HomeNurse Inc.

2015 EMPLOYEE BENEFITS GUIDE

1 MEDICAL BENEFITS

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact BC/BS of GA
1-855-397-9267 or www.bcbsga.com
Group #: A24601
Plan Name: Home Nurse, Inc

The Home Nurse medical benefits are insured by BC/BS of Georgia. All medical plans offer access to the Blue Open Access POS network. Employees may select the Bronze plan, the Silver plan, the Gold plan or waive coverage altogether.

For enrolled members, Register on the bcbsga.com website and:

-Find in network providers and facilities
-Track claims and account activity
-Review prescription drug costs
-Get answers to coverage questions
-Compare plan options and features
-Find health advice
And much more

Follow these easy steps to locate a doctor, hospital or health facility participating with BC/BS of GA:

STEP 1: Go to www.bcbsga.com
Click on "Find a Doctor"
STEP 2: Select "Georgia" as the state you are searching and select "Blue Open Access POS" as the plan/network you are searching
STEP 3: On the next page, you can search by provider type, provider name, or location.

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Group #: A24601
Plan Name: Home Nurse, Inc

MEDICAL BENEFITS

BCBSHP Bronze Blue Open Access POS 5000/20% H.S.A		
Overview	You may use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges, as well as any Co-payments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Single	$5,000	$10,000
Family *(The Family deductible can be met by any combination of amounts from all / any covered family members but no member is required to meet more than the Single deductible before cost share begins)*	$10,000	$20,000
Annual Out-of-Pocket Maximum	*Includes Deductible and Copays*	
Single	$6,350	$12,700
*Family**	$12,700	$25,400
Coinsurance	Plan pays 80% after Deductible Member pays 20% after Deductible	Plan pays 60% after Deductible Member pays 40% after Deductible
*All individual Out-of-Pocket Maximum amounts will count towards the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.All copaymentand deductible amounts apply to the Out-of-Pocket Maximum. Out-of-Pocket Maximums accumulated separately for in-network and out-of-network services.		
Lifetime Maximum Benefit	Unlimited	
Primary Care Physician Office Visits	$30 Copay after Deductible	Plan pays 60% after Deductible
Specialist Physician Office Visits	$60 Copay after Deductible	Plan pays 60% after Deductible
Preventive Care	Plan pays 100%, not subject to Deductible or Copays	Plan pays 60% after Deductible
Retail Health/Convenience Care Clinics *(ex: CVS Minute Clinic, Walgreens Take Care Clinic)*	$30 Copay after Deductible	Plan pays 60% after Deductible
Hospital Inpatient Expenses	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Hospital Outpatient Expenses	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Urgent Care Facility	$60 Copay after Deductible	Plan pays 60% after Deductible
Emergency Room	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Rehabilitation Services *(ex: physical/speech/occupational)*	Plan pays 80% after Deductible 20 visit limit per calendar year	Plan pays 60% after Deductible 20 visit limit per calendar year
Durable Medical Equipment	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Prescription Drugs		
Retail Pharmacy (30 day supply)	Medical Deductible must be met first, then: $15 Copay after Deductible for Tier 1 Drugs $35 Copay after Deductible for Tier 2 Drugs $70 Copay after Deductible for Tier 3 Drugs Member pays 25% after Deductible for Tier 4 Drugs	Plan pays 75% after Deductible
Mail Order Maintenance Drug (90 day supply)	Medical Deductible must be met first, then: $37.50 Copay after Deductible for Tier 1 Drugs $87.50 Copay after Deductible for Tier 2 Drugs $175 Copay after Deductible for Tier 3 Drugs Member pays 25% after Deductible for Tier 4 Drugs	Not Covered
Employee Contributions (per month)		
Employee Only	$92.00	
Employee + Spouse	$483.42	
Employee + Child(ren)	$424.71	
Employee + Family	$816.13	

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UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact BC/BS of GA
1-855-397-9267 or www.bcbsga.com
Group #: A24601
Plan Name: Home Nurse, Inc

