2026

BENEFIT ENROLLMENT GUIDE

BE WELL. SAVE WELL. LIVE WELL.

KIRBY MEDICAL CENTER

Note: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 11 for more information.

BE READY FOR ENROLLMENT

Kirby is committed to providing our employees with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental and vision coverage, as well as financial security to our employees and their families. This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you.

ENROLLMENT

DO I NEED TO ENROLL?

Before deciding whether you need to enroll in Kirby's health and group benefits, keep in mind that there are many good reasons to take a close look at all the benefits and options Kirby offers you, even if you're already covered under Kirby benefits.

For instance, you may experience changes from year to year. And there likely will be changes to what you pay for coverage each year. So, it's a good idea to make sure your benefits still fit you — and that you're not paying for more coverage than you need.

You must complete your enrollment through Paylocity if you want to:

- Change or add to your medical, dental, or vision coverage for next year.
- Update your beneficiary forms.
- Contribute to the Health Care and/or Dependent Care Flexible Spending Accounts (FSAs).

If you don't enroll, your benefits coverage will end at the close of the current plan year. All employees must make new elections in Paylocity during the Open Enrollment period.

WHEN CAN I ENROLL?

As a benefits-eligible employee, you have the opportunity to enroll in or make changes to your benefit plans during our annual benefits enrollment period. Annual enrollment begins on October 27th and you have until November 7th to make your elections. Coverage will begin effective 1/1/2026.

If you're enrolling as a new employee, you become eligible for benefits on your date of hire and you must enroll within 30 days to have coverage for the rest of the plan year.

WHO CAN I COVER?

You have the option of enrolling yourself and your eligible dependents in medical, dental, and/or vision benefits. Eligible dependents include your:

- Spouse or domestic partner
- Child(ren) up to age 26 regardless of marital or student status
- Unmarried child(ren) of any age who are incapable of supporting themselves due to a mental or physical disability and who are totally dependent on you

Covering Dependents?

You may be required to provide proof of eligibility for any new dependent you want to add to your coverage. Kirby may conduct a dependent eligibility audit at any time.

Domestic Partner Coverage

Domestic partners are eligible to enroll as dependents in the benefit plans. You and your partner must meet specific criteria to qualify for domestic partner coverage. In general, employee premium contributions for domestic partners must be deducted from pay on an after-tax basis (not pretax). In addition, any premium contributions made by Kirby on behalf of your domestic partner are considered taxable income to you. Please contact Human Resources for more information and forms.

WHAT IF THINGS CHANGE?

The benefits you choose will be in place 1/1 - 12/31. You can't change your coverage during that time unless you have a qualified life event. You must make any eligible changes within 30 days of any qualified life event that takes place. Qualified life events include, but are not limited to:

- Marriage, legal separation, or divorce
- Birth, legal adoption of a child, or placement of a child with you for legal adoption
- Death of your spouse, domestic partner, or a dependent child
- Change in residence (if your current coverage isn't available in the new location or if you are offered an option that you were not previously offered)

After a qualified life event, your new coverage will begin immediately.*

*Within 60 days of the event if you, your spouse, or your eligible dependent child loses coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or becomes eligible for state-provided premium assistance.

MEDICAL AND PRESCRIPTION DRUG BENEFITS

Each person's health care needs are different. That's why our medical plan offers multiple options so that you can choose the coverage level best-suited to your personal situation. Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which **you** are responsible.

