Mueller Family McDonald's

serving up smiles since 1972

Welcome to Muellers McDonalds' Enrollment Benefits Guide!
We encourage you to read the entire enrollment guide before you enroll.
Note: This enrollment is for the period of October 1st, 2025 - September 30th, 2026.

This is a summary of your benefits only. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to your Summary Plan Description (SPD) or Certificate of Coverage. If information in this Employee Benefits Guide differs from the legal contract, the legal contract is the ruling document. **SPD's or Certificates of Coverage are available from your Human Resources Department.**

Plan Sponsor is not bound by any typographical errors and/or omissions contained herein.

ANDUS Health Benefits

Contents

Mullers McDonald's reviews the benefit packages offered to employees to ensure that they remain competitive within the industry.

We recognize that our employees' needs and preferences vary. As a result, we offer a variety of benefit options and coverage levels. These plan options offer you the opportunity to customize your benefits to meet your needs and your family's needs.

Benefit Eligibility

Muellers McDonald's is offering **Medical** (administered through HealthNow Administrative Services (HNAS)) and **Pharmacy** (administered through Prime Therapeutics) to all regular full-time employees and regular part time employees per ACA guidelines.

To receive the highest level of benefits under the Health Insurance Plan, you should use **Highmark (BCBS)** facilities and physicians for your medical care. However, if you do not use the **Highmark (BCBS)** network, you still have coverage (with differences in copayments and deductibles) depending upon the plan and network used.

Highmark BCBS (as your PPO Network) approves prior authorizations (PA) for specific services requiring a PA. Please see your full plan document for services requiring a PA. Highmark's PA determines medical necessity, this does not guarantee the service/drug is covered under your plan.

To see if a specific drug or service is covered under your plan, please refer to your plan document or reach out to Highmark (Claim Administrator) and/or Andus LLC for confirmation.

Please make sure to present your medical ID card to your provider.

Dependent Eligibility

You may enroll your eligible dependents when you are enrolled in benefits. Eligible dependents include:

- Your legally-married spouse
- Your dependent children. Included in the definition of dependent children are: your naturally born children, legally adopted children, step-children, or court-ordered dependent children for whom you are court appointed legal guardian.
- Your dependent children up to the age of 26, whether they are full-time students or not. Coverage ends at the end of the month in which the child turns 26.

Note: Proof of relationship is required when adding dependents to the coverage. Please check with Human Resources regarding acceptable documentation.

Qualifying Life Events

The choices you make will be in effect for the plan year beginning October 1st, 2025, through September 30th, 2026. However, you may make changes during the year if you experience a qualifying life event. Examples include: Marriage, Divorce, Birth/adoption of a Child , Death in the Family, Losing Existing Health Coverage

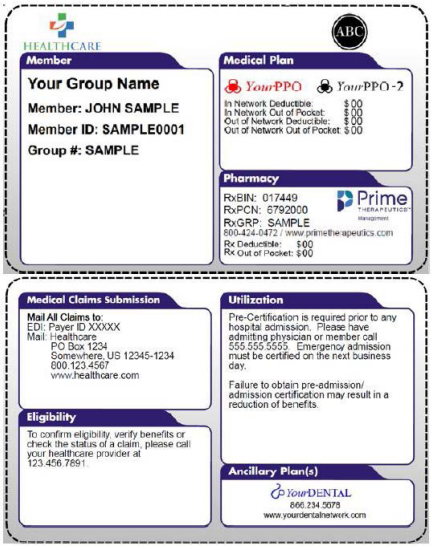
If you need to report a life event change during the year, you will need to contact Human Resources within 30 days of the event.

