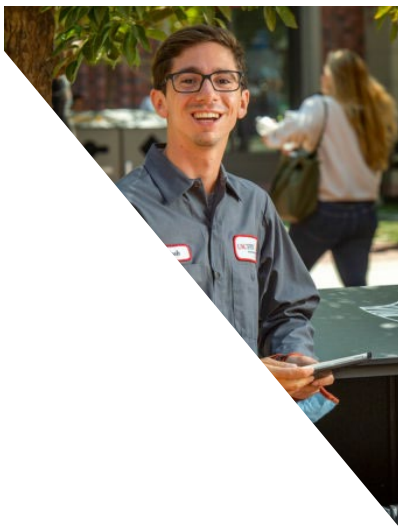








USC University of Southern California

2024 | Keck Community Medical Group Employees

Benefits Guide

Your Benefits, Your Choice

Inside

Welcome!

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

We encourage you to read this guide, share it with your family members, and ask any questions you may have.

How to Enroll

You will receive a notification in your USC email to enroll in your benefits through Workday. (In some cases, you may receive this notification before your start date.) Gather all enrollment information (birthdates, Social Security numbers, etc.) and log into Workday from the Employee Gateway to complete enrollment.

Employee Gateway
https://employees.usc.edu/
Type the link into your web browser or scan the QR code using your smartphone device.

You may wish to log into the Workday Help site to consult the user guides on benefits enrollment, and setting up direct deposit, to help you complete these processes.

Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the HR Service Center at uschr@usc.edu or 213-821-8100

Eligibility

Employee Eligibility

All full-time and part-time employees will be eligible for benefits. You must enroll within 30 days of your hire date. Most benefits take effect upon the first of the month following date of hire; but double deductions for premiums may be incurred depending on hire date*

***IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

How to Make Changes to Benefits

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. Per IRS regulations, if you have a qualifying life status change, you may change your medical, dental, flexible spending accounts, and/or life insurance benefits within **31 days** of that qualifying life event.

Qualifying life events include:

- Marriage or divorce
- Birth or adoption of a child
- Dependent's gain or loss of group health coverage
- Change in child's dependent status (e.g., being over the age limit)
- Death of a spouse, child or other qualified dependent
- Change in employment status under another employer-sponsored plan.
- And More!

Please visit the Life Changes page for a full list of eligible qualifying life events.

Dependent Eligibility

- **Medical, Dental, Vision:** Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.
- **Other Coverages:** Employees enrolled in Voluntary Life/AD&D coverage also have the option to enroll their Dependent Spouse/Domestic Partner and Dependent Children. It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. See page 11 for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please refer to the policy certificate or HR for more information.

Definition of "Eligible Dependents"

This definition applies to medical, dental, and vision benefits.

- Your legal spouse or domestic partner who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- The employee's dependent children until the end of the month, in which, they turn age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

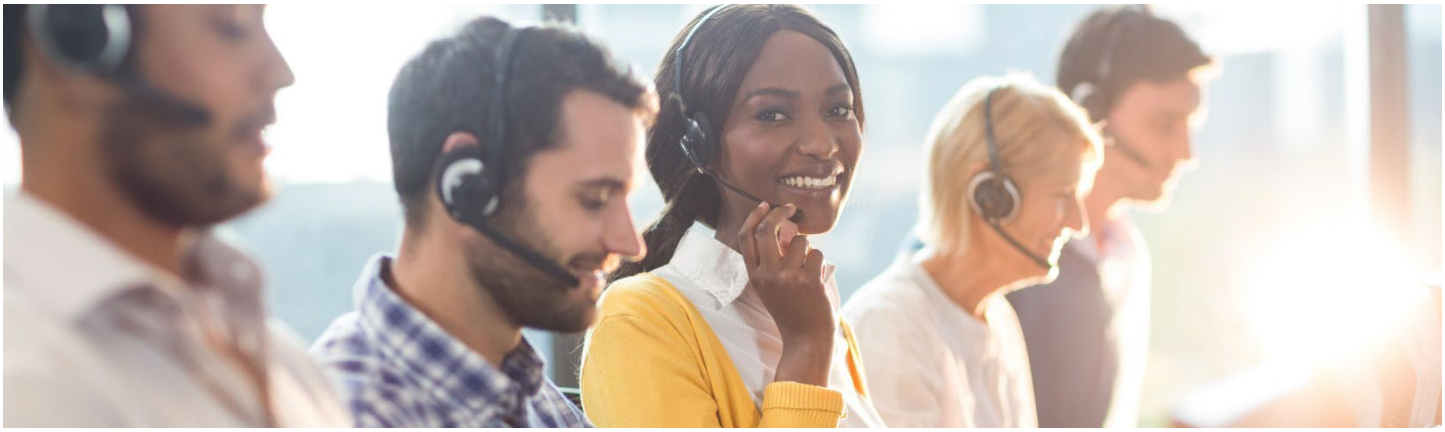
Employee Contributions (per pay period)

