

SCHOOLS HEALTH INSURANCE FUND



2026 - 2027 OPEN ENROLLMENT GUIDE

Through membership in the Schools Health Insurance Fund (SHIF), your employer offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your benefit options through your employer's membership with the Fund and choose the best coverage for you and your family.



IT'S TIME TO REVIEW YOUR BENEFITS FOR 2026-2027

ENROLLMENT DEADLINE:
May 8, 2026

THE FUND WILL HOLD A PASSIVE OPEN ENROLLMENT

"Passive" open enrollment means if you are currently enrolled in benefits, your current plan elections will remain in place from July 1, 2026 through June 30, 2027, unless you elect to make a change.

To obtain enrollment forms to make a change, please contact your Benefits Administrator.

WHAT IS THE SCHOOLS HEALTH INSURANCE FUND?

The SHIF was established to provide public school districts with a platform to purchase health insurance covered in a shared-services environment.

ENROLLMENT INSTRUCTIONS

You must complete an enrollment form and return it to your benefits administrator by **May 8, 2026** if:

- You wish to add coverage for an eligible dependent;
- You are currently enrolled and wish to terminate coverage for yourself or a covered dependent;
- You have previously declined benefits but would like to now enroll for coverage for yourself and your eligible dependent(s) if applicable, effective July 1, 2026;
- You are an employee, non-Medicare retiree, or COBRA participant that is currently enrolled in coverage and you wish to change your current plan elections, effective July 1, 2026.

QUALIFIED LIFE EVENTS

You cannot make changes to your elections or covered dependents during the plan year unless you experience a **qualified life event**. To make a change, you must contact your personnel department **within 60 days of the event**. Qualified life events include:

- Marriage or divorce
- Loss or reduction of coverage for you or your spouse
- Birth or adoption of a child
- Death of a covered dependent

BENEFIT CONTACTS & RESOURCES



QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE
ELIGIBILITY, ENROLLMENT, PLAN OPTIONS, CONTRIBUTIONS, QUALIFYING LIFE EVENTS, ETC.		Please contact your entity's Human Resources/Benefits Office	
MEDICAL BENEFITS - AETNA Benefit questions, claims, locating a provider, printing new ID cards	Aetna	800-370-4526	www.aetna.com
MEDICAL BENEFITS - AMERIHEALTH Benefit questions, claims, locating a provider, printing new ID cards	AmeriHealth Administrators	844-352-1706	www.myahabenefits.com
PRESCRIPTION DRUG BENEFITS	Express Scripts	800-467-2006	www.express-scripts.com
DENTAL BENEFITS		Please see reverse side of your ID card	

All plans above may not be offered by your employer. If you are not sure in which plan you are enrolled and/or eligible to elect, please refer to your ID card or contact your employer.

HealthyLearn[®]

HealthyLearn is a health and wellness resource available to all HIF members that provides a wealth of health and wellness information in a simple, straightforward manner.



ADDITIONAL FEATURES INCLUDE:

- Health Resources
- Health Tip-of-the-Day
- Symptom Checker and HealthTrackers
- Wellness and Disease Management
- Nutrition and Weight Loss
- And much more!

Learn more and get started on your path to wellness today by visiting Healthy Learn at healthylearn.com/connerstrong

HOW TO FIND IN-NETWORK PROVIDERS



FIND PARTICIPATING AETNA PROVIDERS

- **STEP 1:** Visit Aetna’s website at www.aetna.com
- **STEP 2:** At the middle of the webpage on the right, click on **“Find a Doctor”**
- **STEP 3:** On right side of page under **Guest**, select **“Plan from an employer”** (1st choice on the list)
- **STEP 4:** Under **Continue as Guest**, enter your zip code, city, state or county
- **STEP 5:** You will be asked to **“Select a Plan”**, please refer to your ID card for correct plan selection

If You’re Enrolling in...	DocFind plan selection is...
Aetna Choice POS II Plans (POS II, NJEHP)	Category Heading: Aetna Open Access Plans Plan Name: Aetna Choice POS II (Open Access)
Aetna HMO	Category Heading: Aetna Standard Plan Plan Name: HMO
Aetna Garden State Plan	Category Heading: Aetna Whole Health Plan Plan Name: (NJ) Aetna Whole Health New Jersey Choice POS II

FIND PARTICIPATING AMERIHEALTH ADMINISTRATORS PROVIDERS

- **STEP 1:** Visit the AHA website at www.myahabenefits.com
- **STEP 2:** At the bottom of the webpage on the right, click on **“Find a Doctor”**
- **STEP 3:** Search providers by category, specialty, and much more!

Once you search for a list of doctors, you can click on the provider’s name and then view information such as:

- Credentials
- Hospital affiliations
- Reviews from other members
- Office house
- Gender
- Specialty
- Language spoken
- National Provider Number (NPI)

Easily compare up to five doctors and hospitals at once. You can compare specialties, education, board certifications, quality reviews, and more!

