Benefits Enrollment Guide

October 1, 2024 through
September 30, 2025 Plan Year

POQUOSON CITY
PUBLIC SCHOOLS

MEDICAL | DENTAL | HSA | FSA | EAP | LIFE

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact AssuredPartners. Poquoson City Public Schools has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Web / Email	Phone
Medical Sentara Health	www.sentarahealthplans.com/members	1-877-552-7401 or 757-552-7401 8 a.m. to 6 p.m EST Monday - Friday
Health Savings Account HealthEquity	www.HealthEquity.com	866-346-5800
Dental MetLife Dental	www.metlife.com/mybenefits	800-638-5433
Flexible Spending Accounts Ameriflex	www.myameriflex.com	888-868-3539
Voluntary Group Life/AD&D Insurance Securian Financial	http://varetire.org/members/benefits/life-insurance/index.asp	800-441-2258
Voluntary Worksite Benefits Colonial Life	www.coloniallife.com	800-325-4368 (TDD for Hearing Impaired Customers: 800-798-4040)
Voluntary Benefits Assistance Pierce Group Benefits VA Service Center	www.PierceGroupBenefits.com/PoquosonCityPublicSchools	800-387-5955
Employee Assistance Program (EAP) Sentara Health	www.SentaraEAP.com	800-891-8174
Commonwealth of Virginia 457 Deferred Compensation Plan	http://www.varetirement.org/dcp.html	877-327-5261
Legal Resources of Virginia	www.legalresources.com	800-728-5768
Poquoson Schools Benefits Helpline AssuredPartners Monday-Friday, 8 am - 5:30 pm ET	PoquosonSchools@assuredpartners.com	888-321-8737 Option 3 410-229-8356 (fax)

POQUOSON CITY
PUBLIC SCHOOLS

Welcome to your Employee Benefits!

Poquoson City Public Schools takes into consideration our employees' evolving needs, as well as ensuring a level of security and protection when making decisions regarding the benefits program being offered.

We recognize the important role employee benefits play as a critical component of an employee's overall compensation. We also strive to maintain a benefits program that is competitive within our industry.

This benefits guide, together with other enrollment materials, are provided to help you understand your benefit choices and navigate through the Open Enrollment / New Hire process.

Before you enroll, please read this guide to become familiar with the benefit options. Your decisions will impact your benefit selections and what you pay for these benefits.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Poquoson City Public Schools reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Eligibility

Full time and regular part time employees with a schedule of **30 hours or more per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Newly hired employee, and their eligible dependents, coverage becomes effective on the first of the month following the first pay check.

Eligible Dependents

Your dependents are eligible to participate in Poquoson City Public Schools' benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26.

Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

For all benefits, you must enroll within 30 days from your date of hire.

Pre-Tax Benefits: Section 125

Poquoson City Public Schools' benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

You must notify Human Resources within 30 days from the life event status change in order to make a change in your benefit selections.

Benefit Election Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for **the entire plan year.** You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility;
- other Qualifying Events; such as
  - Entitlement to Medicare or Medicaid. If an employee, spouse or dependent becomes entitled to Medicare or Medicaid, the employee may make a prospective election change to cancel or reduce coverage of self, spouse or dependent. In addition, if an employee, spouse or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the employee may commence or increase coverage of self, spouse or dependent.
  - Judgment, decree or order. A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order that requires health coverage for an employee's child or for a foster child who is a dependent of the employee.
  - Special requirements relating to the Family and Medical Leave Act (FMLA). An employee taking leave under the FMLA may revoke an existing election and make another election for the remaining portion of the period of coverage.

In order to be permitted to make a change of election relating to your health or dental coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health or dental coverage under this Plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

Benefit Election Changes continued

If you experience a Life Event Status Change as defined below:

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to Human Resources. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, contact Human Resources.

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact Human Resources to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

Medical Coverage

Poquoson City Public Schools offers employees the option to select the medical coverage through Sentara Health that best meets their personal and family needs at varying price points of affordability.

For **employees hired on or before June 30, 2017**, there are two options for coverage:

- Sentara Plus Equity 3200/0%
- Sentara POS 500/25/20%

For **employees hired on or after July 1, 2017**, there is one option for coverage:

- Sentara Plus Equity 3200/0%

Coverage under both plans include comprehensive medical care and prescription drug coverage. Your new Sentara Health plans are "open access". This means you DO NOT need to have a referral to see a specialist. The next page gives a comparison summary of the medical plans offered.

