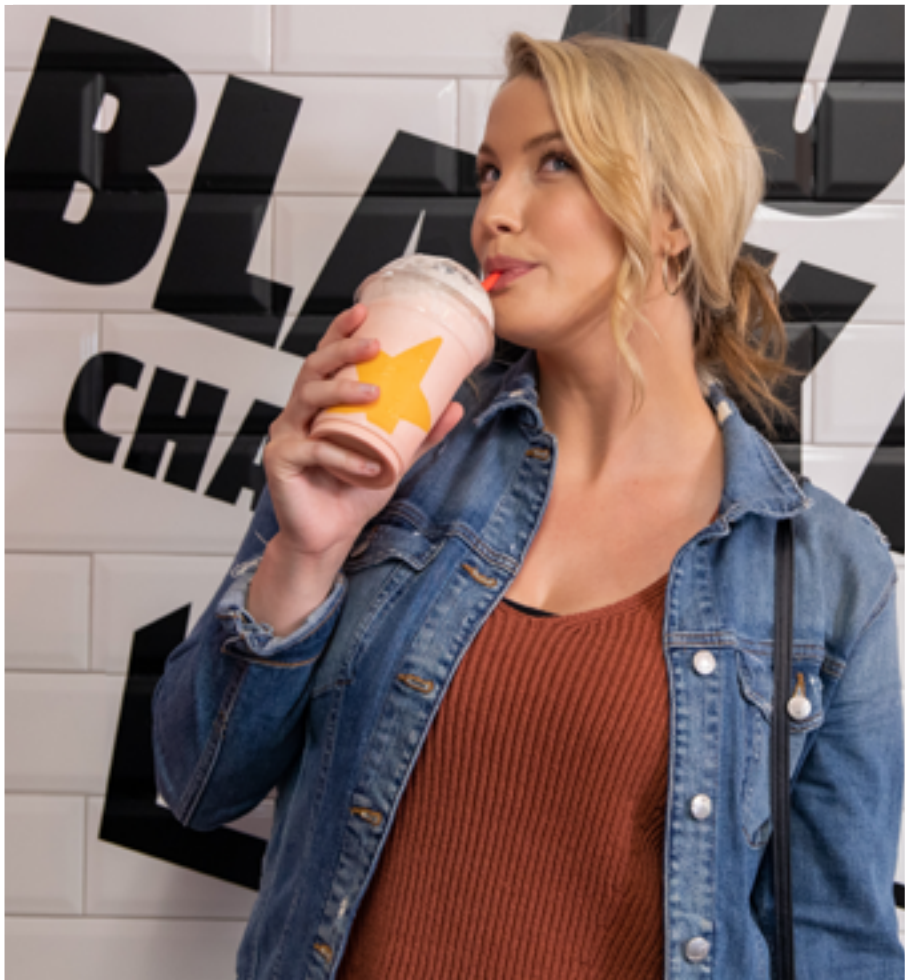
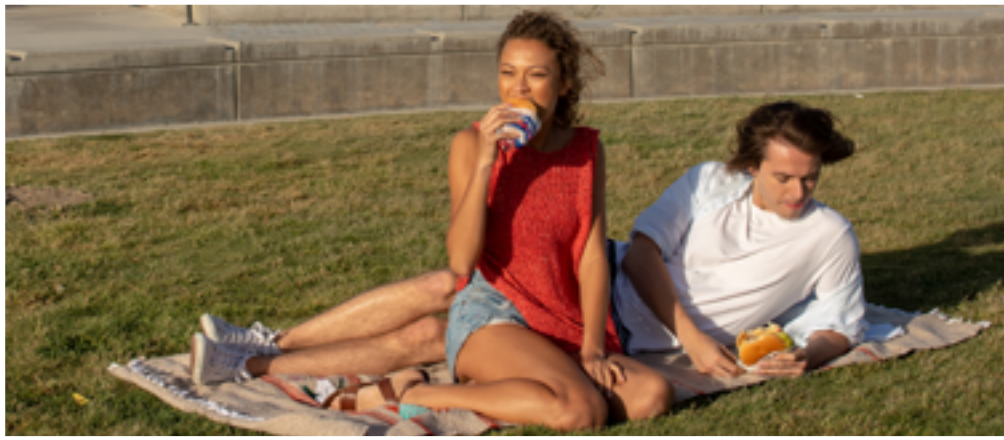
It's time to enroll!

YOUR 2021 BENEFITS

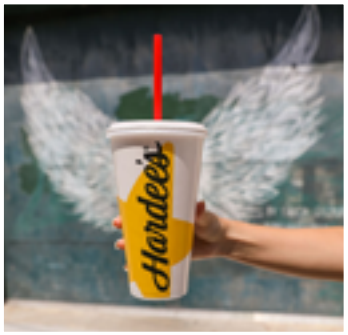




CKE RESTAURANTS®

2021 BENEFITS eGUIDE

CKE Restaurants provides a wide variety of benefits to help you save money, protect you financially and support the needs of you and your family. This guide provides an overview of your benefits. If you would like more detail than this guide provides, view your Summaries of Benefits and Coverage (SBCs) or plan brochures at **ckebenefits.com**.



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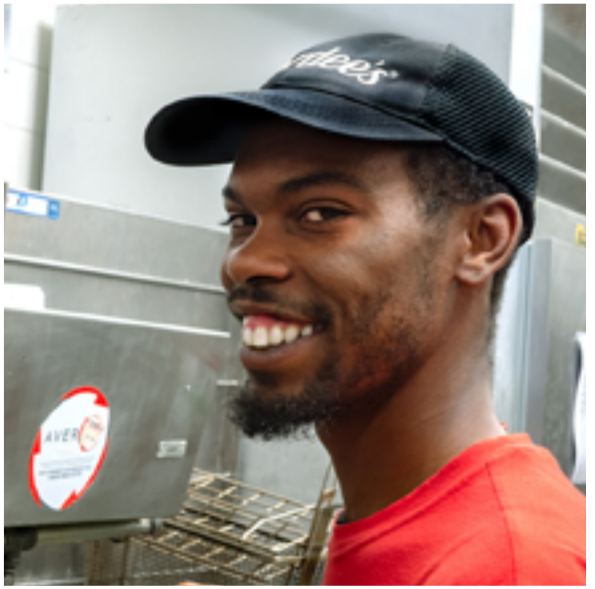


Benefit basics

ELIGIBILITY

You

- **Regular full-time employees** are eligible for the benefits described in this guide. Benefits begin on the first of the month following your hire date, provided you enroll by the deadline.
- **Hourly crew members and shift leaders** are eligible for accident and critical illness insurance and the Employee Assistance Program. Benefits begin on the first of the month following 90 days of employment.
- **ACA full-time employees:** If you are an hourly crew member or shift leader and have been determined to be full-time in accordance with Affordable Care Act rules, you'll become eligible for medical, dental, and vision coverage. You will receive more details if you become eligible.

Your dependents

If you enroll yourself, you may also enroll your eligible dependents for medical, dental, vision, life/AD&D, and the voluntary insurance plans. Eligible dependents are generally defined as:

- Your legal spouse
- Your child(ren) up to age 26 (biological, step, foster, legally adopted or placed for adoption, children for whom you have legal guardianship and children for whom you are required to provide coverage under a Qualified Medical Child Support Order)
- Your disabled children age 26 or older who are incapable of self-care

ENROLLING

Generally, there are two times you can enroll for benefits: 1) when you first become eligible and 2) during Open Enrollment. Once you enroll, your choices remain in effect for the entire calendar year. You cannot change your benefits during the year unless you have a qualified life event, described to the right.

To enroll for your 2021 benefits:

1. Go to the Benefits homepage at **ckebenefits.com**.
2. Click "Enroll now" if enrolling as a new hire, or "2021 Open Enrollment" if enrolling during Open Enrollment.
3. At the **Employee Navigator** screen, log in with your username and password or click "Register as a new user" (Company Identifier: **CKE**). If you don't have one, follow the prompts to create a username and password.
4. Once logged on to **Employee Navigator**, click the Start Enrollment button.