COST OF COVERAGE

BENEFIT	BLUE CROSS BLUE SHIELD $3,000 PPO		BLUE CROSS BLUE SHIELD $5,000 PPO - NO HRA	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual/Calendar Year Deductible (Individual/ Family)	$3,000/$9,000**	$3,000/$9,000**	$5,000/$10,000	$13,700/$27,400
Out-of-Pocket Maximum* (Individual/Family) (Includes Deductible)	$5,000/$14,700	$10,000/$30,000	$6,850/$13,700	$27,400/$82,200
Lifetime Maximum	Unlimited		Unlimited	
Coinsurance (Portion You Pay)	10%	50%	20%	50%
Physician Services				
Office Visit	$25	50%	$40	50%
Specialist Visit	$35	50%	$65	50%
Preventive Care	0%	50%	0%	50%
Diagnostic Services	10%	50%	20%	50%
Outpatient Services	10%	50%	20%	50%
Inpatient Hospital Services (Per Admission)	10%	50%	20%	50%
Emergency Treatment				
Urgent Care Copay	$35	50%	$80	50%
Emergency Room Copay (Waived If Admitted)	$175	$175	$250	$250
PRESCRIPTION DRUGS				
Retail (30-day Supply)				
Generic	$10	$10	$20	$20
Non-Preferred Generic	$30	$30	$40	$40
Preferred Brand	$60	$60	$50	$50
Non-Preferred Brand	20%	20%	20%	20%
Mail Order (90-day Supply)				
Generic	$27.50	-	$55	-
Non-Preferred Generic	$82.50	-	$110	-
Preferred Brand	$165	-	$137.50	-
Non-preferred Brand	20%	-	20%	-

*Includes all Medical and Rx copays, deductibles, and coinsurance. Deductibles are not individually accumulated — they cross apply.

**Kirby will continue to fund your Health Care Reimbursement Account (HRA) through Paylocity; please see the chart below for funding amounts.

NOTE: Your medical plan options must offer certain preventive care benefits to you in-network without cost sharing and these preventive care benefits generally are updated annually. Under the Affordable Care Act, the medical plans generally may use reasonable medical management techniques to determine frequency, method, treatment or setting for a recommended preventive care service. You may obtain a list of preventive care services at www.bcbsil.com/provider/clinical/clinical-resources/preventive-care.

EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS – KIRBY $3,000 PPO (MONTHLY)	2026 TOTAL MONTHLY PREMIUM	2026 EMPLOYEE MONTHLY PREMIUM	2026 KIRBY MONTHLY CONTRIBUTIONS
Employee Only	$1,032.70	$219.10	$813.60
Employee + Spouse/Domestic Partner	$2,254.88	$475.94	$1,778.94
Employee + Child(ren)	$2,098.63	$443.60	$1,655.03
Employee + Family	$2,950.83	$623.20	$2,327.63
EMPLOYEE CONTRIBUTIONS – KIRBY $5,000 PPO – NO HRA (MONTHLY)	**2026 TOTAL MONTHLY PREMIUM**	**2026 EMPLOYEE MONTHLY PREMIUM**	**2026 KIRBY MONTHLY CONTRIBUTIONS**
Employee Only	$849.51	$138.28	$711.23
Employee + Spouse/Domestic Partner	$1,852.57	$390.62	$1,461.95
Employee + Child(ren)	$1,725.96	$364.58	$1,361.38
Employee + Family	$2,425.50	$511.86	$1,913.64
KIRBY HRA CONTRIBUTIONS (ANNUAL)			
Employee Only	$2,100.00		
Employee + Spouse/Domestic Partner	$4,200.00		
Employee + Child(ren)	$4,200.00 (Child); $6,300.00 (Children)		
Employee + Family	$6,300.00		

ADVANTAGES OF A HEALTH REIMBURSEMENT ACCOUNT (HRA)

If you are enrolled in the Blue Cross Blue Shield $3,000 PPO health plan offering, you are automatically enrolled in the Kirby Health Reimbursement Account (HRA) with Paylocity. A Health Reimbursement Account is a tax-advantaged benefit that allows employees to save on the cost of health care. Enrolling in an HRA provides two major advantages to employees: (1) a reduced health insurance premium resulting from the High Deductible Health Plan, and (2) availability of employer-sponsored funds to pay for medical expenses incurred prior to the point at which the insurance deductible is met.

