WOLFCHASE HONDA-NISSAN

2017-2018 Medical Plan Options

	Plan #1	Plan #2
Plan Name	PPO 3500/5000	PPO 5000/6600
Plan Type	PPO	PPO
IN-NETWORK BENEFITS:		
Provider Network	Health Smart	Health Smart
Provider Directory Website	www.HEALTHSMART.com	www.HEALTHSMART.com
Local Hospitals	Baptist Affiliated Hospitals	Baptist Affiliated Hospitals
Wellness	$0; deductible waived	$0; deductible waived
Primary Care Office Visit	30%; deductible waived	30%; deductible waived
Specialist Office Visit	30%; deductible waived	30%; deductible waived
Walk In Clinics	30%; deductible waived	30%; deductible waived
Diagnostic Lab, In Physician Office	30%; deductible waived	30%; deductible waived
Diagnostic X-ray, In Physician Office	30%; deductible waived	30%; deductible waived
24/7/365 Teledoc	$0; deductible waived	$0; deductible waived
Urgent Care, Physician Charges	30%; deductible waived	30%; deductible waived
Emergency Room	$250; deductible waived	$250; deductible waived
Prescription Drugs:		
Generic	$8 co-pay; deductible waived	$10 co-pay;deductible waived
Preferred Brand	$40 co-pay; deductible waived	$75 co-pay; deductible waived
Non-Preferred Brand	$60 co-pay; deductible waived	$150 co-pay;deductible waived
Specialty	$120 co-pay; deductible waived	$300 co-pay; deductible waived
Complex Imaging (MRI, CAT Scans, etc.)	30%; after deductible	30%; after deductible
Surgery	30%; after deductible	30%; after deductible
In / Outpatient Hospital	30%; after deductible	30%; after deductible
Individual Deductible	$3,500	$5,000
Family Deductible	$7,000	$10,000
Health Smart Coinsurance	50%	50%
Annual Out-of-Pocket Maximum (Includes deductible, coinsurance & co-pays)	$5,000	$6,600
Out-of-Pocket, Maximum for Family	x2	x2
Benefit Year Period	Calendar Year	Calendar Year
OUT-OF-NETWORK BENEFITS:	$7,000 Deductible; 50% coinsurance; $15,000 Out-of-Pocket	$10,000 Deductible; 50% coinsurance; $19,800 Out-of-Pocket
Weekly Employee Contributions		
Single Coverage	$40.30	$24.03
Employee & Spouse Coverage	$141.75	$107.57
Employee & Children Coverage	$116.85	$ 87.07
Employee & Family Coverage	$227.99	$178.59
All Payroll Deductions are before-tax via our Section 125 Cafeteria Plan		

MUST ENROLL NOW OR WAIT UNTIL OPEN ENROLLMENT (OCT. 1ST) UNLESS QUALIFYING FOR SPECIAL ENROLLMENT

This is a brief overview only. Refer to your Evidence of Coverage or the Summary of Benefits and Comparison for details.

Wolfchase Nissan

Effective: 05/01/2017

Employee Benefits Program

Telemedicine

TELADOC™

...when you need care!

Teladoc is a convenient alternative to urgent care or ER visits. U.S. board-certified physicians are available anytime, anywhere, and can resolve many non-emergency medical issues.

DIAGNOSE, TREAT, AND PRESCRIBE

Teladoc physicians can prescribe medication when medically necessary for a wide range of conditions.

A welcome kit is being mailed to your home with instructions for setting up your Teladoc® account, completing your medical history and requesting a consult. Once you're set up, a **Teladoc doctor is always just a call or click away.**

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for Free

MyDrConsult.com

1-800-DOC-CONSULT (362-2667)