MAKING CHANGES

Open Enrollment is your once-a-year opportunity to change your benefits for the upcoming calendar year. Outside of Open Enrollment, you can generally only change your benefits if you experience a qualifying life event. Examples includes:

- Marriage, divorce, or legal separation
- Birth, adoption, or placement for adoption of a child
- Change in work schedule that affects benefits eligibility (e.g., full-time to part-time)
- Gain or loss of coverage through your spouse's employer
- A change in your spouse's or child's eligibility for benefits
- Eligibility for Medicare or Medicaid
- Death of a spouse or covered child

If you have a qualifying life event:

- You must notify the Benefits Center and/or make changes to your coverage in **Employee Navigator within 30 days of the event**. The change(s) will be effective on the date of the event.
- The benefit change(s) must be directly related to the life event, and you may be asked to provide documentation such as a marriage license or birth certificate.
- If you miss the 30-day enrollment window, you must wait until the next Open Enrollment window to change your benefits.
- In the event of birth or adoption of a child, the 30-day deadline applies, even if you have other children covered.

WHEN COVERAGE ENDS

Medical, dental and vision coverage end on the last day of the month in which you are employed by CKE. Life/AD&D, disability, FSA and HSA participation ends on your last day of work. Under certain circumstances, you may continue your healthcare coverage for a period of time under COBRA.

NEED HELP ENROLLING?
Contact Health Advocate. Turn the page to learn more.

Health Advocate

CLAIMS ASSISTANCE AND CARE ADVICE

Navigating the healthcare system can be a challenge.

Meet Health Advocate. It's a free service that just makes healthcare easier, so you get the right coverage, the right care and the right support – at the right time.

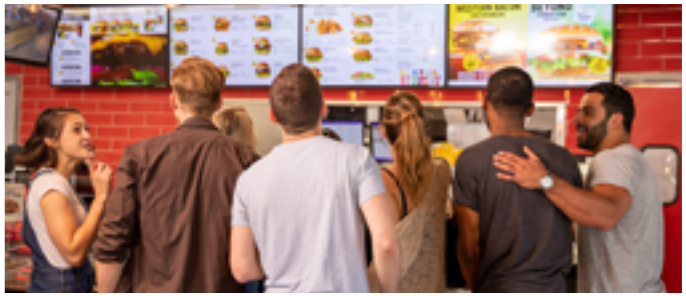
With Health Advocate, experienced benefits specialists can:

- Help you understand your plan options and suggest the right plan for you
- Explain your share of the costs for each option
- Check networks to see if your doctors participate
- Help you research treatment options and find the best provider for your needs
- Answer your questions about health conditions, diagnoses and treatments, no matter how complex
- Get symptom advice from a nurse 24/7
- Help you understand your bill
- Resolve claims problems and billing issues
- Learn ways to save money
- And more!

Services are available to eligible employees and their covered family members. See the program brochure on **ckebenefits.com**.

4 ways to get started with Health Advocate

CALL: **866-695-8622**
VISIT: **HealthAdvocate.com/members**
EMAIL: **answers@HealthAdvocate.com**
DOWNLOAD THE APP: **at the App Store or Google Play**



CKE BENEFITS

Have general questions about your benefits? Contact CKE Benefits at **888-253-3115** or via email at **benefits@ckr.com**.

Your 2021 costs

(Per-paycheck unless otherwise indicated)

MEDICAL page 6

UHC	HDHP with HSA	Silver PPO	Gold PPO
Employee only	$34.62	$85.38	$145.38
Employee + spouse	$92.31	$210.00	$332.31
Employee + child(ren)	$80.77	$166.15	$263.08
Family	$143.08	$309.23	$493.85

DENTAL page 13

UHC	DPPO Low	DPPO High
Employee only	$3.67	$5.43
Employee + spouse	$15.84	$24.64
Employee + child(ren)	$18.09	$32.50
Family	$32.23	$44.40

VISION page 14

UHC	Vision Plan
Employee only	$5.51
Employee + spouse	$8.17
Employee + child(ren)	$8.32
Family	$12.77

LIFE & AD&D (Lincoln Financial) page 17

- Basic life and AD&D is provided to regular full-time employees by CKE at no cost to you.
- Regular full-time employees are eligible for voluntary and spouse life/AD&D. The cost is based on the employee's age and can be viewed when you log onto **Employee Navigator** to enroll.
- Voluntary child life is a flat biweekly rate for all covered children (not per child) and can also be found on **Employee Navigator**.

DISABILITY (Lincoln Financial) page 18

Short-term and long-term disability coverage is provided to regular full-time employees at no cost to you.

ACCIDENT page 20

Lincoln Financial	Accident
Employee only	$3.85
Employee + spouse	$6.30
Employee + child(ren)	$6.76
Family	$9.17

CRITICAL ILLNESS page 20

Your cost for critical illness coverage is based on coverage level, tobacco use, and the age of the covered person, and can be viewed when you log onto **Employee Navigator** to enroll.

Medical

WHO'S ELIGIBLE?
- Regular full-time
- ACA full-time

You have three options for medical coverage, administered by UnitedHealthcare (UHC). Under all three plans, you can go to any provider you choose, but benefits are highest when you see a provider in the UHC Choice Plus network. Visit **myuhc.com** (or **welcometouhc.com** if not yet enrolled) to locate network providers.

The **HDHP with HSA** is a high-deductible health plan. It does not have copays and pay benefits only after you meet the deductible. But an HDHP with HSA offers several advantages:

» Lower employee premiums
» A Health Savings Account (HSA) that allows you to set aside tax-free money to pay eligible expenses
» A $500 company HSA matching contribution if you contribute at least $500 of your own money to the HSA

The **Silver and Gold PPOs** are traditional medical plans with office visit and prescription drug copays. These plans have lower deductibles and a higher level of coverage than the HSA plan, but they also have higher employee premiums.

Turn to **pages 7-8** to compare all three medical options. See pages **10-12** for more details on the HDHP with HSA.

In addition to the above plans, you have several low-cost voluntary insurance plans that can help lower your out-of-pocket medical costs. See pages **19-20** for details.

Continued on next page

MAKE AN INFORMED CHOICE

You owe it to yourself to get to know all your medical options. After all, the goal is to choose a plan that results in the lowest out-of-pocket cost for you. That means there's more to consider than just the deductible and whether the plan has copays.

You may even need to do a little math to determine which plan is right for you!

Consider this: If you've always chosen the plan with the lowest deductible, you may be paying more out of pocket than necessary. This is because the lowest deductible plan also has the highest employee contributions.

FIND NETWORK PROVIDERS:

» **myuhc.com** (if enrolled)
» **welcometouhc.com** (if not yet enrolled)

Medical *continued from previous page*

MEDICAL BENEFITS	HDHP with HSA		Silver PPO		Gold PPO	
Choice Plus Network	In-network	Out-of-network[1]	In-network	Out-of-network[1]	In-network	Out-of-network[1]
CKE HSA contribution (see page **10**)	$500 match if you contribute at least $500		N/A		N/A	
Annual deductible[2]						
Individual	$3,500	$7,000	$2,000	$4,000	$500	$1,000
Family	$7,000	$14,000	$4,000	$8,000	$1,000	$2,000
Out-of-pocket maximum[3]						
Individual	$6,450	$14,000	$4,000	$8,000	$3,000	$6,000
Family	$12,900	$28,000	$8,000	$16,000	$6,000	$12,000
You pay… (after deductible unless otherwise indicated[2])						
Preventive care	$0	Not covered	$0	50%	$0	50%
Office visits						
Primary care	30%	50%	$30 copay	50%	$25 copay	50%
Specialist	30%	50%	$60 copay	50%	$50 copay	50%
Virtual visits **New for 2021!** (see page **9**)	$50	Not covered	$0	Not covered	$0	Not covered
Outpatient surgery (per visit)[3]	30%	50%	20%	50%	20%	50%
Hospital care (per admission)[3]	30%	50%	20%	50%	20%	50%
Emergency room (per visit)	30%	30%	$350 copay; no deductible		$350 copay; no deductible	

[1] *Out-of-network services are subject to reasonable and customary (R&C) limits. If you go out-of-network, you will be responsible for paying amounts exceeding R&C limits. Network providers have agreed not to exceed R&C limits.*

[2] *The deductible must be met before coinsurance applies. If a service is covered with a per-visit copay, the deductible does not apply. All plans have an embedded deductible. This means a covered individual does not have to meet the full family deductible before coinsurance begins. Each individual only has to meet the individual deductible, then the plan begins to pay benefits (per applicable coinsurance).*

[3] *Once you reach the out-of-pocket maximum, the plan will pay 100% for covered services for the remainder of the calendar year. The out-of-pocket maximum includes copays and amounts paid toward the deductible.*

Note: This is not a complete list of covered services. See your Summary Plan Description (SPD) for a complete list.

