2023 Benefits at a Glance
Hourly Employees

LONG FALLS PAPERBOARD

161 Wellington Road, Brattleboro, VT 05301; 1-802-257-0365
www.longfallspaperboard.com

Welcome to your 2023 benefits!

Long Falls Paperboard is pleased to provide you and your family with a wide range of competitive benefits. Your benefits are an important part of your total compensation. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

This benefits guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully, ask questions if needed, and make sure to enroll by the deadline.

Photo Credit Kevin Armstrong

Eligibility

Benefit	Minimum Hours	Waiting Period
Medical, Dental, Vision	24 hours	Date of Hire
Life, Voluntary Life, Short Term Disability	24 hours	Day following 90 days

Eligible dependents include:

- Spouse;
- Children under the age of 26, regardless of student, dependency or marital status;
- Children past the age of 26 who are fully dependent on you for support due to a mental or physical disability (and are indicated as such on your federal tax return).

Benefits End

Your Long Falls Paperboard-sponsored benefits end on your date of termination.

Changing Benefits After Enrollment

During the year, you cannot make changes to your medical, dental or vision unless you experience a Qualified Life Event, such as marriage or the birth of a child. If you experience a Qualified Life Event (examples below), you should contact the Benefits Coordinator within 30 days of the event, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

How to Enroll

If you are a new hire, you have 30 days to enroll from your date of hire. You must complete your enrollment to receive benefit coverage for the plan year.

Before You Enroll:

- Carefully review the benefits listed in this guide and determine the medical, plan that's best for you and your family.
- Ensure family members meet the eligibility requirements.
- Understand the cost of the plans you selected.
- Select, review and submit your desired coverage.

Check with the Benefits Coordinator if you have questions.

Medical

Long Falls Paperboard's medical coverage provides you and your family the protection you need for everyday health issues or unexpected medical expenses.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below.

Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care.

The plans have different:

- **Deductibles** — the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
- **Copays** —a fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurances** — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** — the most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.
- **Prescriptions** — Deductible, coinsurance and copays may apply

Before You Enroll

Consider this:

1. Think about the per-pay-period cost and out-of-pocket expenses you will incur and your possible future medical expenses. The option that has the highest per-pay-period cost typically has a lower deductible, pays more and/or copays when you need care.
2. Want to stay with your doctor? Ensure they are in the plan's network by visiting the https://www.bcbsvt.com/. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.

Medical

The table below summarizes the key features of the medical coverage. Please refer to the official plan documents for additional information on coverage and exclusions.

	BCBSVT Gold	BCBSVT Silver	BCBSVT Select CDHP Gold	BCBSVT Select CDHP Silver
	In-Network	**In-Network**	**In-Network**	**In-Network**
Calendar Year Deductible				
Individual	**$1,400**	**$4,000**	**$2,675**	**$5,150**
Family	**$2,800**	**$8,000**	**$5,350**	**$10,300**
Calendar Year Out-of-Pocket Maximum (Includes Deductible)				
Individual	**$5,600**	**$9,100**	**$2,675**	**$5,150**
Family	**$11,200**	**$18,200**	**$5,350**	**$10,300**
		You pay		
Coinsurance	30%	50%	0%	0%
Preventive Care	$0	$0	$0	$0
Telemedicine	$20	$20	$20	$20
Primary Care Physician	3 visits per member at no cost share, then $20	3 visits per member at no cost share, then $20	$0 *	$0 *
Specialist	$50	$90	$0 *	$0 *
Urgent Care	$60	$100	$0 *	$0 *
Emergency Room	$150 *	$500 *	$0 *	$0 *
Lab & X-ray	30% *	50% *	$0 *	$0 *
Hospitalization	30% *	50% *	$0 *	$0 *
Diagnostic Imaging (MRI/CT)	30% *	50% *	$0 *	$0 *
Pharmacy				
Rx Deductible	$200 / $400	$500 / $1,000	Combined with medical	Combined with medical
Rx Out-of-Pocket Max	$1,400 / $2,800	$1,400 / $2,800	$1,500 / $3,000	$1,500 / $3,000
Retail Rx (up to 30-day supply)				
Generic	$12	$20	$0 *	$0 *
Preferred Brand-Name	$55 *	$70*	$0 *	$0 *
Non-Preferred Brand-Name	50% *	50% *	$0 *	$0 *
Wellness drugs	Same as any other Prescription	Same as any other prescription	$5 / 40% / 60%	$15 / 40% / 60%
Mail Order Rx (90-day supply)	3x copay	3x copay	2x copay	2x copay

**After Deductible*

Health Savings Account (HSA)

A Health Savings Account (HSA) is a personal savings account that you own and can use to pay for qualified out-of-pocket medical expenses. Your contributions to the HSA are taken out of your paycheck and are tax-free. Once you enroll in the HSA, you'll receive a debit card to pay for qualified out-of-pocket medical expenses. Your HSA can be used to pay for your health care expenses and those of your spouse and dependents, even if they are not covered by the High Deductible Health Plan (HDHP).

