2026 Benefits Guide

AllTrails

FULL TIME EMPLOYEES

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KEEPING *you covered wherever* LIFE TAKES YOU

Open enrollment is from October 27th, through November 7th. All enrollments or changes will be effective December 1, 2025.

WELCOME TO OPEN ENROLLMENT

AllTrails knows that healthcare is not a one size fits all. Just as every person is different, so is their healthcare needs. We encourage employees to review our plan options to ensure you are electing the best plan for you and your family's needs.

WHAT'S CHANGING THIS YEAR

We are pleased to announce that AllTrails will keep all health benefits and contributions the same this year! The IRS maximums have increased on all spending and retirement accounts!

ACTIVE ENROLLMENT

Employees will need to log in to Rippling and enroll in benefits for the new plan year. If you do not take action in Rippling, you will not have benefits starting December 1, 2025.

A NOTE FROM SENIOR LEADERSHIP

Please take some time to review this Open Enrollment Guide to get a full picture of your benefits. We encourage you to explore your options and choose the coverage that best fits your personal needs. You can find detailed plan summaries and documents on the Rippling site to help you make informed choices. Your health and well-being are important to us—if you have any questions, reach out anytime at benefits@alltrails.com.

Thank you for all that you do to make AllTrails a success. Happy hiking!

YOUR HEALTH JOURNEY

EMPLOYEE ELIGIBILITY

AllTrails benefits are open to all full-time employees scheduled to work at least 30 hours per week. All benefits are effective first of the month following date of hire.

FAMILY MEMBER ELIGIBILITY

Eligible employees may enroll the following dependents:

- Your spouse or domestic partner
- Children up to age 26, including natural children, stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order
- Disabled children over age 26 if unmarried, incapable of self- support, dependent on you for primary support and the disability occurred before the age of 26

QUALIFYING EVENTS

You have 30 days from the date of a qualifying life event to modify any current benefit elections. Modifications in your benefits must be consistent with the change in your family status.

A qualifying event is an event that allows you to make specified changes to your benefit enrollment status outside of the regular benefit enrollment period(s). If you experience a qualifying event and would like to enroll, change or drop your benefits, notify HR within 30 days.

HOW MUCH WILL IT COST

AllTrails offers two medical plan options that are 100% employer-paid, plus a buy-up option for full-time employees and their dependents. In addition, AllTrails rewards employees with 100% company-paid dental, vision, and Life/AD&D coverage. If you'd like to add extra life insurance, you can do so at an additional cost.

YOUR HEALTH OPTIONS

AETNA

AllTrails partners with Aetna to offer three competitive, comprehensive and sustainable medical plans.

THREE PPO PLANS TO CHOOSE FROM

AllTrails offers three plans to choose from: a HDHP HSA eligible plan, a PPO 1000 and a PPO 0 plan. If you prefer to have less out of pocket expenses when you visit a doctor, consider the $0 deductible buy-up PPO plan, where you will pay more out of your paycheck but less at time of service. If you prefer to pay less out of your paycheck, consider the $1000 deductible PPO plan or the HDHP plan where you will see less come out of your paycheck, and you will pay more if and when you visit a doctor.

AETNA NETWORK

Our medical plan uses the Aetna National Open Access Managed Choice (OAMC) Network, one of the largest provider networks in the country. With this plan, you can see any doctor or specialist you choose — no referral required — while still enjoying lower costs when you use in-network providers.

OUT OF NETWORK

Out-of-network care means you visit a doctor or facility not contracted with Aetna. You can still get care, but you'll pay more since the plan covers a smaller portion of the cost. To save money, choose Aetna in-network providers whenever possible.

KEY TERMS TO UNDERSTAND

Deductible: Amount that you have to pay before the plan will start paying for medical services.
Co-Insurance: The percentage of a health care cost that you pay after meeting the calendar year deductible.
Out-of-pocket maximum: The most you will have to pay for qualified medical services in one calendar year.

By understanding these terms you can be sure to pick the best plan for you and your family.