Employee Contributions

Option 1	Biweekly Employee Contributions	
HDHP	Salary Employees	Hourly Employees
Employee	$62.00	$120.00
Employee + Spouse	$202.44	$488.38
Employee + Child	$118.05	$183.27
Employee + Children	$167.14	$289.85
Family	$266.30	$664.22

Option 2	Biweekly Employee Contributions	
PPO	Salary Employees	Hourly Employees
Employee	$42.97	$42.97
Employee + Spouse	$529.61	$529.61
Employee + Child	$367.30	$367.30
Employee + Children	$520.02	$520.02
Family	$696.70	$696.70

*Below is the front and back of the enrollment card if you enroll in benefits
Please note that your medical card will arrive as part of the package from Prime Therapeutics. This card is for both Medical and Rx



Medical Benefits Summary - HDHP

Benefit	In-Network	Out-of-Network
Primary Care Copay	0% coinsurance	20% coinsurance
Specialty Care Copay	0% coinsurance	20% coinsurance
Adult & Pediatric Preventive Care	No Charge	20% coinsurance
Outpatient Radiology (Imaging:CT/PET scans, MRIs)	0% coinsurance	20% coinsurance
Outpatient Laboratory (Blood Work/X-ray)	0% coinsurance	20% coinsurance
Outpatient Surgery	0% coinsurance	20% coinsurance
Rehabilitation/Habilitation Services	0% coinsurance	20% coinsurance
Inpatient Hospital	0% coinsurance	20% coinsurance
Emergency Room	0% coinsurance	Same as in-network
Urgent Care	0% coinsurance	Same as in-network
Skilled Nursing Care	0% coinsurance	20% coinsurance
Home Health Care	0% coinsurance	20% coinsurance
Mental Health-Inpatient	0% coinsurance	20% coinsurance
Mental Health-Outpatient	0% coinsurance	20% coinsurance
Durable Medical Equipment	0% coinsurance	Not Covered
Deductible/Maximum	**In-Network**	**Out-of-Network**
Plan Year Deductible Individual Family	 $6,350 $12,000	 $10,000 $20,000
Out-of-Pocket Maximum Single Family	 $7,050 $14,100	 $15,000 $30,000

Medical Benefits Summary - PPO

Benefit	In-Network	Out-of-Network
Primary Care Copay	$20 copay / visit Deductible does not apply	20% coinsurance
Specialty Care Copay	$40 copay / visit Deductible does not apply	20% coinsurance
Adult & Pediatric Preventive Care	No charge Deductible does not apply	20% coinsurance
Outpatient Radiology (Imaging:CT/PET scans, MRIs)	0% coinsurance	20% coinsurance
Outpatient Laboratory (Blood Work/X-ray)	0% coinsurance	20% coinsurance
Outpatient Surgery	0% coinsurance	20% coinsurance
Rehabilitation/Habilitation Services	$40 copay / visit Deductible does not apply	20% coinsurance
Inpatient Hospital	0% coinsurance	20% coinsurance
Emergency Room	$75 copay / visit Deductible does not apply	Same as in-network
Urgent Care	$20 copay / visit Deductible does not apply	Same as in-network
Skilled Nursing Care	0% coinsurance	20% coinsurance
Home Health Care	No charge Deductible does not apply	20% coinsurance
Mental Health-Inpatient	0% coinsurance	20% coinsurance
Mental Health-Outpatient	$20 copay / visit Deductible does not apply	20% coinsurance
Durable Medical Equipment	No charge Deductible does not apply	20% coinsurance
Deductible/Maximum	**In-Network**	**Out-of-Network**
Plan Year Deductible Individual Family	 $500 $1,000	 $5,000 $10,000
Out-of-Pocket Maximum Single Family	 $8,700 $17,400	 $15,000 $30,000

Rx Benefits Summary

Option 1 - HDHP	Retail Pharmacy (30-day supply)	Mail Order Pharmacy (90-day supply)
Generic Drugs	0% coinsurance	0% coinsurance
Preferred Brand Drugs	0% coinsurance	0% coinsurance
Non-Preferred Brand Drugs	0% coinsurance	0% coinsurance
Specialty Drugs (only available as an up to 30-day supply)	Specialty follows the tier structure above	

