



Open Enrollment: October 12 - 23, 2027

EMPLOYEE BENEFITS 2027



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WELCOME

At Madix it's our employees who make the difference in our success. That's why, each year, you have the opportunity to choose from a variety of benefits that can make a real difference in your life. We offer a broad range of benefits, including health care, life insurance, disability insurance, and much more. You can customize a benefits program that's exactly right for your personal situation.

This guide provides a summary of your benefit options as well as any material modifications to our benefit offerings from the previous year. Please review it carefully and make your elections before the deadline.

All elections you make during the Open Enrollment period will be effective on January 1, 2027. No changes will be allowed at any other time unless you have a Qualifying Life Event (such as a birth, death, divorce, marriage, etc.).

If you have any questions about your benefits choices or about how to enroll, please contact your local HR department.

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 28 for more details.

A LETTER FROM OUR CFO

Dear Madix Associates,

Congratulations to each of you as we celebrate 70 years as a company! This longevity as an organization shows our resiliency, creativity, and business acumen to maximize successes and navigate challenges through our history. Let's continue to mimic our founders to be Strong as Steel doing everything in our power to accommodate a customer's request while valuing people so they feel safe, valued, and fulfilled.

With 2027 around the corner, now is a good time to review your employee benefit elections for medical, dental, vision, and other voluntary insurance offerings. Open enrollment will be held October 12th – 23rd with selections available in Workday to review. We will also have benefit counselors on site to answer questions. Please be on the lookout for dates and times then contact your local HR representatives if you need additional information.

The Madix group health plan continues to be one of the company's largest investments, with projected costs of approximately \$12 million in 2027. To help manage rising healthcare costs while maintaining comprehensive coverage, weekly employee medical contributions will increase by 5% effective January 1, 2027, across all coverage tiers. To help offset this increase, individual plan deductibles will be reduced by \$150. Medical coverage will remain with the same carrier, and there will be no significant changes to plan design, covered benefits, copays, or deductibles. Dental and vision premiums will remain unchanged. Please log into Workday to review the 2027 benefit rates.

Equitable will continue to provide voluntary insurance products such as short and long-term disability, critical illness, and hospital indemnity coverage at group rates. Please review offerings for any updates to premiums. Other benefit opportunities to take advantage of including the 401(k) plan with Fidelity (company match up to 4%), telemedicine provided by MDLive (\$0 copay), and Medicare education provided by Medicare Choice Group. Be sure to visit www.401k.com to review your weekly contribution and investment elections so you are ready for retirement when that day comes.

70 years – an incredible accomplishment that can only be matched by another 70 years! With your care for our customers and for each other, we will go beyond the next 70 years! Thank you for your efforts as we continue to be a leader in the markets we serve.

Respectfully,

JUSTIN

Justin L. Saunders, VP/Chief Financial Officer

BENEFITS QUESTIONS? WE CAN HELP

2027 Open Enrollment Support is available!

Madix is excited to provide onsite enrollment support during this year's open enrollment!

Benefits Specialists will be available to help with:

- General benefit questions
- Enrollment assistance
- Dependent and beneficiary additions
- Connect you with the right insurance carrier or benefit provider

Benefits Specialists will be available onsite:

Terrell

October 13th, 14th and 15th

Eclectic

October 19th and 20th

Goodwater

October 21st and 22nd

New Hire and Qualifying Life Events

New to Madix and enrolling for the first time? Experienced a life event and need to make changes to your benefits?

Benefit Specialists are available via phone on a first come, first served basis Monday – Friday 8:00 am to 5:00 pm CST.

Please call **866-996-0222** to speak to a Benefit Specialist OR book an appointment to receive a call at a designated time by going to **madixinc.simplybook.me/v2** or scanning the QR code.



HIGHLIGHTS FOR 2027

Here's a list of what's changing—and what's not—for the 2027 plan year. The changes outlined below will take effect January 1, 2027, unless otherwise noted.

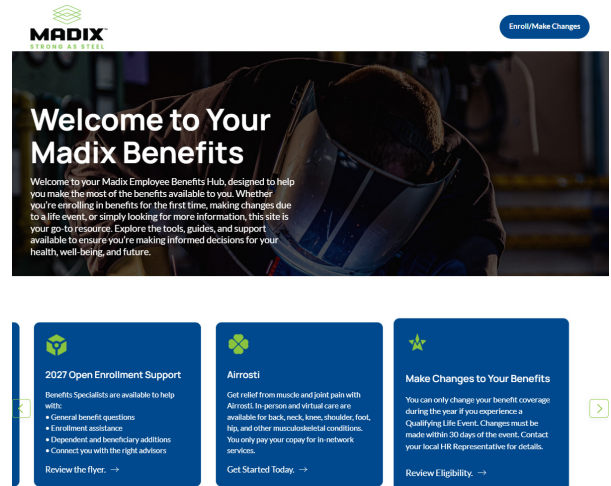
- Continuous glucose monitors for employees or dependents with diabetes will be covered under your pharmacy benefit. This means you will pay the pharmacy copay for your CGM instead of the medical coinsurance amount.
- No changes to out-of-pocket maximums.