Included in your medical plan:
Telemedicine - $0
Preventive Care - $0
Wellness: Virgin Pulse
Mental Health: TalkSpace
Online Therapy: AbleTo

KEEPING YOUR HEALTH ON TRACK

Your prescription drug coverage makes it easier and more affordable to get the medications you need to stay healthy. Whether it's managing an ongoing condition or treating a short term illness, the Opus Anthem plan helps lower the cost of both generic and brand-name prescriptions. You have access to a wide network of pharmacies and convenient options like home delivery — so you can focus on feeling your best without worrying about high medication costs.

PHARMACY (RX) BENEFIT

Your medical card will also be the same card you show at the local pharmacy of your choice to fill prescriptions.

MAIL ORDER WITH CVS CAREMARK THROUGH AETNA

For medications you take regularly, you may be able to have these sent to your home with CVS Caremark. To see if you qualify, Log into aetna.com and go to the **Pharmacy Home** page.

WHAT MEDICATIONS ARE COVERED

To learn more about our Aetna Pharmacy Formulary Lists at any time, visit: www.aetna.com > find a medication.

PRESCRIPTION DRUG COSTS

Prescription copays are the same regardless of which medical plan you are on. If you are enrolled in the HDHP plan, prescriptions are first subject to the overall deductible.

	RETAIL (30 DAY)	MAIL ORDER / RETAIL (90 DAY)	SPECIALITY
Generic	$10	$20	30% up to a maximum of $250/script
Preferred Brand	$30	$60	
Non-Pref Brand	$50	$100	

WELLBEING WITH AETNA

Take advantage of free, interactive online programs through Aetna that are deisgned to support your health and well-being!

ABLETO PROGRAM

Life can feel overwhelming at times, especially during big changes or when managing ongoing health concerns. That's why help is always just a click or call away.

With the AbleTo program, you'll get virtual, one-on-one support to help you manage emotions, reduce stress, and improve your overall health. Visit ableto.com/aetna or call 844.330.3648 to get started.

TALKSPACE THERAPY

Aetna partners with Talkspace to make mental health care easier and more accessible. You can connect with a licensed therapist in just a few days and have sessions through live video, audio, chat, or text — whichever works best for you. Learn more at talkspace.com/aetna.

VIRGIN PULSE

With Aetna, you'll have access to the Virgin Pulse program, designed to help you build healthy habits around fitness and nutrition. And if you're managing a chronic condition, Aetna's Health Connections Disease Management program offers personalized support from nurses, health coaches, and care teams to help you stay on track.

MEDICAL PLANS & COSTS

This table is an overview of your medical plan options. For more detail and benefits, check the full Summary Plan Descriptions online at www.rippling.com.

	HDHP Plan		Base Plan		Buy-Up Plan	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Deductible						
Individual	$2,000	$3,000	$1,000	$2,000	$0	$2,500
Family	$4,000**	$6,000**	$2,000	$4,000	$0	$5,000
Annual Out-of-Pocket Maximum						
Individual	$4,000	$8,000	$4,000	$8,000	$2,500	$12,500
Family	$8,000**	$16,000**	$8,000	$16,000	$5,000	$25,000
Office Services						
Preventive Care	No Charge	40%*	No Charge	40%*	No Charge	40%*
Primary Care Visit	20%*	40%*	$25	40%*	$15	40%*
Specialist Visit	20%*	40%*	$50	40%*	$30	40%*
Urgent Care	20%*	40%*	$50	40%*	$50	40%*
Inpatient Surgery	20%*	40%*	20%*	40%*	20%*	40%*
Emergency Care	20%*		20% after $300 copay / per visit		$300 copay / per visit	
Prescriptions						
Generic	$10*	Not Covered	$10	Not Covered	$10	Not Covered
Brand (Pref/Non-Pref)	$30* / $50*	Not Covered	$30 / $50	Not Covered	$30 / $50	Not Covered
Specialty	30% up to $250*	Not Covered	30% up to $250	Not Covered	30% up to $250	Not Covered

*After Deductible

** Individual within Family plan deductible is $3,300 INN or OON & Out of Pocket Max is $4,000 INN & $8,000 OON

MEDICAL MONTHLY COST OF COVERAGE

Deductions are taken from your paycheck on a pre-tax basis unless otherwise required. See HR for domestic partner rates. Imputed income may apply.

