2025 CSC Employee Benefits Summary

Benefits offered

CSC is committed to providing a Total Rewards package that helps you be better off tomorrow than you are today.

Eligibility information

If you work full time, 30 or more hours per week, you and your qualified dependents are eligible to enroll in medical, dental, vision, disability, life, legal, identity theft, critical illness-accident-hospital indemnity (supplemental to current medical plans) insurance, and spending accounts after 30 days of employment. **Benefits are effective on the 31st calendar day after your start date and must be elected in MyCSC within the first 30 days of employment**.

Medical insurance	Flexible spending accounts (FSA)	Accident insurance	Group legal plan
Dental insurance	Health savings accounts (HSA)	Critical illness insurance	Identity protection
Vision insurance	Life and disability insurance	Hospital indemnity insurance	

If you work fewer than 30 hours per week, and are classified as a part-time or temporary employee, you are eligible for single coverage for medical, dental, and vision.

Spousal coverage

CSC offers spousal medical coverage to those who cannot receive group medical coverage from their own employer or if the coverage offered to them does not meet the coverage and affordability requirements of the Affordable Care Act. Spouses are eligible to participate if legally married or required by law.

Dependent coverage

Children are eligible up to age 26.

If your spouse or child also works at CSC

If your spouse also works at CSC, the medical spousal limitation does not apply (you can enroll your spouse). In addition, spouse life insurance may not be selected by either individual due to both being covered by employee basic life insurance. If your child works for CSC, child life insurance may not be elected due to the child being covered by employee basic life insurance.

Making changes during the year

Generally, you can only change your benefit elections during the annual benefits open enrollment period, except for any qualified life event (QLE), such as marriage, divorce, loss of coverage, birth, or adoption. You must notify Human Resources within 30 days of any QLE to make a change. Otherwise, you will have to wait until the next open enrollment period. Any changes you make to your benefit choices must be directly related to the QLE. Proof of the change will be required.

Contact information

Benefit:	Contact:	Phone:	Website
Medical insurance	Aetna Medical	888-478-9498	aetna.com
Pharmacy insurance	CVS Caremark	833-268-1265	caremark.com
Dental insurance	Aetna Dental	888-478-9498	aetna.com
Vision insurance	VSP	800-877-7195	vsp.com
Flexible spending accounts	Baker Tilly	800-307-0230	myflexdollars.com
Health savings accounts	Baker Tilly	800-307-0230	myflexdollars.com
Life and disability insurance	Sun Life	800-247-6875	sunlifeconnect.com
Accident, critical illness, hospital indemnity	Voya	877-236-7564	presents.voya.com/EBRC/CSCglobal
Group legal plan	ARAG	800-247-4184	araglegal.com/account
Identity protection	Allstate	800-789-2720	allstate.com

Medical insurance

Coverage	Aetna EPO		Aetna POS		Aetna CDHP	
	In network	Out of network	In network	Out of network	In network	Out of network
Annual deductible						
Individual	$0	No coverage	$400	$400	$2,000	$4,000
Family	$0	No coverage	$1,200	$1,200	$6,200	$12,000
Out-of-pocket maximum						
Individual	$2,000	No coverage	$2,000	$2,000	$4,000	$8,000
Family	$6,000	No coverage	$6,000	$6,000	$7,900	$16,000
Coinsurance level	0%	No coverage	10%	30%	10% after deductible	30% after deductible
Preventive care	$0 (no deductible)	No coverage	$0 (no deductible)	30% after deductible	0% (no deductible)	30% after deductible
Physician's office visits						
Primary care	$30 copay	No coverage	$25 (no deductible)	30% after deductible	$25 after deductible	30% after deductible
Specialists	$50 copay	No coverage	$50 (no deductible)	30% after deductible	$50 after deductible	30% after deductible
Hospital care and urgent care						
Inpatient facility	$250 per day for first 5 days	No coverage	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Urgent care	$30 copay	No coverage	$30 (no deductible)	30 % after deductible	$30 after deductible	30% after deductible
Emergency care						
Emergency room services	$200 copay	$200 copay	$200 copay	$200 copay	$200 copay	$200 copay

Prescription coverage	Aetna EPO		Aetna POS		Aetna CDHP	
	In network	Out of network	In network	Out of network	In network	Out of network
Generic (retail/90-day)	$20/$40	No coverage	$20/$40	No coverage	After deductible $20/$40	No coverage
Preferred brand Drugs (retail/90-day)	$40/$80	No coverage	$40/$80	No coverage	After deductible $40/$80	No coverage
Non-preferred brand drugs (retail/90-day)	$60/$120	No coverage	$60/$120	No coverage	After deductible $60/$120	No coverage

Medical plan biweekly rates

Plan	Employee only	Employee plus one	Employee plus two or more
Aetna EPO	$95	$189	$287
Aetna POS	$110	$214	$315
Aetna CDHP	$79	$155	$229

Pharmacy coverage

The pharmacy benefit, paired with your Aetna medical coverage, is managed by CVS Caremark beginning Jan. 1, 2025.