Did You Know?

Need benefits information? Visit MadixBenefits.com year-round to review your plans, compare options, and access helpful benefits resources for you and your family.

Whether you're looking to maximize your healthcare benefits, plan for the unexpected, or support your financial well-being, Madixbenefits.com is your one-stop-shop.

Check it out today and take charge of your benefits!



HOW TO ENROLL



Enroll Through Your Workday Login!

Download the app or log in from your computer to access Workday and review:

- Benefit Information and complete Open Enrollment
- Pay information—no more paper pay stubs to keep up with or shred!
- Update bank account information for direct deposits
- Change tax status for federal and state withholding taxes
- Update contact info (address, phone, email, etc.)
- Request approval for time off from your supervisor or view available balances

Login Information

Madix Workday link

wd12.myworkday.com/madixinc/login.html

Option 1: If you have a madixinc.com email address, please click the SSO option and use your email address and email password to log on to Workday. Follow the steps to complete the multi-factor authentication (MFA) prompts.

Option 2: If you do not have a madixinc.com email address, please click the Native Login option and use your Workday username (first name.last name) and existing password. If you do not know your password, please contact your local HR representative.



Download the Workday app or log on to complete Open Enrollment between October 12–23, 2026!

ELIGIBILITY

If you work at least 30 hours per week, you are eligible for benefits. You may also enroll your eligible dependents for coverage. This includes the following:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency, or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return

Qualifying Life Events

Generally, you may only change your benefit elections during the Open Enrollment period. However, since life happens, you also may change your benefit elections during the year if you experience a Qualifying Life Event.

	QUALIFYING LIFE EVENT	DOCUMENTATION NEEDED
Change in marital status	Marriage	Copy of marriage certificate
	Divorce	Copy of divorce decree
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

Qualifying Life Events

During the year, you cannot make changes to your medical, dental, or vision unless you have a Qualifying Life Event. Changes must be made within 30 days of the Qualifying Life Event, otherwise you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualifying Life Event). For more information, please contact your local HR representative.

New Hire Benefits Enrollment

Employees who are new to Madix have 30 days from date of hire to complete the process. Madix uses Workday to help you enroll in company benefits. To assist you, Madix provides one-on-one telephone conferences with a benefits specialist who will walk you through your options, if you prefer.

Benefit specialists are available via phone on a first come, first served basis Monday – Friday 8:00am to 5:00pm CST. Please call **866-996-0222** to speak to a Benefit Specialist OR book an appointment to receive a call at a designated time by visiting madixinc.simplybook.me/v2/.



Our medical coverage provides you and your family with the protection you need for everyday health issues or when the unexpected happens. You can choose from either of the medical plans, each of which offers

- Comprehensive health care benefits
- In-network preventive care covered at 100%
- Coverage for eligible children up to age 26
- Prescription drug coverage

Choose the Plan That's Right for You

Madix offers two PPO plans, the Base PPO plan and the Buy Up PPO plan. The Base plan has a lower weekly premium but a higher deductible and out-of-pocket maximum. The Buy Up plan has a higher weekly premium but a lower deductible and out of pocket maximum.. The plans have different:

- **Annual deductible amounts:** The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay
- **Out-of-pocket maximums:** The most you will pay each year for eligible network services including prescriptions
- **Copay and coinsurance:** Money you pay toward the cost of covered services

Onsite Clinic

Madix offers an onsite clinic for all employees. A certified physician's assistant or nurse practitioner is available to treat acute health conditions. Avoid waiting rooms at doctors' offices and return to work quicker. The onsite clinic is not available for dependents. **Please ask the onsite medical personnel for additional services such as annual physicals, health management, and more.**

For appointments, please contact your immediate supervisor.

Telemedicine

MDLIVE gives you 24/7/365 access to U.S. board-certified doctors through your phone and secure video on a computer or tablet. At no cost, you and your covered dependents can speak with doctors about medical conditions and symptoms such as:

- Cold and flu
- Allergies
- Skin irritations
- Behavioral health concerns
- And more!

In some cases, doctors can send prescriptions to your nearest pharmacy. Start chatting with a MDLIVE doctor today

DOWNLOAD
MDLive app



VISIT
MDLive.com/BCBSTX



Call: 888-680-8646

MEDICAL PLAN

MEDICAL PLAN

**STRETCH YOUR
HEALTH CARE
DOLLAR**

Staying in the BCBSTX Network

BCBSTX has what's referred to as a "network" of providers who have agreed to partner together to provide discounts for BCBSTX plan members.

- **GO ONLINE:** Visit bcbstx.com and click on "find a doctor." Select a health care provider type, enter your ZIP code, then choose Preferred Provider Organization (PPO) in the drop-down menu. Click "NEXT" to generate a list of doctors and facilities in your area.
- **CALL BCBSTX:** Once you receive your BCBSTX ID card, you can call the customer service phone number listed on the back. A representative can help you find a participating provider or confirm whether your current doctor is in the network.
- **ASK YOUR DOCTOR:** In most cases, the billing department of your doctor's office will know whether they are part of the BCBSTX network. If not, they will probably be willing to contact BCBSTX on your behalf (using your Group Number and Member Number from your ID card) to verify that their services will be covered at the discounted BCBSTX rates.