MEDICAL BENEFITS

BCBSHP Silver Blue Open Access POS 5000/20%/6350		
Overview	You may use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges, as well as any Co-payments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Single	$5,000	$10,000
Family	$10,000	$20,000
Annual Out-of-Pocket Maximum	*Includes Deductible and Copays*	
Single	$6,350	$12,700
*Family**	$12,700	$25,400
Coinsurance	Plan pays 80% after Deductible Member pays 20% after Deductible	Plan pays 60% after Deductible Member pays 40% after Deductible
*All individual Out-of-Pocket Maximum amounts will count towards the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount. All copayment and deductible amounts apply to the Out-of-Pocket Maximum. Out-of-Pocket Maximums accumulated separately for in-network and out-of-network services.		
Lifetime Maximum Benefit	Unlimited	
Primary Care Physician Office Visits	$40 Copay	Plan pays 60% after Deductible
Specialist Physician Office Visits	$60 Copay	Plan pays 60% after Deductible
Preventive Care	Plan pays 100%, not subject to Deductible or Copays	Plan pays 60% after Deductible
Retail Health/Convenience Care Clinics *(ex: CVS Minute Clinic, Walgreens Take Care Clinic)*	$40 Copay	Plan pays 60% after Deductible
Hospital Inpatient Expenses	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Hospital Outpatient Expenses	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Urgent Care Facility	$60 Copay	Plan pays 60% after Deductible
Emergency Room	$250 Copay, then plan pays 80% after Deductible (copay waived if admitted)	$250 Copay, then plan pays 80% after Deductible (copay waived if admitted)
Rehabilitation Services *(ex: physical/speech/occupational)*	$40 Copay 20 visit limit per calendar year	Plan pays 60% after Deductible 20 visit limit per calendar year
Durable Medical Equipment	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Prescription Drugs		
Prescription Drug Deductible (Calendar Year)	$500 Single /$1,000 Family (Deductible does not apply to Tier 1 Drugs)	
Retail Pharmacy (30 day supply)	$15 Copay for Tier 1 Drugs $35 Copay after Rx Deductible for Tier 2 Drugs $70 Copay after Rx Deductible for Tier 3 Drugs Member pays 25% to a $250 max after Rx Deductible for Tier 4 Drugs	Plan pays 75% after Deductible
Mail Order Maintenance Drug (90 day supply)	$37.50 Copay for Tier 1 Drugs $87.50 Copay after Rx Deductible for Tier 2 Drugs $175 Copay after Rx Deductible for Tier 3 Drugs Member pays 25% to $250 max after Rx Deductible for Tier 4 Drugs	Not covered
Employee Contributions (per month)		
Employee Only	$158.66	
Employee + Spouse	$616.74	
Employee + Child(ren)	$548.03	
Employee + Family	$1,006.11	

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact BC/BS of GA
1-855-397-9267 or www.bcbsga.com
Group #: A24601
Plan Name: Home Nurse, Inc

MEDICAL BENEFITS

BCBSHP Gold Blue Open Access POS 1500/30%/4500		
Overview	You may use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges, as well as any Co-payments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Single	$1,500	$3,000
Family	$3,000	$6,000
Annual Out-of-Pocket Maximum	*Includes Deductible and Copays*	
Single	$4,500	$9,000
*Family**	$9,000	$18,000
Coinsurance	Plan pays 70% after Deductible Member pays 30% after Deductible	Plan pays 60% after Deductible Member pays 40% after Deductible
*All individual Out-of-Pocket Maximum amounts will count towards the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount. All copayment and deductible amounts apply to the Out-of-Pocket Maximum. Out-of-Pocket Maximums accumulated separately for in-network and out-of-network services.		
Lifetime Maximum Benefit	Unlimited	
Primary Care Physician Office Visits	$20 Copay	Plan pays 60% after Deductible
Specialist Physician Office Visits	$40 Copay	Plan pays 60% after Deductible
Preventive Care	Plan pays 100%, not subject to Deductible or Copays	Plan pays 60% after Deductible
Retail Health/Convenience Care Clinics *(ex: CVS Minute Clinic, Walgreens Take Care Clinic)*	$20 Copay	Plan pays 60% after Deductible
Hospital Inpatient Expenses	Plan pays 70% after Deductible	Plan pays 60% after Deductible
Hospital Outpatient Expenses	Plan pays 70% after Deductible	Plan pays 60% after Deductible
Urgent Care Facility	$40 Copay	Plan pays 60% after Deductible
Emergency Room	$200 Copay, then plan pays 70% after Deductible (copay waived if admitted)	$200 Copay, then plan pays 70% after Deductible (copay waived if admitted)
Rehabilitation Services *(ex: physical/speech/occupational)*	$20 Copay 20 visit limit per calendar year	Plan pays 60% after Deductible 20 visit limit per calendar year
Durable Medical Equipment	Plan pays 70% after Deductible	Plan pays 60% after Deductible
Prescription Drugs		
Prescription Drug Deductible	None	
Retail Pharmacy (30 day supply)	$15 Copay for Tier 1 Drugs $35 Copay for Tier 2 Drugs $70 Copay for Tier 3 Drugs Member pays 25% to a $250 max for Tier 4 Drugs	Plan pays 75% after Deductible
Mail Order Maintenance Drug (90 day supply)	$37.50 Copay for Tier 1 Drugs $87.50 Copay for Tier 2 Drugs $175 Copay for Tier 3 Drugs Member pays 25% to a $250 max for Tier 4 Drugs	Not Covered
Employee Contributions (per month)		
Employee Only	$304.07	
Employee + Spouse	$907.56	
Employee + Child(ren)	$817.04	
Employee + Family	$1,420.53	

5 UNDERSTANDING YOUR H.S.A PLAN

H S A B E N E F I T S

If you enroll in the Bronze Blue Open Access POS 5000/20% H.S.A plan, you are eligible to open and contribute to a Health Savings Account (H.S.A). You are not required to open an account, but enrolling in the BC/BS Bronze H.S.A plan allows you to open an H.S.A at your preferred bank if you so choose.