CVS Virtual Care Telemedicine

As an Aetna member, you have access to several valuable programs and resources. Virtual visits, powered by CVS Virtual Care, allow you to consult a doctor for nonemergency situations and receive mental health services by phone, mobile app, or online video. Speak to a medical professional or schedule an appointment at a time that works best for you.

CVS Virtual Care visits have a $0 copay for 2025 for those employees enrolled in the Aetna EPO or Aetna POS plans. Please note that the $0 copay applies only to those visits within the CVS Virtual Care application. Virtual visits with primary doctors and specialists will be subject to applicable copays as per the summary of benefits and coverage document. Employees in the CDHP plan will be subject to a copay determined by the type of service they elect.

You can schedule 24x7 care (available to adults and children over 18 months) in minutes. CVS virtual clinic and mental health appointments are available within a week. You can get care for:

- **Common illnesses:** Cough, cold, flu, urinary tract infection, minor injuries, and rashes
- **Chronic conditions:** Diabetes, high blood pressure, high cholesterol
- **Mental health services:** Depression, anxiety, life changes (i.e., divorce, loss of loved one), psychiatric evaluation, and addiction support
- **Medication services:** Prescription refills, birth control, and medication management

For more information, visit CVS.com/virtual-care or call 1-877-993-4321.

Dental insurance

With the Aetna Dental PPO plan, savings are possible when using a participating dentist, because they have agreed to provide care for covered services at negotiated rates.

Nonparticipating dentists may charge more than the Aetna standard rate. In this instance, you would be responsible for the difference between the provider charge and the standard rate negotiated by Aetna.

For a complete list of covered services, please refer to your summary plan description.

	Aetna network dentist (lowest service costs)
Individual annual deductible	$25
Family annual deductible	Does not apply
Preventive	100% (no deductible)
Basic treatment	80% after deductible
Major treatment	50% after deductible
Annual maximum	$2,000
Orthodontic treatment	50% after deductible (adult and child)
Orthodontic lifetime	$2,000

Dental plan biweekly rates

Plan	Employee only	Employee plus one	Employee plus two or more
Aetna Dental PPO	$10	$20	$29

Vision insurance

For a complete list of covered services, please refer to your summary plan description.

There is a 30% savings on additional glasses and sunglasses, including lens enhancements from the same VSP provider on the same day as your WellVision Exam. Or get 20% off from any VSP provider within 12 months of your last WellVision Exam.

VSP benefit	In network
Eye exam	$10 copay every 12 months
Frames	$150-$170 allowance every 24 months
Lenses	$25 copay included in prescription glasses – single vision, bifocal, or trifocal
Enhancements	Progressive lenses or anti-glare coating - $0 copay
Enhancements	Average 40% savings on other lens enhancements
Contacts	$150 allowance (if bought instead of glasses)
Lasik or PRK	15% off retail or 5% off promotional price at contracted facilities

Vision plan biweekly rates

Plan	Employee only	Employee and spouse	Employee and children	Family
VSP	$3.18	$6.34	$6.77	$10.82

Flexible spending accounts (FSA)

An FSA can be used to pay for your (or your dependents') qualified medical, dental, vision, child, or dependent care expenses. The dollars you put into the account are pretax, reducing your taxable income. Please be conservative with your account election because the IRS has a "use-it-or-lose-it" rule, which states that you lose any leftover dollars in your flexible spending account at the end of the plan year that exceed the amount established by the IRS for carryover each year.

