generally limited to $23,500. If you do participate in more than one retirement plan, you are responsible for tracking and reporting the amount of all of your contributions to the plans so that the total amount of all your contributions to all plans in which you participate does not exceed the applicable limits. Note also that the sum of all of your deferrals, and any contributions made by the Employer (if applicable), to all retirement plans that you participate in are generally limited to the lesser of $70,000 or 100% of your compensation in 2025.

For further details, or if you have questions, please contact the Benefits Lead at 507.663.0627.

Health Insurance Portability and Accountability Act "HIPAA"

Federal HIPAA law requires us to notify you about two very important Plan provisions prior to your enrollment. You have the right to enroll under a "Special Enrollment Provision" if you acquire a new dependent, or you or an eligible dependent declines coverage because of alternative coverage and later lose such coverage due to certain qualifying reasons.

1. Your health premiums are deducted on a pre-tax basis and are therefore subject to the rules and regulations of IRS Code Section 125.

2. Once you have made your health plan elections during the Annual Benefits Enrollment or during your initial enrollment period, there are limited circumstances under which you can make changes known as family status or HIPAA Special Enrollment events:
    - If you have a family status change as defined by IRS Code Section 125 during the plan year, you are allowed to make coverage level changes to your coverage that are consistent with that event.
    - If you have a family status change that is also a HIPAA Special Enrollment event and your employer offers more than one health plan, you will also be able to move to another health plan offered by the employer.

Example: You currently have "single" Plan 1 health coverage, but will have a new dependent as a result of marriage: this is a HIPAA Special Enrollment. You can add your new spouse to your health insurance coverage (change from "single" to "family" coverage) and you may also move to a different plan (Plan Option 2, Plan Option 3, etc).

A family status change may also be a HIPAA Special enrollment. What makes a family status change ALSO a HIPAA Special Enrollment is when the event involves circumstances previously unknown which necessitate the addition of coverage for yourself or your dependent. Please refer to the "Special Enrollment Provisions" on the next page for details.

Special Enrollment Provisions

1. Loss of Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, and that coverage terminates due to certain qualifying reasons (i.e., COBRA exhaustion or state law continuation rights; eligibility loss due to legal separation, divorce, death, employment termination, or reduction in hours; or because employer contributions for other coverage cease) you may in the future be able to enroll

yourself or your dependents in the benefit plans, provided that you request enrollment within 30-days after your other coverage ends - and that you meet certain other important conditions described in the Summary Plan Description. You must inform us in writing at the time you decline coverage that you are declining coverage because of other health insurance coverage in order to be eligible for this special enrollment period.
In general, coverage will become effective the day following the date on which your other coverage would normally end.

Effective April 01, 2009, two additional special enrollment provisions have been added:

- If you or a dependent lose eligibility for Medicaid or coverage under a state children's health insurance program (SCHIP)
- If you or a dependent become eligible for a state premium assistance subsidy under the plan through Medicaid or SCHIP.

Special enrollment for these two new special enrollment provisions must be requested within 60-days after the termination of coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

2. Marriage, Birth, or Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption - and that you meet certain other important conditions as described in your Summary Plan Description. In general, coverage will become effective the date of marriage, birth, adoption, or placement for adoption.

All coverage request changes must be consistent with the family status change.

Should you wish to receive a replacement copy of our HIPAA privacy notice please contact your benefit administrator and they will mail one to you. This privacy notice is the one you received when you first become enrolled into our health benefit plan.

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Emily Grote
Benefits Lead
201 Orchard St. S.
Northfield, MN 55057
egrote@northfieldschools.org
507-663-0627

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives,

close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.
- We have the obligation to provide and you have the right to obtain a paper copy of this notice from us every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April14, 2004, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

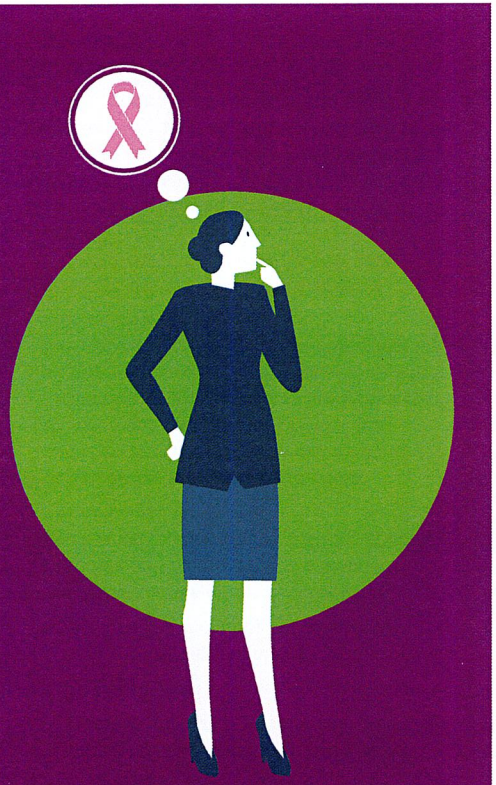
Please contact us for more information:

Molly Viesselman
Director of Human Resources
Title IX Coordinator
201 Orchard St. S.
Northfield, MN 55057

507-663-0624

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: (877) 696-6775



YOUR RIGHTS AFTER A MASTECTOMY

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

Your Rights After A Mastectomy

If you have had a mastectomy or expect to have one, you may be entitled to special rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The following questions and answers clarify your basic WHCRA rights.

I've been diagnosed with breast cancer and plan to have a mastectomy, which my plan covers. Will my health plan cover reconstructive surgery too?

If your group health plan or health insurance company covers mastectomies, it must provide certain reconstructive surgery and other benefits related to the mastectomy, including:

- all stages of reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses, and
- treatment of physical complications of the mastectomy, including lymphedema.