Point of Service Plan (POS)

Under the POS plan, you have the choice of selecting a Primary Care Physician (PCP) to coordinate your care or you can coordinate your care yourself. A PCP is a doctor who specializes in family, general, internal or pediatric medicine. When coordinating care, you generally pay less out-of-pocket if you allow your PCP to coordinate your care and your services are received from an in-network provider. When utilizing non-participating providers you will have greater out-of-pocket expense.

Qualified High Deductible Health Plan (HDHP)

A HDHP provides coverage after you meet the Plan's deductible. Under the Plan, all expenses, except preventive care expenses, are subject to the plan's deductible. This includes prescription drug coverage. With this coverage, you take control of how your healthcare dollars are spent.

Sentara Health encourages, but does not require you to select a primary care physician; therefore, you make your own decisions about your doctors, your care and your costs. Further, coverage is available both in and out-of-network. By staying in-network, you take advantage of special rates and discounts that have been negotiated with participating doctors and facilities which means a higher level of reimbursement and less out-of-pocket cost to you and your family members.

Health, Wellness and Support for You

Included in your plan are valuable discounts through our **Gym Network 360** program. Discounts are available on gym memberships, as well as nutrition, weight loss and healthy eating programs. For access to Gym Network 360, visit our Health and Wellness Discounts page at **www.sentarahealthplans.com/members**.

Sentara Health includes **MyLife MyPlan** – a suite of online tools and resources to help you with such things as weight management, smoking cessation, or more. Some of the programs and tools included in your plan are:

- An interactive Digital Health Assistant (DHA)
- Personal Health Assessment
- Diabetes Prevention Program
- Individual Self-Paced Programs such as Yoga, Tai Chi, Meditation, and Get off Your Butt (our smoking cessation program) to name a few
- Educational publications on a variety of health related topics such as nutrition, exercise, stress management, smoking cessation, and other opportunities for improving health.
- Reminders for things such as preventive care screenings and services.

The plan also includes Virtual Visits through **MDLIVE**. Telemedicine services are covered under your plan and can be accessed through your smart phone, tablet or computer. Board certified doctors can diagnose minor illnesses and can write prescriptions when necessary.

Medical Plan Comparisons

	Sentara Plus Equity 3200/0%		Sentara POS 500/25/20%	
	IN-NETWORK, YOU PAY:	OUT-OF-NETWORK, YOU PAY:	IN-NETWORK, YOU PAY:	OUT-OF-NETWORK, YOU PAY:
Annual Deductible (Individual / Family)	$3,200 / $6,400	$5,600 / $11,200	$500 / $1,000	$1,000 / $2,000
Out-Of-Pocket Maximum (Individual / Family)	$4,000 / $8,000	$8,000 / $16,000	$4,000 / $8,000	$6,000 / $8,000
HSA eligible?	Yes		No	
Preventive Services includes routine physical exams, well-child care, women's preventive health services	No charge	30% AD	No charge	30% AD
PCP Office Visits	0% AD	30% AD	$25	30% AD
Specialist Office Visits	0% AD	30% AD	$50	30% AD
MDLIVE	0% AD	30% AD	$15	30% AD
Diagnostic Test (x-ray)	0% AD	30% AD	20% AD	30% AD
Advanced Diagnostic Imaging (MRI / PET / CAT scans)	0% AD	30% AD	20% AD	30% AD
Urgent Care Centers	0% AD	30% AD	$50	30% AD
Emergency Room	0% AD	Covered as in-network	20% AD	Covered as in-network
Inpatient Hospital Services (facility fee)	0% AD	30% AD	20% AD	30% AD
Outpatient Services (facility fee)	0% AD	30% AD	20% AD	30% AD
Prescription Drugs				
Tier 1 - Selected Generic Retail / Mail Order	$15 / $38 AD	30% AD	$15 / $38	30%
Tier 2 - Selected Brand & Other Generic Retail / Mail Order	$50 / $125 AD	30% AD	$50 / $125	30%
Tier 3 - Non-Selected Brand Retail / Mail Order	$85 / $213 AD	30% AD	$85 / $213	30%
Tier 4 - **Specialty** Retail Only	20% up to $300 AD	30% AD	20% up to $300	30%

AD - after deductible

Mail order is through OptumRx (866-244-9113) and specialty prescription drugs are through Proprium Pharmacy (855-553-3568).