- **Health care flexible spending account:** A health care FSA can be used to pay for out-of-pocket medical, dental, and vision expenses not covered by insurance. The maximum plan year election is $3,300. The annual election amount is available at the start of the plan year.
- **Dependent care flexible spending program:** A dependent care flexible spending account allows you to be reimbursed for qualified child care and dependent care expenses using pretax dollars. The annual IRS limit for individuals whose tax filing status is single or married, filing jointly will be $5,000 per year. If your tax filing status is married, filing separately, the IRS limit is $2,500 per year for each spouse.
    - Eligible dependents: Children under age 13 who are claimed as a dependent for tax purposes, disabled spouse, or disabled dependents of any age.
- **Limited purpose flexible spending account (LPFSA):** A limited purpose flexible spending account can be used to pay for out-of-pocket dental and vision expenses not covered by insurance. The maximum plan year election is $3,300. Annual election amount is available at the start of the plan year. A LPFSA is only available to employees enrolled in a consumer-driven (high-deductible) health plan.
- **Transit and parking flex spending account (FSA):** This account allows you to elect pretax payroll deductions to pay for transit and parking expenses related to work. The maximum contribution allowed for 2025 is $325 per month.

Please note that if you separate from CSC, your FSA account terminates effective the date of separation and you cannot submit receipts for reimbursement with a date of service after your last day of work.

Both FSAs and HSAs allow employees to set aside money for health care costs referred to as "qualified expenses," including deductibles, copayments and coinsurance, and monthly prescription costs.

An FSA debit card will be mailed to participants as an easy, automatic way to pay for qualified health care expenses. The debit card lets you electronically access pretax contributions you set aside in your flexible spending account.

Carryover health FSA funds: The plan allows for carryover up to $660 of unused health FSA balances remaining at the end of a plan year into the next year.

Health savings account (HSA)

Employees can participate in an HSA to go along with the consumer-driven health plan (CDHP) option. These accounts may help you save money by reducing your taxable income when you pay for qualified expenses.

Per IRS regulations, employees may not be enrolled in a health savings account if they (or a spouse) are enrolled in a health care flexible spending account or if the employee is enrolled in any part of Medicare.

An HSA is a bank account that you own and use to pay for current and future qualified health care expenses. Key features include:

- Tax-savings vehicle that lets you set aside tax-free money to pay for eligible health care expenses. You decide which expenses to pay from your HSA.
- Your balance rolls over year to year. There is no "use-it-or-lose-it" rule like in an FSA.
- Once the account balance reaches a certain limit, the employee may choose to invest the funds.
- If you leave your current employer or retire, you take the money with you. You own the account.

Please note that while the employee is not required to upload receipts, they should maintain these receipts for tax purposes. Employees will also receive IRS Form 5498-SA for contributions and a 1099-SA for distributions that occurred in each tax year.

HealthcareBank is the custodian of the FDIC-insured portion of the Baker Tilly health savings account.

Employees participating in the consumer-driven health plan (CDHP) will receive instructions on how to open an account electronically through Baker Tilly.

During the enrollment process in MyCSC, employees will have the opportunity to accept the terms and conditions of the HSA account which will expedite the process.

2024 HSA contribution limits:

- Self: $4,300
- Family: $8,550
- Catch-up contributions (age 55 or older)*: $1,000

*Catch-up contributions can be made during the year by HSA-eligible participants who will turn 55 by year-end.

Basic life and AD&D insurance (company paid)

Employees receive coverage equal to their base annual earnings up to a maximum of $50,000. Accidental death and dismemberment (AD&D) benefits are paid in addition to any life insurance if you die in an accident or become seriously injured or physically disabled.

Supplemental life and AD&D insurance

Newly eligible employees have an opportunity to elect coverage for themselves, spouses, and children up to the guaranteed issue amount without having to show evidence of insurability. **Any plan election made after the initial offering, regardless of the level of coverage, will be required to go through the evidence of insurability (EOI) process and be approved by Sun Life before the coverage goes into effect.**

Employee supplemental life – Additional life insurance can be purchased in the amounts of $50,000, $100,000, $250,000, $500,000, $750,000, and $1 million, regardless of annual salary. **EOI will have to be shown and approved by Sun Life for amounts more than $500,000 for newly eligible employees**. AD&D benefits are paid in addition to any life insurance if you die in an accident or become seriously injured or physically disabled.

Employee coverage and biweekly cost for voluntary life and AD&D

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$50,000	$1.85	$1.85	$2.54	$2.77	$3.00	$4.15	$6.23	$11.31	$17.31	$32.77
$100,000	$3.69	$3.69	$5.08	$5.54	$6.00	$8.31	$12.46	$22.62	$34.62	$65.54
$250,000	$9.23	$9.23	$12.69	$13.85	$15.00	$20.77	$31.15	$56.54	$86.54	$163.85
$500,000	$18.46	$18.46	$25.38	$27.69	$30.00	$41.54	$62.31	$113.08	$173.08	$327.69
$750,000	$27.69	$27.69	$38.08	$41.54	$45.00	$62.31	$93.46	$169.62	$259.62	$491.54
$1 million	$36.92	$36.92	$50.77	$55.38	$60.00	$83.08	$124.62	$226.15	$346.15	$655.38