Option 2 - PPO	Retail Pharmacy (30-day supply)	Mail Order Pharmacy (90-day supply)
Generic Drugs	$25 / prescription Deductible does not apply	$50 / prescription Deductible does not apply
Preferred Brand Drugs	$50 / prescription Deductible does not apply	$150 / prescription Deductible does not apply
Non-Preferred Brand Drugs	$70 / prescription Deductible does not apply	$210 / prescription Deductible does not apply
Specialty Drugs (only available as an up to 30-day supply)	Specialty follows the tier structure above	

Prime THERAPEUTICS™

Take Control of Your Health Plan

Human Resources
Muellers

Mike Lupole

mlupole@mjlbenefits.net

Coverage Verification
HealthNow Administrative Services

info@hnas.com

855-550-3733

HealthNow Administrative Services

Claims and Benefits
Andus LLC

www.andushealthbenefits.com

610-234-6231

customerservice@andusllc.com

ANDUS Health Benefits

Pharmacy Rx
Prime Therapeutics

www.primetherapeutics.com

800-424-0472

Prime THERAPEUTICS™

Specialty Drugs
Payer Matrix

www.payermatrix.com

877-305-6202

customerservice@payermatrix.com

PayerMatrix

Medical
Highmark (Blue Cross Blue Shield)

www.highmarkblueshield.com

833-241-5704

HIGHMARK

Muellers McDonald's Prescription Drug Program for Specialty Drugs has been enhanced as of **10/1/2025**

All Plan Participants using specialty drugs are required to meet prior authorization criteria and administrative review under the Payer Matrix program. You must enroll in the Payer Matrix program or you will be responsible for 100% co-insurance or the full cost of your medication.

Muellers Mcdonald's is sponsoring this program and you will not be responsible for any payments to Payer Matrix as a Plan participant.

If you are taking a specialty drug you will be required to call Payer Matrix, in order to receive your specialty drug without delay or interruptions. **You should contact Payer Matrix TODAY and in advance of your next prescription due date. Be Proactive!**

- Please read, complete, and sign the two attached forms as soon as possible.

  The Payer Matrix Enrollment & Communication Consent Form

  The Payer Matrix Authorization Form

- For help, contact a Payer Matrix Case Coordinator toll free at (877) 305-6202 from 9 a.m. to 8 p.m. EST, Monday through Friday.
- **Check to be sure that you have completed the forms and SIGN both. Please fax, email or mail them to Payer Matrix:**
  - Fax the forms to (484) 494-6670
  - Take a smart phone photo of each and email them to CustomerService@PayerMatrix.com
  - Payer Matrix
    407 Elmwood Avenue
    Sharon Hill, PA. 19079

A Payer Matrix Case Coordinator will then contact you to complete the enrollment process and gather any additional information required to help you maximize your benefit for specialty medications under the Muellers McDonald's program. Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, you will be asked to provide this information directly to the alternate funding program, and such information will not be provided to the Fund.

If, you are **NOT** eligible for a Payer Matrix identified alternate funding program, Payer Matrix will automatically submit your case for benefit reconsideration. Should your case meet Muellers McDonald's reconsideration criteria, your out-of-pocket costs will be adjusted to the appropriate selected plan co-insurance and other limitations of your selected plan will apply. All specialty medication prescriptions paid for by Muellers McDonald's through benefit reconsideration must be dispensed/coordinated by **Magellan Rx** who will collect your co-insurance as outlined in your selected benefit.

Payer Matrix

Please complete, sign and return to: Payer Matrix, LLC, 407 Elmwood Ave, Sharon Hill, PA 19079
Ph: (877) 305-6202 | Fax: (484) 494-3444 | Email: CustomerService@PayerMatrix.com

PROGRAM ENROLLMENT & COMMUNICATION CONSENT FORM

PATIENT INFORMATION

PATIENT'S NAME

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last Name:

First Name:

Middle Initial:

Sex: ☐ Male ☐ Female

PERSONAL INFORMATION

Birth Date:

Social Security Number [last 4 digits]

Marital Status [check one] ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widowed

CONTACT INFORMATION

ADDRESS:

Street Address:

P.O. Box:

City: | State: | Zip:

TELEPHONE NUMBERS

Cell: | Home:

Work: | Other:

Best Phone Number To Call You [check one]

☐ Cell ☐ Home ☐ Work ☐ Other

Best Time To Call [check one]

☐ Morning ☐ Afternoon ☐ Evening ☐ Other

INSURANCE INFORMATION

PRIMARY INSURED

Subscriber's Name:

Address [if different] | Home Phone:

Employer: | Employer Phone Number:

Employer Address:

PRIMARY INSURANCE

Name of Primary Insurance:

Social Security Number [last 4 digits]

Birth Date:

Group No:

Policy No:

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Other

Prescription Card #:

BIN #: | PCN #:

SECONDARY INSURANCE [IF APPLICABLE]

Name of Secondary Insurance:

Subscriber's Name:

Group No:

Policy No:

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Other

CONTACT PREFERENCES

I agree to allow Payer Matrix to contact me through all of the following methods regarding my Protected Health Information (PHI) [1] and I authorize Payer Matrix to leave messages for me when I am unavailable unless I note otherwise below.

Check **ALL** methods **AUTHORIZED** for communication:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Other ☐ Text Message ☐ Email

☐ Mail to Home Address ☐ Mail to Other Address:

RELEASE OF INFORMATION

I have signed a Payer Matrix "PATIENT HIPAA AUTHORIZATION" form pursuant to which I have authorized Payer Matrix to obtain my PHI (which may include history, diagnosis, labs, test results, treatment and other health information) from those individuals or companies identified below (include the prescriber of your specialty medication(s) and when possible a member of your household that could confirm the delivery of your specialty medication(s)):

Prescriber of Specialty Drug: | Phone:

Other Persons to Confirm Drug Delivery: | Phone:

PATIENT SIGNATURE

I certify that I am not enrolled in Medicare, Medicaid, Tricare or any other federally sponsored or subsidized healthcare program that pays for any portion of my prescription drug costs. I understand that one of the purposes of completing this document is to enroll in Patient Assistant Programs or other public or private pharmaceutical assistance programs or services and I desire to do so. I understand and accept the risks associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions, patient responsibilities and any other instruction that Payer Matrix may impose.

By my signature below, I acknowledge that I have read and understand the information provided on this Program.

Patient Name Printed: | Patient Signature: | Date:

Authorized Representative Name Printed: | Relationship to Patient:

[1] Protected Health Information ("PHI") is defined by the Health Insurance Accountability and Portability Act of 1996, as amended, and implementing regulations ("HIPAA"). PHI includes information: (i) about an individual's physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; (ii) that identifies the individual or which can be used to identify the individual; and (iii) that is created or received by a health care provider or health plan

Payer Matrix

Please complete, sign and return to: *Payer Matrix, LLC*, 407 Elmwood Ave, Sharon Hill, PA 19079
Ph: (877) 305-6202 | Fax: (484) 494-3444 | Email: CustomerService@PayerMatrix.com

PATIENT AUTHORIZATION FORM

The purpose of this Authorization is to allow Payer Matrix, LLC ("Payer Matrix"), through the Payer Matrix Program, to contact Patient Assistance Programs or other private or public pharmaceutical assistance programs (collectively, "PAPs") in an effort to obtain free or reduced-charge medications on my behalf and to provide a good faith effort to obtain cost reductions to me and my health plan, as more fully described below:

I understand that any prescription drug access assistance received by me in the form of a product subsidy or a medication dispensed to me at no cost is contingent upon my ability to meet the eligibility criteria of the PAP.

I agree that Payer Matrix does not have any obligation to provide PAP enrollment or coverage assistance to me. I understand that I am not guaranteed eligibility to receive my prescription at a reduced cost or no cost from a PAP.

In the event that I am eligible for a PAP, I acknowledge that participation is temporary and that I may be asked to reapply at designated intervals as determined by the PAP. I understand that the PAP may be changed or discontinued at any time, and at such time those services will no longer be provided.