How a Health Savings Account (HSA) Works

Eligibility

Anyone who is:

- Covered by a High Deductible Health Plan (HDHP);
- Not covered under another medical plan that is not an High Deducible Health Plan (HDHP);
- Not entitled to Medicare benefits; or
- Not eligible to be claimed on another person's tax return

Your Contributions

You choose how much to contribute from each paycheck on a pretax basis. You can contribute up to the IRS maximum of $3,590/individual or $7,230/family. You can make an additional "catch-up" contribution of up to $1,000 per year if you are age 55 or older.

Eligible Expenses

You can use your HSA to pay for medical, dental, vision and prescription drug expenses incurred by you
and your eligible family members. Please note: Funds available for reimbursement are limited to the balance in your HSA.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses — or pay for expenses out of your own pocket and save your HSA dollars for future health care expenses.

Your HSA is always yours – no matter what

One of the best features of an HSA is that money left over at the end of the year remains in the account so you can use it the following year or at any time in the future. And if you leave the Long Falls Paperboard or retire, your HSA goes with you.

Health Savings Account (HSA)

The Triple Tax Advantage

HSAs offer three significant tax advantages:

1. You can use your HSA funds to cover qualified medical expenses, including dental and vision expenses — tax-free.
2. Unused funds grow and can earn interest over time — tax-free.
3. You can save your HSA dollars to use for your health care when you leave Long Falls Paperboard or retire — tax-free.

If you want to pay less per paycheck for health care coverage and save tax-free money for future medical expenses, consider enrolling in the HDHP with HSA.

How a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) Work Together

Year 1 Example: You enroll in the HDHP with HSA during enrollment		Year 2 Example: You enroll in the HDHP plan again next year
You contribute $3,600 for a total of $3,600		$2,850 rolls over from last year and you contribute $3,600 for a total of $6,450
You use the HSA to pay $700 of eligible expenses		You use the HSA to pay $1,250 of eligible expenses
You have $2,900 in the HSA to roll over to next year!		**You have $5,200 in the HSA to roll over to next year!**

Dental

Dental insurance helps cover the costs you pay each time you see the dentist including cleanings and X-rays. This coverage is designed to help pay a percentage of associated dental care costs after a member receives dental care.

Plan Features				
	Calendar- year deductible		**Coinsurance your policy pays**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventative	$0	$0	100%	100%
Basic	$25	$25	90%	80%
Major	$25	$25	60%	50%
Orthodontia	$0	$0	50%	50%

Additional Provisions	
Family deductible	2 times the per person deductible amount
Combined deductible	Your deductibles that are in and out-of-network for basic and major services are combined.
Combined maximum	Maximums for preventative, basic, and major procedures are combined. In-network calendar year maximums are $1,200 per person or non-network calendar year maximums are $1,200 per person.
Orthodontia lifetime maximum	$1,750 PPO in-network maximum/ $1,750 PPO out-of-network maximum
Maximum accumulation	Included
Plan type	Unscheduled

Vision

Vision insurance is designed to help you cover the cost when you go to visit an optometrist. This coverage is designed to help pay a percentage of associated vision care costs after a member receives vision care.

VSP Choice Network	
Exams	Every 12 months, one exam is covered in full after $10 copay
Prescription glasses **Lenses**- 1 pair covered every 12 months **Frames**- covered up to $150 every 24 months; 20% off amount over allowance	$10 copay • Single lenses • Lined bifocal lenses • Lined trifocal lenses • Lenticular lenses • Polycarbonate lenses for dependent children under age 18
Lens enhancements	Standard progressive lenses covered once every 12 months with $0 copay Most other popular lens enhancements are covered after a copay
Elective contacts	Covered up to $150 every 12 months. Contact lenses can be chosen instead of glasses.
Contact fitting and evolution	Up to $60 copay
Necessary contacts	Covered in full after $10 copay every 12 months Contact lenses can be chosen instead of glasses

This can vary based on state laws and provider location. Savings may not apply at participating retail chains.

Group Term Life & Accidental Death & Dismemberment (AD&D)

Life insurance will pay your beneficiary a lump-sum payment if you should pass away while covered under the term of this policy. The money can help your family pay for basic living expenses, final arrangements, tuition and more. AD&D insurance is also provided, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Protect what means the most to you, the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries.