Please Note: If searching for a Garden State Plan Provider, for accurate results, fill in your location and search for the Local Value Network at the top of the page.

DIGITAL PRESCRIPTION ID CARDS



CONNECT TO YOUR DIGITAL PRESCRIPTION ID CARD

Anytime. Anywhere.

No more digging through cards at the pharmacy counter. Easily create your digital profile at www.express-scripts.com or on the Express Scripts mobile app to gain instant access to your prescription ID card.

You can view your card online or on the app, download it to your digital wallet, or even print a card from the Express Scripts site.

A digital profile also helps you connect to:

- Lower-cost medication options
- Nearby, in-network pharmacies
- More ways to manage your medications

DON'T WAIT UNTIL YOU'RE AT THE PHARMACY

Connect to your ID card today!

Visit www.express-scripts.com to download the Express Scripts mobile app to create your profile in a few easy steps. You can also text **JOIN** to **69717** for a link to the Express Scripts registration page.

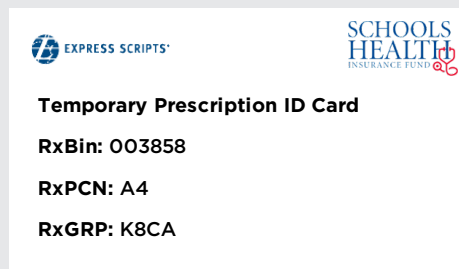
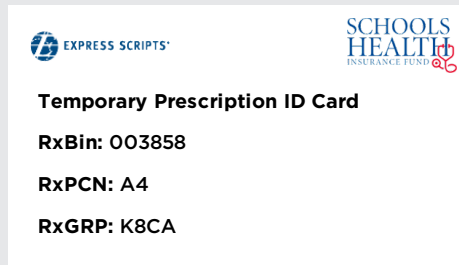
Scan the QR code to
download the mobile app
from the App Store or
Google Play.



TEMPORARY ID'S

For the temporary ID's below, when visiting a pharmacy, make sure to ask the pharmacist to do the following when submitting a claim:

- Enter Bin Number
- Enter Processor Control Number
- Enter Rx Group Number
- Enter 9-digit member ID number (Employee SSN)
- Enter the members date of birth



** This is a temporary sample ID card. Please visit the Express Scripts website or download the Express Scripts app for your actual ID card.*

UNDERSTANDING YOUR PRESCRIPTION DRUG PROGRAM

HOW TO GET STARTED WITH EXPRESS SCRIPTS HOME DELIVERY

Contact Express Scripts

- For transfers from a retail pharmacy, sign in at www.express-scripts.com, or
- Speak with a prescription benefit specialist by calling **800.698.3757** (Monday - Friday, 7:30 am to 5:00 pm, CT)

DIY - Do It Yourself

- Complete a home delivery order form
- Get a 90-day prescription from your doctor plus refills for up to one year (if applicable)
- Include your home delivery copayment (acceptable forms include credit/debit card, check, or money order)
- Mail your form and prescription to Express Scripts at the address on the form. You can also have your doctor ePrescribe or fax your prescription.

Your medication will arrive by mail within 8 days of receipt of your initial prescription.

RECOMMENDED DRUG DOSING

Your prescription drug plan includes a program that reviews prescribed drug quantities to ensure your medications are being safely prescribed in accordance with FDA guidelines.

The drug quantity review program provides the medications you need for good health, while make sure the dose you are receiving is considered safe.

For instance, if FDA guidelines allow one pill/dose per day, the program will allow a maximum of 30 pills for a month's supply. This quantity will give you the right amount to take for a daily dose considered safe and effective.



SAVE TIME AND MONEY!

AMERIHEALTH ADMINISTRATORS COVERED MEMBERS

Avoid long waits at the Emergency Room and reduce your out-of-pocket costs by utilizing Virtual/Telephonic Office Visits and Urgent Care Centers for ailments that are not life-threatening. Both of these options provide fast, effective care - when you need care fast.

KNOW WHERE TO GET CARE

Visits to the ER can be very costly, so before you go to the ER, consider whether your condition is truly an emergency or if you can receive care from Virtual/Telephonic Office Visits or at an Urgent Care Center instead.