HRA plans are employer-funded medical reimbursement plans. Kirby sets aside a specific amount of pre-tax dollars for employees to pay for health care expenses on an annual basis. The HRA can help generate significant savings in overall health benefits. Below are the levels that Kirby funds the HRA annually:

- EE = $2,100.00
- EE+1 = $4,200.00
- EE+ Family =$6,300.00

Additionally, Kirby allows for employees to roll over HRA funds given the following rules: An employee is allowed to roll over their HRA balance; however, the balance of the account cannot exceed the deductible.

Please reach out to Human Resources with questions on eligible expenses.

RETIREE HEALTH REIMBURSEMENT ARRANGEMENT

Employees with at least 10 years of service that retire from a benefits-eligible position may elect to participate in a Retiree HRA if they are between the ages of 60-64. The HRA is funded with $6,000 each January 1st for use by the retiree for the purchase of any health insurance plan, and any qualifying healthcare expenses. Employees that begin the Retiree HRA mid-year receive a pro rata amount. There is no balance carryover. Each January 1st the balance is reset to $6,000.

DENTAL BENEFITS

Your dental health is an important part of your overall wellness. The following dental insurance option is offered through Delta Dental. Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which **you** are responsible.

Your Delta Dental PPO Plus Premier plan includes the following features: Enhanced Benefit Program offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high risk cardiac conditions, and suppressed immune systems) that can be positively affected by additional oral health care.

COST OF COVERAGE

BENEFIT	DELTA DENTAL PPO NETWORK	DELTA DENTAL PREMIER® NETWORK	NON-NETWORK
Maximum Benefit	$1,500	$1,500	$1,500
Deductible	$0	$0	$0
Preventive Services	0%	0%	0%
Basic Services	20%	20%	20%
Major Services	50%	50%	50%
Orthodontia to Age 19	50%	50%	50%
Lifetime Ortho Maximum	$2,000	$2,000	$2,000
EMPLOYEE CONTRIBUTIONS (MONTHLY)			
Employee Only	$16.44		
Employee + Spouse/Domestic Partner	$41.65		
Employee + Child(ren)	$41.65		
Family	$62.48		

VISION BENEFITS

Kirby offers you and your dependents vision coverage through EyeMed. This information is only a summary of your vision coverage; contact Human Resources for more information about the vision plan.

COST OF COVERAGE

BENEFIT	IN-NETWORK MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
Exam	$10	Up to $35
Lenses	$10	Varies
Frames	$140 Allowance; 20% Off Balance Over $140	Up to $70
Contact Lenses Instead of Glasses		
Conventional/Disposable	$155 Allowance; 15% Off Balance Over $155	Up to $124
Medically Necessary	Paid in Full	Up to $200
BI-WEEKLY PAYCHECK DEDUCTIONS		
Employee Only	$5.00	
Employee + 1	$7.00	
Family	$10.00	

NOTE: ID Card not required for vision services.

INCOME PROTECTION BENEFITS

Kirby provides eligible employees with a variety of plans to provide replacement income for you or your beneficiaries in the event of disability, accident, or death. The following information is a summary of coverage only. Refer to your summary plan description (SPD) or certificate of coverage for more details.

Kirby provides the following benefits at no cost to you:

- Basic Life Insurance
- Accidental Death and Dismemberment (AD&D)
- Long-Term Disability

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Basic Life and AD&D

Kirby provides you with Basic Life Insurance in the amount of 2x and AD&D coverage in the amount of 2x earnings. Employees that work at least 24 hours per week are eligible.

Additional conditions apply. Please see HR for details.

Supplemental Term Life

You have access to Supplemental Life Insurance through Prudential, which gives you the opportunity to buy valuable life insurance coverage for yourself, your spouse, and your dependent children - all at affordable group rates. Employees that work at least 30 hours per week are eligible.

Additional conditions apply. Please see HR for details.