****Employees 70 and over can purchase a reduced amount of life insurance based on age. Volume and rates will be displayed on the benefit enrollment screen.**

Spouse supplemental life – Spouse life can be purchased in the amounts of $25,000, $50,000, $75,000, or $100,000. **EOI will have to be shown and approved by Sun Life for amounts of more than $50,000 for newly eligible employees**. Spouse life may not be elected for more than 100% of the employee basic and supplemental life combined. AD&D benefits are paid in addition to any life insurance if your spouse dies in an accident or becomes seriously injured or physically disabled.

Spouse coverage and biweekly cost for voluntary life and AD&D

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$25,000	0.92	0.92	1.27	1.38	1.50	2.08	3.12	5.65	8.65	16.38
$50,000	1.85	1.85	2.54	2.77	3.00	4.15	6.23	11.31	17.31	32.77
$75,000	2.77	2.77	3.81	4.15	4.50	6.23	9.35	16.96	25.96	49.15
$100,000	3.69	3.69	5.08	5.54	6.00	8.31	12.46	22.62	34.62	65.54

Spouse rate based on employee's age

****Employees 70 and over can purchase a reduced amount of life insurance for a spouse based on age. Volume and rates will be displayed on the benefit enrollment screen.**

Dependent child supplemental life – Child life insurance coverage can be purchased in the amount of $20,000 for any dependent up to age 26. Dependent child life requires no EOI approval, however, it does require a qualifying life event or annual open enrollment to elect coverage if selecting outside the initial enrollment period. AD&D benefits are paid in addition to any life insurance if your child dies in an accident or becomes seriously injured or physically disabled.

Dependent child coverage and biweekly cost for voluntary life and AD&D

$20,000 coverage	**$2.11 per pay**

Employee supplemental life and spouse life rates are based on the employee's age as seen in the charts above. Rates will be automatically calculated for employees in their enrollment screen in MyCSC. **Rates based on age will change throughout the year as age band thresholds are crossed.**

Please note that if your spouse works at CSC and is covered by basic life insurance, you may not elect spouse life insurance. In addition, if your child works at CSC and is covered by basic life insurance, you may not elect child life insurance.

Upon separation from CSC, life and disability coverage terminates on the last day worked.

Did you know more than one in four people in their 20s will become disabled before retiring? Be prepared for the unexpected.

In the event you become disabled from a non-work-related injury or sickness, disability benefits are available as a source of income replacement.

Short-term disability (STD)

Employees are offered 100% employer paid short-term disability benefits that will pay 75% of an employee's pre-disability weekly earnings, minus any payments you may receive from any state-sponsored disability or paid family leave (PFL) plan, beginning one week into your absence for a period of up to 12 weeks. Benefits begin on the eighth day of illness or injury.

Long-term disability (LTD)

Employees are provided with a long-term disability benefit at no cost that will pay 60% of their base monthly earnings (maximum up to $10,000 per month). Employees can purchase supplemental LTD insurance that will pay 66.67% (maximum up to $15,000 per month). The length of the benefit payments depends on your age when you become disabled. Benefits begin after 90 days of disability.

Age at disability	Duration of benefit
Less than age 60	To 65, but not less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69+	12 months

Maternity, parental, and adoption leave

CSC provides you with time off to bond with your new addition and transition back to work. You are eligible for this benefit after 30 days of employment.

Maternity: 12 weeks of fully paid maternity leave.

Parental: Six weeks fully paid parental leave within the first six months following the birth or adoption of a child.

Adoption leave: Six weeks of fully paid adoption leave.

Voluntary benefits

Accident insurance

Accident coverage may be purchased for yourself and your family to help **offset unexpected accident-related costs.** Accident insurance works to complement your medical coverage and **pays in addition to what your medical plan may or may not cover**.

Accident coverage provides a financial cushion for life's unexpected events by providing you with a lump-sum payment. The payment you receive is yours to spend however you like.

Accident insurance is an economical way for you to supplement your health care plan.

There are no medical exams to take and no health questions to answer to enroll in coverage.

