SMCCCD

HEALTH & WELFARE PLAN

EMPLOYEE PLAN SUMMARY

February 1, 2013

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PLAN INFORMATION

Plan Name:	SMCCCD Health & Welfare Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	January 1 through December 31 of the same calendar year
Effective Date of this Employee Plan Summary:	February 1, 2013
Original Effective Date of Plan:	February 1, 1965
Funding Method:	Funded through fully-insured contracts and self-insured arrangements
Source of Contributions:	From SMCCCD's general assets and Employee contributions, when required
Plan Sponsor and Plan Administrator:	San Mateo County Community College District 3401 CMS Drive San Mateo, CA 94402 (650) 358-6767
Plan Sponsor's Employer Identification Number:	94-3084147
Contract Administrator for IRC Section 125 Plan:	Payflex Systems USA, Inc. 10802 Farman Drive, Suite 100 Omaha, NE 68145

Grandfathered Status

This Plan believes its Component Health Plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (ACA). As permitted by ACA, grandfathered health plans can preserve certain basic health coverage already in effect when ACA was enacted and may not include certain consumer protections applicable to other plans. However, grandfathered health plans must comply with certain other consumer protections. Questions regarding which protections do and don't apply to grandfathered health plans and what might cause a plan to lose grandfathered status can be directed to the Plan Administrator at:

San Mateo County Community College District
attn: Human Resources Representative
3401 CMS Drive, San Mateo, CA 94402
(650) 358-6827

You may also contact the U.S. Department of Health and Human Services at http://www.healthcare.gov/.

INTRODUCTION

San Mateo County Community College District (SMCCCD) maintains the SMCCCD Health & Welfare Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to, its eligible employees, their spouses and eligible dependents.

These benefits are provided under various insurance contracts entered into between SMCCCD and insurance companies or service providers (issuers) as well as through self-insured plans funded by the general assets of SMCCCD.

The benefit plans offered under this Plan and their contract issuers or contract administrators are listed in Appendix A. Detailed information on the benefits listed in Appendix A may be found in the insurance contracts, evidence of coverage, or official plan documents for each benefit (Plan Documents).

This document, together with the Plan documents for each benefit, constitutes the Employee Plan Summary for the Plan. If the terms of this Employee Plan Summary conflict with the terms of the related documents, the terms of the related documents will control, unless superseded by applicable law.

Certain of the benefits provided by this Plan are health plans and thereby subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including regulations affecting the maintenance, creation or use of Protected Health Information (PHI) (as that term is defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the Plan for a description of how your medical information may be used and disclosed and how you can get access to this information.

Specific Plan Information

(a) **Eligibility Rules.** Please refer to Appendix C of this Employee Plan Summary to determine your eligibility for participating in each particular benefit program. The specific Plan Documents will also define eligible dependents (if applicable) and the terms under which you may participate (including the definition of an eligible employee and a description of any waiting period which may precede the date your coverage begins).

(b) **Cessation of Participation.** Unless otherwise stated in the Plan Document your coverage will cease upon the earliest of the following:

1) the date the Plan is terminated;

2) the date your eligible class is eliminated;

3) the date you cease to be a member of an eligible class; or,

4) the date you cease to pay any required contributions toward the cost of the Plan.

(c) **Benefits Provided.** Each Plan Document will contain a complete description of the benefits available and any limitations or exclusions applicable to those benefits.

(d) **Contributions.** SMCCCD at its discretion may require employee contributions as a condition of participation in any particular benefit plan.

Additional Health Plans Provisions

FMLA: Family and Medical Leave Act of 1993. Notwithstanding the above rule regarding termination of participation or any other provision to the contrary in this Plan, if you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), SMCCCD will continue to maintain your health benefits on the same terms

and conditions as though you were still an active employee. Except as otherwise provided by FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave. If earlier, your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time. Except as otherwise provided in FMLA, if you fail to return to work after the FMLA leave, you will be required to reimburse SMCCCD for the cost of the coverage SMCCCD provided you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on).