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Summary Plan Description.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

	Employee Monthly Cost	
	Sentara Plus Equity 3200/0%	Sentara POS 500/25/20%
Employee Only	$0.00	$21.50
Employee + Child	$164.00	$231.00
Employee + Children	$169.00	$236.00
Employee + Spouse	$194.00	$282.50*
Family	$358.00	$469.00*

*** If your legal spouse is eligible for medical coverage where he or she is employed and you enroll them in the Sentara POS medical plan, you will pay an additional $100 per month surcharge.** You will be required to complete a Spousal Affidavit, which can be found on our website: **https:/www.poquoson.k12.va.us/careers/employee-information.**

Sentara®

Sentara Well-being Rewards

HEALTHY EMPLOYEES ARE VITAL TO A SUCCESSFUL BUSINESS.

Powered by our partnership with WebMD® Health Services, the Sentara Well-being Rewards program offers a flexible and inclusive solution for employers to engage their workforce in activities that lead to better health outcomes.

Employees are encouraged to complete activities from the list below in an effort to learn more about their overall health while setting attainable and timebound goals to improve it. Activities can be logged and monitored using the WebMD ONE Portal, accessible through the Sentara Health Plans website or mobile app. Rewards for completed activities will be dispersed on a monthly basis with up to **$250*** in rewards for the year.

PROGRAM ACTIVITIES INCLUDE:

Complete a Personal Health Assessment	**$50**
Get Preventive Screenings	
Annual Physical	**$50**
Colorectal Cancer Screening	**$25**
Mammogram	**$25**
Prostate Cancer Screening	**$25**
Skin Cancer Screening	**$25**
Connect with Condition Management	
Diabetes	**$50**
Cardiovascular	**$50**
Respiratory	**$50**
Partners in Pregnancy	**$50**
Explore WebMD ONE (complete all 3)	
Sign Up for a Newsletter	**$25**
View Health Topic	
Find a Recipe	

**Rewards may be considered income and are subject to applicable taxes.*

Complete a Daily Habit (max of 4 for up to $200)	
Asthma	**$50**
Back Health	**$50**
Balanced Living	**$50**
Balance Your Diet	**$50**
CAD	**$50**
COPD	**$50**
Cope with the Blues	**$50**
Diabetes	**$50**
Enjoy Exercise	**$50**
Heart Failure	**$50**
High Blood Pressure	**$50**
Keep Stress in Check	**$50**
Lose Weight	**$50**
Maternal Health (1, 2, or 3)	**$50**
Pregnant Partner Support	**$50**
Quit Tobacco	**$50**
Sleep Well	**$50**
Stay Connected	**$50**
Work Life Balance	**$50**

For more information, visit:
sentarahealthplans.com

Sentara Health Plans is a trade name of Sentara Health Plans, Sentara Health Insurance Company, Sentara Health Administration, Inc., and Sentara Behavioral Health Services, Inc.

Health Savings Account

Health Savings Accounts (HSA's) are financial accounts that you can use to accumulate tax-free funds to pay for qualified health care expenses for you and your eligible dependents, as defined by the Internal Revenue Service. If you enroll in the Sentara Equity POS plan, an HSA account through HealthEquity will automatically be opened for you. Poquoson City Public Schools makes an annual contribution towards an HSA account for employees who enroll in the HSA plan.

	PCPS CONTRIBUTION	
	INITIAL ONE TIME	ANNUAL STARTING YEAR TWO
Individual	$600	$200
Employee + Child	$900	$300
Employee + Children	$1,200	$400
Employee + Spouse	$1,200	$400
Family	$1,200	$400

If you already have a HSA opened with a financial institution, you have the option to transfer your account to HealthEquity. You may wish to consider moving your account to HealthEquity for the best integrated experience with your health plan.

The account acts like a regular savings account with a debit card and accrues interest. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

HSA Advantages

- The money in your HSA always belongs to you. Any money you haven't spent at the end of the plan year will stay in your account—you do not have to "use it or lose it" during the plan year, as you do with a health care FSA.
- At age 65, monies can be used for non-eligible medical expenses with no penalty.
- You can use monies in your account to pay for eligible medical expenses for all family members – even if they are not on your plan!
- When you retire or leave Poquoson City Public Schools, you could use the money in your HSA to pay for COBRA coverage, Medicare premiums and out-of-pocket expenses, or long-term care insurance.