	HDHP Plan	Base Plan	Buy Up Plan
Employee Only	$0	$0	$78.79
Employee + Spouse	$0	$0	$219.53
Employee + Child(ren)	$0	$0	$138.49
Family	$0	$0	$235.02

HEALTHY SMILES

A healthy smile is an important part of your overall well-being. Our dental plan helps you keep up with regular checkups, cleanings, and any care you may need—so you can smile with confidence. Whether it's preventive visits or unexpected dental work, you're covered with quality care and flexible options.

On our plan, dental providers agree to participate in a network by offering discounted fees on dental procedures. When you visit a contracted provider, you receive lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

To avoid unexpected out-of-pocket costs, check to make sure your dental provider is in-network!

SERVICES	BENEFIT
Annual Benefit Maximum	$2,000
Annual Individual Deductible	$50
Annual Family Deductible	$150
Preventive Care	100%
Basic Restorative	90%
Major Restorative	60%

HOW TO FIND A DENTIST

Visit: www.guardianlife.com

Call: 888.600.1600

Plan name: PPO DentalGuard Preferred

Your Member ID with Guardian is your Social Security Number

OUT-OF-NETWORK

Under our dental plan, the reimbursement for services provided by out-of-network dentists is capped at the Maximum Allowable Charge (MAC). For example, if you visit an out-of-network dentist who charges $150 for a cleaning (covered at 100%), but the MAC is set at $100, our insurance will cover up to $100 and you will be responsible for the remaining $50.

MONTHLY COST OF COVERAGE

Tier	Cost
Employee Only	$0
Employee + Spouse	$37.38
Employee + Child(ren)	$49.50
Employee + Family	$94.50

CLEAR VISION STARTS HERE

VISION

Did you know that the muscles that control your eyes are the most active muscles in your body? They are constantly moving to help you focus and track objects! Maintain and/or improve your vision health through your AllTrails VSP/Guardian vision plan.

PREVENTIVE EYE EXAMS

Your vision health can often be a good indicator of your overall health. So quite literally, your eyes are the window to your health. Even if you don't plan to use extended vision care services, a preventive eye exam offers significant benefits. It can not only spot potential vision problems, but it can also detect chronic conditions such as diabetes, high cholesterol and high blood pressure.

VISION MONTHLY COST OF COVERAGE

TIER	COST
Employee Only	$0
Employee + Spouse	$4.02
Employee + Child(ren)	$11.24
Employee + Family	$11.24

READY TO USE YOUR BENEFITS?

Explore more options and buy your glasses or contacts online at **www.eyeconic.com**! Once you have linked your benefits you will be able to see how your coverage will be applied to different options that you are reviewing. Eyeconic features a virtual try-on tool so you can see how the glasses will look on you before you make your purchase.

BENEFITS	IN-NETWORK
Exam copay	$10
Frames	$130 Allowance
Materials Copay	$25
Contact Lenses	$130 Allowance
Exams	Covered once every 12 months
Frames	Covered once every 24 months
Lenses or Contact Lenses	Covered once every 12 months

INVEST IN YOUR HEALTH SAVE FOR YOUR FUTURE

THREE TYPES OF SAVINGS ACCOUNTS

Savings Accounts are a great way to lower your taxable income using pre-tax dollars for qualified healthcare expenses including medical, dental, vision and prescription expenses. There are three types of Savings Accounts to consider:

- Flexible Spending Accounts
- Health Savings Account
- Commuter Account

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) lets you save pre-tax dollars to pay for eligible medical expenses, helping you lower your taxable income. The money in your account grows tax-free and rolls over from year to year, so you never lose what you don't spend. Plus, your HSA funds are yours to keep—even if you change jobs or retire—making it a smart way to plan for both current and future health care cost.

COMMUTER BENEFIT

Commuter benefits allow you to put aside pre-tax dollars monthly for qualifying mass transit expenses. Qualified transit expenses include money spent for commuting on the train, bus, subway, uberPOOL, Lyft Line, BART, or ferry services. Create your profile at www.rippling.com to submit your claims and send funds to your bank account.