FMLA: Military Family Leave. FMLA includes the following additional leave rights:

- Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active military duty or a reservist being called to active military duty in the Armed Forces and is deployed to a foreign country (servicemember).
- An eligible employee who is the spouse, son, daughter, parent, or next of kin of an eligible covered servicemember as defined below is entitled to up to 26 work weeks of leave in a single 12-month period to care for the servicemember. For purposes of this subparagraph, "eligible covered servicemember" shall mean a veteran who was a member of the Armed Forces (including a member of the National Guard or a military reservist) who is undergoing medical treatment, recuperation, or therapy for a serious illness or injury. A "serious illness or injury" includes illnesses or injuries that either (i) occurred during the servicemember's active duty, or (ii) existed prior to the servicemember's active duty and which were aggravated by service in the line of duty. The military service of the eligible covered servicemember must have ended within 5 years of the first date the eligible employee takes leave.
- An eligible employee who is the spouse, son, daughter, or parent of a servicemember may take "rest and recuperation" leave of up to 15 days to spend time with the servicemember who is on a short-term, temporary, rest and recuperation leave during the period of the servicemember's deployment. SMCCCD may require the eligible employee to provide a copy of the servicemember's orders that indicate the dates of the servicemember's rest and recuperation leave.

USERRA: Employees on Military Leave. Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Special Open Enrollment Rights for Certain Individuals under Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in one of the health care options offered by the Plan Sponsor, 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. If you otherwise decline to enroll, you may be required to wait until the group's next open enrollment to do so. You also may be subject to additional limitations on the coverage available at that time.

Any requests for special enrollment or to obtain more information should be directed to:

San Mateo County Community College District
attn: Human Resources Representative
3401 CMS Drive
San Mateo, CA 94402
(650) 358-6827

Certificate of Creditable Coverage. A certificate of creditable coverage (certificate) is a written certification of the period of your creditable coverage under this Plan including COBRA continuation coverage, if applicable. If a certificate is automatically provided at the end of your coverage, the period included on the certificate is the last period of continuous coverage ending on the date the coverage ceased. If you request a certificate from the Plan Administrator, a certificate must be provided for each period of continuous coverage ending within the 24-month period prior to the date of the request. A separate certificate may be provided for each period of continuous coverage. The certificate also certifies the length of any waiting periods you served for coverage under the Plan.

The certificate enables you to provide proof to a new employer or insurance plan that you had health coverage through your employment with SMCCCD. The certificate may help you avoid or reduce the preexisting condition limitation or exclusion period under another plan.

You can request a certificate at any time within 24 months after you lose coverage under the Plan or you lose COBRA continuation coverage, whichever is later. You may submit your written request to the Plan Administrator or you may call SMCCCD at:

San Mateo County Community College District
attn: Human Resources Representative
3401 CMS Drive
San Mateo, CA 94402
(650) 358-6827

After your request is received, the certificate will be provided to you by the earliest date that the Plan Administrator, acting in a reasonable and prompt manner, can provide it. The certificate is required to be provided to you even if you have already received an automatic certificate when your coverage otherwise ended.

Medicaid and the Children's Health Insurance Program (CHIP). If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed in Appendix D, you can 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, you can contact your state Medicaid or CHIP office using the information contained in Appendix D, or call 1-877-543-7669 or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Preexisting Condition Exclusions. This Plan may impose preexisting condition exclusions. If you have a medical condition before coming to this Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to

conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the Plan within 30 days after birth, adoption, or placement for adoption, or to children under the age of 19.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce or eliminate the 12-month exclusion period by your creditable coverage, you should give SMCCCD a copy of any certificates of creditable coverage you have. If you do not enroll during your initial open enrollment period (late enrollee) you may be subject to an exclusionary period up to 18 months. If you do not have a certificate, but you do have prior health coverage, SMCCCD will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact SMCCCD if you need help demonstrating creditable coverage. Any questions about preexisting condition exclusions and creditable coverage should be directed to:

San Mateo County Community College District
attn: Human Resources Representative
3401 CMS Drive
San Mateo, CA 94402
(650) 358-6827

Newborns' and Mothers' Health Protection Act of 1996. 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 less than 48 hours (or 96 hours).