Know What Your Plan Requires

Approval from your health plan (called preauthorization or prior authorization) may be required before some services may be covered, including:

Inpatient admissions for:

- Hospital
- Rehabilitation
- Skilled nursing
- Long-term acute care/subacute care

Certain outpatient procedures and surgeries:

- Spinal cord stimulation
- Artificial intervertebral disc

Be sure to check your benefits information to see a more detailed list of services that require preauthorization. Your network provider will usually preauthorize your service for you. It's a good idea to confirm with your provider that they have gotten the needed approval before you have the service.



For questions, call the Customer Service number on the back of your BCBSTX member ID card.



Additional Programs Through BCBS

Blue Access For Members

Looking to save on health care costs while taking charge of your wellness? Through the BCBS Member Rewards program, you can earn cash rewards when you visit eligible high-quality, lower-cost in-network providers. Plus, your health benefits include a variety of tools and resources designed to help you live healthier on your own schedule. To access these programs and more:

- Visit bcbstx.com
- Register for Blue Access for MembersSM
- Select the My Health tab to explore your available health and wellness resources.

How Do Member Rewards Work?

1. When a doctor recommends treatment, log into your Blue Access account at bcbstx.com.
2. In Provider Finder, select Doctors and Hospitals, then click on Find a Doctor or Hospital, and search for the recommended procedure.
3. Choose a Member Rewards eligible location and you may earn a cash reward.
4. Complete your procedure and, once verified, you will receive a check within 4 to 6 weeks.



Questions?

Call the number on the back of your BCBS member ID card.

24/7 Nurseline

When you need help deciding whether you should go to the emergency room or make an appointment with your doctor, 24/7 Nurseline is here to help. Call any time, day or night, with questions about fevers, burns, and other health issues. Get started by logging in to Blue Access for Members (BAM) at bcbstx.com. Then go to the "My Health" tab for more information.

Benefits Value Advisors

Get the most out of your benefits and save money when you talk to a BCBSTX Benefits Value Advisor. Benefits Value Advisors can help with anything from reviewing general benefits information to locating in-network providers for services like:

- CAT or CT scans
- MRIs
- Endoscopy procedures
- Colonoscopy procedures
- Back or spinal surgery
- Knee surgery
- Shoulder surgery
- Hip or joint replacement surgery
- And more!



Call 800-521-2227 and request to speak with a BVA, or use the Blue Access for Members (BAM) Provider Finder tool online to get started. If you have a BVA-eligible procedure without calling BVA first or shopping online, you will need to pay a \$100 copay. Contact a BVA. **Contact a BVA or use the BAM provider finder tool to have the \$100 copay waived!**

SAVE MONEY ON MEDICAL SERVICES

MEDICAL PLAN COMPARISON

	BLUE CROSS BLUE SHIELD OF TEXAS BASE PPO		BLUE CROSS BLUE SHIELD OF TEXAS BUY-UP PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible				
Individual	\$1,350	\$5,500	\$850	\$3,000
Family	\$2,500	\$10,500	\$1,500	\$5,500
Calendar Year Out-of-Pocket Maximum (Includes Deductible)				
Individual	\$5,500	No maximum	\$4,500	No maximum
Family	\$10,500	No maximum	\$8,500	No maximum
Coinsurance	You Pay		You Pay	
Preventive Care	\$0	N/A	\$0	N/A
Primary Care Physician	\$40 copay	50%*	\$20 copay	40%*
Specialist	\$60 copay	50%*	\$30 copay	40%*
Airrosti	\$60 copay	N/A	\$30 copay	N/A
Urgent Care	\$40 copay	50%*	\$20 copay	40%*
Emergency Room	\$100 copay, then 20%		\$100 copay, then 20%	
Chiropractic	20%*	50%*	20%*	40%*
Hospital				
Inpatient Hospitalization	20%*	50%*	20%*	40%*
Outpatient Surgery	20%*	50%*	20%*	40%*
MRI, CT Scans, Diagnostic Radiology, Joint Replacement, Bariatric Surgery, Musculoskeletal, or Reduction Mammoplasty	\$100 copay; waived if BVA contacted prior to service		\$100 copay; waived if BVA contacted prior to service	
Lab/X-ray				
Billed by Doctor's Office	20%*	50%*	20%*	40%*
Billed by Outside Facility	20%*	50%*	20%*	40%*
Pharmacy, RxBenefits, CVS/Caremark				
Retail Rx (up to 30-day supply)				
Tier 1	\$15 copay	Retail copay + Cost Difference	\$10 copay	Retail copay + Cost Difference
Tier 2	\$40 copay		\$35 copay	
Tier 3	\$60 copay		\$50 copay	
Specialty	30% Coinsurance**		30% Coinsurance**	
Mail Order Rx (up to 90-day supply)				
Tier 1	2.5 x Retail Copay		2.5 x Retail Copay	
Tier 2				
Tier 3				

