

2026

BENEFITS

Guide



Anchor Bay Schools

ACA Eligible Employees



Table of Contents

Welcome Page.....2

Medical Plan Highlights.....3

Essentials Rx Overview.....5

MESSA Resources.....6

Legal Notices.....7

Language Services.....15

The details in this booklet are intended as an easy to read summary and provide only a general overview of the plan. It is not intended to be a contract. Additional limitations and exclusions may apply. If there is a discrepancy between this booklet and the applicable plan documents, the plan documents will prevail.



A guide to your MESSA benefits

2026 open enrollment is November 1, 2025 to November 18, 2025.

Dear Anchor Bay Schools member:

The open enrollment period is your opportunity to review and update your health benefits selections for the coming year. It's important for you to understand the benefits available to you, so you can make the best decisions for you and your family.

This benefit guide provides an overview of your MESSA benefit options. Please review it carefully before making your benefit selections.

Once you're ready, you can log in to your MyMESSA account at messa.org to access the online benefits website. After open enrollment closes on November 18, 2025, you cannot change your benefit selections until the next open enrollment period.¹

Any changes you make will become effective January 1, 2026.

If you have any questions, call MESSA's Member Service Center at 800-336-0013. We're here to help!

Access the online benefits website by logging in to your MyMESSA account at messa.org to:

- Review your current enrollment.
- Make any benefit selection changes.
- Submit benefit selection by November 18, 2025.

¹Allowances are made for "qualifying events," such as marriage, birth, your spouse's losing coverage from another insurer, or other limited instances.

Essentials by MESSA

Medical plan highlights

Effective Date: 1/1/2026

MESSA Account: Anchor Bay Schools

Employee Group: ACA Eligible Employees

In-network health care benefits for you and your covered dependents

All services must be medically necessary and performed by a payable provider.

This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100% of the cost or the applicable out-of-network cost share amounts. For coverage details, go to messa.org to log in to your MyMESSA account or call the MESSA Member Service Center at 800-336-0013 or TTY 888-445-5614.

Plan features	In-network
Annual deductible The amount you pay for health care services before your health insurance begins to pay. If one member of the family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family members will be paid when the family deductible has been met. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.	\$375 individual/\$750 family
Medical copayment A fixed amount you pay for a medical visit.	\$10 Teladoc Health 24/7 care for minor illnesses, injuries and mental health, \$25 Teladoc Health virtual primary care visit, \$25 office visit for medical, mental health and/or substance use disorder treatment, \$25 chiropractic and osteopathic manipulations, \$50 specialist visit, \$50 urgent care, \$200 emergency room, if not admitted
Medical coinsurance A fixed percentage you pay for a medical service.	20%
Prescription drug coverage Subject to prescription copayments and coinsurance.	Essentials by MESSA
Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.	\$10,600 individual/\$21,200 family Your out-of-pocket maximum is subject to change each Jan. 1 according to the maximum limit allowed by the Affordable Care Act.
Covered service	In-network cost share
Preventive care Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications.	No cost to you
Prenatal and postnatal care Prenatal and postnatal doctor visits.	
In-network services subject to deductible and applicable copayment	
Allergy testing and therapy Subject to deductible and coinsurance Specialist visit copayment may apply.	Chiropractic and Osteopathic manipulations Up to a combined 12 visits per calendar year.

Emergency room (ER) Copayment waived if admitted or due to an accidental injury.	Mental health and substance use disorder - outpatient care
Office visit e.g. primary care physician, obstetrics and gynecology and pediatric visits.	Specialist visit
Teladoc Health visits 24/7 care for minor illnesses, injuries and mental health; virtual primary care visits.	Urgent care
In-network services subject to deductible and applicable coinsurance	
Ambulance	Autism - applied behavior analysis (ABA) services
Diagnostic lab and X-ray	Durable medical equipment (DME) Must be obtained from a payable DME provider.
Hearing care Hearing related services performed by an M.D., D.O. or an audiologist (AUD) performing for the audiogram hearing evaluation and testing.	Home health care
Human organ transplant Must be performed at an approved facility.	Inpatient hospital
Medical supplies	Mental health and substance use disorder - inpatient care
Outpatient physical, occupational and speech therapy Up to a combined benefit maximum of 30 visits per individual per calendar year, including therapeutic massage performed by an approved provider (excludes massage therapist).	Prosthetics and orthotics
Radiation and chemotherapy	Skilled nursing facility Up to a maximum of 120 days per calendar year.
Home delivery of prescription medications	
MESSA members can save time and money by ordering prescription medications through the Optum Rx mail order pharmacy. For more information, go to messa.org to log in to your MyMESSA account and link to the Optum Rx website. For general questions about your prescription coverage, call MESSA at 800-336-0013 or TTY 888-445-5614. For questions about a prescription order, call Optum Rx at 800-903-8346.	
Medical care outside the U.S.	
MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website (www.bcbsglobalcore.com) to find in-network providers prior to your departure.	
Covered services and approved amounts	
In-network providers bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements.	
Out-of-network providers may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.	
<i>Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) & 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association.</i>	
Life and accidental death & dismemberment insurance	
Life insurance: \$5,000 policy for you.	
Accidental death & dismemberment insurance (AD&D): \$5,000 policy for you.	
<i>Life and AD&D insurance underwritten by Life Insurance Company of North America.</i>	