California Maternity Coverage. Group health plans and health insurance issuers with policies or contracts issued in the State of California generally may not, under California 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, the law generally does not prohibit the mother's or newborn's treating physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In addition, California law requires the Plan to cover a post-discharge follow up visit for the mother and newborn within 48 hours of discharge when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or plan facility visit. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the plan's facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

Furthermore, the Plan may not:

(a) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee in accordance with the coverage requirements.

(b) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee in a manner inconsistent with the coverage requirements.

(c) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(d) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(e) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(f) Require the treating physician to obtain authorization from the health plan prior to prescribing any services covered by this section.

Women's Health and Cancer Rights Act of 1998 (WHCRA). WHCRA requires coverage of treatment related to mastectomy. If you or your dependent is eligible for mastectomy benefits under this coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

(a) Reconstruction of the breast on which mastectomy has been performed;

(b) Surgery and reconstruction on the other breast to produce a symmetrical appearance;

(c) Prostheses; and

(d) Treatment for physical complications of all stages of mastectomy, including lymph edemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan.

Mental Health and Addiction Equity Act of 2008. All group health care coverage maintained under this Plan, which provides both medical and surgical benefits and offers mental health or substance use disorder benefits thereunder shall provide such benefits subject to the following:

(a) The financial requirements applicable to such mental health or substance use 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 use disorder benefits; and

(b) The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

Genetic Information Nondiscrimination Act of 2008 (GINA). 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, we ask that you not provide any genetic information when responding to any 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 assisted reproductive services.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Employee Plan Summary or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 (under 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 child."

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A or Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 after the qualifying event occurs. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event.

You must provide this notice to:

San Mateo County Community College District
attn: Human Resources Representative
3401 CMS Drive
San Mateo, CA 94402
(650) 358-6827

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employees lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 for continuation coverage. You must provide notice to us of receipt of a determination by the Social Security Administration of total disability within 60 days of the date of

the notice, the name of the qualified beneficiary who has become disabled, a copy of the determination letter, and the original date of disability.

You must provide this notice to:

San Mateo County Community College District
attn: Human Resources Representative
3401 CMS Drive
San Mateo, CA 94402
(650) 358-6827

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

SMCCCD Health & Welfare Plan
San Mateo County Community College District
3401 CMS Drive
San Mateo, CA 94402
(650) 358-6767

Continuation of Coverage under California Group Health Policies

COBRA Qualified Beneficiaries under federal law who are covered under a group health policy issued in California are eligible to receive up to 18 months of additional COBRA coverage for medical care upon completion of the 18 months received under federal COBRA. This provision does not apply to self-funded medical plans. *The combination of federal and state COBRA coverage may not exceed 36 months in any event.* The 36 month period dates back to the original qualifying event. The additional COBRA period of coverage terminates the earliest of:

- The date the maximum period of coverage expires;
- The date coverage ceases because a premium payment is not made on time;
- The date the employer no longer provides any group health plan; or,
- The date the employee or qualified beneficiary moves out of insurer's services area.

Shorter Maximum for Health FSAs

The maximum federal COBRA period for a health flexible spending arrangement (health FSA) maintained by the Employer ends on the last day of the Plan Year in which the qualifying event occurred. To qualify for COBRA under an FSA, the participant's COBRA contribution must be equal to or less than the unused amount remaining in the account at the time of the qualifying event.

PLAN ADMINISTRATION

In General

SMCCCD is the Plan Administrator of the Plan and a Named Fiduciary. SMCCCD is the Plan's agent for service of legal process.

SMCCCD has the duty and authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each Employee shall, from time to time, upon request of SMCCCD, furnish to SMCCCD such data and information as SMCCCD shall require in the performance of its duties under the Plan.

SMCCCD may designate any individual, partnership or corporation as the Administrator to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

SMCCCD may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan.