*After deductible **Member will have \$0 out-of-pocket responsibility if enrolled in the PrudentRX program through RX Benefits

MEDICAL PLAN RATES 2027

2027 WEEKLY MEDICAL RATES	TOBACCO FREE		TOBACCO USER	
	BASE PPO	BUY-UP PPO	BASE PPO	BUY-UP PPO
Employee Only	\$21.00	\$31.50	\$41.00	\$51.50
Employee & Spouse	\$105.00	\$126.00	\$125.00	\$146.00
Employee & Child(ren)	\$78.75	\$96.60	\$98.75	\$116.60
Family	\$126.00	\$157.50	\$146.00	\$177.50

You'll save \$1,040 annually on medical premiums if you are tobacco free.



DENTAL PLAN



Your dental health is an important part of your overall wellness. Dental insurance gives you a reason to smile—it's affordable and covers preventive care (including regular checkups) as well as fillings, bridges, crowns, and other dental services.

When you enroll in the Dental Plan, you may visit any dentist you choose, but in-network providers offer larger discounts and can file your claims for you. If you prefer to see an out-of-network provider, keep in mind, since they are not under a contract, they may charge you for any amount billed in excess of the negotiated discounted rate.

The amount you pay for your coverage is based on who you cover and which plan you choose.

For more details or to find a provider in the network, visit mybenefits.metlife.com or call **800-ASK-4-MET**.

Download the MetLife app to find a dentist in your area, view your ID card, change your dental office, view your plan and claim your summary, and more! The MetLife US App is available for iPhone and Android.



METLIFE DENTAL PLAN		
	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	\$50	
Family	\$150	
Calendar Year Out-of-Pocket Maximum		
Per Individual	\$1,000 per individual (Basic and Major Services combined)	
	You Pay	
Services		
Office Visit	\$0	
Preventive Care		
Exams, Cleanings, X-rays, Fluoride Treatments	\$0	
Basic Services		
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	20%*	
Major Procedures		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%*	
Orthodontia		
24-Month Treatment Fee: Additional fees will apply for pre-ortho visits and treatment, records and retention, and banding.		
Adults	N/A	
Children (up to 19th birthday)	50% up to a lifetime maximum benefit of \$1,000 per individual; deductible waived	

* After deductible



WEEKLY DENTAL RATES	
Employee Only	\$4.47
Employee & Spouse	\$9.17
Employee & Child(ren)	\$10.11
Family	\$14.49

VISION PLAN

You may elect vision care coverage, which provides affordable, quality vision care nationwide. Although vision care services and supplies are covered in- and out-of-network, your benefits are generally greater when you use network providers. Your costs are based on the family members you choose to cover. For more information, visit eyemed.com, call 866-804-0982, or download the "EyeMed Members" app available for iPhone and Android.



iPhone



Android

EYEMED VISION PLAN		
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	You Pay	Reimbursement
Cost		
Exam	\$0 copay	Up to \$40
Materials	\$15 copay	See below
Covered Services: Lenses		
Single Lenses	\$15 copay	Up to \$30
Bifocals	\$15 copay	Up to \$50
Trifocals	\$15 copay	Up to \$70
Frames	Balance over \$150 allowance	Up to \$105
Covered Services: Contacts in lieu of Frames/Lenses		
Contacts: Medically Necessary	\$0	Up to \$210
Contacts: Elective	Balance over \$150 allowance	Up to \$150
Benefit Frequency		
Exams	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
Contacts	Once every 12 months	Once every 12 months

WEEKLY VISION RATES	
Employee Only	\$1.07
Employee & Spouse	\$2.03
Employee & Child(ren)	\$2.14
Family	\$3.15

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Life and AD&D will continue to be offered by Equitable. It's important to give some serious thought to what expenses and income needs your dependents would have if something happened to you. To make sure you have financial protection, the Company offers several different types of Life and AD&D insurance.

Basic Life insurance. This coverage is provided at no cost to you.

AD&D is provided as part of your Basic Life coverage and provides you specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

Supplemental Life and AD&D Coverage

If you purchase additional Life insurance for yourself, you may also purchase coverage for your spouse and dependent children. Supplemental Optional Life insurance for you, your spouse, and children can help protect your family during difficult times. Eligible employees may purchase Supplemental Life and AD&D for themselves and their family. Employee coverage amounts are offered in amounts up to 5 times your annual salary. Guaranteed Issue (GI) amounts are available.

Guaranteed Issue and Evidence of Insurability

When you are first eligible for Supplemental Life and AD&D, you may purchase up to the lesser of 5 times your base annual salary or \$300,000 in increments of \$10,000 without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective. The same affect coverage will be available for your spouse as well.

Age Reduction

Basic and Supplemental Life and AD&D policies are subject to age reduction. This means that your coverage amount will be reduced beginning at age 65. Please refer to your policy documents for more details.