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year and not enrolled in Medicare, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Only High Deductible Health Plan participants are eligible.

	2024 PLAN YEAR IRS CONTRIBUTION LIMITS
Single	$4,150
Family	$8,300
Catch-Up	$1,000

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a high deductible health plan (HDHP).
- You have no other health coverage or Health Care Flexible Spending Account.
- You are not enrolled in Medicare Part A or Part B.
- You cannot be claimed as a dependent on someone else's tax return.
- You are not active in the military and not receiving health benefits under TRICARE.
- You are a U.S. resident and not a resident of Puerto Rico or American Samoa.
- You have not participated in Veterans benefits within the last 3 months. (Employee must wait at least three (3) months after last receiving VA benefits before they are eligible to elect and open an HSA account.)

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) offer another way to save money on health care and dependent care expenses. You may submit expenses incurred by any of your dependents, whether or not they are covered by the insurance plans you have through your employer. Employees need not be enrolled in the medical plan to participate in FSAs.

If you enroll, you fund the accounts via a payroll deduction each pay period. Money that you contribute to your FSAs is not subject to social security taxes, federal, and in most cases, state income taxes.

Ameriflex is the FSA Administrator. Ameriflex Representatives are available at 888-868-3539. You may also contact Pierce Group Benefits Virginia Service Center at 888-387-5955 for assistance. To check the status of your account or file a claim, register at www.myameriflex.com or download the Ameriflex mobile app.

HCFSA Annual Contribution Limit:
$3,200

Health Care Flexible Spending Account (HCFSA)

Federal regulations do not allow participation in a HDHP with HSA and this type of account. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being.

LPFSA Contribution Limit:
$3,200

Limited Purpose Flexible Spending Account (LPFSA)

Limited Purpose FSAs (LPFSA) are available for employees enrolled in the High Deducible Sentara Equity Plus plan. Limited purpose FSA can be used for qualified dental and vision expenses.

DCFSA Annual Contribution Limit:
$5,000
Or $2,500 if you are married and file a separate tax return.

Dependent Care Flexible Spending Account (DCFSA)

You may use pre-tax dollars from your DCFSA to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.

Employee Assistance Program

We all need help with life's challenges now and then. Whether it's a difficult situation affecting your home life or stress interfering with your work, SentaraEAP is there for you and your immediate family members. You do not have to be enrolled in the medical plan in order to take advantage of the EAP. This benefit is provided by your employer at no cost to you.

When you find yourself in need of some professional support to deal with personal, work, financial or family issues, the Employee Assistance Program (EAP) can help. You and your household members are eligible for up to 5 visits for each personal situation, as needed. Some of the various topics as part of the program include:

- Relationships
- Work-related concerns
- Stress, anxiety, and depression
- Children/Adolescents
- Eldercare
- Grief/Loss
- Anger Management
- Personal development
- Substance abuse

To contact Sentara EAP, call toll-free at **(800) 899-8174** or go online: **www.SentaraEAP.com**

Plan Cost: 100% Employer Paid

Dental Coverage

MetLife

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

Register at **www.metlife.com/mybenefits** to access a personalized self-service site for members to access benefit plan information, claim status, EOB history and locate a network provider.

PDP PLUS NETWORK	MetLife Dental	
	IN-NETWORK	OUT-OF-NETWORK *
Annual Maximum	$2,000 per person	
Plan Year Deductible per individual/family	$50/$150 applies to Type B and C services only	
Type A Preventive Services (deductible waived) include oral exam, x-rays, cleanings, sealants	Plan pays 100%	Plan pays 100%
Type B Basic Services include oral surgery, fillings, root canal	Plan pays 80%	Plan pays 80%
Type C Major Services include crowns, bridges, dentures, implants	Plan pays 50%	Plan pays 50%
Type D Orthodontia Coverage for eligible adults and children up to age 26	Plan pays 50%, up to maximum lifetime benefit of $2,000 per person	Plan pays 50%, up to maximum lifetime benefit of $2,000 per person

*** Out-of-Network Providers & Balance Billing -** Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.

Summaries are for informational purposes only. For specific benefit information, please refer to the applicable Summary Plan Description.