SMCCCD will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Amendment and Termination

SMCCCD intends to maintain the Plan indefinitely, but is under no obligation to continue the Plan and can amend or terminate the Plan by providing written notice to the Plan participants. In terminating or amending the Plan, SMCCCD cannot retroactively reduce the benefits to which a participant is entitled prior to the termination or amendment.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

Effective Date

The following provisions in this Section are effective as of January 1, 2011 unless otherwise stated.

Grandfathered Status

This Plan believes its Component Health Plans are "grandfathered health plans" under the ACA. As permitted by ACA, grandfathered health plans can preserve certain basic health coverage already in effect when ACA was enacted and may not include certain consumer protections applicable to other plans. However, grandfathered health plans must comply with certain other consumer protections promulgated by ACA.

Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children available until they turn age 26. The mandate applies to any adult child whether or not he or she is eligible to enroll in some other employer-sponsored group health plan. Adult children shall include those who are a child of the Plan participant, whether or not they are:

- married or not married;
- Live at home;
- A dependent on the employee's tax return; or,
- A student.

Exception for Grandfathered Component Health Plans. In the event the Plan includes one or more Component Health Plans that are grandfathered, those grandfathered plans are not required to offer coverage to any adult child who is eligible to be enrolled in another group health plan. This exception will apply until the earlier of the first day of the Plan Year in which the Component Health Plan loses grandfathered status or January 1, 2014.

Lifetime Limit Special Enrollment

Group health plans are prohibited from imposing a lifetime limit on the dollar value of Essential Health Benefits. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the Plan. Individuals have 30 days from the date of notice to request enrollment.

Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For Plan Years beginning on or after September 23, 2010, a minimum annual limit of $750,000;
- For Plan Years beginning on or after September 23, 2011, a minimum annual limit of $1.25 million; and,
- For Plan Years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of $2 million.

Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care

Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

Prohibition on Rescissions

The Component Health Plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of ACA.

Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

Insurance Issuer Rebates

In the event that SMCCCD qualifies and receives a return of premium (Rebate) as a result of the issuer's failure to meet the Medical Loss Ratio (MLR) requirements under ACA, the Plan Sponsor, at its option shall either:

- Reduce annual premiums in the year in which the Rebate is received or in the subsequent year; or
- Reduce employee contributions or provide a cash refund (taxable to the employee) in an amount determined under ACA regulations.

Provisions Applicable if a Component Health Plan Loses Grandfathered Status

The following additional provisions will apply as of the date in which a Component Health Plan loses grandfathered status.

(a) **Patient Protections**

- **Emergency Services**. If the Plan provides benefits for emergency services, the Plan:
  - May not require preauthorization, including for emergency services provided out-of-network;
  - Must provide coverage regardless of whether the provider is in- or out-of-network;
  - May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed for in-network emergency services; and
  - Cannot impose a co-payment amount or co-insurance rate that is higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency services must be provided in an amount equal to the greatest of the following three amounts:

- the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)
- the amount the Plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the Plan's usual cost-sharing generally applicable to out-of-network services, or
- the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.

- **Primary Care Provider Designation**. If this Plan requires or allows participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the participant or participant's family members. For children, the participant may designate a pediatrician as the primary care provider.

- **Access to Obstetrical or Gynecological Care**. A participant shall not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

- **Access to Pediatric Care**. If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or Issuer.

(b) **Preventive Care**

Group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

(c) **Nondiscrimination Testing**

Insured group health plans are required to satisfy the nondiscrimination rules of IRC Code §105(h)(2). Upon issuance of regulations, these rules will prohibit discrimination in favor of Highly Compensated Individuals (HCIs). For this purpose, the term "group health plan" does not include certain benefits such as plans providing limited-scope dental or vision benefits under a separate insurance policy or where coverage is elected by participants separately from the medical coverage and a separate contribution is made for such benefits. Therefore, the nondiscrimination rule will not apply to insured plans that provide these "excepted" benefits.