Key Provisions:

- **Employee:**
  - $10,000 increments to a max of the lesser of 5x pay or $500,000
  - Guaranteed Issue of $100,000 (no medical questions asked up to that level during the initial offering)
  - Supplemental AD&D available as well (100% Supplemental Life election)
- **Spouse:**
  - $5,000 increments to a max of $100,000 (not to exceed 50% of employee's optional life amount)
  - Guaranteed Issue of $25,000 (no medical questions asked up to that level!)
  - Supplemental AD&D available as well (100% of Dependent Life election)
- **Child(ren):**
  - 15 days to 6 months = $1,000
  - 6+ months = $1,000 increments to a max of $10,000 (not to exceed 50% of employee's optional life amount)

*Please see enrollment forms and Prudential plan summary for further details.

DISABILITY

You have access to Long-Term Disability (LTD) Insurance through Prudential.

- **Long-Term Disability Insurance:** This benefit pays a portion of your income if you continue to be disabled. To qualify, you must be disabled for 90 days. LTD benefits provide you with 60% of your annual base pay up to a $10,000 monthly maximum. Kirby pays the full cost of this coverage.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Reduce your tax bill while putting aside money for health care and dependent care needs.

Flexible spending accounts (FSAs) allow you to put aside money for important expenses and help you reduce your income taxes at the same time. Kirby offers two types of accounts — a health care FSA and a dependent care FSA.

HEALTH CARE FSA

Deductibles, copays, prescription drugs, medical equipment, etc.

DEPENDENT CARE FSA

Babysitters, day care, day camp, home nursing care, etc.

HOW FLEXIBLE SPENDING ACCOUNTS (FSAs) WORK

1. Each year during the Open Enrollment period, you decide how much to set aside for health care and dependent care expenses.
2. Your contributions are deducted from your paycheck on a before-tax basis in equal installments throughout the calendar year.
3. You can use your FSA debit card to pay for eligible expenses at the point of sale, or you can pay out-of-pocket and submit a claim form for reimbursement.

Please note that these accounts are separate — if eligible, you may choose to participate in one, all, or none. You cannot use money from the health care FSA to cover expenses eligible under the dependent care FSA or vice versa.

PLAN	ANNUAL MAXIMUM CONTRIBUTION	EXAMPLES OF COVERED EXPENSES*
Health Care Flexible Spending Account	$3,400	Copays, deductibles, orthodontia, over-the-counter medications, etc.
Dependent Care Flexible Spending Account	$5,000 ($2,500 if married and filing separate tax returns)	Day care, nursery school, elder care expenses, etc.

NOTE: See IRS Publications 502 and 503 for a complete list of covered expenses.

USE IT OR LOSE IT!

Be sure to calculate your FSA contributions carefully. These funds do not roll over from year-to-year, and you must actively enroll on a yearly basis. You are not automatically re-enrolled.

If you have any money left in your account(s) at the end of the plan year:

- **Health Care FSA:** You may carry over up to $680 for use in the next plan year. You may incur additional claims for an additional 75 days.
- **Dependent Care FSA:** Your balance will be forfeited.

HEALTH CARE ITEMS YOU MIGHT NOT REALIZE ARE FSA ELIGIBLE:

- Sunscreen
- Heating and cooling pads
- First aid kits
- Shoe inserts and other foot grooming treatments
- Travel pillows
- Motion sickness bands

For a complete list of covered expenses, contact Human Resources.

ADDITIONAL BENEFITS

EMPLOYEE ASSISTANCE PROGRAM

Through the Employee Assistance Program (EAP), you and eligible members of your household have 24/7 access to confidential counseling to help you address issues such as relationship struggles, drug and alcohol abuse, financial hardship, and general stress or depression. Many issues can be addressed directly with an EAP professional; in some cases, you may be referred to other resources. The Employee Assistance Program can be reached at **1-800-228-6380** or at **www.carleresolutions.com**.

METLAW

Kirby provides employees with access to MetLaw, a network of over 14,000 attorneys with an average of 25 years of experience for only $21 per month. This service provides employees flexibility to select an attorney that best meets their individual needs. For more information on services covered, please see additional information provided by HR.

*Limits subject to change in accordance with IRS guidelines.

401(k) RETIREMENT PLAN

Please refer to the Kirby Medical Center 401(k) Plan summary on the KMC intranet for more complete details.