YOUR 2021 COSTS

Your per-paycheck premiums for medical coverage are as follows:

	HDHP with HSA	Silver PPO	Gold PPO
Employee only	$34.62	$85.38	$145.38
Employee + spouse	$92.31	$210.00	$332.31
Employee + child(ren)	$80.77	$166.15	$263.08
Family	$143.08	$309.23	$493.85

Continued on next page

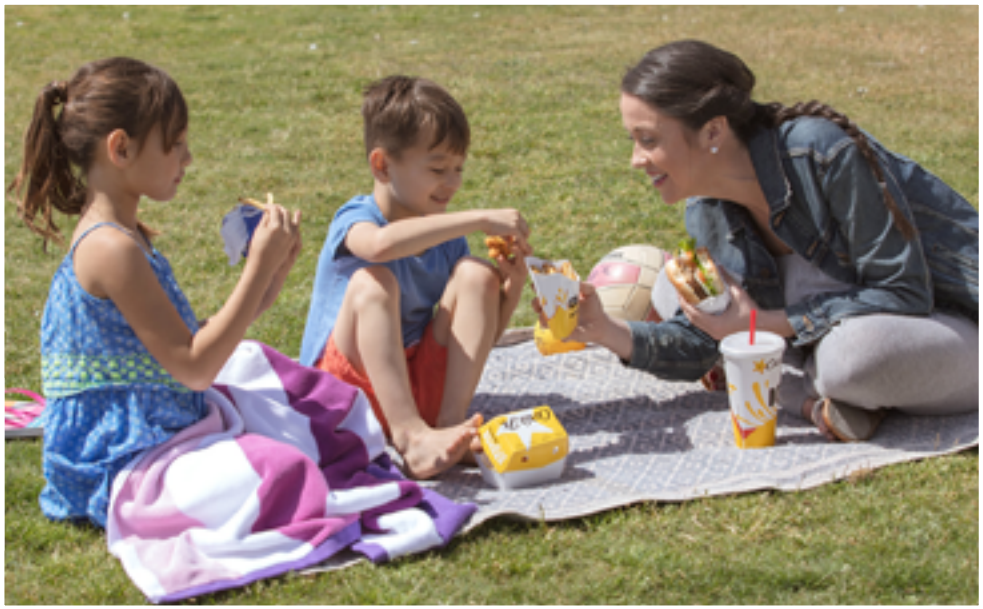
Medical *continued from previous page*

PRESCRIPTION DRUG BENEFITS	HDHP with HSA		Silver PPO		Gold PPO	
Retail (up to 30-day supply) Tier 1 (lower-cost) Tier 2 (mid-range cost) Tier 3 (highest-cost)	After deductible: $10 copay $40 copay $75 copay		No deductible: $15 copay $35 copay $75 copay		No deductible: $10 copay $35 copay $60 copay	
Retail or mail order (up to 90-day supply) Tier 1 (lower-cost) Tier 2 (mid-range cost) Tier 3 (highest-cost)	After deductible: $20 copay $80 copay $150 copay		No deductible: $37.50 copay $87.50 copay $187.50 copay		No deductible: $25 copay $87.50 copay $150 copay	
Lifetime maximum benefit (medical and prescription drug combined)	**Unlimited**	**Unlimited**	**Unlimited**	**Unlimited**	**Unlimited**	**Unlimited**

IS MY MEDICATION COVERED?

If you take prescription medication, you've likely heard the term formulary. Simply put, a formulary is a list of drugs covered by a health plan. Those drugs are often categorized into cost tiers. Tier 1 contains mostly generic drugs, but some brand name drugs may be included. Tier 2 contains a mix of brand name and generic drugs. Tier 3 contains mostly brand name drugs as well as some generics.

If you take medication for an ongoing condition, check **UHC's formulary (drug list)** to see how your medication is covered. The formulary also includes helpful tips.



NEW FOR 2021!

UHC Virtual Visits

Coverage for UHC Virtual Visits is being enhanced for 2021.

Have you ever been faced with a sick child in the middle of the night? Or just wanted care without leaving home? You have a convenient alternative for minor conditions such as sore throat, fever, colds and flu, allergies, rashes, etc.

UHC members can connect with a board-certified doctor via secure video chat or phone 24/7. You can find a Virtual Visit network provider and register for this service by visiting **myuhc.com** or calling the number on your ID card.

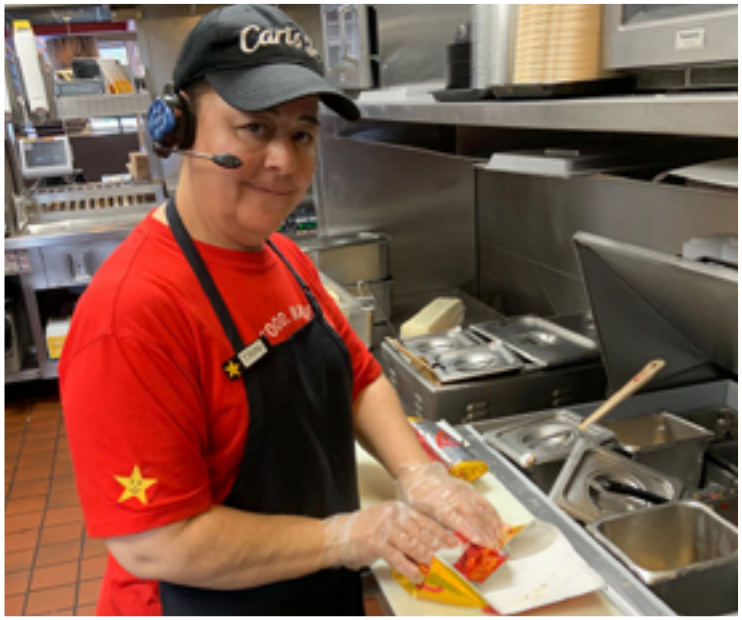
HDHP with HSA	Silver PPO	Gold PPO
You pay $50/visit	You pay $0/visit	You pay $0/visit

SUMMARY OF BENEFITS AND COVERAGE

In accordance with the Affordable Care Act, CKE Restaurants and UHC have created Summaries of Benefits and Coverage (SBCs), which provide additional information about your medical plan. You can view a copy at **ckebenefits.com**.

WHAT DOES THAT MEAN?

Healthcare terminology can be confusing! That's why UHC offers a website — **justplainclear.com** — that defines thousands of healthcare terms in plain, clear language, so you can make informed decisions.



How a Health Savings Account Works

Intrigued by a Health Savings Account but not sure if it's right for you? Here's a graphic to help you understand the benefits and rules of HSAs. If you need more detail, visit the **PayFlex website**.

Contributions HSA dollars from CKE means free money!

When you enroll in the HDHP, you can contribute your own tax-free money to an HSA (via payroll deduction, up to annual IRS limits).* If you contribute at least $500 of your own money to your HSA, **CKE will make a matching contribution of $500.** Then, shortly after enrollment, you will receive an HSA debit card in the mail. It works like a bank debit card at any vendor that accepts healthcare cards.