Accident insurance biweekly rates	
Employee	$2.85
Employee and spouse	$5.70
Employee and children	$6.13
Family	$8.99

Accident insurance benefit type	Voya plan pays you
Emergency room treatment	$225
X-ray	$75
Physical, speech, or occupational therapy (up to six per accident)	$45
Stitches (for lacerations up to 2 inches)	$60
Follow-up doctor treatment	$100
Hospital admission	$2,000
Hospital confinement (per day, up to 365 days)	$300
Surgery open abdominal, thoracic	$1,200
Surgery exploratory or without repair	$175
Blood, plasma, platelets	$600
Critical care unit confinement per day, up to 15 days	$500
Rehabilitation facility confinement per day, up to 90 days	$200
Coma duration of 14 or more days	$17,000
Transportation per trip, up to three per accident	$750
Lodging per day, up to 30 days	$180
Initial doctor visit	$90
Ground ambulance	$360
Air ambulance	$1,500

Medical equipment	$200
Prosthetic device (one) or prosthetic devices (two or more)	$750/$1,200
Major diagnostic exam	$275
Outpatient surgery (one per accident)	$225
Concussion	$225
Burns, second degree, at least 36% of the body	$1,250
Burns, third degree, at least 9 but less than 35 square inches of the body	$7,500
Burns, third degree, 35 or more square inches of the body	$15,000
Skin grafts	50% of the burn amount
Emergency dental work – crown	$350
Extraction	$90
Eye injury, removal of foreign object	$100
Eye injury surgery	$350
Torn knee cartilage surgery with no repair or if cartilage is shaved	$225
Torn knee cartilage surgical repair	$800
Laceration* treated, no sutures	$30
Laceration*, sutures up to 2”	$60
Laceration*, sutures 2”-6”	$240
Laceration*, sutures over 6”	$480
Ruptured disk surgical repair	$800
Tendon, ligament, or rotator cuff exploratory arthroscopic surgery with no repair	$425
Tendon, ligament, or rotator cuff, one, surgical repair	$825
Tendon, ligament, or rotator cuff, two or more, surgical repair	$1,225
Paralysis – paraplegia	$16,000
Paralysis – quadriplegia	$24,000
Dislocation – hip joint nonsurgical/surgical	$3,850/$7,700
Dislocation – knee nonsurgical/surgical	$2,400/$4,800
Dislocation – ankle or foot bones (other than toes) nonsurgical/surgical	$1,500/$3,000
Dislocation – shoulder, nonsurgical/surgical	$1,600/$3,200
Dislocation – elbow and wrist, nonsurgical/surgical	$1,000/$2,200
Dislocation – finger, toe, nonsurgical/surgical	$275/$550
Dislocation – hand bones (other than fingers) nonsurgical/surgical	$1,000/$2,200
Dislocation – lower jaw nonsurgical/surgical	$1,000/$2,200
Dislocation – collarbone, nonsurgical/surgical	$1,000/$2,200
Partial dislocations	25% of nonsurgical amount
Fracture – hip, nonsurgical/surgical	$3,000/$6,000
Fracture – leg, nonsurgical/surgical	$2,500/$3,000
Fracture – ankle, kneecap, or foot (excluding toes, heel) – nonsurgical/surgical	$1,800/$3,600
Fracture – upper arm, nonsurgical/surgical	$2,100/$4,200
Fracture – forearm, hand, or wrist (except fingers), nonsurgical/surgical	$1,800/$3,600
Fracture – finger or toe, nonsurgical/surgical	$240/$480

Fracture – vertebral body, nonsurgical/surgical	$3,360/$6,720
Fracture – vertebral processes, nonsurgical/surgical	$1,440/$2,880
Fracture – pelvis (except coccyx), nonsurgical/surgical	$3,200/$6,400
Fracture – coccyx, nonsurgical/surgical	$400/$800
Fracture – bones of face (except nose), nonsurgical/surgical	$1,200/$2,400
Fracture – nose, nonsurgical/surgical	$600/$1,200
Fracture – upper jaw, nonsurgical/surgical	$1,500/$3,000
Fracture – lower jaw, nonsurgical/surgical	$1,440/$2,880
Fracture – collarbone, nonsurgical/surgical	$1,440/$2,880
Fracture – rib or ribs, nonsurgical/surgical	$400/$800
Fracture – skull (simple except bones of face), – nonsurgical/surgical	$1,400/$2,800
Fracture – skull (depressed except bones of face), – nonsurgical/surgical	$3,000/$6,000
Fracture – sternum, nonsurgical/surgical	$360/$720
Fracture – shoulder blade, nonsurgical/surgical	$1,800/$3,600
Fracture – chip fractures	25% of the closed reduction amount

Critical illness insurance

Employees may purchase critical illness insurance coverage to help offset expenses that may not be covered under existing medical insurance and disability plans. While most medical plans provide coverage for hospital and medical expenses, they don't typically cover costs like daily living expenses, child care, or copays. Critical illness insurance can help close the financial gap. **If one of these events happens on or after your coverage effective date**, and your claim is approved, benefits are payable at a percentage of the critical illness benefit amount shown in the chart.