Facebook.com/Teladoc

Teladoc.com/mobile

Download on the App Store

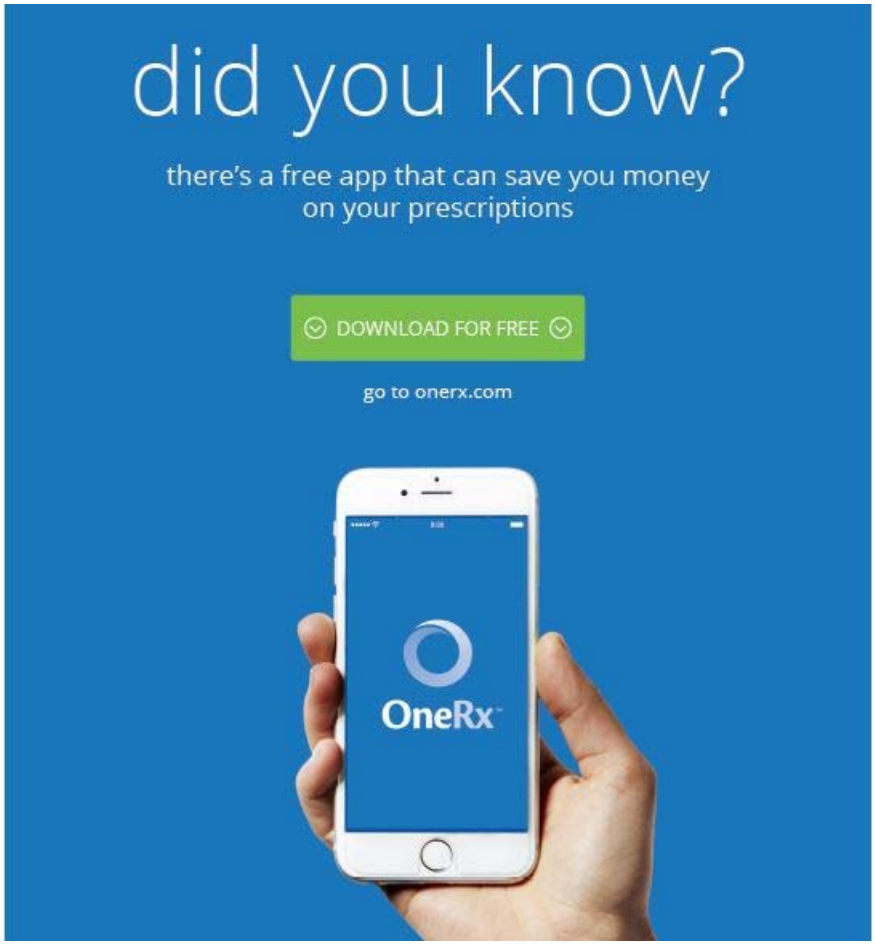
GET IT ON Google Play

Wolfchase Nissan

Effective: 05/01/2017

Employee Benefits Program

OneRx App



- Save $$ whether you're insured or not
- Automatically compares prices at local pharmacies
- Applies pharmaceutical coupons and discounts
- Applies prescription benefits in your insurance plan

Download on the App Store

ANDROID APP ON Google play

Wolfchase Nissan

Effective: 05/01/2017

Employee Benefits Program

General Information About the Plan

Plan Name: Bluff City Nissan Inc. dba Wolfchase Nissan Employee Benefits Program (the "Plan")
Contact: Bluff City Nissan Inc. dba Wolfchase Nissan
2956 N Germantown Rd Bartlett, TN 38133
[Phone Number]

The Plan Administrator has the sole discretionary authority and responsibility to control and administer the Plan in accordance with its terms and has, without limitation, the discretionary authority to interpret the Plan or its terms. The Plan Administrator's powers include making and enforcing rules it deems necessary or proper for the efficient administration of the Plan, allocating its responsibilities under the Plan to other persons, and deciding all questions concerning the Plan, including determining eligibility for benefits under the Plan.

With respect to the coverage described in this Summary Plan Description (SPD), the Plan Administrator has delegated to Cypress Benefit Administrators the discretionary authority related to medical and prescription drug coverage to make determinations on eligibility and claims for benefits under the Plan, and, as such, Cypress Benefit Administrators is a claims review fiduciary of the Plan.

Group/Policy Number:	E49
Claims Administrator:	Cypress Benefit Administrators
Medical & Prescription Drug Coverage:	1-877-236-0844

The Plan Administrator keeps the records for the Plan, and will also answer any questions you may have about the Plan. If you have general questions about the Plan, you may contact Human Resources, which acts on behalf of the Plan Administrator with respect to day-to-day matters, and whose contact information is provided immediately below.

Plan Contact/Sponsor Information:	Bluff City Nissan Inc. dba Wolfchase Nissan Attn: *Human Resources* 2956 N Germantown Rd Bartlett, TN 38133 [Phone Number]
Plan Sponsor's Employer ID Number (EIN):	62-1282675
ERISA Plan Number:	[Plan #]
Agent for Service of Legal Process:	Bluff City Nissan Inc. dba Wolfchase Nissan 2956 N Germantown Rd Bartlett, TN 38133 [Phone Number]

Wolfchase Nissan

Effective: 05/01/2017

Employee Benefits Program

Agent for Service of Legal Process: Bluff City Nissan Inc, dba Wolfchase Nissan
2956 N Germantown Rd Bartlett, TN 38133
PHONE NUMBER

May 1st, 2017 the Plan is operated on as follows:
May 1, 2017 through April 30, 2018 referred to as the "Plan Year"

The Plan is an employee welfare benefit plan, and includes the medical, prescription, drug, dental, vision, disability, and life coverage described in this SPD.