VIRTUAL VISITS/ TELEPHONIC OFFICE VISITS	URGENT CARE CENTER	EMERGENCY ROOM
<ul style="list-style-type: none"> • Cold/Flu • Allergies • Animal/insect bites • Bronchitis • Skin problems • Respiratory infection • Sinus problems • Strep throat • Pink eye/eye irritation • Urinary issues • Dermatology • Behavioral health 	<ul style="list-style-type: none"> • Allergic reactions • Bone x-rays, sprains or strains • Nausea, vomiting, diarrhea • Fractures • Whiplash • Sports injuries • Cuts and minor lacerations • Infections • Tetanus vaccinations • Minor burns and rashes 	<ul style="list-style-type: none"> • Heart attack • Stroke symptoms • Chest pain, numbness in limbs or face, difficulty speaking, shortness of breath • Coughing up blood • High fever with stiff neck, confusion, or difficulty breathing • Sudden loss of consciousness • Excessive blood loss



HOW TO ACCESS TELEMEDICINE 24/7

Virtual Office Visits

Please note that Telemedicine services are different from virtual/telephonic office visits with your participating provider.

Virtual/Telephonic Office Visits with your participating provider may require a copay or coinsurance in accordance with your specific health plan. For more information on your cost-share for virtual office visits, please consult your insurance carrier at the customer service number on the back of your ID card.

TELADOC

- Call **855.835.2364**
- Visit **www.teladoc.com**
- Go to **teladoc.com/mobile** to learn more or download the mobile app from the App Store or Google Play

CVS HEALTH VIRTUAL CARE

AETNA COVERED MEMBERS

YOUR CARE. YOUR WAY

Convenient and affordable virtual care wherever you need it

From your therapy appointments to quick care, CVS Health Virtual Care has got you covered. You can use CVS Health Virtual Care in addition to your traditional network of providers. Access is included as part of your medical plan from Aetna, a CVS Health company because **healthier happens together**.

- **On-Demand Care:** Access 24/7 quick care for minor illnesses and injuries
- **Mental Health Services:** Get counseling for things like anxiety and stress, plus psychiatry services for medication management.
- Extend to in-person care when needed at nearby MinuteClinic locations or in-network provider clinics.

GET STARTED TODAY WITH CVS HEALTH VIRTUAL CARE

- Activate your virtual care benefit by visiting www.cvs.com/virtual-care
- Create an account and confirm your details
- Schedule a mental health appointment, or request on-demand care 24/7/365



Scan the QR
code to activate
your virtual
care benefit



CVS MINUTE CLINICS AND HEALTH HUBS



Covered at \$0 or low cost (HDHP) by Aetna and AmeriHealth. Prior to visiting a Minute Clinic or HealthHub, please check with your medical insurer to find out which facilities in your area may be participating with your plan.

CVS MINUTE CLINIC

CVS Minute Clinics offer a broad range of services to keep you and your family healthy. In addition to diagnosing and treating illnesses, injuries, and skin conditions, they provide wellness services including vaccinations, physicals, screenings, and monitoring for chronic conditions.

Highlights of CVS Minute Clinic:

- Located in select CVS pharmacies and Target stores nationwide
- No appointment necessary
- Visits usually last less than 30 minutes
- A record of your visit can be sent to your family doctor
- Open 7 days a week with convenient evening hours

CVS Minute Clinic practitioners can:

- Treat common illnesses, like strep throat, ear ache, pink eye, and sinus infections
- Treat minor injuries and skin conditions
- Provide vaccinations such as flu, pneumonia, and hepatitis A/B
- Treat patients 18 months and older



HEALTH HUB

CVS HealthHUB offers an expanded range of health services and wellness products for everyday care and chronic conditions. To learn more or to find a HealthHUB location, visit [CVS.com/HealthHUB](https://www.cvs.com/HealthHUB).

HealthHUB offers the following services:

- Nutritional counseling
- Durable medical equipment
- A Health Concierge
- Enhanced Minute Clinic service offerings
- Enhanced pharmacist counseling services
- Community programs and meeting spaces



GET TO KNOW GUARDIAN NURSES



Struggling with a healthcare issue? Take advantage of this Union benefit! Our Mobile Care Coordinator RNs, backed by a team of registered nurses, are ready to respond whenever you are struggling with a healthcare issue.

GUARDIAN NURSES CAN:

- **Visit you at home** or in the hospital to assess your care needs
- **Go with you** to see doctors, to ask questions, and to get answers
- **Be your guide**, coach, and advocate for any healthcare issue
- **Make appointments** so you can be seen as quickly as possible
- **Identify providers** for all care needs and second opinions
- **Resolve problems** with billing, claims, and health insurance
- **Get things you need** such as healthcare equipment
- **Provide decision support** when considering treatments or surgery
- **Explain a new diagnosis** to help you make informed decisions

WHO IS ELIGIBLE?

The services of our Mobile Care Coordinator Nurses are available to members of the Schools Health Insurance Fund and their covered dependents. **All services are offered at no charge to you and are confidential.**

To request help from our Mobile Care Coordinator or the team at Guardian Nurses, call 609.703.0623 or 609.414.6093.



