Your 2027 Plan Notices

MyPlanAdvocate Insurance Solutions, Inc.
Plan Year: January 1 - December 31, 2027

Important information about your health coverage and your rights. Keep this packet with your benefit records and share it with covered family members.

Medicare-Eligible Now or Soon?
Read the prescription drug coverage notice on pages 7-8 before making a Medicare Part D enrollment decision.

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Questions or a Paper Copy?

Human Resources / People Operations
hr@myplanadvocate.com | 877.671.0651
460 West 50 North, Suite 500, Salt Lake City, UT 84101

For 2027 medical and prescription questions, use **myuhc.com** or the member services number on your UHC ID card. HR can help if your card or enrollment is not yet available.

Prepared November 18, 2026. This packet does not replace the Summary Plan Description, insurance contracts, Summary of Benefits and Coverage, event-specific election notices or a separate adopted HIPAA Notice of Privacy Practices. Governing plan documents and applicable law control.

Special Enrollment & Pre-Tax Elections

Loss of Other Coverage or a New Dependent

If you declined health coverage for yourself or an eligible dependent because you had other health insurance or group health plan coverage, you may enroll when that other coverage ends because of a loss of eligibility or the employer stops contributing toward it. If the other coverage is COBRA, special enrollment generally applies when COBRA is exhausted, not when you voluntarily stop paying for it.

Marriage, birth, adoption or placement for adoption may also allow enrollment of you and eligible dependents. **Request an enrollment change promptly through Rippling and HR. Request enrollment within 30 days after the event.** The plan must provide at least 30 days for these HIPAA special-enrollment requests; a more favorable plan deadline, if applicable, controls. The separate Medicaid / CHIP window below is 60 days.

For birth, adoption or placement for adoption, timely special-enrollment coverage is effective as of the event. For marriage or loss of other coverage, coverage must begin no later than the first day of the first calendar month after a completed request, subject to any more favorable plan terms.

Medicaid / CHIP: A Separate 60-Day Window

You and eligible dependents may enroll if Medicaid or CHIP coverage ends because of loss of eligibility, or if you become eligible for Medicaid / CHIP assistance toward this plan's premiums. **Request enrollment within 60 days** after the loss of coverage or the premium-assistance eligibility determination. See the official premium-assistance notice at the end of this packet.

Section 125 Pre-Tax Elections

Eligible benefit contributions may be paid before taxes through MPA's cafeteria plan. Elections generally stay in effect for the plan year. A midyear change is allowed only when permitted by the plan and applicable tax rules; the requested change must meet the relevant conditions. A life event does not automatically permit every benefit change.

Permitted events may include changes in marital or dependent status, employment, eligibility, certain coverage or cost changes, and HIPAA special-enrollment events. Ask HR which rules and documentation apply. Health savings account contribution elections may generally be changed prospectively at least monthly, subject to eligibility, plan procedures and federal limits.

Human Resources / People Operations
hr@myplanadvocate.com | 877.671.0651
460 West 50 North, Suite 500, Salt Lake City, UT 84101

Federal Health Coverage Protections

Women's Health and Cancer Rights Act (WHCRA)

If you have had or will have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided, in consultation with the attending physician and patient, for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to deductibles and coinsurance consistent with those for other medical and surgical benefits under the plan. Consult your selected plan's Summary of Benefits and Coverage and plan document for applicable cost sharing, or call the member services number on your UHC ID card.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not restrict hospital benefits in connection with childbirth to less than 48 hours after a vaginal delivery or 96 hours after a cesarean section. Federal law generally does not prohibit an attending provider, after consultation with the mother, from discharging the mother or newborn earlier. Plans and issuers may not require a provider to obtain authorization for a hospital stay that does not exceed 48 or 96 hours, as applicable.

Patient Protections

If a plan requires or permits designation of a primary care provider, you may select any participating primary care provider available to accept you or your family members. For a child, you may select a participating pediatrician. If a plan requires primary care designation and provides obstetrical or gynecological care, you do not need prior authorization from the plan or another person, including a primary care provider, to obtain that care from a participating specialist in obstetrics or gynecology. The specialist may still need to follow plan procedures, including prior authorization for certain services, a pre-approved treatment plan or referral procedures.

Check your plan document for its provider-designation and referral rules. Call the member services number on your UHC ID card for help selecting a participating provider.

Genetic Information Nondiscrimination Act (GINA)

The group health plan may not use genetic information for underwriting. When responding to a request for medical information, do not provide genetic information unless specifically permitted by law. Genetic information includes family medical history, genetic test results for you or family members, requests for or receipt of genetic services, and certain genetic information about a fetus or embryo.