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account lets you set aside money, before it's taxed, through payroll deductions. There are two types of FSAs, a healthcare FSA and a dependent care FSA. Monies can be used either for eligible health care, including plan deductibles, copays, dental or vision expenses or dependent day care expenses depending on the which account you enroll in. The benefit of using an FSA is that you reduce your taxable income, which means you have more take home pay. The catch is that you have to use the money in your account by the end of the plan year. Otherwise, any unused money may be forfeited (unless the IRS annual rollover applies).

ANNUAL ROLLOVER

If you have money left in your Health Care FSA at the end of the plan year, you don't have to lose it! You can carry over up to $680 of unused funds into the next plan year to use for eligible expenses. Any amount above that limit will be forfeited, so be sure to plan your spending carefully.

2026 IRS MAX CONTRIBUTION

FSA Health: $3,400
FSA Health Carryover: $680
FSA Dep Care: $7,500

Commuter: $340

HSA: Employee Only $4,400
HSA: Fam Coverage: $8,750
HSA: Eligible individuals aged 55+ at the end of your tax year, your contribution limit is increased by: $1,000

KNOW THE DIFFERENCE

HSA VS FSA

SAVINGS ACCOUNTS

Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA) are both great ways to save on health care costs using pre-tax money. While they work in similar ways, there are some key differences to help you decide which is right for you. HSAs are paired with high-deductible health plans and let your funds roll over year to year, while FSA funds generally must be used within the plan year. Here's a quick look at how the different savings accounts compare.

TYPE OF ACCOUNT	HEALTH SAVINGS ACCOUNTS	FLEXIBLE SPENDING ACCOUNTS	FLEXIBLE SPENDING ACCOUNTS
USE	Healthcare	Healthcare	Dependent Care
ELIGIBILITY	Requires enrollment into the High Deductible Health Plan (HDHP)	You do not have to be enrolled in any AllTrails medical plan	No plan enrollment required
CONTRIBUTION ACCESS	You can only access the amount that you have contributed to date	You can access annual contribution amount at the beginning of the year	You can only access the amount that you have contributed to date
CHANGING ELECTION	You can change how much you contribute at any time during the year	You can only make changes during open enrollment or a qualifying life event	You can only make changes during open enrollment or a qualifying life event
UNUSED BALANCE - ROLLOVER OPTIONS	Your unused balance rolls into the next year	You must use funds by the end of the calendar year. Any unused funds over $680 will be forfeited.	You must use funds by the end of the calendar year. No rollover options available
ACCOUNT OWNERSHIP	You own the HSA account, if you leave AllTrails, this is still yours	AllTrails sponsors your FSA account, if you leave us, your access to the funds ends on the last day of employment unless you enroll in COBRA	AllTrails sponsors your FSA account, if you leave us, your access to the funds ends on the last day of employment

PEACE OF MIND - ON US

BASIC LIFE/AD&D INSURANCE

As part of your overall benefits package, AllTrails provides company-paid life insurance of $50,000 to help protect what matters most — your loved ones.

BENEFIT AMOUNT

- Coverage Amount: $50,000
- Cost to You: $0 – fully paid by the company
- When It Pays Out: Upon your passing, a tax-free lump sum is paid to your beneficiary

VOLUNTARY LIFE/ADD

You can buy more! You can purchase more life Insurance as follows:

Employee: $10,000 increments up to a max of $200,000

Spouse: $5,000 increments up to a maximum of $25,000. Benefit amount may not exceed 100% of the employee's voluntary life amount.

Child: $5,000 increments, $10,000 not to exceed 100% of employee's amount.

Individual rates are displayed when enrolling in the Rippling portal.

GUARANTEE ISSUE FOR VOL LIFE/AD&D

At initial eligibility only, there are no health exams required to receive coverage:

Employee: under age 65: up to $200,000
Spouse: under age 65: $25,000
Child: $10,000

AD&D INSURANCE

Accidental Death & Dismemberment (AD&D) insurance provides extra financial protection in case of a accidental death. If you pass away or suffer a major injury — like losing a limb, vision, or hearing — as a result of an accident, AD&D pays a lump-sum benefit to you or your beneficiary.

BENEFICIARY DESIGNATION

A beneficiary is the person (or people) you choose to receive the payout from your life insurance policy if you pass away. This ensures the benefit goes directly to someone you trust — like a spouse, child, or other loved one — to help provide financial support. Be sure to keep this updated in Rippling!