Schools Health Insurance Fund

Mobile Care Coordinator[®]

Powered by Guardian Nurses
Healthcare Advocates



MAXIMIZE YOUR BENEFITS



ALWAYS CONSIDER YOUR IN-NETWORK OPTIONS FIRST

You will typically pay less for covered services when providers are in-network with your medical plan. In-network providers agree to discounted fees. You are responsible only for any copay or deductible that is included in your plan design.

The amount you are required to pay out-of-pocket for out-of-network services may be significant.

TO LOCATE IN-NETWORK PROVIDERS

- **Aetna Participants:** Visit www.aetna.com and select “*Find a Doctor*”
- **AmeriHealth Administrators Participants:** Visit www.myahabenefits.com, select “*Members*” and then “*Find a Doctor*”

MAKE SURE YOU ARE USING IN-NETWORK LABS

- **Aetna Participants** may use either **Quest Diagnostics** or **LabCorp** for lab work.
- **AmeriHealth Administrators Participants** must be sure that their providers send all blood work to a **LabCorp** location or other free standing lab. **Quest Diagnostics is not participating in the AmeriHealth Administrators network.**

IN-PATIENT OR OBSERVATION

The difference between *inpatient* and *observation* status is important because benefits and provider payments are based on the status. Patients admitted under observation status are considered outpatients, even though they may stay in the hospital and receive treatment in a hospital bed.

Hospital admission status may affect coverage for services such as skilled nursing. Some health plans, including Medicare, require a three-day hospital inpatient stay minimum before covering the cost of rehabilitative care in a skilled nursing care center. However, observation stays regardless of length, do not count towards the requirement.

A new law requires hospitals to give Medicare patients notice of an observation status within 36 hours. This status determines how the hospital bills your health plan. Even if you are NOT under Medicare, when you or your family arrives at the hospital, you can ask questions like:

- Is the patient’s status *inpatient* or *observation*?
- How long will the hospital stay be?
- Will there be a need for specialized skilled or rehab care after discharged?

Asking these questions throughout the hospital stay is important because hospitals can change the status from one day to the next. You can ask to have the status changed, but it is important to do so while still in the hospital. If necessary, you can request the hospital’s patient advocate for assistance.

LEGAL NOTICES

Availability of Summary Health Information

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 the 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 available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

A paper copy is also available, free of charge, by contacting your employer.

Special Enrollment Notice

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, 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 Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact your Employer.

Patient Protection and Affordable Care Act

Please note: the Fund medical plans are considered compliant with the Patient Protection and Affordable Care Act. There are no annual limits, dependent children can be covered to age 26 and preventive care is covered at 100% with no member cost-sharing and the pre-existing exclusion limitations have been removed.

As new Health Care Reform requirements become effective, the Fund plans will be modified. We are fully committed to complying with all regulations and intend to notify you as soon as possible of any change(s).

Newborns' and Mothers' Health Protection Act Notice

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).

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (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; and
- 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. If you would like more information on WHCRA benefits, please speak with Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility -

ALABAMA - Medicaid
Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

LEGAL NOTICES

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

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://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.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

Health Insurance Premium Payment Program

All other Medicaid

Website: <https://www.in.gov/medicaid/>

<http://www.in.gov/fssa/dfr/>

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

Iowa Medicaid | Health & Human Services

Medicaid Phone: 1-800-338-8366

Hawki Website: <https://hhs.iowa.gov/medicaid/plans-programs/hawki>

Hawki Phone: 1-800-257-8563

HIPP Website: <https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program>

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

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: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Louisiana Medicaid Website: <https://www.lhdh.la.gov/healthy-louisiana>

Medicaid Customer Service Line: 1-888-342-6207

Louisiana Medicaid email: healthy@la.gov

Louisiana Health Insurance Premium Program (LaHIPP) Website:

<https://www.lhdh.la.gov/lahipp>

LaHIPP phone: 1-877-697-6703

LaHIPP email: La.HIPP@la.gov

LaHIPP fax: 1-888-716-9787

LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

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: 1-800-694-3084

Email: HSHIPPProgram@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://dhcnp.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. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

LEGAL NOTICES

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

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: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or

401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

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

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Model General Notice of COBRA Continuation Coverage Rights

Introduction

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

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

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

LEGAL NOTICES

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Central Jersey Health Insurance Fund and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: WEX

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notification of your approved disability must be sent to WEX.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

LEGAL NOTICES

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

WEX Health Inc. 866-451-3399, Monday – Friday, 6 a.m. to 9 p.m. CST

Your Rights and Protections Against Surprise Medical Bills

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-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 balance 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.

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:

- 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.

If you think you've been wrongly billed, contact the federal agency at No Surprises Helpdesk at 1-800-985-3059 or www.cms.gov/nosurprises, your state department of insurance or your medical plan using the member services number listed on your ID card. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