Spend You can use your HSA money to:

- Pay for eligible non-preventive expenses like doctor visits, prescription drugs, dental and vision care, etc., incurred by you and your eligible dependents
- Help meet your deductible

Build a reserve There's no "use it or lose it"

Any money left in your HSA at year-end rolls over to future years and is yours to use toward future healthcare expenses — even if you leave the company or switch to another plan. It continues to grow in your account tax-free.

Deductible

Once you meet your deductible with any combination of HSA dollars or your own money, the plan pays a percentage of the cost of services. If you reach your out-of-pocket maximum, the plan pays 100% for the remainder of the calendar year.

* **Important rules:** *IRS contribution limits for 2021 are $3,600/individual or $7,200/family. You must be enrolled in the HDHP to establish an HSA. And if you are enrolled in an HSA, you cannot contribute to a Healthcare FSA.*

Why consider the HDHP with HSA?

Would the HDHP with HSA be a good fit for you? Here are two examples to help you decide.

Example #1: Consider what is coming out of your paycheck

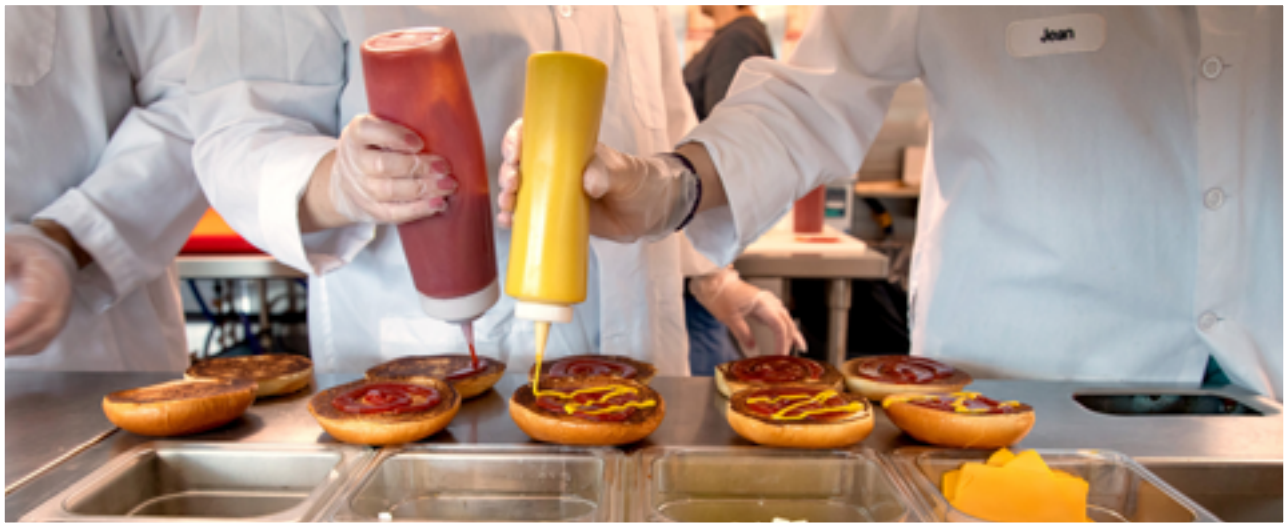
Look how much you could save on payroll deductions if you elect the HDHP with HSA instead of the Gold PPO.

Biweekly payroll deductions

	HDHP with HSA		Gold PPO		You save	
	Biweekly	Annually[1]	Biweekly	Annually[1]	**Biweekly**	**Annually[1]**
Employee only	$34.62	$900	$145.38	$3,780	**$110.76**	**$2,880**
Employee + spouse	$92.31	$2,400	$332.31	$8,640	**$240.00**	**$6,240**
Employee + child(ren)	$80.77	$2,100	$263.08	$6,840	**$182.31**	**$4,740**
Family	$143.08	$3,720	$493.85	$12,840	**$350.77**	**$9,120**

Did you know that when you choose the HDHP with HSA, you save nearly $351/paycheck on family coverage? That's $9,120/year!

[1] *Annual figures rounded to the nearest dollar*



TURN THE PAGE TO SEE EXAMPLE #2

Why consider the HDHP with HSA? *continued from previous page*

Example #2: Don't forget CKE's HSA contribution

If you put just HALF of your annual premium savings (from example #1) in your HSA, CKE will contribute $500 to your HSA. Then look how much you would have available to cover healthcare expenses!

	½ of annual premiums savings[2]		CKE's HSA contribution[3]		Available money
Employee only	$1,440	+	$500	=	**$1,940**
Employee + spouse	$3,120	+	$500	=	**$3,620**
Employee + child(ren)	$2,370	+	$500	=	**$2,870**
Family	$4,560	+	$500	=	**$5,060**

Putting some or all of your premium savings in the HSA helps ensure you have money available to pay out-of-pocket expenses. But the best part is: If you don't spend it all, it's yours to use later.[1]

That's why it's important to choose a plan that matches how you use healthcare services, because you don't get a refund on your premiums if you don't use your medical coverage!

This amount can be used to help satisfy your deductible:

- $3,500/person
- $7,000/family

If you spend less, the unused money carries over to next year.

[1] *Money actually resides in your HSA and can only be used for eligible healthcare expenses.*
[2] *If you choose the HDHP with HSA instead of the Gold PPO.*
[3] *If you contribute at least $500 of your own money to the HSA.*

Dental

WHO'S ELIGIBLE?
- Regular full-time
- ACA full-time

Two dental PPO options (DPPO) are offered through UHC. Both options cover preventive care and restorative services; the High option also covers orthodontia for adults and children. With either option, you can go to any dentist you choose, but you pay less out of pocket when you use UHC network providers. To locate participating providers, visit **myuhcdental.com**.

	UHC DPPO Low In-network*	UHC DPPO High In-network*
You pay:		
Annual deductible	$50/person; $150/family	$50/person; $150/family
Preventive/diagnostic (such as exams, cleanings, bitewing x-rays)	$0	$0
Basic (such as fillings, simple extractions)	20% after deductible	20% after deductible
Major (such as crowns, bridges, dentures)	50% after deductible	50% after deductible
Orthodontia for adults and children	Not covered	50%; $2,000 lifetime maximum benefit
Annual benefit maximum	**$750**	**$3,000**

** Benefits for out-of-network care are the same as for in-network care, but if you use an out-of-network dentist and your provider's charges exceed reasonable and customary (R&C) limits, you will be responsible for the difference. In-network providers have agreed not to exceed R&C limits.*

YOUR 2021 COSTS

Your per-paycheck premiums for dental coverage are as follows:

	DPPO Low	DPPO High
Employee only	$3.67	$5.43
Employee + spouse	$15.84	$24.64
Employee + child(ren)	$18.09	$32.50
Family	$32.23	$44.40

HELP ME CHOOSE

The High Plan has higher employee premiums because it covers orthodontia for adults and children and has a higher annual benefit maximum.

Vision

WHO'S ELIGIBLE?
- Regular full-time
- ACA full-time

CKE offers a vision plan through UHC. In addition to coverage for exams, frames, lenses and contacts, the plan also includes benefits for prescription glasses with blue light protection and anti-reflective lenses. These enhancements help you see better by limiting the reflection of bright lights. This additional benefit is ideal for employees concerned about eye strain and eye health from looking at a computer screen. Under the plan you can see any vision provider you choose, but benefits are highest when you use a network provider. Visit **myuhc.com** for a list of network providers.