Imputed Income

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds \$50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.



DISABILITY INSURANCE

Disability coverage will continue to be offered through Equitable.

If you have a serious injury or illness that keeps you from working, how would you pay your bills? Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or injury.

Please refer to the STD and LTD Benefit Summaries for specific definitions of a qualifying disability.

Short-Term Disability (STD)

Pregnancy, a scheduled surgery, or an unplanned illness or non-work-related injury could keep you off the job and without income for an extended period of time. STD can protect part of your paycheck should you become disabled.

COVERAGE	BENEFIT
Short-Term Disability	• 50% of your weekly earnings to \$1,000 maximum for 11 weeks • Benefit begins after 14 days of disability

Long-Term Disability (LTD)

LTD makes sure you have a portion of your income replaced if you can't work for an extended period of time due to an illness or injury. This coverage is coordinated with other benefits you may receive while disabled, such as Social Security and Worker's Compensation, unless the injury is work-related in which case LTD would offset Worker's Compensation. LTD payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever comes first. Certain exclusions and pre-existing condition limitations may apply.

COVERAGE	BENEFIT
Long-Term Disability	• 50% of your monthly earnings to a \$6,000 maximum • Benefit begins after 90 days of disability and payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner



An Example: How STD and LTD can Work Together

Let's say you have an accident on the ski slopes and you must be away from work due to your injuries. Here's how your disability benefits would work:

- For the first 14 days away from work—you would use your available Paid Time Off (PTO) time and receive your regular pay.
- For the next 11 weeks, you would receive STD benefits equal to 50% of your pay, up to \$1,000 per week.
- If you are out longer than 90 days and cannot perform your job, LTD benefits would begin and would replace 50% of your pay, up to a maximum of \$6,000 per month. These benefits would continue until you no longer meet the definition of disabled as defined by the insurance company.

First 2 weeks

Available PTO time is used



Next 11 weeks

Approved STD replaces 50% of your weekly pay



After 90 days

LTD begins if approved



PLANNING FOR RETIREMENT

What does retirement look like for you? Maybe you plan to travel the world. Or maybe you'd like to take up some hobbies closer to home. Whatever your goal, it's important to take responsibility for your own finances so you have the income you need in the future.



One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 401(k) savings plan allows you to save for retirement on a pretax basis. You can begin contributing to the plan at any time once you become eligible and make contributions to your account through convenient payroll deductions.

Increase Your Retirement Savings With a 401(k)

Here's how your disability benefits work:

- Contribute using convenient payroll deductions up to the IRS limit of \$24,500 a year (2026 limit - see below for more information).
- Change the amount of your contributions or stop your payroll contributions at any time.
- Decide how to invest your 401(k) or allow the plan to choose for you.
- Age 50 or older? Make an additional "catch-up" contribution of up to \$8,000 to save even more.
- Individuals aged 60–63 years old can make catch-up contributions up to \$11,250 annually to a workplace plan.
- Full-time employees age 21 or older are eligible on their first day of employment.
- Enroll at [401k.com](https://www.401k.com) or by calling **800-835-5097**.
- Make sure your 401(k) beneficiary is up to date by contacting Fidelity at the 800 number or online at [401k.com](https://www.401k.com).
- Fidelity's mobile services and apps let you access your accounts whenever—and wherever—you want. Download the Fidelity Mobile App for Apple, Android, and Amazon devices.



The official 2027 401(k) contribution limits have not yet been announced by the IRS. The IRS typically publishes updated retirement plan contribution limits in late October or early November after reviewing inflation data through September.

Employees can obtain the most current information from the following sources:

1. IRS Retirement Plans Website
 - » <https://www.irs.gov/retirement-plans>
2. Our 401(k) Plan Provider
 - » Watch for emails, website announcements, and enrollment communications from our retirement plan administrator after the IRS releases the new limits.
3. Human Resources
 - » HR will communicate any changes to contribution limits.
4. The Madix benefits microsite
 - » [MadixBenefits.com](https://www.MadixBenefits.com)

ACCIDENT INSURANCE

Just as it sounds, Accident insurance can help you pay for costs you may incur after an accidental injury. This type of injury includes things such as a car accident, a fall while skiing, or even a fall down the stairs at home. This benefit is paid regardless of any other insurance coverage you might have (including your medical coverage).



