## ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

## ALASKA – Medicaid

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

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

## CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
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+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

## FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

## GEORGIA – 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

## INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

## IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

## MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

## MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

## MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005



## KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

## KENTUCKY – 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://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

## LOUISIANA – 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)

## MAINE – Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

## MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

## NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

## NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

## NEW HAMPSHIRE – Medicaid

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

## NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

## NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

## NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

## NORTH DAKOTA – Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

## OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

## SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

## TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

## UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

## VERMONT – Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

## VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924



## OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

## PENNSYLVANIA – Medicaid

Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

## RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

## SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

## WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

## WEST VIRGINIA – Medicaid and CHIP

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

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

## WYOMING – Medicaid

Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

### SUMMARY ANNUAL REPORT
### For SAMUEL, SON & CO. (USA), INC. EMPLOYEE WELFARE BENEFITS PLAN

This is a summary of the annual report of the SAMUEL, SON & CO. (USA), INC. EMPLOYEE WELFARE BENEFITS PLAN, EIN 06-1251791, Plan No. 516, for period 01/01/2022 through 12/31/2022. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA). SAMUEL, SON & CO. (USA), INC has committed itself to pay certain self-insured Medical, Dental, and Vision claims incurred under the terms of the plan.

**Insurance Information**
The plan has contracts with METROPOLITAN LIFE INSURANCE COMPANY to pay Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment, Critical Illness, Hospital, and Accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2022 were $3,848,977.

**Your Rights To Additional Information**
You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report: insurance information, including sales commissions paid by insurance carriers; To obtain a copy of the full annual report, or any part thereof, write or call the office of SAMUEL, SON & CO. (USA), INC at 251 LITTLE FALLS DRIVE, WILMINGTON, DE, 19808 or by telephone at 630-783-8900. You also have the legally protected right to examine the annual report at the main office of the plan (SAMUEL, SON & CO. (USA), INC, 251 LITTLE FALLS DRIVE, WILMINGTON, DE, 19808) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 07/31/2023)



# Important Legal Notices About Your Benefits

As of October 2023

**Samuel is required by law to provide the following notices about your benefits.**
**No action is required; these notices are provided for information purposes only.**

## Newborns' and Mother's Health Protection Act

Under Federal law, group health plans and health insurance issuers generally may not restrict benefits for any length of hospital stay for the mother or newborn child in connection with childbirth 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 and/or 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 insurance issuer for prescribing a length of stay up to 48 hours (or 96 hours, as applicable).

## Women's Health & Cancer Rights

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies.

This law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast, to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

Coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

## Wellness Program

Samuel's health plan is committed to helping you achieve your best health. Effective January 1, 2022, rewards for following a tobacco-free lifestyle are available to all employees enrolled in the health plan through a voluntary wellness program. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means (e.g. tobacco cessation counseling). Contact us at (630) 783-8900 and we will work with you (and, if you wish, with your doctor) to find a reasonable alternative to earn the reward that is right for you in light of your health status.

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. 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 or managers 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. 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. 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.

## HIPAA Privacy Notice

For purposes of the health benefits offered under the plan, the plan uses and discloses health information about you and any covered dependents only as needed to administer the plan or as otherwise permitted under applicable law. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the plan will comply with the applicable health information privacy requirements of Federal regulations issued by the Department of Health and Human Services. The plan's privacy policies are described in more detail in the plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in company-sponsored health and welfare benefits plans are reminded that the Notice of Health Information Privacy Practices may be obtained, without charge, by submitting a request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice. Please contact the insurer to request a copy of the insurer's Privacy Notice.

## HIPAA 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/your dependents' other coverage). You must request enrollment within 30 days from the end date of your/your dependents' other coverage (or after the employer stops contributing toward that coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

## Genetic Information Nondiscrimination Act (GINA)

As of November 21, 2009, the Genetic Information Nondiscrimination Act (GINA) prohibits employers from obtaining any genetic information (including family medical history) from applicants or employees, except under certain very limited circumstances. Therefore, it will generally be unlawful for employers to ask applicants and employees whether a relative has, or has ever had, certain medical conditions, such as cancer, diabetes or heart disease. Although questions about the health of an employee's family member are not likely to elicit information about whether an employee currently has a disability, GINA will generally prohibit such questions.