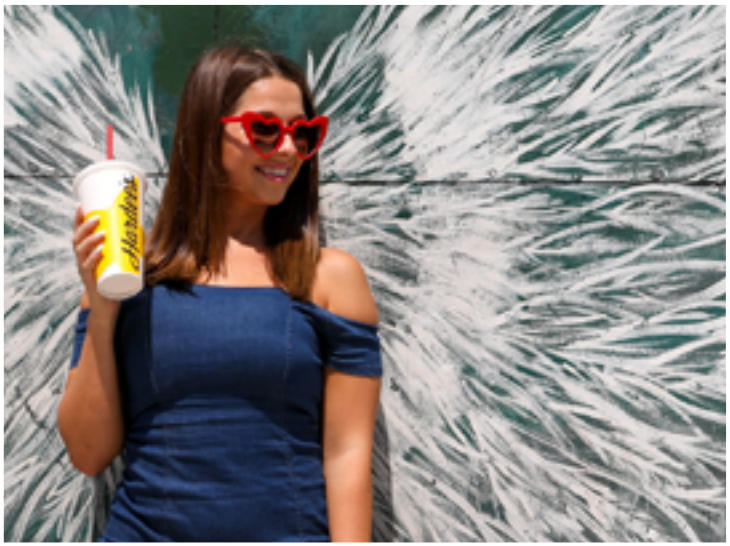
	Vision Plan In-network*
You pay:	
Annual deductible	$0
Eye exams (one per 12 months)	$20 copay
Frames (one pair per 12 months)	$0 up to $130 retail allowance
Lenses (once per 12 months; $10 materials copay)	$0
Contacts (in lieu of lenses/frames)	Elective: $0, up to $130 allowance Necessary: $0
Laser vision surgery	Plan provides discounts; visit **myuhc.com**

** The plan also provides benefits for out-of-network care, up to certain limits.*

YOUR 2021 COSTS

Your per-paycheck premiums for vision coverage are as follows:

	Vision Plan
Employee only	$5.51
Employee + spouse	$8.17
Employee + child(ren)	$8.32
Family	$12.77



Flexible spending accounts

WHO'S ELIGIBLE?
- Regular full-time

CKE offers two flexible spending accounts (FSAs) – a Healthcare FSA and a Dependent care FSA – administered by PayFlex.

With FSAs, you set aside tax-free money from your paycheck to pay for out-of-pocket expenses like deductibles, copays, coinsurance, childcare and adult daycare. You pay less for these expenses because the money is not taxed when it is deducted from your paycheck or when you use it to pay for eligible expenses.

HOW FSAs WORK

You can contribute to one or both of the FSAs. You do not have to be enrolled in other coverage to participate. You cannot contribute to the Healthcare FSA if you are enrolled in a Health Savings Account (HSA).

	Healthcare FSA	Dependent care FSA
You can contribute…	Up to $2,750/year – tax-free	Up to $5,000/year[1] – tax-free
To reimburse yourself for…	Eligible healthcare expenses paid out of your pocket (rules apply)	Day care expenses for your eligible dependents (rules apply)

[1] *If you're married and file separate tax returns, the maximum you can contribute is $2,500/year.*

ELIGIBLE EXPENSES

Below are some examples of eligible expenses; visit **payflex.com** to see a complete list:

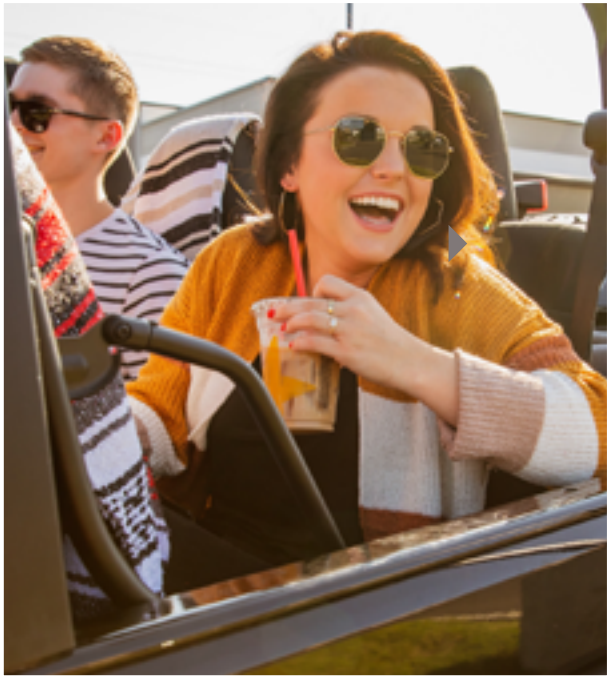
Healthcare FSA

- Out-of-pocket medical, dental, vision, hearing and prescription drug expenses
- Certain over-the-counter medicines if prescribed by a physician
- Over-the-counter health-related supplies
- Other out-of-pocket health expenses considered tax-deductible by the IRS

Dependent care FSA

- Day care fees and associated expenses for your children under age 13
- Dependent care fees for a disabled spouse or child or a tax-dependent parent or elderly person

The dependent care FSA is designed to help you pay for dependent day care expenses so you (and your spouse, if applicable) can work. It is NOT for dependent healthcare expenses.



TURN THE PAGE TO LEARN HOW TO GET STARTED WITH FSAs.

Flexible spending accounts

continued from previous page

FSA rules

Because FSAs offer such favorable tax breaks, certain rules apply:

Don't forfeit your contributions

Be careful not to overestimate your expenses for the calendar year. You must use all the money in your FSAs by year-end and submit all claims no later than March 31 of the following year. Otherwise, remaining funds will be forfeited.

No contribution changes

Once you decide how much to contribute to each account, you can't change it until the next Open Enrollment (unless you experience a qualifying life event)

No transfers

If you participate in both FSAs, you cannot transfer money between your two accounts or use money in one to pay expenses for the other.

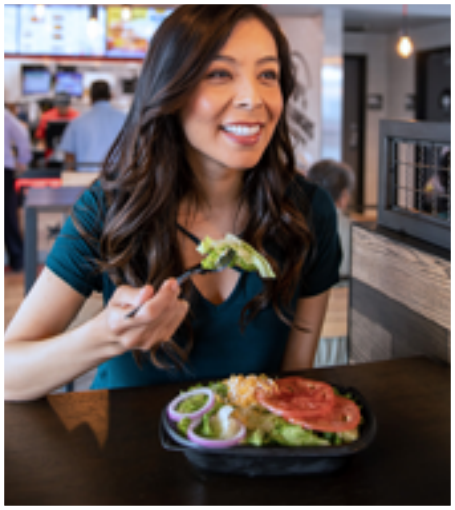
FSAs 101

Intrigued by the FSAs, but need some more information? Check out this **PayFlex flier** that contains helpful tips and details on the PayFlex Mobile® app.

HOW TO GET STARTED

1. Estimate your healthcare and dependent care expenses separately for 2021.
2. Decide how much to contribute to each account. Be careful not to overestimate your expenses as unused funds at year-end are forfeited.
3. Your contributions will be deducted from your paycheck before taxes are taken out of your check and deposited into your account(s). (If you contribute to the Healthcare FSA , your full annual election amount is available to you at the beginning of the calendar year.)
4. Get reimbursed with the tax-free money in your account(s) using one of the following options:
   - For Healthcare FSA expenses, use the PayFlex debit card you receive in the mail after enrollment.
   - For both healthcare and dependent care expenses, pay as you normally would, then submit a claim to PayFlex. You can even have your claims payment deposited directly into your checking or savings account.

You must re-enroll every year (during Open Enrollment) to keep participating in the FSAs, even if you wish to keep your same contribution. Once you enroll, you will receive a welcome packet from PayFlex with complete rules and tips for maximizing your savings with the FSAs.



Life and AD&D

Life insurance and accidental death and dismemberment (AD&D) insurance provide financial protection in the event you or a covered family member dies or becomes seriously injured in an accident. Coverage is provided through Lincoln Financial.

BASIC COVERAGE

CKE automatically provides regular full-time employees with basic life insurance of 1x your annual salary (up to $500,000) and an equal amount of AD&D coverage, at no cost to you.

VOLUNTARY COVERAGE

You can purchase voluntary coverage to supplement your basic coverage. If you elect voluntary life for yourself, you can also elect it for your family, as follows:

	Voluntary life	Voluntary AD&D
For you:	1, 2, 3, 4 or 5x your annual salary, up to $1 million	1, 2, 3, 4 or 5x your annual salary, up to $1 million
For your spouse:	Up to $250,000 (in $10,000 increments)[1]	Up to $250,000 (in $10,000 increments)[1]
For each unmarried dependent child:	$10,000 per child (in $2,000 increments)[1]	$10,000 per child (in $2,000 increments)[1]

[1] *Spouse life coverage cannot exceed 50% of your voluntary amount. If you elect child life, coverage includes all your children.*

WHO'S ELIGIBLE?