In addition to the insurance, this plan includes a wellness benefit for completing an annual eligible health screening test! Employees and spouses each receive an annual benefit of $50. Children receive 100% of the employee's benefit per child with an annual maximum of $200 for all children.

Annual wellness benefit

Eligible individual	Annual wellness benefits
Employee	$50
Spouse	$50
Dependent child(ren)	$50 each child up to a total of $200 max per family

Coverage amount

Eligible individual	Initial benefits
Employee	$30,000
Spouse or domestic partner	$15,000
Dependent child(ren)	$15,000

Biweekly cost for critical illness

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Employee only	$2.63	$3.18	$4.29	$5.26	$9.42	$12.88	$17.86	$22.43	$27.55	$35.03	$47.63
Employee and spouse	$3.81	$4.56	$6.30	$8.17	$14.47	$19.73	$28.18	$36.00	$43.54	$54.69	$73.11
Employee and children	$3.25	$3.81	$4.92	$5.88	$10.04	$13.50	$18.48	$23.05	$28.18	$35.65	$48.25
Family	$4.43	$5.18	$6.92	$8.79	$15.09	$20.35	$28.80	$36.62	$44.17	$55.32	$73.73

Overview of covered conditions and percentage payable	
Heart attack (see plan document for specifics and limitations)	100%
Cancer	100%
Stroke	100%
Kidney failure (see plan document for specifics and limitations)	100%
Coronary artery bypass	25%
Major organ transplant (see plan document for specifics and limitations)	100%
Carcinoma in situ	25%
Transient ischemic attacks (TIA)	10%
Ruptured or dissecting aneurysm	10%
Abdominal aortic aneurysm	10%
Thoracic aortic aneurysm	10%
Open heart surgery for valve replacement or repair	25%
Severe burns	100%
Transcatheter heart valve replacement or repair	10%
Coronary angioplasty	10%
Implantable cardioverter defibrillator (ICD) placement	25%
Pacemaker placement	10%
Benign brain tumor	100%
Skin cancer	10%
Bone marrow transplant	25%
Stem cell transplant	25%
Coma	100%
Amyotrophic lateral sclerosis (ALS)	100%
Parkinson's disease	25%
Advanced dementia or Alzheimer's disease	25%
Huntington's disease	100%
Infectious disease (hospitalization requirement) (see plan document for specifics and limitations)	25%
Addison's disease	10%
Myasthenia gravis	50%
Systemic lupus erythematosus (SLE)	50%
Systemic sclerosis (scleroderma)	10%

In addition to the covered conditions mentioned above, coverage for your insured children includes:

Childhood covered conditions	
Cerebral palsy	100%
Congenital birth defects	100%
Cystic fibrosis	100%
Down syndrome	100%
Gaucher disease, type 2, or type 3	100%
Infantile Tay-Sachs	100%
Niemann-Pick disease	100%
Pompe disease	100%

Hospital indemnity

Out-of-pocket costs from a stay in a hospital or other medical facility can be overwhelming. As expenses add up, hospital indemnity insurance can help. Hospital indemnity insurance doesn't replace your medical coverage; instead, it complements it. The benefit payments don't *go out* to pay for medical bills or treatments you may need, instead they come in—directly to you—to be used however you'd like.

With hospital indemnity insurance, you'll receive a fixed daily benefit if you have a covered stay in a hospital, intensive care unit, or rehabilitation facility that occurs on or after your coverage effective date. Benefit amounts are listed below and depend on the type of facility and number of days of confinement. Any combination of facility confinement and admission benefits payable includes a limit. When you are admitted to a covered medical facility, you become eligible for an admission benefit for the first day of confinement. This benefit is payable once per confinement, up to a maximum of eight admission(s) per calendar year.

Hospital indemnity insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

When you are admitted to a covered medical facility, you become eligible for an admission benefit of $2,000 for the first day of confinement after 20 hours. This benefit is payable once per confinement, up to a maximum of eight admission(s) per calendar year. Beginning on day two of your confinement, for each day that you have a stay in a covered facility, you'll be eligible for a fixed daily benefit payment for up to 10 days maximum. The benefit amount and maximum number of days per confinement varies by facility.