(d) **Claims Appeal Process**

In addition to the claims appeals procedures described in the Plan and this Employee Plan Summary, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable state external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process applicable to the internal claims process:
    - if the applicable state has not established an external review process that meets the requirements applicable to the internal claims process; or
    - if the plan is a self-insured plan that is not subject to state insurance regulation (including a state law that establishes an external review process whose terms are similar to the process applicable to the internal claims process.)

Continuing Effect of This Section

The provisions of ACA described in this Section shall continue in effect, for the Component Health Plans contained herein, as modified by further legislation and regulatory guidance.

CLAIMS AND APPEAL PROCEDURES

Insofar as these procedures are consistent with the provisions of ACA, the procedures outlined below must be followed by Plan participants ("claimants") to obtain payment of benefits under this Plan.

Non-Health Claims

For purposes of all non-health insured welfare plan coverage (disability, Life, AD&D, etc.) the certificate booklet provided by the issuers contains a detailed description of the issuer's claims submission rules and claims appeal procedures.

Health Claims

For purposes of the Health Claims and Claims Appeal Procedure contained in this Employee Plan Summary, the term "Administrator" will mean either the issuer or the Plan Administrator depending upon the policy or plan under which the claim has been filed.

You must follow the procedures outlined below to obtain payment of health benefits under this Plan.

You should direct All claims and questions regarding health claims to the Administrator. The Administrator shall have final authority for adjudicating all claims and a full review of the decision on such claims.

As an individual claiming benefits under the Plan, you shall be responsible for supplying, at such times and in such manner as the Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Administrator in its sole discretion shall determine that you have not incurred a covered expense or that the benefit is not covered under the Plan, or if you have failed to furnish such proof as is requested, no benefits shall be payable to you under the Plan.

When Health Claims Must Be Filed

Health claims must be filed with the Administrator within one year of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied, unless it is shown that it was not reasonably possible to file within this time frame.

The Plan, upon receipt of a written notice of a claim, will furnish you a form for filing proof of loss. If such forms are not furnished within 15 days after notice is given, you will be considered to have complied with the requirement of the Plan with respect to proof of loss and written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

A health Claim is considered to be filed when the following information is received by the Administrator:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges;
- The name of the Plan;
- The name of the participant; and,
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrator will determine if enough information has been submitted to adjudicate the claim. If not, the Administrator may request more information. The Administrator must receive the additional information within 45 days from your receipt of the request for additional information. Failure to do so may result in claims being declined or benefits reduced.

Timing of Claim Decisions

The Administrator shall notify you of a denial within the following time periods:

(e) If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

(f) If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by the Administrator and you.

Claims Appeal Procedure

Nature of Denial. The notice of a denial of a claim shall be written in a manner calculated to be understood by you and shall set forth:

(g) The specific reason for the denial;

(h) Specific references to the pertinent Plan provisions on which the denial is based, including a copy of any internal guideline used in the benefit determination or notice of where and how you can obtain a copy free of charge;

(i) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary;

(j) An explanation of the Plan's claims appeals procedures;

(k) If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or notice of where and how you can obtain a copy free of charge; and,

(l) For purposes of urgent care, a description of the expedited review process.

Timing of an Appeal:

Within 180 days after the receipt of the above material, you shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your duly authorized representative may:

(m) Request a review by providing written notice to the Administrator;

(n) Submit written comments, documents, records and other information relating to the claim; and,

(o) Upon request, have reasonable access to and copies of all documents, records, and other information relevant to the claim.

Timing of Notification of Benefit Determination on Review

The Administrator shall notify you of the Plan's benefit determination on review within the following timeframes:

(p) All Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

(q) Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Internal Review and Decision

(a) **Full and Fair Review.** The Plan Administrator, as Plan Fiduciary, shall take into account all comments, documents, and other information submitted by you without regard to whether the information was submitted with the original claim and without deference to the original determination. The decision shall be based in whole or in part on a medical judgment, with consultation with the appropriate independent health care professionals, if the claim involves investigational or experimental treatment, or issues of medical necessity, and shall identify such professionals.