GINA also generally prohibits group health plans and health insurers from adjusting group premium or contribution amounts on the basis of genetic information, requesting or requiring an employee or an employee's family members to undergo genetic testing, and collecting genetic information (including family medical history) for underwriting purposes or prior to or in connection with enrollment.

## Affordable Care Act

In March 2010, comprehensive health care reform law was enacted in two parts. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was later amended by the Health Care and Education Reconciliation Act on March 30, 2010. "Affordable Care Act" is used to refer to the final, amended version of the law. Among other things, the Affordable Care Act established health insurance marketplaces or exchanges where individuals can purchase health insurance. You are encouraged to visit www.healthcare.gov for important information that could apply to you regarding the Affordable Care Act and the marketplace where U.S. consumers can shop for health insurance. If you have questions, call 1-800-318-2596 (TTY: 1-855-889-4325) or visit www.healthcare.gov.

## Availability of Summary of Benefits and Coverage

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes a Summary of Benefits and Coverage (SBC) available to you, which summarizes important information about any health coverage options in a standard format, to help you compare options. The SBC is available online at samuel-benefits.us. A paper copy is also available, free of charge, by contacting Human Resources.



## Important Notice About Your Prescription Drug Coverage and Medicare

**If you qualify for Medicare, please read and keep this important notice.** If you enroll in one of the plans approved by Medicare that offers prescription drug coverage, you may need to provide a copy of this notice when you join.

This notice has information about your current prescription drug coverage under the medical plan and your options under Medicare's prescription drug coverage, to help you decide whether or not to join a Medicare drug plan. Information on where you can get help to make decisions on 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 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. The Plan has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep your existing coverage and will not pay a higher premium (a penalty) if you later decide to enroll in Medicare prescription drug coverage.

*When Can I Join a Medicare Drug Plan?*

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. If you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Remember, your current plan coverage pays for other health expenses, in addition to prescriptions.

*When Will I Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?*

If you are enrolled in the medical plan, you can choose to join a Medicare prescription drug plan later without paying a penalty, as long as you don't go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage.

Starting with the end of the last month you were first eligible to join a Medicare drug plan (but didn't join), if you go 63 continuous days or longer without credible prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage, For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

*What Happens to My Current Coverage If I Decide to Join a Medicare Drug Plan?*

If you decide to join a Medicare drug plan, and you are covered under Samuel's group health plan as an active employee (or you are the spouse or dependent of an active employee and are covered under Samuel's plan), you can keep your prescription drug coverage through Samuel and that coverage will coordinate with the Medicare prescription drug plan. To drop Samuel prescription drug coverage, you must drop your Samuel group health plan coverage (Samuel does not allow you to drop prescription drug coverage separate from the general medical coverage). If you drop your coverage under the Medicare drug plan, you can elect to re-enroll in the Samuel group health plan during the next annual enrollment period, or if you experience a qualified change in status (as defined by the Internal Revenue Service) or special enrollment event.

*For More Information*

If you have questions about this notice, contact your local HR representative. You will receive this notice each year. You will also receive this notice before the next period you can enroll in Medicare prescription drug coverage, or if this coverage changes. You may also request a copy of this notice at any time.



For more information about your options under Medicare prescription drug coverage, refer to 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. You can also visit www.medicare.gov, call your State Health Insurance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number), or 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 details, visit Social Security at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

## Your Rights and Protections Against Surprise Medical Bills

This notice describes your rights under the No Surprises Act in regards to services you receive under the group health plan.

*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-ofnetwork 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.



*Air Ambulance*

You also have protection from balance billing for air ambulance services, but only if you meet your health plan's requirements for coverage of air ambulance services.

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:

  o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

  o Cover emergency services by out-of-network providers.

  o 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.

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

## Medicaid / CHIP Special Enrollment Period

If you or a dependent are eligible for, but did not enroll in, the group health plan because of coverage under a Medicaid or CHIP plan, and such coverage is terminated due to loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s) in the group health plan following such loss of coverage. However, you must request enrollment within 60 days after the date eligibility for coverage under the Medicaid or CHIP program is lost.

If you or your children are eligible for Medicaid or CHIP and you're eligible for coverage under the group health plan, your state may have a premium assistance program that can help you 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 visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help 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 the group health plan, you are permitted to enroll in the plan if you are not already enrolled. You must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, please contact the Department of Labor at www.askebsa.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, 2022. Contact your state for more information on eligibility.