Group Life	Benefit	Guaranteed issue	Benefit reduction
You	$41,000	If you're under 70: $250,000 If you're 70 or older: The lesser of $250,000 or the amount with the prior carrier	35% reduction at age 65, with an additional 15% reduction at age 70

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%
Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	$10,000
Repatriation - If you die at least 100 miles from your home	Up to $2,000

Short-Term Disability

Help protect one of your most valuable assets - the ability to earn an income. If you're temporarily disabled and can't work for a short amount of time, you can rely on short-term disability insurance to replace a portion of your weekly income.

Your primary weekly benefit is $500 with a maximum of 66 2/3% of your pre-disability earnings minus other income sources. Other income sources could include but aren't limited to Social Security, other earnings, worker's compensation, state disability (if applicable), and salary continuance. Your benefits are determined by your base wage.

Short – Term Disability Coverage	
Primary weekly benefit	$500 with a maximum of 66 2/3% of your earnings
Benefit amount	Your primary weekly benefit minus other income sources
Elimination period	Benefits begin on the 1st day for accidents and the 8th day for sickness
Benefit payment period	Up to 26 weeks
Maternity	Pregnancy and childbirth are treated the same as any other disability

Voluntary Term Life & Accidental Death & Dismemberment (AD&D) – Employee Paid

Protect what means the most to you, the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries. More details are in your Principal booklet.

Group Life	Benefit	Minimum	Guaranteed issue	Maximum	Benefit reduction
You	Select a benefit in increments of $10,000	$10,000	If you're under 70: $150,000 If you're 70 or older: $10,000	$300,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your spouse	Select a benefit in increments of $5,000	$5,000	If your spouse is under 70: $30,000 If your spouse is 70 or older: $10,000	$150,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your child(ren)	Options: $5,000 or $10,000				

Voluntary AD&D

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%
Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	$10,000

Planning For Retirement

What does retirement look like for you? Whatever your vision for retirement is, it's important to plan ahead so you have the income you'll need in the future.

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 401(k) savings plan allows you to save for retirement on a pretax basis. You can begin contributing to the plan through pretax payroll deductions as soon as you become eligible.

Increase Your Retirement Savings with a 401(k)

- Long Falls Paperboard will match your contribution 50% for each dollar you contribute to the plan, up to the first 6%.
- Automatic enrollment is 6% unless you opt out. Automatic increase is 1% per year up to a maximum of 10%
- You can contribute using convenient payroll deductions up to the IRS limit of $22,500 per year.
- You can change the amount of your contributions or stop your payroll contributions at any time.
- You can decide how to invest your 401(k) or allow the plan to choose for you.
- Are you age 55 or older? You can make an additional "catch-up" contribution of up to $7,500 to save even more.

Vanguard®

My.vanguardplan.com

866-794-2145

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Medicare Navigation & Tuition Repayment Assistance offered by The Richards Group

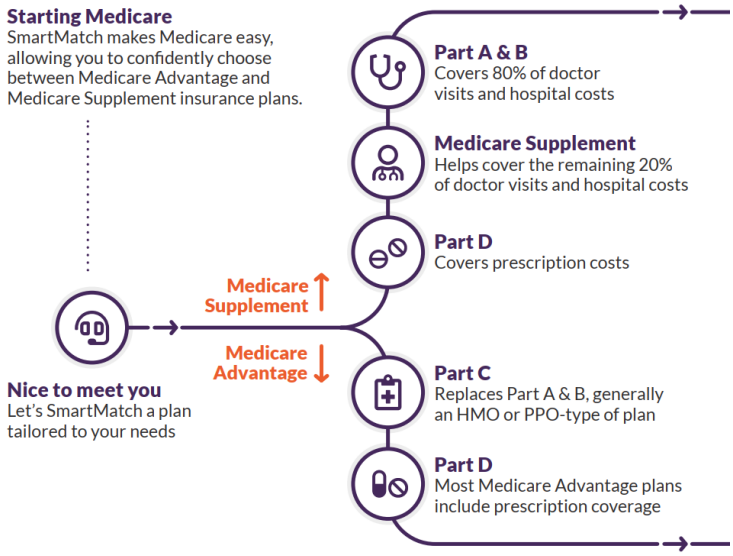
Medicare Navigation: SmartConnect

Medicare is very complex, and it is important that you have an advocate who can provide you the proper Medicare education and guidance.

There are different paths you can choose in Medicare plans, and it can be very time consuming and difficult to filter through these options yourself. It is important that you find the appropriate plan in your area that best fits your medical needs and is within your financial budget.