An H.S.A is an employee-owned account that allows you to set aside money for your eligible medical expenses (including vision and dental expenses) incurred this year or in future years. Your contributions to the account are made with pre-tax dollars so you save on taxes when you contribute. Because you own the account, you can take your H.S.A with you should you ever leave the company and, unlike a flexible spending account, any unused balance in your H.S.A rolls over from year to year.

You must be enrolled in a qualified High Deductible Health Plan in order to contribute to an H.S.A. In future years, if you decide to dis-enroll from the HDHP plan, you can continue to use any money in your H.S.A for qualified medical expenses, but you are ineligible to contribute any additional funds to the account. For 2015, Home Nurse employees must enroll in the BC/BS Bronze plan in order to contribute to an H.S.A

If you withdraw funds from the account for non medical expenses, you will be subject to a penalty. At age 65, however, any unused funds in your H.S.A can be withdrawn without penalty for non-medical purposes. If you withdraw the funds in your H.S.A after age 65, you would be subject to normal income tax on the money in the account, but you would not be limited to just using the money for medical related expenses.

If you open an H.S.A, you will receive a debit card for easy access to your funds. You can use this debit card to pay for qualified medical expenses without having to file anything for reimbursement —this card can be used at doctor's offices, pharmacies, hospitals, and other healthcare provider locations. It is recommended to save the receipts for every purchase you make with the card as you may need the receipts to verify expenses.

There are limits to how much you can contribute to your H.S.A each calendar year. For 2015, the contribution limits are:

Single: $3,350

Family: $6,650

If you are over age 55, you can contribute an additional $1,000 to your H.S.A for 2015.

Please use the list on the next page as a guide to help you determine whether a medical expense is qualified or not for an H.S.A distribution.

H S A B E N E F I T S

The following items are qualified medical expenses and may be paid for using your HSA:

- Ambulance
- Annual Physical
- Artificial Limb
- Artificial Teeth
- Nursing Home (for medical care)
- Thermometers
- Abortion
- Acupuncture
- Bandages
- Birth Control Pills
- Blood Pressure Monitor
- Blood Sugar Test Kit
- Blood Tests
- Body Scan
- Body Scan
- Braille Books
- Breast Pump/Supplies
- Breast Reconstruction
- Christian Science (fees to practitioners for care)
- Cold/Hot Pack for medical care
- Condoms
- Contact Lenses and supplies
- Contraceptives
- Crutches
- Dental Treatment
- Dentures and cleaners
- Dermatologist
- Diabetic Supplies
- Diagnostic Devices
- Doctor's Fees not covered by insurance
- Drug Addiction (inpatient treatment)
- Drugs (with prescription)
- Eye Exam
- Eye Surgery (including laser eye surgery)
- Eyeglasses
- Fertility Enhancement
- First Aid Supplies
- Flu Shot
- Guide Dog (incl. maintenance costs - food, vets, etc….)
- Gynecologist
- Hearing Aids (incl. batteries and repair)
- Homeopathic Care
- Immunizations
- Laboratory Fees
- Lactation Expenses (see breast pump)
- Medical Alert Bracelet
- Operations (non cosmetic)
- Optometrist
- Orthopedist
- Orthotic Inserts
- Osteopath
- Out-of-Network
- Oxygen for medical condition
- Physical Examination
- Pregnancy Test Kit
- Prosthesis
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Splints
- Sterilization
- Surgery (non-cosmetic)
- Therapy.
- Vasectomy
- Vision Surgery
- Wheelchair
- X-Ray

The following items are NOT qualified medical expenses

- Baby Sitting
- Bottled Water
- Controlled Substances
- Cosmetic Surgery
- Cosmetics
- CPR Class
- Dancing Lessons
- Dental Floss
- Diaper Service
- Diet Foods
- Electrolysis Hair Rem.
- Exercise Equip.
- Facial Tissues
- Finance Charge
- Funeral Expenses
- Funeral Expenses
- Health Club Dues
- Household Help
- Illegal Treatments
- Marijuana
- Maternity Clothes
- Medigap Premiums
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees

2015 Health Plan Notices

* Women's Health and Cancer Rights Act of 1998

Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The law prevents discrimination from health insurers and employers.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

MANDATED NOTICES

Important Notice from Holman Enterprises About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Home Nurse and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Home Nurse has determined that the prescription drug coverage offered by BC/BS of MT is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Holman coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Holman coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Home Nurse and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes through Home Nurse. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:	Home Nurse
Contact--Position/Office:	Sandra Lohnes
Address:	2920 N Expressway, Griffin GA 30224
Phone Number:	770-227-5757

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
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	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	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	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084

INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	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
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	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, 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

OMB Control Number 1210-0137 (expires 10/31/2016)

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are an employee 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 or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if employees 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.

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are an employee declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

_____ _____

Employee Name – Please Print Employee Social Security Number

_____ _____/_____/_____

Employee Signature Date

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Home Nurse Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. Home Nurse retains the right to modify or eliminate these benefits at any time and for any reason.