Essentials by MESSA In-network Rx Overview



1475 Kendale Blvd., P.O. Box 2560
East Lansing, MI 48826-2560
517-332-2581 • 800-292-4910

What you pay for a prescription from an in-network pharmacy

	Up to 34-day supply	90-day supply
Specific preventive medications mandated by federal law are covered 100%	No cost to you	No cost to you
Generics	\$10 copayment	\$30 copayment
Preferred brand Most brand-name drugs with no generic equivalent or therapeutic alternative	20% coinsurance \$40 minimum – \$80 maximum	20% coinsurance \$120 minimum – \$240 maximum
Nonpreferred brand Brand-name drugs for which there's a generic alternative or preferred brand-name drug	20% coinsurance \$60 minimum – \$100 maximum	20% coinsurance \$180 minimum – \$300 maximum

The amount you pay for brand-name medications can vary because coinsurance is based on the price of the drug when it is filled. Prescription types (generic, brand-name and specialty) are subject to change without notice. Up to a 90-day supply of insulin may be obtained from the same amount as a 34-day supply for an in-network provider.

Specialty medications are handled separately. Specialty drugs must be obtained by mail through Walgreens Specialty Pharmacy or select Walgreens retail pharmacies. If you obtain them from any other provider, you may be responsible for the total cost. The initial quantity of select specialty drugs may be limited, and your cost will be reduced accordingly. Additional fills for specialty drugs are limited to a 30-day supply. To fill your specialty medication prescription, call Walgreens Specialty Pharmacy at 866-249-5367.

Money-saving features of this plan

This prescription plan includes a number of money-saving features including prior authorization, step therapy and quantity limits. Additionally, brand-name drugs are not covered when a generic equivalent is available.

To help keep your costs down, some prescription drugs are not covered by this plan. These excluded drugs have preferred alternatives with similar effectiveness, quality and safety. If you fill a prescription for an excluded drug, you will pay the full retail price.

This is a brief overview of the Essentials by MESSA Rx plan. For additional information, including eligibility, limitations and exclusions, please contact MESSA at 800-336-0013.



Member Service Center | 800-336-0013

Our Member Service Center is available Monday through Friday 8 a.m. to 5 p.m. Our member service specialists are experts at answering questions about your plan and helping with claims.

Your MESSA field representative | 800-292-4910

A local field representative is available to help you and your group. Your field representative can explain benefits and answer questions, attend meetings or arrange visits from other MESSA experts, including nurse educators.

Medical case management | 800-441-4626

MESSA's medical case management nurses can help members and dependents with a catastrophic injury or serious illness get access to the right care at the right time and return to their highest quality of life.

Health promotion consultant | 800-292-4910

MESSA's health promotion consultant can help you and your coworkers develop or strengthen a worksite wellness program.



Privacy Practices

MESSA understands the importance of your protected health information (hereafter referred to as “PHI”) and follows strict policies in accordance with state and federal privacy laws to keep your PHI private. PHI is information about you that can reasonably be used to identify you and information that relates to your past, present, or future physical or mental health, the provision of health care or the payment of that care. Notices of the Privacy Practices for MESSA, BCBSM, NYL and VSP can be found at messa.org/privacy.

Continuation Coverage Rights Under COBRA

Introduction

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

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

You may have other options available to you when you lose group health coverage.

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse’s hours of employment are reduced;

- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify MESSA within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once MESSA receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA

continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

■ **Disability extension**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify your employer in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

■ **Second qualifying event extension**

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

Are there other coverage options besides COBRA continuation coverage?

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

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

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

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

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

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

For more information visit [medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you).

Questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer.

Keep your Plan informed of address changes

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

Notice of 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.

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility; or
- You or your dependent becomes eligible for premium subsidies.

To request special enrollment or obtain more information, contact your MESSA field representative at 800-292-4910, ext. 7817.

Newborns' and Mothers' Health Protection Act Notice

Under the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), group health

plans and health insurance issuers generally may not 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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. If you would like more information on WHCRA benefits, contact your MESSA field representative at 800-292-4910, ext. 7817.