The Richards Group is partnered with SmartConnect™ an exclusive, no-cost program created specifically to connect Medicare-eligible working adults to the world of Medicare benefits. This resource will simplify the Medicare enrollment process by providing you the education, plan evaluation and enrollment assistance:

Visit SmartConnect:
https://gps.smartmatch.com/therichardsgroup
or scan the QR code



Tuition Repayment Assistance: GradFin

The Gradfin Tuition Repayment Assistance Program is designed to help employees pay back student loan debt and improve their financial well-being. Consultation services provided through GradFin are provided to employees free of charge. Their services include:

- One-on-one education consultations to review your current loan status and discuss personalized payoff options to save on your loans
- Competitive interest rate reduction when you refinance your loans, including up to a $300 bonus if you refinance with GradFin.
- The lowest interest rates in the industry through their lending platform which is made up of ten lenders to maximize the chances that you will be approved for a new loan.

To schedule a one-on-one consultation visit:
www.gradfin.com/platform/trg/ or scan the QR code

Glossary

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Annual Maximum Benefit: A cap on the benefits your insurance Long Falls Paperboard will pay in a year while you’re enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you’ve paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you’ve paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance Long Falls Paperboard pays the rest. Your deductible starts over each plan year.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guaranteed issue amount, you will have to complete an Evidence of Insurability form and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don’t contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn’t include your monthly premiums. It also doesn’t include anything you may spend for services your plan doesn’t cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Contact Information

Coverage	Administrator	Contact	
Medical	Blue Cross Blue Shield of Vermont	800-247-2583	www.bcbsvt.com
Dental	Principal	800-247-4695	www.principal.com
Vision	Principal	800-877-7195	www.principal.com
Health Savings Account	Health Equity	866-346-5800	www.healthequity.com
Ancillary Benefits	Principal	800-843-1371	www.principal.com
401 (k) Retirement	Vanguard	866-794-2145	my.vanguardplan.com
Discount Marketplace	Benefithub	https://longfallspaperboard.benefithub.com “CREATE AN ACCOUNT” Referral Code: SR8ZJX Enter Your Email Address “Create Account” Complete Account Registration	

Women's Health and Cancer Rights Act Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), 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 at 1-800-247-2583 for more information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, please refer to the Summary of Benefits and Coverage for details about your plan's deductibles and coinsurance. If you would like more information on WHCRA benefits, call your plan administrator 1-800-247-2583.

Newborns' and Mothers' Health Protection Act

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

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.dol.gov/agencies/ebsa/about-ebsa/ask-a- question/ask-ebsa 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.

ALABAMA – Medicaid

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

ALASKA – Medicaid

The Alaska Health Insurance Premium Payment Program
Website: http://myakhipp.com
Phone: 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

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+)

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://hcpf.colorado.gov/child-health-plan-plus
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/programs/third-party-liability/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: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid
Phone 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov
Phone: 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: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov
Phone: 877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: https://ldh.la.gov/subhome/1 or http://www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium application: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 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: 800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

Website: https://dhhs.ne.gov/pages/accessnebraska.aspx
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 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: 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
CHIP Phone: 800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid
Phone: 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: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website:
https://oklahoma.gov/ohca/insureoklahoma.html
Phone: 888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov
Phone: 800-699-9075

PENNSYLVANIA –Medicaid

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

RHODE ISLAND– Medicaid and CHIP

Website: https://eohhs.ri.gov/
Phone: 855-697-4347, or401-462-0311
(Direct RIte ShareLine)

SOUTH CAROLINA –Medicaid

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

SOUTH DAKOTA– Medicaid

Website: https://dss.sd.gov/medicaid/Eligibility
Phone: 888-828-0059

TEXAS –Medicaid

Website:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH –Medicaid and CHIP

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

VERMONT– Medicaid

Website: https://dvha.vermont.gov/members
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON –Medicaid

Website: https://www.hca.wa.gov
Phone: 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: 855-MyWVHIPP
(855-699-8447)

WISCONSIN – Medicaid and CHIP

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

WYOMING –Medicaid

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

To see if any other states have added a premium assistance program since July 31, 2022, 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 https://www.cms.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

You may have other options available to you when you lose group health coverage. 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.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get 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, 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 other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

You're protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

When balance billing isn't allowed, you also have the following protections:

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

Employee Premiums: Weekly Cost

Medical				
	BCBSVT Gold	BCBSVT Silver	BCBSVT Select CDHP Gold	BCBSVT Select CDHP Silver
Employee	$76.42	$38.49	$64.61	$30.45
Employee + Spouse	$152.84	$76.98	$129.22	$60.91
Employee + Children	$147.49	$74.28	$124.70	$58.77
Family	$214.74	$108.16	$181.56	$85.57
Dental				
Employee			$3.10	
Employee + One			$6.13	
Employee + Two			$12.15	
Vision				
Single			$1.28	
Two Adults			$2.85	
Parent + Child(ren)			$3.09	
Family			$5.01	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