(b) **Decision.** The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. If your appeal is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, you will receive an explanation of the scientific or clinical judgment applied on the benefit determination, or notice of where and how you can obtain a copy. If your health plan is subject to California law, you have a right to a voluntary independent medical review of denials for medical necessity or experimental/investigational services through the Department of Managed Care and/or the Department of Insurance. Please refer to your health plan booklet or evidence of coverage for details.

External Review for Nongrandfathered Component Health Plans

In the event a Component Health Plan loses grandfathered status, it will be subject to ACA must also offer claimants the opportunity to pursue External Review following exhaustion of the Internal Appeals procedures set forth in this section.

(a) **Requesting an External Review.** In the event that an Internal Appeal results in a denial based upon medical judgment or a rescission (in whole or in part), the claimant may request an External Review by giving written notice of the appeal to the Plan Administrator within 120 days after the claimant receives the notice of decision on the Internal Appeal.

(b) **Eligibility for External Review.** Within 5 business days following the date of receipt of the External Review request, the Plan Administrator will complete a preliminary review of the request to determine whether the matter is eligible for External Review. A matter is eligible for External Review only if it meets all of the following requirements:

- The claimant is or was covered under the Plan at the time the health care item or service was requested;
- The denial does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Plan (in other words, the External Review process does not apply to eligibility determinations);
- The claimant has exhausted the Plan's Internal Appeal process; and
- The claimant has provided all the information required to process an External Review.

(c) **Notice of External Review Eligibility.** Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. The notification will advise claimant that:

- The claim is not eligible for External Review;

- The claim is eligible and ready for External Review; or
- It is unclear whether the claim is eligible for External Review because claimant has not provided all the information required.

(d) **External Review Process.** If the claim is eligible and ready for External Review, the Plan Administrator will assign an Independent Review Organization (IRO) that is accredited by URAC (a nonprofit organization promoting healthcare quality by accrediting healthcare organizations) or by a similar nationally recognized accrediting organization to conduct the External Review.

- The IRO will notify the claimant in writing of the request's eligibility and acceptance for External Review, including a statement that the claimant may submit in writing, within 10 business days, additional information which the IRO must then consider when conducting the External Review; and
- Within 5 business days after the date of assignment to the IRO, the Plan Administrator will provide the IRO the documents and any information considered in deciding the Initial Claim and the Internal Appeal.

(e) **Decision:**

- Within 45 days after it receives the request for External Review, the IRO will deliver a notice of decision to claimant.
- The IRO's decision shall be binding on all parties unless and until there is a judicial decision otherwise.

OTHER IMPORTANT INFORMATION

Privacy of Information

In the administration of this Plan, SMCCCD or of one of its Business Associates may be required to use or disclose protected information for purposes of paying or causing to be paid benefits under this Plan. SMCCCD has established the following policy regarding the use and disclosure of protected information. SMCCCD hereby agrees to:

- Not use or disclose protected health information other than as permitted or required by the Plan document or by law;
- Ensure that any agents to whom it provides protected health information agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor;
- Report to the group health plan any use or disclosure of protected health information inconsistent with Plan provisions;
- Make protected health information available as required under other privacy rules provisions;
- Make internal practices and records regarding protected health information available to the HHS Secretary; and,
- Where feasible, return or destroy all protected health information received from the group health plan when no longer needed for the purpose for which disclosure was made.

Please refer to the Plan's Notice of Privacy Practices for details.

Controlling Documents

The information contained in this Employee Plan Summary is only a general discussion of the relevant provisions of the Plan found in the official Plan Document. In all events, the provisions of the official Plan Document shall control with regard to all matters concerning the administration and operation of the Plan. The official Plan Document is available for your review at the offices of San Mateo County Community College District.