	Employee Monthly Cost
	MetLife Dental
Employee Only	$32.56
Employee + 1	$61.79
Employee + 2 or more dependents	$110.24

Commonwealth of Virginia 457 Deferred Compensation Plan

Poquoson City Public Schools participates in the Commonwealth of Virginia's 457 Deferred Compensation Plan. This plan allows you to save for retirement on a tax-deferred basis through convenient payroll deductions. Your contributions and any earnings are tax-deferred.

There are two types of contributions you may make to your Commonwealth of Virginia 457 Plan:

Pre-tax contributions – you pay taxes on these contributions later, which lowers your taxable income now.

Roth (after-tax) contributions – you pay taxes on these contributions now and make tax-free withdrawals later, as long as certain criteria are met. (Virginia Retirement System Hybrid members are not eligible to make Roth contributions.)

The plan offers a variety of investment options. You do not have to take your money out of the Commonwealth's 457 Deferred Compensation Plan when you retire or terminate employment. You can leave your money in the plan until you are age 70 ½, when you may be required to take minimum distributions.

Visit **http://www.varetirement.org/dcp.html** for more information. You may also call toll-free at **877-327-5261**.

Optional Group Life Insurance

If you are covered under the Virginia Retirement System Group Life Program, you may purchase additional coverage for yourself through the Optional Group Life Insurance Program through Securian Financial. If you elect optional group life insurance coverage, you may also cover your spouse and dependent children. Optional group life insurance provides benefits for natural and accidental death or dismemberment. You pay the premiums through payroll deduction.

If you enroll in the Optional Group Life Insurance Program within 31 days of your employment date or a qualifying life event, you are not required to provide evidence of insurability. However, you will be required to provide evidence of insurability if you apply and/or wish to add your spouse or dependent children after 31 days from your employment date or qualifying life event, you wish to purchase more than $375,000 in coverage for yourself, you wish to increase your coverage, or your spouse's insurance amount is more than half your salary.

Plan Cost: 100% Employee Paid

For more information please visit **http://varetire.org/members/benefits/life-insurance/index.asp** or contact Securian Financial toll-free at **800-441-2258**.

Legal Resources of Virginia

Poquoson City Public Schools will continue to offer employees the opportunity to enroll in an employee legal plan through Legal Resources of Virginia. The Legal Resources Comprehensive Legal Plan provides 100% coverage for you, your spouse and qualifying dependent children for a broad range of legal services, protecting you and your family from the high cost of attorney fees. Coverage is provided for many common legal needs, such as:

- Legal advice and consultation
- Wills and estate planning
- Purchase, sale or refinance primary residence
- Family law
- Traffic violations
- Civil actions

For more information, contact Legal Resources of Virginia toll-free at **800-728-5768** or online at **www.LegalResources.com**.

Plan Cost: 100% Employee Paid

	Employee Monthly Cost
Legal Resources	$18.50

Voluntary Worksite Plans

Pierce Group offers employees the opportunity to purchase additional benefit plans for:

- Vision
- Disability
- Life
- Accident
- Cancer
- Critical Illness
- Hospital Protection

For more information, please visit **www.piercegroupbenefits.com/poquosoncitypublicschools**. You may also contact Pierce Group Benefits Virginia Customer Service Center at **800-387-5955**, open Monday - Friday from 8:30 AM - 600 PM.

Plan Cost: 100% Employee Paid

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

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.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

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 preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Elimination Period: Elimination period is the length of time between when an injury or illness begins, and receiving benefit payments from an insurer.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Vesting: If you participate in an employers 403(b) retirement plan you become fully vested -- or entitled to the contributions your employer has made to the plan, including matching and discretionary contributions -- after a certain period of service with the employer.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families**.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any employer contribution makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See **https://www.healthcare.gov/have-job-based-coverage/**).

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: **healthcare.gov**).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit **healthcare.gov** or call **800-318-2596**.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices continued

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

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

IIf 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, 2024. Contact your State for more information on eligibility –

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

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

CALIFORNIA – Medicaid
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 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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

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

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

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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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

MAINE – Medicaid
Enrollment Website:
https://www.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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: 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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
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 RIte 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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

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

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
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, 2024, 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

POQUOSON CITY
PUBLIC SCHOOLS

Benefits Help: 888-321-8737 Option 3 PoquosonSchools@assuredpartners.com