Emergency Room Visits



Medical Exams
including major diagnostic exams



Hospital Stays



Physical Therapy



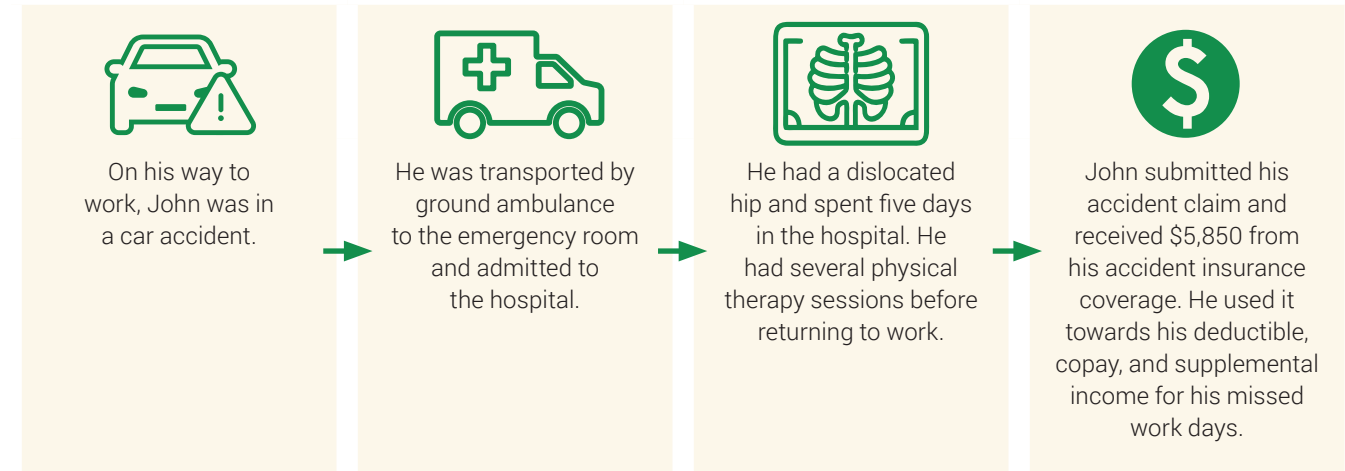
Fractures and Dislocations



Transportation and Lodging
if you are away from home when the accident happens

How the Plan Works

Again, these benefits are in addition to any health insurance benefits you may receive. The benefit amount is paid directly to you. You can use this money in any way you like, including deductibles, child care, housecleaning, groceries, utilities, or any purpose that can help you meet your personal, financial, or household needs. **Below is an example:**



JOHN'S ACCIDENT INSURANCE BENEFITS PAID A TOTAL OF: \$5,850					
Ground Ambulance	\$300	MRI	\$150	Dislocated Hip	\$3,000
Emergency Room	\$150	Hospital Stay: Admission	\$1,000	Appliances	\$100
X-ray	\$50	Hospital Stay: Daily (5 days)	\$1,000	Physical Therapy (4 sessions)	\$100

Please refer to the benefit summary for details of this coverage.

CRITICAL ILLNESS & HOSPITAL INDEMNITY

Critical Illness Insurance

Critical illnesses can have a huge impact on your life. A critical illness can keep you from working and can make it difficult to do simple, everyday things. Critical Illness insurance through Equitable helps reduce financial and emotional stress by paying a lump-sum cash benefit if you are diagnosed with a covered condition. You decide how to use the money—to cover medical expenses, deductibles, copays, travel to treatment, child care, or everyday bills.

These illnesses can include, but are not limited to, the following:



Heart Attack



Alzheimer's Disease



Stroke



Multiple Sclerosis



Parkinson's Disease



Major Organ Failure

How the Plan Works

Critical Illness insurance through Equitable pays a lump-sum cash benefit if you are diagnosed with a covered condition after your coverage begins. The amount you receive depends on the benefit level you elected and the condition diagnosed. Benefits are paid directly to you, not to your doctor or hospital, and you decide how to use the money—for out-of-pocket medical expenses, travel to treatment, child care, mortgage or rent, or other household bills.

The plan also includes:

- **Additional Occurrence Benefit** – provides coverage if you are later diagnosed with a different, unrelated covered condition (6 months must separate diagnoses).
- **Recurrence Benefit** – pays again if you have a recurrence of the same covered condition (12 months must separate diagnoses).
- **Portability** – keep your coverage if you leave Madix, up to age 70.

COVERAGE AMOUNTS	
Employee	\$5,000 to \$30,000 (in \$5,000 increments)
Spouse	\$5,000 to \$30,000 (up to 100% of employee benefit)
Child	2,500 to \$5,000 (up to 50% of employee elected amount)

Wellness Benefit

You and your covered dependents are eligible for a \$50 annual benefit when you complete a qualifying health screening such as a mammogram, colonoscopy, pap smear, lipid panel, PSA test, diabetes screening, and more. This benefit is paid directly to you and can be claimed once per covered individual each calendar year.

Visit equitable.com/employeebenefits and log on to EB360® or call **866-274-9887** for claims, benefit details, or questions.

Group Name: Madix, Inc. Policy Number: 010822

Hospital Indemnity Insurance

The Hospital Indemnity insurance plan is designed to provide financial protection by paying you a direct benefit due to a hospitalization. You can use the benefit to cover out-of-pocket expenses and extra bills that can occur.

Lump sum benefits are paid directly to you based on the amount of coverage listed below, regardless of the actual cost of treatment.