Type of Funding/Administration: Medical & Prescription Drug Coverage

The medical and prescription drug portion of the Plan described in this SPD is fully insured and is administered in accordance with the provisions of the administrative services agreement with the Claims Administrator named above. The dental, vision, disability, life coverage is insured and is administered in accordance with the provisions of the insurance policy issued by the Insurer named above. Plan benefits are funded through the employer's general assets. No amounts are held in trust or are otherwise segregated from the general assets of the Employer.

Participants are required to contribute to the cost of the coverage

Type of Funding/Administration: Dental, Vision, Disability & Life Coverage

The dental, vision, disability, life coverage is insured and is administered in accordance with the provisions of the insurance policy issued by the Insurer named above. Plan benefits are provided pursuant to an insurance policy, the premiums for which are paid from the employer's general assets. The Insurer(s), not LSCI, Inc. is responsible for paying claims under the Plan. Participants are required to contribute to the cost of coverage.

Amendment or Termination of the Plan

The Plan may, at any time, in the Plan Sponsor's sole discretion, be amended or terminated, without advance notice to any person (except as may be required by law). Any amendment or termination of the Plan (or any coverage(s) under the Plan) will not affect any proper entitlement to benefits incurred prior to the effective date of such amendment or termination. No person shall have any vested right to continue benefits under the Plan.

Effect of the Plan Document

This SPD provides a summary of the terms, conditions, and benefits under the Plan for eligible employees and their eligible dependents. It does not give the details on all the terms of the official Plan documents (including the insurance policy). If there is any conflict between the information in this SPD and the provisions of the Plan documents, the Plan documents control.

Your Rights Under ERISA and Other Applicable Law

This statement of ERISA rights is required by federal law and regulation.

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

• Examine, without charge, at the office of the Plan Administrator and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan (if applicable) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

• Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

• Receive a summary of the Plan's annual financial report (if applicable). If applicable, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA – General Notice and Qualifying Event Notice

• Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

• Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the group health plan (if applicable), if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when: (i) you lose coverage under the Plan; (ii) you become entitled to elect COBRA continuation coverage; (iii) your COBRA continuation coverage ceases; or (iv) you request a certificate of creditable coverage before losing coverage, or within 24 months after losing coverage.

• Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision (or lack thereof) concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions Effective: 05/01/2017

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Availability of Summary Health Information—Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
Choosing a health coverage option is an important decision. To help you make an informed choice, the Plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

Your Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, *you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage)*.

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. However, *you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption*.
Also, a special enrollment period for group health plan coverage may be available if (i) you or your dependent child(ren) lose coverage under a Medicaid or CHIP plan, if that coverage is terminated due to loss of eligibility; or (ii) you or your dependent child(ren) become eligible for financial assistance under Medicaid or CHIP with respect to coverage under the Plan. However, *you must request enrollment within 60 days of the occurrence of one of these events*.

You may be required to provide supporting documentation when requesting special enrollment. To request special enrollment or obtain more information, contact Human Resources.

Procedures for Requesting a Certificate of Creditable Coverage (HIPAA_)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a Certificate of Creditable Coverage be issued to individuals losing health coverage. A Certificate of Creditable Coverage will be issued automatically when you or your dependent's applicable group health plan coverage (including continuation coverage) under the Plan terminates. You may also request a Certificate of Creditable Coverage, free of charge, at any time while covered and up to 24 months after the date coverage terminates. A third party whom you designate in writing may also obtain a copy of the certificate on your behalf. All requests for a Certificate of Creditable Coverage should include your full name, home address, and, if the certificate is to be delivered to a third party other than yourself, the name and address of that party. Requests for a certificate should be in writing, mailed to the Plan Administrator at the following address:

Bluff City Nissan Inc. dba Wolfchase Nissan
2956 N Germantown Rd Bartlett, TN 38133
Telephone: xxx-xxx-xxxx

If you designate a plan or issuer of health insurance (such as that offered by a subsequent employer) to receive the certificate on your behalf and the plan or issuer agrees to accept the information contained in the certificate by non-written means (for example, by telephone), the Plan may provide the information exclusively in that manner.

Patient Protection Notices Required by the Affordable Care Act

[**If applicable (do not include if grandfathered), and if not adequately addressed in the EOC/certificate, include (and tailor accordingly):**]The plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your provider.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. For more information, refer to the SPD.