COBRA: Continuing Health Coverage

General Notice of COBRA Continuation Coverage Rights
This notice explains your rights to temporarily continue group health coverage when it would otherwise end because of certain qualifying events. Read it with your covered spouse and dependents. Your Summary Plan Description and any COBRA election notice provide additional rules and procedures.

What Is COBRA Continuation Coverage?

COBRA is a temporary extension of health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985. After a qualifying event, COBRA must be offered to each qualified beneficiary who would otherwise lose coverage because of the event. Qualified beneficiaries generally are employees, spouses and dependent children covered on the day before the event. A child born to or placed for adoption with a covered employee during COBRA may also have rights.

Each qualified beneficiary has an independent right to elect coverage. A parent or guardian may elect for a minor child. Those electing COBRA may be required to pay the full cost of coverage plus an allowed administrative charge.

When an Employee May Qualify

An employee may qualify if coverage ends because the employee’s hours are reduced or employment ends for a reason other than gross misconduct.

When a Covered Spouse May Qualify

A covered spouse may qualify if coverage ends because the employee dies, has a reduction in hours, ends employment other than for gross misconduct, becomes entitled to Medicare Part A or Part B, or becomes divorced or legally separated from the spouse.

When a Dependent Child May Qualify

A covered dependent child may qualify if coverage ends because of the employee’s death, reduction in hours, termination other than for gross misconduct, Medicare entitlement, divorce or legal separation, or because the child stops being eligible as a dependent under the plan.

Other Coverage Options

COBRA may not be your only option. You may be eligible for coverage through the Health Insurance Marketplace, Medicaid, CHIP or another employer’s plan. These options may cost less. Compare premiums, providers, prescription coverage and enrollment deadlines before deciding.

COBRA: Notices & Enrollment

Tell the Plan About Qualifying Events

The employer must notify the Plan Administrator when the qualifying event is the employee's death, termination of employment, reduction in hours or Medicare entitlement, as required by COBRA.

You must notify the Plan Administrator of divorce, legal separation or a child's loss of dependent status. The notice period must be at least 60 days after the latest of the qualifying event, the date coverage is lost because of that event, or the date you are informed of the notice procedure. Follow the procedure in your Summary Plan Description and election notice. Do not assume the employer already knows.

Contact Natalie Ware at 877.671.0651 or hr@myplanadvocate.com promptly for the required notice procedure. Written notices may be directed to MyPlanAdvocate Insurance Solutions, Inc., Attn: HR / COBRA, 460 West 50 North, Suite 500, Salt Lake City, UT 84101. Include the names of affected covered people, the event and event date, and requested supporting documentation. Keep proof of delivery.

Election and Payment Deadlines

After the Plan Administrator receives notice of a qualifying event, eligible qualified beneficiaries will receive an election notice. You must have at least **60 days** from the later of the election notice date or the date coverage would otherwise end to elect COBRA. Timely elected and paid coverage is generally retroactive to the date coverage was lost.

Your initial payment is due no earlier than **45 days after your election**. Ongoing premiums generally have a 30-day grace period. Follow the amounts, due dates and payment instructions in your election notice. Coverage can end if required premiums are not paid on time.

How Long Can Coverage Last?

Termination of employment or reduction in hours generally provides up to **18 months**. Other qualifying events generally provide up to **36 months** for a covered spouse or dependent child. Special rules may apply when an employee became entitled to Medicare before termination or reduced hours; a spouse or child may be eligible for up to 36 months measured from the Medicare entitlement date.

Coverage may end earlier if premiums are not paid, the employer stops maintaining any group health plan, a qualified beneficiary becomes covered under another group health plan after electing COBRA, or becomes entitled to Medicare after electing COBRA. Other lawful termination rules and the election notice apply.

Keep addresses current. Tell the Plan Administrator when your or a family member's address changes, and keep copies of all COBRA notices.

COBRA: Extensions and Medicare

Disability Extension: Up to 29 Months

If the Social Security Administration determines that a qualified beneficiary was disabled at a time during the first 60 days of COBRA coverage, and the disability continues through the original 18-month period, eligible family members may receive up to 11 additional months, for a total of 29 months.

Provide the disability determination within the notice deadline in the plan's COBRA procedures and before the original 18 months ends. The permitted notice period must be at least 60 days after the latest of the determination, qualifying event, coverage loss or notice of the procedure. Notify the Plan Administrator within 30 days after a final Social Security determination that the person is no longer disabled. A higher premium, up to 150% of plan cost, may apply during the disability extension.