Michelle's Law

Notice of extended coverage to participants covered under a group health plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the

dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

Your Plan permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his/her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- Medically necessary leave of absence means a leave of absence or any other change in enrollment of a dependent child from a post-secondary educational institution that:
 - Begins while the child is suffering from a serious illness or injury
 - Is medically necessary; and
 - Causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

- If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:
- One year after the first day of the leave of absence; or

- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more information regarding the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits, please contact MESSA's Member Service Center at 800-336-0013.

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. However, you may be able to buy individual insurance coverage through the Health Insurance Marketplace; for more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed in this section, 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 by calling **877-KIDS NOW (877-543-7669)** or by going online to insurekidsnow.gov to find out how to apply. If you qualify, ask if your state has a program that might help you pay the premiums or 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. **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 askebsa.dol.gov or call **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, 2024. Contact your state for more information on eligibility.

ALABAMA — MEDICAID

Website: myalhipp.com

Phone: 855-692-5447

ALASKA — Medicaid

The AK Health Insurance Premium Payment Program

Website: myakhipp.com

Phone: 866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS — Medicaid

Website: myarhipp.com

Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA — Medicaid

Health Insurance Premium Payment (HIPP)

Program website: dhcs.ca.gov/hipp

Fax: 916-440-5676

Phone: 916-445-8322

Email: hipp@dhcs.ca.gov

**COLORADO — Health First Colorado
(Colorado's Medicaid Program) & Child
Health Plan Plus (CHP+)**

Health First Colorado website:

healthfirstcolorado.com

Health First Colorado Member Contact Center:
800-221-3943/State Relay 711

CHP+: **hcpf.colorado.gov/child-health-plan-plus**

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

Health Insurance Buy-In Program (HIBI):

mycohibi.com/HIBI

HIBI Customer Service: 855-692-6442

FLORIDA — Medicaid

Website: **flmedicaidtplrecovery.com/**

flmedicaidtplrecovery.com/hipp/index.html

Phone: 877-357-3268

GEORGIA — Medicaid

GA HIPP website: **medicaid.georgia.gov/**

**[healthinsurance-premium-payment-program-
hipp](http://healthinsurance-premium-payment-program-hipp)**

Phone: 678-564-1162, Press 1

GA CHIPRA website: **medicaid.georgia.gov/**

**[programs/third-party-liability/childrens-
health-insurance-program-reauthorizationact-
2009-chipra](http://programs/third-party-liability/childrens-health-insurance-program-reauthorizationact-2009-chipra)**

Phone: 678-564-1162, Press 2

INDIANA — Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: **in.gov/medicaid/**

in.gov/fssa/dfr/

Family and Social Services Administration

Phone: 800-403-0864

Member Services Phone: 800-457-4584

IOWA — Medicaid and CHIP (Hawki)

Medicaid website: **[Iowa Medicaid | Health &
Human Services](http://Iowa Medicaid | Health & Human Services)**

Medicaid phone: 800-338-8366

Hawki website: **Hawki - Healthy and Well Kids**

in Iowa | Health & Human Services

Hawki Phone: 800-257-8563

HIPP website: **Health Insurance Premium**

[Payment \(HIPP\) | Health & Human Services](http://Payment (HIPP) | Health & Human Services)
 [\(iowa.gov\)](http://(iowa.gov))

HIPP phone: 888-346-9562

KANSAS — Medicaid

Website: **kancare.ks.gov**

Phone: 800-792-4884

HIPP Phone: 800-967-4660

KENTUCKY — Medicaid

Kentucky Integrated Health Insurance Premium
Payment Program (KI-HIPP) website: **[chfs.ky.gov/
agencies/dms/member/Pages/kihipp.aspx](http://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx)**

Phone: 855-459-6328

Email: **KIHIPPPROGRAM@ky.gov**

KCHIP website: **kynect.ky.gov**

Phone: 877-524-4718

Kentucky Medicaid website: **[chfs.ky.gov/
agencies/dms](http://chfs.ky.gov/agencies/dms)**

LOUISIANA — Medicaid

Website: **medicaid.la.gov**

Phone: 888-342-6207 (Medicaid hotline)

Website: **ldh.la.gov/lahipp**

Phone: 855-618-5488 (LaHIPP)

MAINE — Medicaid

Enrollment website: **[mymaineconnection.gov/
benefits/s/?language=en_US](http://mymaineconnection.gov/benefits/s/?language=en_US)**