Privacy of Protected Health Information—Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

The Plan maintains a HIPAA Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's HIPAA Notice of Privacy Practices, please contact HCS at 615 822.0483.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information, refer to the SPD or contact the Plan Administrator (contact information is provided under "General Information About the Plan" above).

Qualified Medical Child Support Orders (QMCSOs)

The Plan will comply with the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or a judgment from a court or administrative body (including a National Medical Support Notice) directing the Plan to cover a child of a participant under the group health plan coverage provided through the Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedures for determining if the order is valid. Coverage under the applicable coverage(s) of the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO.

If you have any questions or would like to receive, without charge, a copy of the Plan's written procedure for determining whether an order is a QMCSO, contact your carrier.

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 are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, 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 The Interstate Companies be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that The Interstate Companies 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, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

Effective: 05/01/2017

Newborns & Mothers Health Protection Act (NMHPA)
The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). This law was effective for group health plans for plan years beginning on or after January 1, 1998.

On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns' Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999. The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery. The type of coverage provided by the plan (insured or self-insured) and state law will determine whether the Newborns' Act applies to a mother's or newborn's coverage.
The Newborns' Act provisions always apply to coverage that is self-insured. If the plan pro
vides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act.
All group health plans that provide maternity or newborn infant coverage must include a statement in their summary plan description (SPD) advising 'Act requirements.

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, 2015. You should contact your state for further information on eligibility—

See next page for chart.

To see if any other states have added a premium assistance program since January 31, 2016, 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)

ALABAMA – Medicaid

www.myalhipp.com/ Phone: 1-855-692-5447

COLORADO – Medicaid

www.colorado.gov/hcpf Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid

www.flmedicaidtplrecovery.com/hipp/

Phone: 1-877-357-3268

INDIANA – Medicaid

Plan for low-income adults 19-64	All other Medicaid
www.hip.in.gov	www.indianamedicaid.com
Phone: 1-877-438-4479	Phone 1-800-403-0864

KANSAS – Medicaid

www.kdheks.gov/hcf/ Phone: 1-785-296-3512

LOUISIANA – Medicaid

www.dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 1-888-695-2447

MASSACHUSETTS – Medicaid and CHIP

www.mass.gov/MassHealth Phone: 1-800-462-1120

MISSOURI – Medicaid

www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

NEBRASKA – Medicaid

www.dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx

Phone: 1-855-632-7633

NEW HAMPSHIRE – Medicaid

www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

NEW YORK – Medicaid

www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH DAKOTA – Medicaid

www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OREGON – Medicaid

www.oregonhealthykids.gov www.hijossaludablesoregon.gov

Phone: 1-800-699-9075

SOUTH CAROLINA – Medicaid

www.scdhhs.gov Phone: 1-888-549-0820

TEXAS – Medicaid

www.gethipptexas.com/ Phone: 1-800-440-0493

VERMONT– Medicaid

www.greenmountaincare.org/ Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:	CHIP Website:
www.coverva.org/programs_premium_assistance.cfm	www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924	CHIP Phone: 1-855-242-8282

WEST VIRGINIA – Medicaid

www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx

Phone: 1-877-598-5820, HMS Third Party Liability

ALASKA – Medicaid

www.health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

GEORGIA – Medicaid

www.dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

IOWA – Medicaid

www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KENTUCKY – Medicaid

www.chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570

MAINE – Medicaid

www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-442-6003 TTY: Maine relay 711

MINNESOTA – Medicaid

www/mn.gov/dhs/ma/ Phone: 1-800-657-3739

MONTANA – Medicaid

www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEVADA – Medicaid

www.dwss.nv.gov/ Medicaid Phone: 1-800-992-0900

NEW JERSEY – Medicaid and CHIP

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

NORTH CAROLINA – Medicaid

www.ncdhhs.gov/dma Phone: 919-855-4100

OKLAHOMA – Medicaid and CHIP

www.insureoklahoma.org Phone: 1-888-365-3742

PENNSYLVANIA – Medicaid

www.dhs.pa.gov/hipp Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

www.eohhs.ri.gov/ Phone: 401-462-5300

SOUTH DAKOTA - Medicaid

www.dss.sd.gov Phone: 1-888-828-0059

UTAH – Medicaid and CHIP

Medicaid Website:	CHIP Website
www.health.utah.gov/medicaid	www.health.utah.gov/chip

Phone: 1-877-543-7669

WASHINGTON – Medicaid

www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx

Phone: 1-800-562-3022 ext. 15473

WISCONSIN – Medicaid and CHIP

www.dhs.wisconsin.gov/publications/p1/p10095.pdf

Phone: 1-800-362-3002

WYOMING – Medicaid

www.wyequalitycare.acs-inc.com/ Phone: 307-777-7531