- Regular full-time

WHAT IS AD&D?

AD&D coverage essentially doubles the value of your life insurance coverage if you die in an accident. AD&D coverage also provides benefits if you survive an accidental injury but lose the use of a body part (such as the loss of an eye or limb).

EVIDENCE OF INSURABILITY

In certain cases, you (and/or your spouse) may be required to submit evidence of insurability (EOI) and be approved before your life insurance coverage becomes effective. EOI is required if:

- » You decline voluntary or spouse life coverage when first eligible but wish to elect it at a later date
- » You elect to increase your or your spouse's life coverage
- » Life coverage elections exceed the following guarantee issue amounts:
  - Your voluntary life: $250,000
  - Spouse coverage: $20,000

If EOI is required, you will be advised when you go online to enroll.

Disability

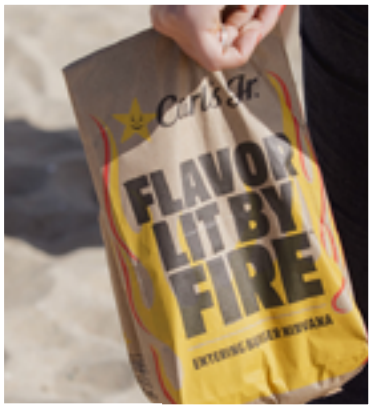
WHO'S ELIGIBLE?
- Regular full-time

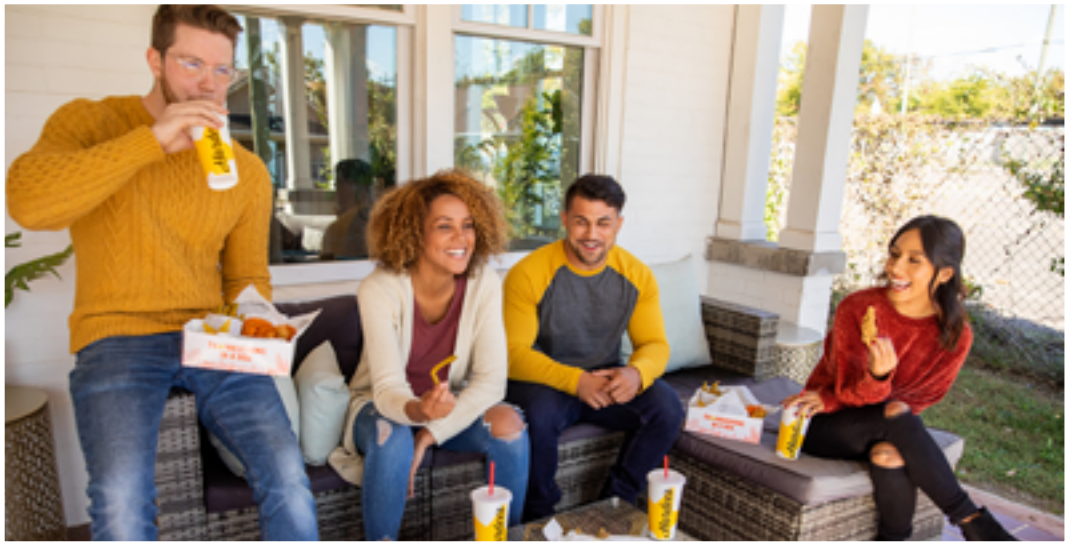
Disability coverage, administered by Lincoln Financial, continues a portion of your paycheck if a serious illness or injury keeps you from working.

If you are a regular full-time employee, short-term disability is provided by CKE at no cost to you. Long-term disability coverage generally picks up where short-term disability coverage leaves off to protect you financially if your disability continues for an extended period.

	Short-term disability	Long-term disability
Benefits begin:	After 14 days of disability	After 180 consecutive days of disability
Plan pays:[1]	60% of your base pay, up to $1,500/week	40% of your base pay, up to $10,000/month You may purchase buy-up coverage to increase income replacement to 60%
Benefits continue:[1]	Up to 26 weeks	Benefits generally continue until you are no longer disabled or reach normal retirement age

[1] *Limits may apply*



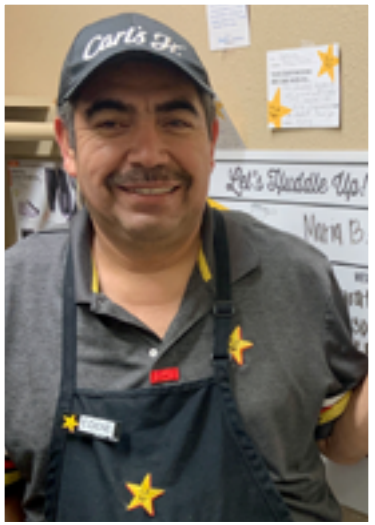


Voluntary insurance plans

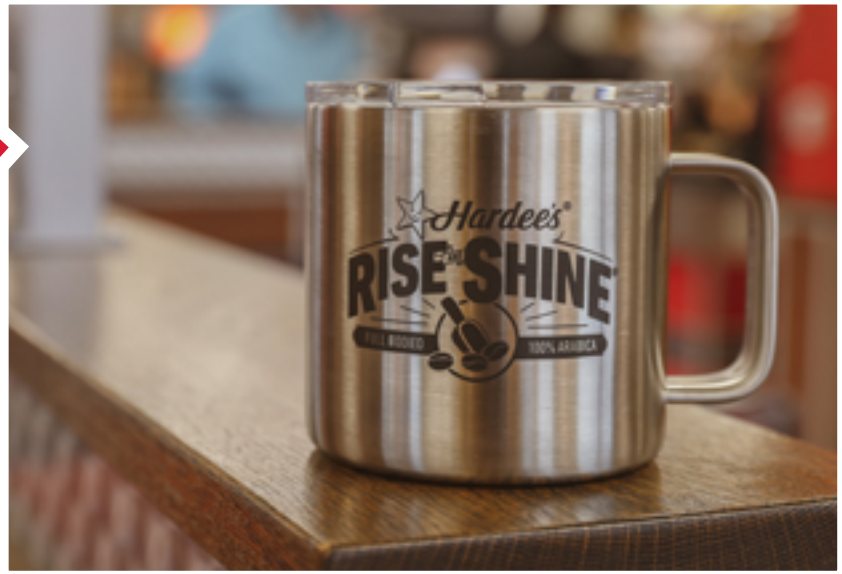
WHO'S ELIGIBLE?
- All full-time
- Part-time

All full-time and part-time employees can choose from two voluntary insurance plans designed to enhance your financial protection: accident and critical illness insurance. This section provides an overview; for more details see the individual plan brochures on **ckebenefits.com**.

	Accident	Critical illness
Pays benefits for:	Accidental injury	Covered critical illnesses
Can be paired with:	Any medical plan	Any medical plan
Used as a stand-alone plan?	Yes	Yes
Family coverage available?	Yes	Yes
Pays in addition to any insurance you have?	Yes	Yes
Required to answer medical questions to purchase coverage?	No	Not if you enroll when first eligible



TURN THE PAGE FOR HIGHLIGHTS ON EACH VOLUNTARY PLAN.



Accident

WHO'S ELIGIBLE?
- All full-time
- Part-time

You can't always avoid accidents, but you can protect yourself from costs associated with them. Accident coverage, through Lincoln Financial, pays cash benefits when an accidental injury occurs. You can use the money to pay for expenses not covered by insurance, such as your deductible or coinsurance, and living expenses like mortgage, rent and transportation. Below are some examples of covered injuries and benefit amounts:

Service	Plan pays[1]:
Ambulance (ground)	$225
Ambulance (air)	$1,125
Initial care visit	$75
Emergency room	$150
Hospital admission	$1,000
Hospital stay	$200/day
Intensive care unit	$400/day

[1] Amount paid is based on injury and service required. Limits apply.