Eligibility Conditions

An employee is eligible to participate in the 401(k) Plan if they have attained age 18 and have completed three months of service. You may enter the Plan on the first of the month following eligibility. Full-time, part-time, and PRN employees may participate. To be eligible for Profit Sharing, you must be a participant, employed on the last day of the Plan year, and have completed at least 1,000 hours of service during the Plan year.

Employee Contributions

As a participant under the Plan, you may elect to reduce your compensation by a specific percentage and have that amount contributed to the Plan as a salary deferral. There are two types of salary deferrals – Pre-Tax 401(k) and post-tax Roth 401(k).

Matching Contributions and Vesting

Kirby Medical Center may make matching discretionary contributions to the Plan. KMC may also make discretionary Profit Sharing contributions. The Plan has a vesting schedule that determines the percentage of matching contributions a participant will retain following employment separation. The vesting schedule is based on years of service with Kirby Medical Center and participants are 100% vested after six (6) years of service. The current employer match is 150% of up to the first 4% of the employee's contribution.

PET INSURANCE

Your pets are an important part of your family. Kirby offers pet insurance through Nationwide. Coverage is available for dogs, cats, birds, reptiles, and other exotic pets. Coverage may cover accidents, common illnesses, chronic illnesses, procedures, and more. Call **1-877-738-7874** or visit **PetsNationwide.com** to sign up.

OTHER COVERAGE

Employees may enroll in various insurance programs through AFLAC and/or other carriers. These coverages vary, and premiums may or may not be payable via payroll deduction. Please see Human Resources to learn more about coverages not otherwise listed in this benefit guide.

BENEFITS QUESTIONS?

If you have questions regarding eligibility, benefit plans, enrollment periods, or would like additional information, contact Human Resources.

REFERENCES AND RESOURCES FOR ADDITIONAL INFORMATION

BENEFIT	CONTACT	CALL	VISIT/EMAIL	PLAN/GROUP ID
Medical/Prescription Drug	Blue Cross Blue Shield of Illinois	1-800-346-7072	www.bcbsil.com	Group ID #433889; 433890
Dental	Delta Dental	1-800-323-1743	www.deltadentalil.com	11606
Vision	EyeMed	1-866-939-3633	www.eyemed.com	9708918
Life Insurance	Prudential	1-800-842-1718	www.prudential.com	62431
Long-Term Disability				
Flexible Spending Accounts	Paylocity Consumer Support Team	1-800-631-3539	batinfo@paylocity.com	313200
HRA				
Voluntary Benefits - AFLAC	Aflac, James Schwerdtfeger	1-217-454-8208	james_schwerdtfeger@us.aflac.com	N/A
Pet Insurance	Nationwide	1-877-738-7874	www.petsnationwide.com	Kirby Medical Center
EAP	Carle Resolutions	1-800-228-6380	www.carleresolutions.com	N/A
401(k) Savings	Susan Busby	1-217-762-1534	sbusby2@kirbyhealth.org	N/A
	American Trust, Diana Jordan	1-217-820-1699	Djordan@Americantrust.com	N/A
COBRA	Paylocity	1-800-631-3539	batinfo@paylocity.com	313200
HR Department	Abigail Turner	1-217-762-1858	aturner@kirbyhealth.com	N/A

ABOUT THIS GUIDE: Actual plan provisions for Kirby ("the Company") benefits are contained in the appropriate plan documents, including the Summary Plan Description (SPD) and incorporated benefit/carrier booklets. The Benefit Enrollment Guide is a summary only and does not describe each benefit option. This Benefit Enrollment Guide provides updates to your existing SPD as of the first day of plan year, which describes your health and welfare benefits in greater detail. Until the Company provides you with an updated SPD, this guide is intended to be a Summary of Material Modification (SMM) and should be retained with your records along with your SPD. As always, the official plan documents determine what benefits are available to you. If any discrepancy exists between this guide and the official documents, the official documents will prevail. The Company reserves the right to amend or terminate any of its plans or policies, make changes to the benefits, costs, and other provisions relative to benefits at any time with or without notice, subject to applicable law.