Second Qualifying Event: Up to 36 Months

A spouse or child already receiving COBRA after termination or reduced hours may extend coverage to a total of 36 months if a second qualifying event occurs during the initial period and would have caused a coverage loss without COBRA. Examples include death, divorce, legal separation, Medicare entitlement where it would cause a coverage loss, or loss of dependent status. Notify the Plan Administrator within the required period, which must be at least 60 days under the applicable COBRA notice rules. An extension is not automatic.

Marketplace or Another Employer's Plan

Losing job-based coverage may allow enrollment in the Marketplace or another employer's plan. The Marketplace window generally runs 60 days before and 60 days after coverage loss. Electing COBRA does not extend it. Voluntarily dropping COBRA generally does not create a new Marketplace window outside annual enrollment; exhausting COBRA generally does. Another employer's plan may have a shorter deadline. Visit HealthCare.gov or call 800.318.2596.

COBRA and Medicare

COBRA is not active-employment coverage for Medicare enrollment purposes. The Medicare Part B special-enrollment period generally ends eight months after employment or active-employment group coverage ends, whichever occurs first. COBRA does not extend it. If Medicare entitlement starts after a COBRA election, COBRA may end for that person; if Medicare entitlement predates the COBRA election, entitlement alone does not eliminate COBRA rights. Medicare is generally primary to COBRA. Contact Medicare before delaying enrollment.

Questions About Your Rights

For plan procedures, contact Natalie Ware: 877.671.0651 or hr@myplanadvocate.com. For private-sector COBRA and ERISA rights, contact the U.S. Department of Labor, Employee Benefits Security Administration: **866.444.3272** or dol.gov/agencies/ebsa.

Important Medicare Part D Notice

Important Notice from MyPlanAdvocate Insurance Solutions, Inc.
About Your Prescription Drug Coverage and Medicare

2027 Creditable Prescription Drug Coverage
MPA has confirmed that prescription drug coverage under all four 2027 UnitedHealthcare medical options is expected to pay, on average, at least as much as standard Medicare prescription drug coverage.

Please read this notice carefully and keep it where you can find it. Compare your employer prescription coverage, including covered drugs and costs, with Medicare drug plans available in your area before making an enrollment decision.

Coverage Addressed by This Notice

Plan Year: January 1 - December 31, 2027
Employer: MyPlanAdvocate Insurance Solutions, Inc.
Medical / Prescription Carrier: UnitedHealthcare / Optum Rx
Medical Options: UHC PPO $3,000; UHC PPO $1,000; UHC HSA $3,500 / 80%; and UHC HSA $3,500 / 100%

Two Important Things to Know

1. Medicare prescription drug coverage is available through a stand-alone Medicare Prescription Drug Plan or a Medicare Advantage plan that includes drug coverage. Medicare drug plans provide at least a standard level of coverage established by Medicare; some offer additional coverage for a higher premium.

2. Because the prescription coverage under the options listed above is creditable for 2027, you may keep it instead of enrolling in a Medicare drug plan without a Part D late-enrollment penalty, provided you do not later go 63 consecutive days or longer without creditable drug coverage after your Medicare initial enrollment period.

What Happens if You Join a Medicare Drug Plan?

Before enrolling in Medicare or dropping employer coverage, contact HR and UHC to understand the effect on your and your dependents' medical and prescription benefits and which coverage pays first. Do not assume drug coverage can be dropped separately. If you drop MPA coverage, returning is subject to plan eligibility and enrollment rules; re-enrollment is not guaranteed.

Medicare Part D: Enrollment and Help

When Can You Join a Medicare Drug Plan?

You may enroll when you first become eligible for Medicare and during Medicare's annual enrollment period, **October 15 - December 7**. Losing employer or union coverage, or losing creditable drug coverage through no fault of your own, may create a special enrollment period. It generally lasts for two full months after the month coverage ends; notice timing and the reason for the loss may affect the deadline. Contact Medicare promptly because the special-enrollment window and the 63-day penalty rule are different.

When Could You Owe a Late-Enrollment Penalty?

After your Medicare initial enrollment period, going **63 consecutive days or more** without Medicare drug coverage or other creditable prescription coverage may result in a Part D late-enrollment penalty when you later enroll.

The penalty is generally **1% of the national base beneficiary premium for each full uncovered month**, rounded to the nearest $0.10 and added to your monthly Medicare drug premium. It is not calculated using your chosen plan's actual premium. The base beneficiary premium can change each year, so the penalty may change. You generally pay it while you have Medicare drug coverage. People receiving Extra Help do not pay this penalty.

More Information About Your MPA Coverage

Contact Human Resources at **877.671.0651** or **hr@myplanadvocate.com**. You may request another copy at any time. Creditable-coverage notices are provided annually before October 15, when required following coverage changes, and at other required times.