I certify that the information I have provided to Payer Matrix in the Program Enrollment & Communication Consent Form ("Program Enrollment Form") is accurate and complete. I certify that I am not enrolled in Medicare, Medicaid, Tricare or any other federally sponsored or subsidized healthcare program that pays for any portion of my prescription drug costs. I understand that Payer Matrix may contact me by telephone, mail, text or email (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice) as specified in the Program Enrollment Form and by other means upon my prior written consent in connection with a PAP.

I also understand that one of the purposes of this document is to give my permission for the disclosure and use of my Protected Health Information[1] to the extent my permission is required under HIPAA and any other applicable state and federal law.

I request and authorize my healthcare providers, healthcare insurers, pharmacies, and laboratory testing facilities that have provided treatment, payment, or services to me or for me to disclose any of my PHI that pertains to payment for my prescription, to Payer Matrix, or at the written direction of Payer Matrix, to third parties affiliated with or contracted by Payer Matrix, for the following purposes: (i) to determine my eligibility for participation in PAPs or other separate private or public payer programs; (ii) if necessary, to account for and assist with my withdrawal from a PAP and/or transfer to a separate private or public payer program; (iii) to act as my authorized representative to the PAP and dispensing pharmacy to confirm enrollment, track my prescription dispenses and confirm deliveries; and (iv) to use certain information of mine that does not identify me to help improve, develop, and evaluate products, services, materials, programs, and treatment related to my condition or treatment, as well as for health economic outcomes research and market research.

[1] Protected Health Information ("PHI") is defined by the Health Insurance Accountability and Portability Act of 1996, as amended, and implementing regulations ("HIPAA"). PHI includes information: (i) about an individual's physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; (ii) that identifies the individual or which can be used to identify the individual; and (iii) that is created or received by a health care provider or health plan

Payer Matrix

Please complete, sign and return to: *Payer Matrix, LLC,* 407 Elmwood Ave, Sharon Hill, PA 19079
Ph: (877) 305-6202 | Fax: (484) 494-3444 | Email: CustomerService@PayerMatrix.com

PATIENT AUTHORIZATION FORM

I understand that once Payer Matrix receives my PHI, it may disclose my PHI to my healthcare providers and insurers to determine my PAP eligibility. I understand that Payer Matrix may send me information about PAPs that might help me pay for my prescriptions; ask me for financial, insurance and/or medical information, and share my information as required or permitted by this Authorization and applicable law.

I understand that this Authorization allows Payer Matrix and/or PAPs to market its products or services to me or perform other related functions (i.e., communicate with me about access to discounted medications and encourage me to apply for eligibility for programs offered by PAPs) that may result in financial remuneration to Payer Matrix and/or PAP(s).

I understand that I am not required to sign this Authorization and that no healthcare provider or insurer will condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I will not be able to participate in the Payer Matrix Program. I understand that I may cancel this Authorization at any time by providing notification in writing to Payer Matrix, LLC, 407 Elmwood Ave., Sharon Hill, PA 19079. Once notification of cancellation is received and processed, Payer Matrix will not use or disclose my health information on a going forward basis.

I understand that canceling my Authorization will not affect any use of my health information that occurred before my request was processed. This Authorization shall be valid for ten (10) years from the execution date reflected on the signature line set forth below (unless a shorter period is prescribed by state law).

I understand that, unless otherwise restricted by state law, any health information released pursuant to this Authorization is subject to re-disclosure by Payer Matrix and/or any other recipient and will no longer be protected by HIPAA.

PATIENT SIGNATURE

Patient Name:

Patient Signature / Legal Representative:

Indicate Relationship If Legal Representative:

Date:

[1] Protected Health Information ("PHI") is defined by the Health Insurance Accountability and Portability Act of 1996, as amended, and implementing regulations ("HIPAA"). PHI includes information: (i) about an individual's physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; (ii) that identifies the individual or which can be used to identify the individual; and (iii) that is created or received by a health care provider or health plan

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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.