Important Notices

About This Guide
This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. Boulder County reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

Reminder of Availability of Privacy Notice
This is to remind plan participants and beneficiaries of the Boulder County Health and Welfare Plan (the “Plan”) that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the Boulder County Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

Boulder County, Human Resources
East Wing Courthouse
2025 14th St.
Boulder, CO 80302

If you have any questions, please contact the Boulder County Human Resources Office at 1-303-441-3860.

Women’s Health and Cancer Rights Act
Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

• Reconstruction of the breast on which the mastectomy has been performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• Prostheses and physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. Therefore, the following deductibles and coinsurance apply:

Consumer Driven Health Plan with HSA:
In-network Deductible: $1,750 / $3,500
In-network Coinsurance: 20%

Low Option Copay Plan:
In-network Deductible: $1,250 / $2,500
In-network Coinsurance: 20%

High Option Copay Plan:
In-network Deductible: $750 / $1,500
In-network Coinsurance: 10%

If you would like information on WHCRA benefits, call your plan administrator at 1-303-441-3860.

Newborns’ and Mothers’ Health Protection Act Disclosure
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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA
Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact the Boulder County Human Resources Office for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

This guide contains information about the creditable status of the Rx coverage.
Medicare Part D Notice of Creditable Coverage

Your Options

Please read this notice carefully and keep it where you can find it. This
notice has information about your current prescription drug coverage
with Boulder County 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. If you are
considering joining, 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. Information about where you can get help to make decisions
about your prescription drug coverage is at the end of this notice.

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. Boulder County has determined that the prescription drug coverage
offered by the Boulder County High Plan, Low Plan and the Consumer
Driven Health Plan through Cigna 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 Can You 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.
However, if you lose your current creditable prescription drug 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 Boulder County
coverage will not be affected. If you do decide to join a Medicare drug
plan and drop your current Boulder County coverage, be aware that
you and your dependents may not be able to get this coverage back.

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
Boulder County 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.

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 Boulder County
changes. You also may request a copy of this notice at any time.

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 for personalized
  help. See the inside back cover of your copy of the “Medicare & You”
  handbook for their telephone number.
- 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: 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).

Date: January 1, 2020
Name of Entity/Sender: Boulder County Contact: Emily I. Cooper
Boulder County
Address: East Wing Courthouse
2025 14th St
Boulder, CO 80302
Phone Number: 1-303-441-3860
Continuation Coverage Rights Under COBRA

Introduction
You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 (www.healthcare.gov). 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 coverage would otherwise end because of a life event known as 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 must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- 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 any of the following qualifying events happen:

- 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.”

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the 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 after the qualifying event occurs. You must provide this notice to: Boulder County Human Resources.

How is COBRA 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. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice will lose his or her right to elect COBRA.

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. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.
Continuation Coverage Rights Under Cobra

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration’s determination of disability within 60 days after the latest of the date of the Social Security Administration’s disability determination; the date of the covered employee’s termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee’s termination or reduction in hours. You must also provide this notice within 18 months after the covered employee’s termination or reduction in hours in order to be entitled to this extension.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the Plan Administrator informed of 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

For further information regarding the plan and COBRA continuation, please contact:

Boulder County Benefits Manager
Emily I. Cooper
East Wing Courthouse
2025 14th St
Boulder, CO 80302
1-303-441-3860

Summaries of Benefits and Coverage (SBCs)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available on the Boulder County Benefits Website. If you would like a paper copy of the SBCs (free of charge), you may also call 1-303-441-3860.

Boulder County is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.
Notice Regarding Wellness Program

The Boulder County Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary Member Health Assessment or “MHA” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total cholesterol, glucose, as well as body mass index (BMI) or waist circumference, systolic and diastolic blood pressure, and a self-reported signed tobacco affidavit. These clinical metrics make up the four Health Metrics. You are not required to complete the MHA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a $10/month premium credit for completing the MHA and biometric screening. Although you are not required to complete the MHA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives of up to $20/month in premium credits may be available for employees who meet national, medically recognized ideal ranges in three out of the four Health Metrics or make any improvements from the prior screening in a missed metric. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting The Wellness Program at 1-720-233-8753 or bcwellness@healthbreakinc.com.

The information from your MHA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as personalized coaching from Healthbreak/SimplyWell or disease management services from Cigna. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors, managers, or any employee of Boulder County and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) nurses and/or coaches from Healthbreak/SimplyWell in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Sensitive information is protected at multiple levels throughout the online wellness platform. All solutions are HIPAA compliant. Confidential data is available only to participants to whom it belongs. Clients (employers) only have access to aggregate data, not participant data. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Emily I. Cooper at 1-303-441-3860.
### 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 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, 2019. Contact your State for more information on eligibility.

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<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>CHIP Website</th>
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<td><a href="https://ncdhhs.gov/medicaid">Website</a></td>
<td><a href="http://www.covernorthcarolina.gov">Website</a></td>
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<td>Ohio</td>
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<td>Pennsylvania</td>
<td><a href="https://www.dhs.pa.gov/mypermedicaid/healthinsurancepremiumpaymentprogram/index.htm">Website</a></td>
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<td><a href="https://health.wy.gov/healthcare/premium-payment-program.html">Website</a></td>
<td><a href="http://www.coverwyoming.gov">Website</a></td>
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</tbody>
</table>

To see if any other states have added a premium assistance program since July 31, 2019, 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
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP) continued

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 12/31/2019)
**Glossary**

**ACA (Patient Protection and Affordable Care Act)**
Also called Health Care Reform, the intent of the Affordable Care Act is to make affordable health care available to all Americans. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, free preventive care, etc.

**Brand Name Drug**
The original manufacturer’s version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

**Coinsurance**
A percentage of costs you pay “out-of-pocket” for covered expenses after you meet the deductible.

**Copay (Copayment)**
A fee you have to pay “out-of-pocket” for certain services, such as a doctor’s office visit or prescription drug.

**Deductible**
The amount you pay “out-of-pocket” before the health plan will start to pay its share of covered expenses.

**Employer Contribution**
Each year, the company provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you’ll receive when you enroll. If you’re enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

**Generic drug**
Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

**HDHP**
High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

**Health Savings Account (HSA)**
A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

**Out-of-pocket maximum**
The most you pay each year “out-of-pocket” for covered expenses. Once you’ve reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

**Plan year**
The year for which the benefits you choose during Annual Enrollment remain in effect. If you’re a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

**Preventive care**
Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.