Free Medicare Help

Medicare: Medicare.gov or 800.633.4227 (TTY 877.486.2048).
State Health Insurance Assistance Program: shiphelp.org or 877.839.2675.
Extra Help / Social Security: ssa.gov/medicare/part-d-extra-help or 800.772.1213 (TTY 800.325.0778).

Keep this notice with your benefit records.
A Medicare drug plan may ask for evidence of prior creditable coverage.

Date Prepared: November 18, 2026
Sender: MyPlanAdvocate Insurance Solutions, Inc.
Contact: Human Resources / People Operations
Address: 460 West 50 North, Suite 500, Salt Lake City, UT 84101
Phone: 877.671.0651 | **Email:** hr@myplanadvocate.com

UHCRewards: Your Rights

A Voluntary Program

UHCRewards is a voluntary program available to eligible members under the applicable program terms. Review the UHCRewards information in your UnitedHealthcare account for available activities, reward limits, eligibility and program rules. UHCRewards information is general information and does not replace advice from your health care professional.

Another Way to Earn the Same Reward

Unable to Meet a Health-Related Standard?
If you are unable to meet a standard related to a health factor to receive a UHCRewards reward, you may qualify for another way to earn the same reward. Call **866.230.2505** or the number on your UHC ID card. UHC will work with you and, if necessary, your doctor to find an alternative that is appropriate for you.

Reasonable alternative standards or a waiver must be available when applicable federal wellness rules require them. A reasonable accommodation may also be available under applicable disability law. Contact UHC for program assistance or MPA HR for help requesting an accommodation.

Your Health Information

Review the program's privacy notice and any notice provided before a health risk assessment, medical examination or biometric screening. Those notices explain the information collected, how it is used, who receives it and the safeguards that apply. Ask questions before you provide information.

Where the ADA or GINA applies, an employee health program must meet the applicable voluntary-program and confidentiality requirements. Individually identifiable medical information must not be used for prohibited employment decisions. You may raise privacy, accommodation or retaliation concerns with HR.

Program Assistance

UHCRewards: 866.230.2505 or the number on your UHC ID card.
UnitedHealthcare Member Account: myuhc.com
MPA HR: hr@myplanadvocate.com | 877.671.0651

Program terms govern reward limits, tax treatment and geographic restrictions. This notice does not create a separate MPA screening program.

Privacy and Surprise-Billing Resources

How to Obtain Privacy Information

To request the group health plan's HIPAA Notice of Privacy Practices or ask about privacy rights, requests or complaints, contact **Human Resources at hr@myplanadvocate.com or 877.671.0651**. Written requests may be sent to MyPlanAdvocate Insurance Solutions, Inc., Attn: HR / Health Plan Privacy, 460 West 50 North, Suite 500, Salt Lake City, UT 84101.

The separate adopted privacy notice explains how the plan uses and discloses health information, your rights and how to exercise them. Carrier and provider notices also apply to their own activities. This annual packet is an availability notice and does not replace or adopt a HIPAA Notice of Privacy Practices.

Your Federal Surprise-Billing Protections

When the No Surprises Act applies, emergency services, certain out-of-network services at in-network hospitals or ambulatory surgical centers, and covered out-of-network air ambulance services generally cannot be balance billed beyond applicable in-network cost sharing. Emergency care does not require prior authorization. Protected cost sharing counts toward in-network deductibles and out-of-pocket limits.

At an in-network facility, protections include emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist and intensivist services. Those providers cannot ask you to waive these protections. Limited notice-and-consent exceptions may apply to certain other services and post-stabilization care. You do not have to give up your protections or obtain out-of-network care. Federal protections generally do not cover ground ambulance bills. State law may provide additional protections.

If a bill seems wrong, contact the **member services number on your UHC ID card** before paying it. For federal questions or complaints, call **800.985.3059** or visit cms.gov/nosurprises. Ask the administrator which federal and state protections apply and for the plan's formal disclosure.

Premium Assistance Under Medicaid / CHIP

The following five pages reproduce the U.S. Department of Labor's **July 31, 2026** model notice and state contact directory, downloaded from DOL on November 18, 2026. Contact the state where you live to ask about help paying employer-plan premiums. If you qualify for premium assistance, request special enrollment in this plan within **60 days** of the eligibility determination.

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, 2026. 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	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
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: https://dss.mo.gov/mhd/hipp Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ 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)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	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	

To see if any other states have added a premium assistance program since July 31, 2026, 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.

OMB Control Number 1210-0137 (expires 5/31/2029)