BENEFITS OVERVIEW			
Initial Confinement Benefit	\$500	Portability	Included
Daily Hospital Confinement	\$100/day	Pre-Existing Conditions Exclusion	None
Daily Critical Care Unit Confinement	\$200/day	Guarantee Issue	Included

ADDITIONAL BENEFITS

Employee Assistance Program

Everyone needs a little help from time to time. That's why we offer you and your eligible family members access to licensed counselors through our Employee Assistance Program (EAP) through Magellan Health, Inc. The EAP is available to you whether or not you elect other benefits coverage through the Company.

You can contact the EAP for help with the following:

- Stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Financial issues
- Child care issues—including identifying schools, daycare, tutors, and more
- Aging parents
- Pet care
- Maintenance and repair providers
- Community volunteer opportunities

Through the EAP, you and your family can receive immediate support and guidance, as well as assessments and referrals for further services.

It's important to note that all EAP conversations are voluntary and strictly confidential. In addition, there's never a cost to you when you contact an EAP counselor; the Company pays the full cost. However, if you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.



Magellan also offers apps that are available to help with a variety of conditions. Search for Magellan Health Services in the App Store or Google Play.



EAP services can be accessed online, 24/7, at magellanascent.com by creating a user email and password, by calling **800-327-1393**, or via the apps.



ADDITIONAL BENEFITS CONT.

Enhanced Identity Theft Insurance



For 2027, Madix will continue offering identity theft protection through **LifeLock with Norton Benefit Essential**.

With LifeLock, your coverage includes identity and account monitoring across financial, credit, and public records, as well as dark web surveillance to detect when your personal data appears in unsafe places. You'll receive timely alerts if your information is exposed in a data breach or if unusual credit activity occurs. The plan also provides stolen wallet protection to help you quickly replace important cards and documents, plus 24/7 access to U.S.-based specialists who will work directly with you to restore your identity if fraud occurs. In addition, you're backed by up to \$1 million in reimbursement coverage for stolen funds, personal expenses, and legal or expert fees related to identity theft.

WEEKLY COST	
COVERAGE LEVEL	COST
Employee Only	\$1.96
Employee + Family	\$3.92



Medicare Choice Group

Medicare Choice Group's team of Medicare experts guide you through every step of the Medicare decision process and enrollment.

1. Schedule a 1-on-1 consultation with a Medicare expert.
2. Get recommendations for which plans will suit your needs.
3. Plan your Medicare transition timeline with help from an advisor.
4. Enroll in your Medicare plan with confidence.

To learn more, call **(214)-393-6471** or visit visit.medicarechoicegroup.com/madixinc.

Airrosti

Airrosti provides highly effective, personalized care for acute and chronic musculoskeletal pain and conditions. Airrosti can treat injuries/pain in your neck/back, knee, shoulder, foot, hip, and more! Services are available in-person or virtually. Airrosti is a network provider and you will only pay a copay for your visit.



To begin your recovery plan, call **(800)-404-6050** or visit Airrosti.com, or Airrosti.com/RemoteRecovery.



IMPORTANT CONTACTS

COVERAGE	CONTACT	PHONE	WEBSITE	APPS
Benefit Enrollment Support	Avant Specialty Benefits	866-996-0222	madixinc.simplybook.me/v2/	N/A
Medical	BCBSTX	800-521-2227	bcbstx.com	Text BCBSTXAPP to 33633 or search for BCBSTX*
Benefit Value Advisor	Benefit Value Advisor	800-521-2227	bcbstx.com/member/online-account	Text BCBSTXAPP to 33633 or search for BCBSTX*
Telemedicine	MDLive	888-680-8646	MDLive.com/BCBSTX	Search for MDLive
Pharmacy	CVS/Caremark	800-334-8134	caremark.com	Search for CVS Caremark*
Dental	MetLife	800-ASK-4-MET (800-275-4638)	mybenefits.metlife.com	Search for MetLife US*
Vision	EyeMed	866-804-0982	eyemed.com	Search for EyeMed Members*
Basic and Supplemental Life and AD&D	Equitable	866-274-9887	equitable.com	Search for Equitable Mobile App*
Disability	Equitable	866-274-9887	equitable.com	Search for Equitable Mobile App*
Accident Insurance, Critical Illness, and Hospital Indemnity	Equitable	866-274-9887	equitable.com	Search for Equitable Mobile App*
401(k) Retirement	Fidelity Investments	800-835-5097	401k.com	Search for Fidelity Investments**
Employee Assistance Program	Magellan	800-327-1393	member.magellanhealthcare.com	Search for Magellan Health Services*
Identity Theft	LifeLock Benefit Solutions	800-607-9174	lifelock.com	Search for LifeLock for Norton 360*
Medicare Education	Medicare Choice Group	214-393-6471	visit.medicarechoicigroup.com/madixinc	N/A
COBRA	WEX	800-519-8366	cobralogin.wexhealth.com/	N/A
Workday	HR	*	wd12.myworkday.com/madixinc	Workday: madixinc

*In the App Store or Google Play **In the App Store, Google Play, or Amazon

REQUIRED NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22% of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not

enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 10.22% of the employee’s household income.^{1 2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular

eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

WHAT ABOUT ALTERNATIVES TO MARKETPLACE HEALTH INSURANCE COVERAGE?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit [healthcare.gov/medicaid-chip/getting-medicaid-chip](https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip) for more details.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