Phone: 800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium webpage:

maine.gov/dhhs/ofi/applications-forms

Phone: 800-977-6740

TTY: Maine relay 711

MASSACHUSETTS — Medicaid and CHIP

Website: **mass.gov/masshealth/pa**

Phone: 800-862-4840

TTY: 711

Email: **masspremassistance@accenture.com**

MINNESOTA — Medicaid

Website: **mn.gov/dhs/health-care-coverage/**

Phone: 800-657-3672

MISSOURI — Medicaid

Website: **[dss.mo.gov/mhd/participants/pages/
hipp.htm](http://dss.mo.gov/mhd/participants/pages/hipp.htm)**

Phone: 573-751-2005

MONTANA — Medicaid

Website: dphhs.mt.gov/

MontanaHealthcarePrograms/HIPP

Phone: 800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA — Medicaid

Website: ACCESSNebraska.ne.gov

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA — Medicaid

Website: dhcfp.nv.gov

Phone: 800-992-0900

NEW HAMPSHIRE — Medicaid

Website: dhhs.nh.gov/programs-services/

medicaid/health-insurance-premium-program

Phone: 603-271-5218

Toll-free: 800-852-3345 ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY — Medicaid and CHIP

Medicaid website: state.nj.us/humanservices/

dmahs/clients/medicaid

Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: njfamilycare.org/index.html

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

NEW YORK — Medicaid

Website: health.ny.gov/health_care/medicaid

Phone: 800-541-2831

NORTH CAROLINA — Medicaid

Website: medicaid.ncdhhs.gov

Phone: 919-855-4100

NORTH DAKOTA — Medicaid

Website: hhs.nd.gov/healthcare

Phone: 844-854-4825

OKLAHOMA — Medicaid and CHIP

Website: insureoklahoma.org

Phone: 888-365-3742

OREGON — Medicaid

Websites: healthcare.oregon.gov/Pages/index.aspx

Phone: 800-699-9075

PENNSYLVANIA — Medicaid and CHIP

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

Phone: 800-692-7462

CHIP website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://Children's Health Insurance Program (CHIP) (pa.gov))

CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND — Medicaid and CHIP

Website: eohhs.ri.gov

Phone: 855-697-4347, or 401-462-0311 (Direct RIt e Share Line)

SOUTH CAROLINA — Medicaid

Website: scdhhs.gov

Phone: 888-549-0820

SOUTH DAKOTA — Medicaid

Website: dss.sd.gov

Phone: 888-828-0059

TEXAS — Medicaid

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

Phone: 800-440-0493

UTAH — Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

Website: medicaid.utah.gov/upp/

Email: upp@utah.gov

Phone: 888-222-2542

Adult Expansion Website: medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program Website:

medicaid.utah.gov/buyout-program/

CHIP Website: chip.utah.gov/

VERMONT — Medicaid

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

Phone: 800-250-8427

VIRGINIA — Medicaid and CHIP

Websites: coverva.dmas.virginia.gov/learn/premiumassistance/famis-select
coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: 800-432-5924

WASHINGTON — Medicaid

Website: hca.wa.gov
Phone: 800-562-3022

WEST VIRGINIA — Medicaid and CHIP

Website: dhhr.wv.gov/bms/mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 855-MyWVHIPP
(855-699-8447)

WISCONSIN — Medicaid and CHIP

Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING — Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July, 31, 2024, or for more information on special enrollments rights, contact either of the following:

U. S. Department of Labor
Employee Benefits Security Administration
Website: dol.gov/agencies/ebsa
Phone: 866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Website: cms.hhs.gov
Phone: 877-267-2323, menu option 4, ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management

and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Language services

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة إلى المساعدة، فمن حقك الحصول على المساعدة والمعلومات بلغتك بدون أي كلفة. للتحدث إلى مترجم، اتصل بالرقم المخصص لخدمات أعضاء MESSA الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的MESSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthës, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

MESSA, io e' celebrata per tutti gli uomini che parlano e che non hanno nulla di nuovo e di nuovo, ma solo per quelli che non sono e che non sono.

যদি আপনার বা আপনি সাহায্য করেন এমন কারো সহায়তার প্রয়োজন হয়, তাহলে কোনো খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার রয়েছে। কোনো দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে প্রদত্ত MESSA সদস্য পরিষেবার নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi członków MESSA wskazany na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigen, haben Sie das Recht kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer der MESSA-Mitgliederbetreuung auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, chiama il numero del servizio membri MESSA presente sul retro della tua tessera.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたMESSAメンバーサービスの電話番号までお電話ください。

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты.

Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć i informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za usluge članova MESSA na zadnjoj strani vaše kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you need help filing a grievance, MESSA's general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, or by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights-GeneralCounsel@messa.org.

You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov, or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.