The plan also pays cash benefits for x-rays, fractures, dislocations, concussions, burns, traumatic brain injuries, sports injuries, pain management, physical therapy, mobility devices, accidental death and dismemberment, expenses associated with the accidental injury like transportation and lodging, and more.

See the plan brochure on **ckebenefits.com** for a complete benefits list.

YOUR 2021 COSTS

Your per-paycheck premiums for accident coverage are as follows:

Employee only	$3.85
Employee + spouse	$6.30
Employee + child(ren)	$6.76
Family	$9.17

Critical Illness

When a serious illness strikes, this coverage can provide vital financial help. The plan, provided through Lincoln Financial, pays cash benefits you can use to pay expenses not covered by insurance. You can also use the money for everyday expenses like housekeeping, transportation and day care. Covered critical illnesses include:

- Accidental injury (brain injury, severe burns, permanent paralysis)
- Cancer (invasive)
- Cancer (non-invasive)*
- Advanced COPD
- Arterial/vascular disease*
- Heart attack
- Kidney failure
- Major organ failure
- Stroke

** Covered at 25%-30% of your coverage amount*

If child coverage is elected, additional childhood conditions, such as type 1 diabetes, Down syndrome, spina bifida and others, are covered.

	Depending on coverage option elected, the plan pays the following upon diagnosis*:		
Employee	$10,000	$15,000	$20,000
Spouse	$5,000	$7,500	$10,000
Child(ren)	$2,500	$5,000	$10,000

** Dependent coverage cannot exceed 50% of employee's coverage election.*

Pre-existing condition exclusion

Under the critical illness plan, no benefits are payable during your first 12 months of coverage as the result of a pre-existing condition. A pre-existing condition is one for which you received medical advice or treatment from a medical professional in the 12-month period before your coverage begins. However, after you have been covered by the plan(s) for 12 months, the pre-existing condition limit no longer applies.

See the plan brochure on **ckebenefits.com** for more details about this coverage.

YOUR 2021 COSTS

Your cost for critical illness coverage is based on coverage level, tobacco use, and the age of the covered person, and can be viewed when you log onto **Employee Navigator** to enroll.

Employee assistance program

WHO'S ELIGIBLE?
- All full-time
- Part-time

Need help dealing with a personal or work-related issue? The EmployeeConnect Plus Employee Assistance Program provides confidential counseling services to you and your household family members. Services are free and available 24/7. You do not have to be enrolled in other benefit plans to participate.

The program, administered by ComPsych, can help with issues such as family or marital problems, workplace concerns, parenting, elder care, depression, anxiety, or other emotional problems, drug or alcohol dependence, eating disorders, and grief and loss. The program can also help with financial and/or legal concerns, including a discount on select fees.

Call **855-327-4463** or visit **guidanceresources.com** (Web ID: **Lincoln**) to get started. The program covers up to six counseling sessions per person per issue per year. If you need additional assistance, you may be referred to your medical plan's behavioral health benefits.

401(k)

WHO'S ELIGIBLE?
- Regular full-time

The 401(k) plan lets you set aside money on a pre-tax basis to save for retirement. Once you become eligible to participate, you can join the plan at any time, even outside Open Enrollment. Here are some plan highlights:

When you can join	You can join the plan the first of the month following your hire date. Newly eligible employees are automatically enrolled with a 2% contribution. You can change your contribution amount or waive participation by visiting **wellsfargo.com** or by calling **800-728-3123**. If you do not actively select your investments, your contributions will be invested in one of the Vanguard Target Retirement Funds, based on the year you turn 65.
How to enroll or change your contributions	Enrollment is automatic for new employees (2% contribution). You can change your contribution amount or start or stop participation at any time by visiting **wellsfargo.com** or by calling **800-728-3123**.
How much you can contribute	You can contribute from 1% to 75% of your eligible pay, up to IRS contribution limits. Your contributions are deducted from your paycheck each pay period. If you turn 50 or older in 2021 and reach the annual IRS limit, you may make additional "catch-up contributions." You can also sign up for automatic contribution increases, a great way to gradually save more.
How much CKE contributes	For every dollar you contribute, CKE will make a 25% matching contribution, up to 6% of your salary. Matching contributions are made on a per-pay period basis.
How your contributions are invested	You can invest your contributions and CKE's matching contributions in a wide variety of investment options. Funds range from conservative to aggressive. You may change your investment elections or transfer money from one fund to another at any time by visiting **wellsfargo.com** or by calling **800-728-3123**. You also have the option to add automatic rebalancing to your account to help keep your investments in line with your chosen risk level and asset allocation.
When you become vested	While you are always 100% vested in your own contributions, you become vested (or gain ownership) in CKE's matching contributions over time. You gain 25% ownership after one year of service, 50% after two years, and 100% after three years of service.

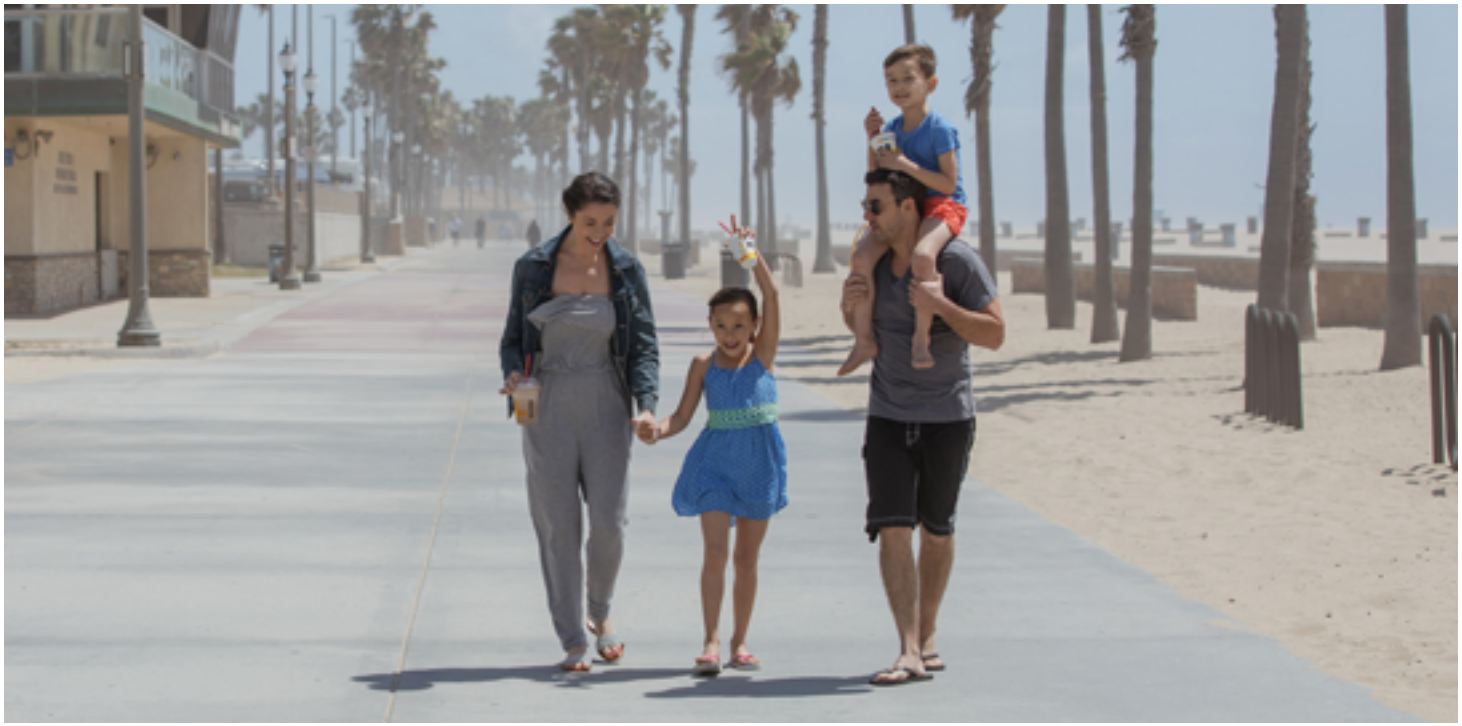
Connecting with your 401(k) account

You have several ways to stay in touch with your account:

Phone: Call **800-SAVE-123** (**800-728-3123**), M-F, 6 a.m.-10 p.m. Central time. To access your account by phone, you need your Social Security number and PIN (initially the last four digits of your SSN).