If you have any questions or complaints, please contact:

Eric Henderson
Director of Human Resources
500 Airport Road, Terrell TX 75160
ehenderson@madixinc.com

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: Madix, Inc.
Employer Address: 500 Airport Road
City: Terrell
State: TX
Zip Code: 75160
Employer Identification Number (EIN): 75-1094810
Employer Phone Number: (214) 515-5400
Who can we contact about employee health coverage at this job? Human Resources, Eric Henderson, Joaquin Garcia

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to all full-time employees. Eligible employees are Full-time employees working at least 30 hours per week. With respect to dependents, we do offer coverage. Eligible dependents are your legally married spouse, a child under the limiting age shown in your schedule of coverage, a child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child is made, and any other child included as an eligible dependent under the plan.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process.

¹ Indexed annually; see [irs.gov/pub/irs-drop/rp-22-34.pdf](https://www.irs.gov/pub/irs-drop/rp-22-34.pdf) for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

If you have any questions or complaints, please contact:

Eric Henderson
Director of Human Resources
500 Airport Road, Terrell TX 75160
ehenderson@madixinc.com

The following HIPAA Privacy notice is for plans that create, receive, or access member PHI, whether self-insured or fully insured.

Your Information. Your Rights. Our Responsibilities.

This notice describes:

- *How health information about you may be used and disclosed*
- *Your rights with respect to your health information*
- *How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information*

You have a right to a copy of this notice (in paper or electronic form) and to discuss it with madix human resources department if you have any questions.

Please review it carefully.

YOUR RIGHTS

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a list of health care providers who have received your information through certain third parties
- Get a copy of this privacy notice
- Choose in advance whether to receive fundraising communications
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

With your consent, we can use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Fulfill your requests to share information with your consent

- Prevent multiple program enrollments
- Report about court-referred treatment
- Report to prescription drug monitoring programs

OUR USES AND DISCLOSURES

We may use and share your information without your consent as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- For your medical emergencies
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Assist with cause of death inquiries
- Communicate within our program and with contractors
- Respond to management and financial audits and program evaluation
- Prevent or reduce crime in our program

In these circumstances, we must protect your information and limit how we use and share it

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Provide consent when we use or share your information for most purposes

- You may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes. We are not required to agree to your request, and we may say "no" if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our health care operations with your health insurer. We will say "yes" unless a law requires us to share that information

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose in advance about fundraising

You have the right to a clear and obvious notice in advance of, and a choice about whether to receive, fundraising communications for our program.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

With your consent, we may also use and share your information in the following ways:

- To whomever you name in a consent to share your information

- To prevent multiple enrollments in withdrawal management or maintenance treatment programs
- To report participation in treatment required by the criminal justice system
- To report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Example 2: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications

Bill and Pay for your health services

We can use and disclose your health information as we bill or pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

<https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence, only as required by applicable law
- Preventing or reducing a serious threat to anyone's health or safety

For your medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency

Do research

We can use or share your information for health research. Researchers cannot include any patient identifying information in their reports about the research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Legal Proceedings and Lawful Process

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)). When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA.

Communicate within our program and with contractors

We can share your information within our program, with an organization that has administrative control over our program, and with contractors who help us run our program.

Respond to management and financial audits and program evaluation

We can use or share your information to improve the quality of our services, obtain needed credentials, and cooperate with oversight agencies for activities authorized by law, as long as those who view or receive the information agree to destroy or return the information when they are finished and agree not to use it against you.

Disclosure to Law Enforcement

We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a crime that occurred on our premises, or to report certain crimes during a medical emergency that did not occur on our premises. In these situations, we will disclose only what the law allows in these situations.

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Important Notice from Madix About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Madix 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. **Madix has determined that the prescription drug coverage offered by the Base and Buy Up Plans 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 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Madix coverage, be aware that you and your dependents will not be able to get this coverage back.

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 Madix 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 nineteen 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 Madix Benefits Center at 214-515-5400 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 Madix 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 (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: 10/1/2026

Name of Entity/Sender: Eric Henderson

Contact--Position/Office: Madix Benefits Department

Address: 500 Airport Road, Terrell TX 75160

Phone Number: 214-515-5400

COBRA Continuation Coverage and other Health Coverage Alternatives

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."

WHEN IS COBRA CONTINUATION 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;
- 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 Human Resources.

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.

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>.

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/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

Eric Henderson
Director of Human Resources
500 Airport Road, Terrell TX 75160
ehenderson@madixinc.com

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

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their

newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the **Frequently Asked Questions** (FAQs) About the Newborns' and Mothers' Health Protection Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or

have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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 January 31, 2026. Contact your State for more information on eligibility –

If you believe you've been wrongly billed, you may contact the Madix Benefit Department.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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).

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218

STATE	WEBSITE/EMAIL	PHONE
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct Rlte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	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
dol.gov/agencies/ebsa
866-444-EBSA (3272)

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