Updated 10/2025

GLOSSARY

AFFORDABLE CARE ACT (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime dollar limits on medical benefits, covering preventive care in-network without cost-sharing if the plan is grandfathered, etc., among other requirements.

BRAND NAME DRUG

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COINSURANCE

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

COPAYMENT (COPAY)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

DEDUCTIBLE

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

EMPLOYER CONTRIBUTION

Each January, the company provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

GENERIC DRUG

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

HEALTH SAVINGS ACCOUNT (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

OUT-OF-POCKET MAXIMUM

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

PLAN YEAR

The year for which the benefits you choose during enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next enrollment period.

PREVENTIVE CARE

Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).

IMPORTANT NOTICES

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary Plan Descriptions (SPDs), plan document, and/or certificate of coverage for each plan. Your SPDs can be obtained at **www.bcbsil.com**; you may also request a copy free of charge by calling **1-800-346-7072**.

Enclosed are important notices about your rights under your health and welfare plan (PPO PLAN 3000 and PPO PLAN 5000), the "Plan." The information in the accompanying guide provides updates to your existing SPDs as of 01/01/2026 and is intended to be a Summary of Material Modification.

If any discrepancy exists between this guide and the official documents, the official documents will prevail. Kirby Medical reserves the right to amend or terminate any of its plans or policies, make changes to the benefits, costs, and other provisions relative to benefits at any time with or without notice, subject to applicable law.

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the Kirby Medical PPO PLAN 3000 and PPO PLAN 5000 (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the Kirby Medical PPO PLAN 3000 and PPO PLAN 5000 Privacy Notice upon your written request to the Human Resources Department, at the following address:

Kirby Medical Center, Human Resources
1000 Medical Center Dr.
Monticello, IL 61856

If you have any questions, please contact the Kirby Medical Human Resources Office at **1-217-762-1858**.

Patient Protection Notice

PPO PLAN 3000 and PPO PLAN 5000 generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

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 was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance including coverage for nipple and areola reconstruction (including re-pigmentation) to restore physical appearance of the breast, and chest wall reconstruction with aesthetic flat closure;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at **1-217-762-1858**.

Newborns' and Mothers' Health Protection Act Disclosure

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted, and you will continue to pay the same amount as if you were not absent.

If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact Kirby Medical Center for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service-connected illnesses or injuries, as applicable.

IMPORTANT NOTICE FROM KIRBY MEDICAL ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kirby Medical 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. Kirby Medical has determined that the prescription drug coverage offered by the PPO PLAN 3000 and PPO PLAN 5000 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 through December 7th.

However, if you lose (or are losing) 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 Kirby Medical coverage will not be affected.

Your Kirby Medical coverage pays for other medical expenses in addition to prescription drugs. This coverage provides benefits before Medicare coverage does (i.e., the plan pays primary). You and your covered family members who join a Medicare prescription drug plan will be eligible to continue receiving prescription drug coverage and these other medical benefits. Medicare prescription drug coverage will be secondary for you or the covered family members who join a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and voluntarily drop your current medical and prescription drug coverage from the plan, be aware that you and your dependents may not be able to get this coverage back until the next annual enrollment or you experience a qualifying life event.

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 Kirby Medical 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.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Kirby Medical changes. You also 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 drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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.ssa.gov**, or
- Call **1-800-772-1213**. TTY users should call **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: October 27, 2025
Name of Entity/Sender: Kirby Medical
Contact: Abigail Turner
Address: 1000 Medical Center Dr.
Monticello, IL 61856
Phone Number: **1-217-762-1858**

YOUR ERISA RIGHTS

As a participant in the Kirby Medical benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust 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's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description governing the plan on the rules governing your COBRA continuation coverage rights.

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 plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days. 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;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court;
- 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; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim frivolous.

Assistance With Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: **https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices**.

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at: **1-866-444-3272**. You may also visit the EBSA's website on the Internet at: **https://www.dol.gov/agencies/ebsa**.