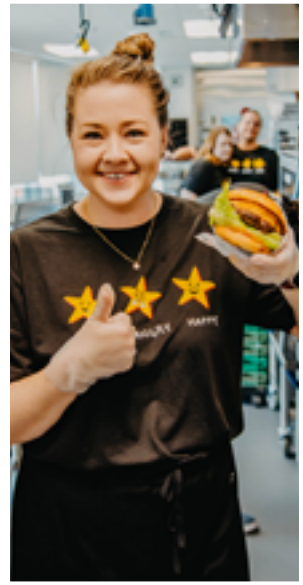
Online: Visit **wellsfargo.com** and click Enroll at the top of the page to register for an account. Then select your plan name from the Account Summary page to go to your account Dashboard.

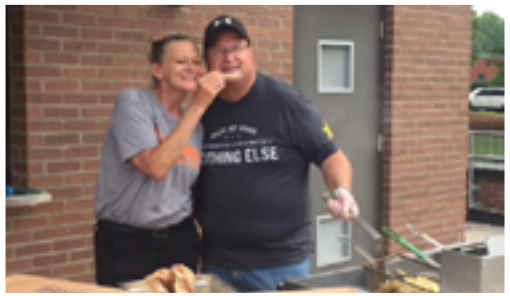
Mobile app: From your smartphone, visit **wellsfargo.com** or download the Wells Fargo app, and sign on with the same username and password you use to access your account on a computer.



Important contacts

Plan	Contact	Web | Email	Phone
General benefits and enrollment questions	Health Advocate	**HealthAdvocate.com/members** **answers@HealthAdvocate.com**	866-695-8622
	CKE Benefits	**ckebenefits.com** **benefits@ckr.com**	888-253-3115
Claims assistance and care advice	Health Advocate	**HealthAdvocate.com/members** **answers@HealthAdvocate.com**	866-695-8622
Enrollment website	Employee Navigator	**employeenavigator.com/benefits/account/login** (Company Identifier: CKE)	N/A
Medical Dental Vision	UnitedHealthcare (UHC)	**myuhc.com** Health4Me mobile app Not yet enrolled: **welcometouhc.com**	866-414-1959
Health Savings Account (HSA) Flexible spending accounts	PayFlex	**payflex.com**	844-729-3539
Life/AD&D	Health Advocate	**HealthAdvocate.com/members** **answers@HealthAdvocate.com**	866-695-8622
	CKE Benefits	**ckebenefits.com** **benefits@ckr.com**	888-253-3115
Disability Accident Critical illness	Lincoln Financial	**mylincolnportal.com**; company code: CKERHINC	888-408-7300 800-423-2765 800-423-2765





This benefit summary provides selected highlights of the CKE Restaurant employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at CKE. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. CKE reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

Important notices

NMHPA Notice

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

WHCRA 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.

Exchange Notice

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact CKE Benefits at 888-253-3115 or benefits@ckr.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] *An employer-sponsored 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 percent of such costs.*

Summary Notice of Privacy Practices

This is a summary of your Group Health Plan's Notice of Privacy Practices, and is a reminder that a copy of the complete Company Privacy Notice can be obtained from the Human Resource Department. Please review this summary carefully. In order to provide you with benefits, the Company Group Health Plan (hereafter referred to as the Plan) may receive personal health information from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This Summary Notice of Privacy Practices is intended to remind you of the ways we may use your information and the occasions on which we may disclose this information to others. The following is a summary of the circumstances under which your health information may be used and disclosed:

- To provide treatment
- To obtain payment
- To conduct health care operations

Important notices *continued from previous page*

We use participants' health information to provide benefits. We may disclose participants' information to health care providers to assist them in providing you with treatment, or to help them receive payment. We may disclose information to insurance companies or other related businesses to receive payment. We may use the information within our organization to evaluate a request for coverage or a claim for benefits, to evaluate quality, and improve health care operations. We may make other uses and disclosures of participants' information as required by law or as permitted by our policies. Your Rights with Respect to your Health Information

- You have the following rights regarding your health information:
- Right to request restrictions
- Right to receive confidential communications
- Right to inspect and copy your health information
- Right to request an amendment to your health information
- Right to an accounting of your health information
- Right to a paper copy of the Notice of Privacy Practices

This is a reminder that you generally have a right to access and in certain instances to request an amendment to your Personal Health Information. This does not apply to information collected in connection with, or in anticipation of, a claim or legal proceeding. We are required by law to maintain the privacy and security of your health information and to provide you with a reminder that our complete Notice of Privacy Practices is available upon request. We reserve the right to implement new privacy and security provisions for health information that we maintain. If we change the Privacy Notice, we will provide you with a copy of the complete revised notice to you at that time. Also, you have the right to express complaints to the contact person referenced below and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to Company should be made in writing to the contact person listed at the end of this notice. For more information on the Plan's privacy policies or your rights under HIPAA, contact Benefits/Human Resources.

HIPAA SPECIAL ENROLLMENT NOTICE

If you decline enrollment in the Company's health plan for you or your dependents including your spouse because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a Company health plan without waiting for the next Open Enrollment period if you

- Lose other health insurance or group health plan coverage, or gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request enrollment within 30 days
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a Company medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.) If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for Protecting Your Health Insurance Coverage).

These publications and other useful information are also available on the Internet at: **http://www.dol.gov/ebsa**, the DOL's interactive web pages - Health Laws, or **www.cms.hhs.gov**.

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums. If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

Important notices *continued from previous page*

Important notice from CKE Restaurants about creditable prescription drug coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage under the CKE medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2021. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2021 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with CKE and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the CKE prescription drug plan, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2021. This is called creditable coverage. Coverage under this plan will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop CKE coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the CKE plan.

You should know that if you waive or leave coverage with CKE and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this CKE coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact the CKE benefits department.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/	Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-855-692-5447	Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program	Website: http://dch.georgia.gov/medicaid
Website: http://myakhipp.com; Phone: 1-866-251-4861; CustomerService@MyAKHIPP.com	Click on Health Insurance Premium Payment (HIPP)
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/	Healthy Indiana Plan for low-income adults 19-64
Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.in.gov/fssa/hip/; 1-877-438-4479;
	Website: http://www.indianamedicaid.com; 1-800-403-0864
COLORADO – Health First Colorado & Child Health Plan Plus	**IOWA – Medicaid**
https://www.healthfirstcolorado.com/; 1-800-221-3943/ State Relay 711	http://dhs.iowa.gov/hawk-I; 1-800-257-8563
Colorado.gov/HCPF/Child-Health-Plan-Plus; 1-800-359-1991/ State Relay 711	
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/; 1-785-296-3512	https://www.dhhs.nh.gov/ombp/nhhpp/; 603-271-5218
	Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov; 1-800-635-2570	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/; 609-631-2392
	http://www.njfamilycare.org/index.html; 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331; 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/; 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
http://www.maine.gov/dhhs/ofi/public-assistance/index.html; 1-800-442-6003	Website: https://dma.ncdhhs.gov/; 919-855-4100

MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/; 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/; 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org; 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm; 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx; 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP; 1-800-694-3084	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633; (402) 473-7000; (402) 595-1178	Website: http://www.eohhs.ri.gov/; 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov; 1-800-992-0900	Website: https://www.scdhhs.gov; 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov; 1-888-828-0059	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/; 1-800-440-0493	Website: http://mywvhipp.com/; 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
https://medicaid.utah.gov/; http://health.utah.gov/chip; 1-877-543-7669	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf; 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/; 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/; 307-777-7531
VIRGINIA – Medicaid and CHIP	**CALIFORNIA – Medicaid**
http://www.coverva.org/programs_premium_assistance.cfm; 1-800-432-5924	https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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