# Annual Notices Packet 2023-2024

Employers that sponsor group health plans should provide certain benefit notices in connection with their plans’ open enrollment periods. Some of these notices must be provided at open enrollment time, such as the summary of benefits and coverage (SBC).

Other notices, such as the Women’s Health and Cancer Rights Act (WHCRA) notice, must be distributed annually.

Although these annual notices may be provided at different times throughout the year, your employer has chosen to include them in their open enrollment materials for administrative convenience.

[Women’s Health and Cancer Rights Act Notice 2](#_Toc115697599)

[Newborns’ and Mothers’ Health Protection Act 2](#_Toc115697600)

[Premium Assistance Under Medicaid and the Children’s Health Insurance Program 3](#_Toc115697601)

[New Health Insurance Marketplace Coverage Options and Your Health Coverage 7](#_Toc115697602)

[Your Rights and Protections Against Surprise Medical Bills 8](#_Toc115697603)

# 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 (BCBS) or 1-800-348-8515 (MVP) 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 (BCBS) or 1-800-348-8515 (MVP).

# 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 theChildren’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 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](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.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa](https://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](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](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhealth.alaska.gov%2Fdpa%2FPages%2Fdefault.aspx&data=05%7C01%7CBerman.Nathaniel%40dol.gov%7Ca5722ebf007e4847fe8808da69a45fb9%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C637938452103798639%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=A5Fggwg0lR2c%2FOwofWNVpVk8b5%2FFX1kaOQNuuEwAAAE%3D&reserved=0)

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](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](http://www.in.gov/fssa/hip/)

Phone: 877-438-4479

All other Medicaid

Website: [https://www.in.gov/medicaid](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](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](https://kidshealth.ky.gov/Pages/index.aspx)

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](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)

Medicaid Phone: 609-631-2392

CHIP Website: [http://www.njfamilycare.org](http://www.njfamilycare.org/default.aspx)

CHIP Phone: 800-701-0710

NEW YORK – Medicaid

Website: [https://www.health.ny.gov/health\_care/medicaid](https://www.health.ny.gov/health_care/medicaid/)

Phone: 800-541-2831

NORTH CAROLINA – Medicaid

Website: [https://medicaid.ncdhhs.gov](https://medicaid.ncdhhs.gov/)

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: [http://www.nd.gov/dhs/services/medicalserv/medicaid](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, or 401-462-0311
(Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

Website: https://dss.sd.gov/medicaid/[Eligibility](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](https://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](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 Optionsand 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](https://www.healthcare.gov/glossary/out-of-pocket-costs/), like a [copayment](https://www.healthcare.gov/glossary/co-payment/), [coinsurance](https://www.healthcare.gov/glossary/co-insurance/), or [deductible](https://www.healthcare.gov/glossary/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.