WHY LIFE INSURANCE IS IMPORTANT

- 1 in 3 households say they would feel the financial impact within a month if a primary wage earner passed away
- Only 52% of Americans have individual life insurance

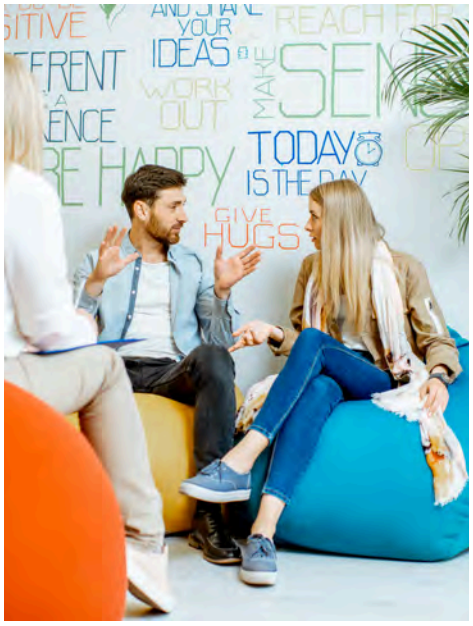
EMPLOYEE WELLBEING

From health and wellness support to help with life's everyday needs and challenges, Guardian's Employee Assistance Program can help with challenges related to personal life, work, family, caregiving, bereavement, legal or financial issues, and even pet care.

EAP COUNSELING SUPPORT

Guardian's EAP through ComPsych is available at no cost to full time employees covered by company life insurance. This benefit is available to you and your family members with confidential, personal and online support on a wide variety of important relevant topics.

This plan provides 24/7 telephone access to clinical experts and resources covering a wide range of topics.



TRAVEL ASSISTANCE

Travel assistance is available when traveling over 100 miles from home and for over 90 days, for both business and pleasure. Services include medical evacuation, prescription assistance, visa and passport requirements, repatriation services and much more.

FUNERAL CONCIERGE

We can't always predict the future, but we can prepare for it. Funeral concierge services helps you make confident, informed decisions, understand your options and stay within budget at a difficult time. You have access to round the clock expert advisers to help you at a time when you need it the most.

ID THEFT & ESTATE GUIDANCE

Services include a fraud resolution kit and consultation with a specialist for victims of identity theft or to learn how to better protect yourself from identity theft. Members have access to online resources to create and execute state-specific wills, powers of attorney and other legal documents.

WE'VE GOT YOUR BACK

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE	POLICY NUMBER
Medical	Aetna	800-872-3862	www.aetna.com	193048
FSA	Rippling	n/a	www.rippling.com	n/a
Dental	Guardian	888-600-1600	www.guardianlife.com	00057098
Vision	Guardian	888-600-1600	www.guardianlife.com	00057098
Life & AD&D	Guardian	888-600-1600	www.guardianlife.com	00057098
Commuter Benefits	Rippling	n/a	www.rippling.com	n/a
Employee Assistance Program (EAP)	ComPsych	855-239-0743	guidanceresources.com	Guardian
Benefit Support	UBF Consulting	877-374-1274	team@ubf.consulting	AllTrails
HR Support	AllTrails	n/a	benefits@alltrails.com	n/a

BENEFITS SUPPORT

UBF Consulting is here to support you! If you have any questions about your benefits or would like to talk to someone about a confidential issue, call UBF. The UBF Client Advocacy team will help you with any benefits questions or concerns. UBF can be reached at team@ubf.consulting.

This brochure highlights the main features of the AllTrails program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. AllTrails reserves the right to change or discontinue its benefit plans at any time.

Important Notices & Disclosures

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

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?
If you decide to join a Medicare Drug Plan, your current coverage will not be affected. The drug plan will coordinate with Part D coverage. The current pre-scription plan offers coverage for generic, brand name formulary and brand name non-formulary prescriptions. If you do decide to enroll in a Medicare Prescription Drug Plan and drop your current prescription drug coverage, be aware that you and your dependents may not be able get this coverage back until Open Enrollment.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

For more information about this notice or your current prescription drug coverage... contact Human Resources for further information.