The plan must consult with you and your attending physician when determining how this coverage will be provided.

I must have a mastectomy for medical reasons, although I have not been diagnosed with cancer. Does WHCRA apply to me?

Yes, the law applies if your group health plan or health insurance company covers mastectomies and you are receiving benefits in connection with a mastectomy – whether or not you have cancer. Despite its name, nothing in the law limits WHCRA rights to cancer patients.

Do all group health plans and health insurance companies have to provide reconstructive surgery benefits?

Generally, WHCRA applies to all group health plans that provide coverage for medical and surgical benefits with respect to a mastectomy, as well as their insurance companies. However, there are exceptions for some "church plans" and "government plans." If your coverage is provided by a "church plan" or "governmental plan," check with your plan administrator.

Will I have to pay a deductible or coinsurance?

Possibly. Group health plans or health insurance companies may impose deductibles or coinsurance requirements on mastectomies and post-mastectomy treatment, but no more than those established for other benefits. In other words, the deductible for post-mastectomy reconstructive surgery should be similar to the deductible for any similar procedure covered by the plan.

Before I changed jobs, I had a mastectomy and chemotherapy which were covered under my previous employer's plan. Now I am enrolled under my new employer's plan and want reconstructive surgery. Is my new employer's plan required to cover it?

If you request reconstructive surgery, your new employer's plan generally must cover it if:

- the plan provides coverage for mastectomies, and
- you are receiving benefits under the plan that are related to your mastectomy.

In addition, your new employer's plan generally must cover the other benefits specified in WHCRA, even if you were not enrolled in your new employer's plan when you had the mastectomy.

The Patient Protection and Affordable Care Act includes additional protections. A group health plan generally cannot limit or deny benefits relating to a health condition that existed before you enrolled in your new employer's plan. For more information, visit **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families** or **HealthCare.gov**.

My employer's group health plan provides coverage through an insurance company. After my mastectomy, my employer changed insurance companies. The new insurance company refuses to cover my reconstructive surgery. Is that legal?

Not if:

- the new insurance company provides coverage for mastectomies,
- you are receiving benefits under the plan related to your mastectomy, and
- you elect to have reconstructive surgery.

If these conditions apply, then the new insurance company must provide coverage for breast reconstruction as well as the other benefits required under WHCRA. It does not matter that you were not covered by the new company when you had the mastectomy.

I understand that my group health plan must provide me with a notice of my WHCRA rights when I enroll in the plan. What information does this notice include?

Plans must provide a notice to all employees when they enroll in the health plan that:

- describes the benefits that WHCRA requires the plan and its insurance companies to cover, which includes:
  - coverage of all stages of reconstruction of the breast on which the mastectomy was performed,
  - surgery and reconstruction of the other breast to produce a symmetrical appearance,
  - prostheses, and
  - treatment of physical complications of the mastectomy, including lymphedema;
- states that mastectomy-related benefits coverage will be provided in a manner determined in consultation with the attending physician and the patient;
- describes any applicable deductibles and coinsurance limitations that apply to the coverage specified under WHCRA. Deductibles and coinsurance limitations may be imposed only if they are consistent with those established for other benefits under the plan or coverage.

What information does the annual WHCRA notice from my health plan include?

Your annual notice should describe the four categories of coverage required under WHCRA and how to obtain a detailed description of the mastectomy-related benefits available under your plan. For example, an annual notice might look like this:

"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 [phone number here] for more information."

Your annual notice may be the same notice provided when you enrolled in the plan if it contains the information described above.

My state also requires health insurance companies to cover minimum hospital stays in connection with a mastectomy (which is not required by WHCRA). If I have a mastectomy and breast reconstruction, am I also entitled to the minimum hospital stay?

If your employer's group health plan provides coverage through an insurance company, you are entitled to the minimum hospital stay required by the state law. Many state laws provide more protections than WHCRA for coverage provided by an insurance company or "insured coverage."

If your employer's group health plan provides...	You are entitled to...
Coverage through an insurance company	Federal and state protections (in states that provide them)
Self-insured coverage	Federal protections only

To find out if your group health coverage is "insured" or "self-insured," check your health plan's Summary Plan Description (SPD) or contact your plan administrator.

If your coverage is "insured" and you want to know if you have additional state law protections, contact your state insurance department.

I have health coverage through an individual policy, not through an employer. Am I covered under WHCRA?

WHCRA rights apply to individual coverage as well. These requirements are generally within the jurisdiction of the state insurance department. Call your state insurance department or the Department of Health and Human Services toll free at **1-877-267-2323**, extension **6-1565**, for more information.

Can I get breast cancer screening or similar preventive services for free?

Possibly. Under the Affordable Care Act, you may receive certain recommended preventive services, such as breast cancer mammography screenings for women aged 40 and older, with no copayment, coinsurance, deductible, or other cost-sharing. For more information, visit **HealthCare.gov/coverage/preventive-care-benefits/**. WHCRA does not require coverage for preventive services related to the detection of breast cancer.

Resources

WHCRA is administered by the U.S. Departments of Labor and Health and Human Services.

Department of Labor

For more information about your WHCRA rights under an employer-sponsored group health plan and other health coverage topics, visit **dol.gov/agencies/ebsa**. To order publications, learn more about our programs and services, or discuss questions about your benefits, contact EBSA at **askebsa.dol.gov** or call toll-free: **1-866-444-3272**.

Department of Health and Human Services

For more information on WHCRA, visit **www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html** or call toll-free: **1-877-267-2323**, extension **6-1565**.

National Association of Insurance Commissioners

To find the contact information for your state office, visit **naic.org/state_web_map.htm**.

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

September 2018

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 March 17, 2025. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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)	**KANSAS – 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: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.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: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, 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

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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)