GENERAL NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

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

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Kirby Medical Center, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Kirby Medical Center.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child.

This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

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

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

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

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

For more information visit **https://www.medicare.gov/medicare-and-you**.

NOTE: https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Kirby Medical Center
1000 Medical Center
Dr. Monticello, IL 61856
1-217-762-1873

SUMMARIES OF BENEFITS AND COVERAGE (SBCs)

Availability Notice

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: **www.bcbsil.com**. A paper copy is also available, free of charge, by calling **1-800-346-7072** (a toll-free number).

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 the Kirby Medical group health plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Abigail Turner, HR Generalist, at **1-217-762-1858**.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

1. ALABAMA – Medicaid
   Website: http://myalhipp.com/
   Phone: 1-855-692-5447
2. ALASKA – Medicaid
   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
3. ARKANSAS – Medicaid
   Website: http://myarhipp.com/
   Phone: 1-855-MyARHIPP (855-692-7447)
4. CALIFORNIA – Medicaid
   Health Insurance Premium Payment (HIPP) Program
   Website: http://dhcs.ca.gov/hipp
   Phone: 916-445-8322
   Fax: 916-440-5676
   Email: hipp@dhcs.ca.gov
5. 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://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
6. FLORIDA – Medicaid
   Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
   Phone: 1-877-357-3268
7. GEORGIA – 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
8. INDIANA – Medicaid
   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
9. IOWA – Medicaid and CHIP (Hawki)
   Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
   Medicaid Phone: 1-800-338-8366
   Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
   Hawki Phone: 1-800-257-8563
   HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
   HIPP Phone: 1-888-346-9562
10. KANSAS – Medicaid
    Website: https://www.kancare.ks.gov/
    Phone: 1-800-792-4884
    HIPP Phone: 1-800-967-4660
11. 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://kynect.ky.gov
    Phone: 1-877-524-4718
    Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
12. 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)
13. MAINE – Medicaid
    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
14. MASSACHUSETTS – Medicaid and CHIP
    Website: https://www.mass.gov/masshealth/pa
    Phone: 1-800-862-4840
    TTY: 711
    Email: masspremassistance@accenture.com
15. MINNESOTA – Medicaid
    Website: https://mn.gov/dhs/health-care-coverage/
    Phone: 1-800-657-3672
16. MISSOURI – Medicaid
    Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 573-751-2005
17. MONTANA – Medicaid
    Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
    Email: HHSHIPPProgram@mt.gov
18. NEBRASKA – Medicaid
    Website: http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 402-473-7000
    Omaha: 402-595-1178
19. NEVADA – Medicaid
    Medicaid Website: http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid
    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
21. NEW JERSEY – Medicaid and CHIP
    Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
    Phone: 1-800-356-1561
    CHIP Premium Assistance Phone: 609-631-2392
    CHIP Website: http://www.njfamilycare.org/index.html
    CHIP Phone: 1-800-701-0710 (TTY: 711)
22. NEW YORK – Medicaid
    Website: https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid
    Website: https://medicaid.ncdhhs.gov/
    Phone: 919-855-4100
24. NORTH DAKOTA – Medicaid
    Website: https://www.hhs.nd.gov/healthcare
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid
    Website: http://healthcare.oregon.gov/Pages/index.aspx
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid and CHIP
    Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
    Phone: 1-800-692-7462
    CHIP Website: https://www.pa.gov/agencies/dhs/resources/chip.html
    CHIP Phone: 1-800-986-KIDS (5437)
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid
    Website: https://www.scdhhs.gov
    Phone: 1-888-549-0820
30. SOUTH DAKOTA – Medicaid
    Website: http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid
    Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP
    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/
33. VERMONT – Medicaid
    Website: https://dvha.vermont.gov/members/medicaid/hipp-program
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP
    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
35. WASHINGTON – Medicaid
    Website: https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. 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)
37. WISCONSIN – Medicaid and CHIP
    Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. 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, 2025, or for more information on special enrollment rights, contact either:

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

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