NOTE: You will receive this notice annually. You will also receive this notice before the next period you can join a Medicare Drug Plan, and if this coverage through the company changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:
• Visit www.medicare.gov
• Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	10/15/2025
Name of Entity:	AllTrails, LLC
Contact- Position/ Office: Address:	Claire Cantrell 530 Bush St #900, San Francisco CA 94108
Phone Number:	415 703 2782

2. WOMEN'S HEALTH AND CANCER RIGHTS ACT 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 has been performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance;
• Prostheses; and treatment of physical complications of all stages of mastectomy, including lymphedema.
These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

3. HIPAA 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 you or your dependents' other coverage). However, you must request enrollment within 30 days after you 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. To request special enrollment or obtain more information, contact Human Resources.

4. QUALIFIED MEDICAL CHILD SUPPORT ORDERS Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions, and procedures as all other plan participants.

5. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
As a participant in the 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 plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan 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 updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
Continue Group Health Plan Coverage
Continue healthcare 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 the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, 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 you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to 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 your 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a 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 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 you 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 cost 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
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 N.W., 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.

6. HIPAA PRIVACY NOTICE
This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully. The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with healthcare benefits. This notice describes the plans' health information privacy policy for your healthcare, dental, personal spending account, and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your healthcare providers.

Our Commitment Regarding Health Information Privacy The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your healthcare expenses. This individually identifiable health information is known as "protected health information' (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans
The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information About You
The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a healthcare provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.
For Payment. The plans may use and disclose your PHI so claims for healthcare treatment, services, and supplies you receive from healthcare providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf
For Healthcare Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce healthcare costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your healthcare treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your healthcare. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.
As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.
Special Use and Disclosure Situations
The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI
if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims or the identity, description, or location of the person who committed the crime.
Workers Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your
PHI to authorized Federal officials 1) for intelligence, counterintelligence, and other national security activities authorized by law, and 2) to enable them
to provide protection to the members of the U.S. Government or foreign heads of state, or to conduct special investigations.
Organ and Tissue Donation. If you are an organ donor, the plans may release medical information
to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal
records, and billing records, but does not include psychotherapy notes.
To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out healthcare treatment, payment, or operations; disclosures made to you; disclosures made prior
to this effective date at the end of this notice; or in certain other situations. To request an accounting
of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right
to request a restriction on the health information
the plans use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address.
To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives — You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

• A power of attorney for healthcare purposes, notarized by a notary public;
• A court order of appointment of the person as the conservator or executor of the individual; or
• An individual who is the parent of a minor child. The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice — The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI
You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints — If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and any of its affiliates will not retaliate against you for filing a complaint.
Other Uses and Disclosures of Health Information. A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.
Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes. Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

7. 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 vaginal delivery, or less than 96 hours following a Caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copay, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're Protected from Balance Billing For:
Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.
When balance billing isn't allowed, you also have these protections:
• You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
• Your health plan must cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
• Your health plan must cover emergency services by out-of-network providers.
• Your health plan must base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
• Your health plan must count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.
If you think you've been wrongly billed, contact HR or for more info or complaints: 800-985-3059 or www.cms.gov/nosurprises/consumers

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).

To see if any other states have added a premium assistance program since January 31, 2024, 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, Ext. 61565

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.

Contact your state for more information on eligibility.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. Contact your state for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447
ALASKA - Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA - Medicaid
Website: Health Insurance Premium Payment (HIPP) Program 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+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www. colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442
FLORIDA - Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html
Phone: 1-877-357-3268
GEORGIA - Medicaid
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
INDIANA - Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA - Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp
HIPP Phone: 1-888-346-9562
KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
KENTUCKY - 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://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA - Medicaid
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
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
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
MASSACHUSETTS - Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
MINNESOTA - Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and-services/other-insurance. jsp
Phone: 1-800-657-3739
MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005
MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
NEBRASKA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178
NEVADA - Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website:http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index. aspx
http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx
Phone: 1-800-692-7462
RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS - Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493
UTAH - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT - Medicaid
Website: http://www.greenmountaincare.org/Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone:1-800-432-5924
WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022
WEST VIRGINIA - Medicaid and CHIP
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
Website:https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm
Phone: 1-800-362-3002
WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269