	Hospital indemnity biweekly rates
Employee	$8.07
Employee and spouse	$16.83
Employee and children	$15.11
Family	$23.88

Please see the plan document or certificate of insurance for exclusions and limitations to the benefits listed above (accident, critical illness, or hospital indemnity), including benefit maximums. If there is any discrepancy between this document and the group policy documents, the policy documents will govern.

ARAG UltimateAdvisor Plus legal plan

ARAG is a professional network that provides members with a wide range of legal needs like the examples shown below—and many more—to help you address life's legal situations.

Areas of coverage	Summary of coverage provided
Consumer protection	Auto repair, buy or sell a car, consumer fraud, consumer protection for goods or services, home improvement, personal property disputes, small claims court
Criminal matters	Juvenile court proceedings, parental responsibilities, criminal misdemeanor
Debt-related matters	Debt collection, garnishments, personal bankruptcy, student loan debt
Driving matters	License suspension or revocation, traffic tickets, license restoration, minor traffic (non-moving)
Tax issues	IRS tax audit, IRS tax collection
Family	Adoption, guardianship or conservatorship, name changes, per-related matters, divorce, alimony, child custody, support, or visitation
Wills and estate planning	Powers of attorney, trusts, wills, estate administration (up to nine hours per event)
Services for tenants	Contracts or lease agreements, eviction, security deposit, disputes with a landlord
Real estate or home	Buying a home, deeds, foreclosure, contractor issues, neighbor disputes, promissory notes, real estate disputes, selling a home, real estate tax appeals, home equity loan, refinancing

Work with a network attorney, and attorney fees are **100% paid in full** for most covered matters. Save thousands of dollars on average and choose from over **15,000 attorneys** in ARAG's network who **average more than 20 years of experience**. See full plan document for complete coverage information including any limitations.

Legal plan	Employee biweekly rate
ARAG UltimateAdvisor Plus	$9.69

Allstate Identity Protection

Since so much of daily life is now spent online, it's more important than ever to stay connected. However, more sharing online means more of your personal data may be at risk. Highlights of the Allstate Identity Protection plan:

Obtain financial account and credit monitoring	**See and control your personal data; view and manage alerts in real time**	**Reimbursement for fraud-related losses (stolen 401k, HSA funds)**
24x7 alerts and fraud recovery	Learn more about your risk by checking your identity health status	Tri-bureau monitoring and annual tri-bureau credit report
Up to $1 million identity theft expense coverage	Receive personalized threat insights to help you protect yourself against the latest trends in scams and fraud	Monitor social media accounts for questionable content or account takeover
Home title fraud expense reimbursement up to $1 million	Stolen wallet emergency cash up to $500	Determine if your IP addresses have been compromised
Professional fraud expense reimbursement up to $1 million	Receive alerts for cash withdrawals, balance transfers, and large purchases	Lock your TransUnion credit report

With the Allstate Identity Protection plan, you can protect yourself and your family (everyone under your roof and wallet). **Single coverage is $3.00 per pay and family coverage is $5.77 per pay**.

Glossary of terms you should know

There are several terms associated with benefit programs and insurance used in this guide. These terms directly affect your coverage amounts and payments.

- **Brand-name drug:** Medications are marketed under a trademark-protected name and are often available from only one manufacturer.
- **Coinsurance:** The portion of covered expenses that you must pay for care, after first meeting a deductible amount, if any.
- **Copayment (copay):** A flat fee that you pay for medical services at the time they're received, regardless of the actual amount charged by your doctor or another provider. This generally applies to office visits and prescription drugs.
- **Deductible:** The amount you pay toward covered services per specified period before the plan begins paying benefits.
- **Evidence of insurability (EOI):** An application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.
- **Guaranteed issue:** Amount of coverage available to an employee without having to provide evidence of insurability.
- **In-network provider:** The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.
- **Member pays the difference:** When you fill a prescription for a covered brand-name drug where a generic equivalent is available, you will pay your brand copay or coinsurance amount plus the difference in cost between the brand drug and its generic equivalent.

- **Out-of-network provider:** The facilities, providers, and suppliers who don't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.
- **Out-of-pocket maximum:** The most you could pay during a coverage period for your share of the cost of covered services.
- **Reasonable and customary (R&C) charge:** The usual amount charged by most doctors for a particular medical service. The R&C charge may be different in two different geographic areas or if the service was provided under different circumstances (for example, in an emergency versus a nonemergency). R&C charges may apply only if you use out-of-network providers. You're responsible for paying any amount that exceeds the R&C limit.