APPENDIX A

SMCCCD HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Insurance Policy Issuers and Contract Administrator

Issuer Name and Address	Policy No.	Type of Benefit
Anthem Blue Cross 21555 Oxnard Street Woodland Hills, CA 91367	003 – CalPERS	HMO, PPO, HDHP
Blue Shield of California 50 Beale Street San Francisco, CA 94105-1808	003 – CalPERS	HMO, PPO
Claremont Behavioral Services 1050 Marina Village Parkway, Suite 203 Alameda, CA 94501	SMCCCD	Employee Assistance Program
Delta Dental of California 100 First Street San Francisco, CA 94105	15997 01691-0117	Dental PPO DHMO
Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155	GL-674642	Basic and Voluntary Life/AD&D, LTD, STD
Kaiser Foundation Health Plans, Inc. Ordway Building 1 Kaiser Plaza Oakland, CA 94612	003 – CalPERS	HMO
Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670	12135474	Vision

Contract Administrator	Policy No.	Type of Benefit
Payflex Systems USA, Inc. 10802 Farman Drive, Suite 100 Omaha, NE 68145	—	Section 125 Plan (FSA)

APPENDIX B

SMCCCD HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Claims Appeals Contact Information

Name	**Phone/FAX/Address** ***(Use Address and Phone Number on ID Card if different)***	
Anthem Blue Cross	attn: Member Services Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060 phone: (800) 999-3643	***Grievances and Appeals:*** attn: Grievance & Appeals Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91365-4310 phone: (800) 365-0609 fax: (818) 234-1089
Blue Shield of California	attn: Member Services Blue Shield P.O. Box 272540 Chico, CA 95927-2540 phone: (800) 334-9849	***Grievances and Appeals:*** attn: Appeals and Grievances Blue Shield P.O. Box 629007 El Dorado Hills, CA 95762-9007 phone: (800) 424-6521 fax: (916) 350-7585
Claremont Behavioral Services	Claremont Behavioral Services 1050 Marina Village Parkway, Suite 203 Alameda, CA 94501 phone: (800) 834-3773 fax: (510) 337-8833	
Delta Dental of California	attn: Customer/Member Services Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330 phone: (800) 765-6003	***Grievances and Appeals:*** attn: Member Appeals Delta Dental Plan of California P.O. Box 7736 San Francisco, CA 94120 fax: (415) 227-4823
Kaiser Foundation Health Plans, Inc.	attn: Claims Department Kaiser Foundation Health Plan P.O. Box 12923 Oakland, CA 94604-2923 claims phone: (800) 390-3510	***Grievances and Appeals:*** attn: Special Services Unit Kaiser Permanente P.O. Box 23280 Oakland, CA 94623 phone: (888) 987-7247
Vision Service Plan (VSP)	attn: Claims Department VSP P.O. Box 997105 Sacramento, CA 95899-7105 phone: (800) 216-6248	***Grievances and Appeals:*** attn: Grievance Unit VSP 3333 Quality Drive – MS 131 Rancho Cordova, CA 95670 fax: (916) 463-3926

APPENDIX B (cont'd)

Contract Administrator	Phone/FAX/Address
Payflex Systems USA, Inc.	attn: Claims Administration PayFlex Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103-3039 phone: (800) 284-4885 fax: (402) 231-4310

APPENDIX C

SMCCCD HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

Employee Class	Line(s) of Coverage	Effective Date of Eligibility	Definition of Full-time
Faculty	All	First day of the month following date of hire	60% (9 units) of a full-time load
Classified and Administrators	All	First day of the month following date of hire	50% (81.25 hours/month) of full-time employment.

Eligibility

1. Coverage for dependents, if elected, begins on the date employee coverage begins, unless specified otherwise under the applicable Plan documents.
2. Coverage also may be available to eligible domestic partners and their eligible dependents.

APPENDIX D

SMCCCD HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION

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

Free or Low-Cost Health Coverage to Children and Families. 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, 2013. You should contact your state Medicaid and/or CHIP office for further information on eligibility.

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid
Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants
Phone (Outside Maricopa Cty): 1-877-764-5437
Phone (Maricopa Cty): 602-417-5437

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website:
www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

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

MONTANA – Medicaid
Website:
http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

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

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-609-631-2392

NEW YORK – Medicaid
Website:
http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid and CHIP
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://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.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

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

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website:
http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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