About this guide

This guide describes the benefit plans and policies available to you. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. This guide is meant only to cover the major points of each plan or policy. It does not contain all the details that are included in your summary plan descriptions (as required by ERISA) found in your other employee benefit materials on the Total Rewards site. **If there is a question about one of these plans and policies, or if there is a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern.**

Note: The benefits described in this guide may be changed at any time and do not represent a contractual obligation, either implied or expressed, on the part of your employer.

Notice of special enrollment rights for health plan coverage

If you have declined enrollment in CSC's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you and your dependents may be able to enroll in some coverages under these plans without waiting for the next enrollment period, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoptions, you may be able to enroll yourself and your eligible dependents, provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

CSC will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP

For these enrollment opportunities, you will have 60 days instead of 30 from the date of the Medicaid or CHIP eligibility change to request enrollment in the CSC group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid or CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Women's Health and Cancer Rights Act 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 reconstructions 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, please contact your plan administrator by submitting an HR Help Desk ticket.

Newborns' and Mothers' Health Protection Act 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). If you would like more information on maternity benefits, contact your plan administrator by submitting an HR Help Desk ticket.

Important notice to employees from CSC about creditable prescription drug coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the CSC medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2025. 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 2025 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 CSC 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 Oct. 15 through Dec. 7. Individuals leaving employer or union coverage may be eligible for a Medicare special enrollment period.

If you are covered by one of the CSC prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under one of these plans 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.

- Aetna POS
- Aetna EPO
- Aetna HDHP
- BCBS IL PPO
- BCBS IL HDHP
- Kaiser HMO
- CHP HMO
- Quartz POS
- Quartz HMO

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 CSC 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 CSC 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 or other qualifying event, or otherwise become newly eligible to enroll in the CSC plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with CSC 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 by 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 CSC coverage changes, or upon your request.

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 medicare.gov for personalized help.
- Call your state health insurance assistance program (see a copy of the *Medicare & You* handbook for the telephone number) or visit the program online at shiptacenter.org.
- 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 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:
Lee Ann Harris – Senior Benefits Analyst
251 Little Falls Drive
Wilmington, DE 19808
(302)636-5400 Ext.61817
HR-Benefits-Americas@cscglobal.com

No Surprises Act notice

Your rights and protections against surprise medical bills

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

What is balance billing (sometimes called surprise billing)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

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

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

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

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

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

When balance billing isn't allowed, you also have these protections:

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

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

Fixed indemnity plan notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.
This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state department of insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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 **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 call **1-877-KIDS NOW** or **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 **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 Jan. 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid program) and Child Health Plan Plus (CHP+)
Website: myalhipp.com Phone: 1-855-692-5447	Health First Colorado website: healthfirstcolorado.com/ Health First Colorado member contact center: 1-800-221-3943/ State Relay 711 CHP+: hcpf.colorado.gov/child-health-plan-plus CHP+ customer service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): mycohibi.com/ HIBI customer service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid eligibility: health.alaska.gov/dpa/Pages/default.aspx	Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162, Press 1 GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: dhcs.ca.gov/hipp Fax: 1-916-440-5676 Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: in.gov/medicaid Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid website: dhs.iowa.gov/ime/members Medicaid phone: 1-800-338-8366 Hawki website: dhs.iowa.gov/Hawki Hawki phone: 1-800-257-8563 HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP website: kidshealth.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid website: chfs.ky.gov/agencies/dms	Medicaid website: dhcfp.nv.gov Medicaid phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: medicaid.la.gov or ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline), or 1-855-618-5488 (LaHIPP)	Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment website: mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium webpage: maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Medicaid website: nj.gov/humanservices/dmahs/clients/medicaid Medicaid phone: 609-631-2392 CHIP website: njfamilycare.org/index.html CHIP phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: health.ny.gov/health_care/medicaid Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: insureoklahoma.org Phone: 1-888-365-3742	Medicaid website: medicaid.utah.gov CHIP website: health.utah.gov/chip Phone: 1-877-543-7669 or 1-866-608-9422
OREGON – Medicaid and CHIP	**VERMONT– Medicaid**
Website: healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: pa.gov/en/agencies/dhs/resources/chip.html Phone: 1-800-692-7462 CHIP Website: dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)	Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 Email: HIPPcustomerservice@dmas.virginia.gov
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: eohhs.ri.gov Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: hca.wa.gov Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: scdhhs.gov Phone: 1-888-549-0820	Website: mywvhipp.com dhhr.wv.gov/bms/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: dss.sd.gov Phone: 1-888-828-0059	Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269, 307-777-7656, or 866-571-0944

To see if any other states have added a premium assistance program since Jan. 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

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