Medical	
Employee Only	Your cost for your medical benefits (your "premiums") are tied to your rate of pay
Employee + 1 adult OR 1 child	
Employee + 2 or more dependents	

Dental & Vision	Dental	Vision
Employee Only	$4.42	$1.00
Employee + 1 adult OR 1 child	$9.05	$2.00
Employee + 2 or more dependents	$13.54	$4.50

Life/AD&D	Basic	Term
Employee Only	100% Company-Paid	100% Voluntary** up to $2,500,000
Spouse	N/A	100% Voluntary** up to $250,000
Dependent Child(ren)	N/A	100% Voluntary** up to $25,000

Disability	Short-Term & Long-Term
Employee Only	**Employees located in California must elect CA disability** Alternatively, employees in California may enroll in CA SDI at 1.1% of income to annual max**



Benefit Contact Information

Coverage	Carrier	Phone Number	Website
Medical Coverage	HealthComp	(800) 442-7247	www.healthcomp.com
Prescription Coverage	Navitus	(855) 673-6504	www.navitus.com
Dental Insurance	Delta Dental	(800) 765-6003	www.deltadentalins.com
Vision Insurance	VSP	(800) 877-7195	www.VSP.com
Flexible Spending Account	HealthComp	(800) 442-7247	www.healthcomp.com
USC Basic, Supplemental, Long-Term Disability	USC Disability	uschr@usc.edu or 213-821-8100	uschr@usc.edu or 213-821-8100
California State Disability	California State Disability Insurance (SDI) Program	Disability Insurance: +1 (800) 480-3287 Paid Family Leave: +1 (800) 238-4373	www.edd.ca.gov/disability/
Life/AD&D Insurance	MetLife	HR Service Center at uschr@usc.edu or 213-821-8100	www.metlife.com/USC/life-insurance/
Accident, Critical Illness, Hospital Indemnity, Legal, and Identity Theft & Fraud Protection	MetLife	+1 (800) 438-6388	https://www.metlife.com/info/USC/
Employee Assistance Program	LifeWorks	cwfl@usc.edu (213) 821-0800	www.usc.lifeworks.com/life/employee-assistance
Retirement	Various Vendors	HR Service Center at uschr@usc.edu or 213-821-8100	HR Service Center at uschr@usc.edu or 213-821-8100

Disability and Paid Family Leave calls centers available 8 a.m. to 5 p.m. (Pacific time), Monday through Friday, except on state holidays.

Accident, Critical Illness, and Hospital Indemnity Customer service is available Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

Medical

HealthComp (www.healthcomp.com) | Navitus - Prescriptions (www.navitus.com)

We provide you the option to purchase affordable medical coverage. For a complete list of in-network and out-of-network benefits, please refer to the full plan documents.

Medical	Tier 1 VHH / Keck Medicine of USC / USC Care Medical Group	Tier 2 Anthem Blue Cross Prudent Buyer Network/ BlueCard® Providers
Annual Deductible **Individual / Family**	None	$500 / $750
Annual Out-of-Pocket Maximum	$5,000 individual / $10,000 employee and all covered dependents combined	
Physician Office Visit	Plan pays 100% after $10 copay (USC Care Medical Group only)	Plan pays 100% after $25 copay*
Preventative Care	Plan pays 100%	Plan pays 100%*
Child immunizations Through age 18	Plan pays 100%	Plan pays 100%*
Maternity - physician office visit	Plan pays 100% after $10 copay (USC Care Medical Group only)	Plan pays 100% after $25 copay*
Maternity - physician delivery	Plan pays 100%	Plan pays 70%
Maternity - hospital charges	Plan pays 100%	Plan pays 70%
Urgent care centers	Not Available	Plan pays 100% after $50 copay*
Emergency care	Plan pays 100% after $100 copay	Plan pays 100% after $100 copay*
Ambulance	Plan pays 80%	
Inpatient hospital	Plan pays 100%	Plan pays 70%
Outpatient surgery center - physician	Plan pays 90%	Plan pays 70%
Outpatient surgery center - facility	Plan pays 100%	Plan pays 70%
Skilled nursing facility Up to 120 days /calendar year	Plan pays 100%	Plan pays 70%
Home health care Up to 50 days /calendar year	Plan pays 70%	
Durable medical equipment	Plan pays 90%	Plan pays 70%
Hospice care	Plan pays 80%	
Mental health/substance abuse Inpatient / Outpatient	Plan pays 100% / Plan pays 100% after $10 copay	Plan pays 70% / Plan pays 100% after $25 copay

**Deductible waived*

Please review the full plan documents for details. *If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.*

Medical

HealthComp (www.healthcomp.com) | Navitus – Prescriptions (www.navitus.com)

Prescription Drugs	USC VHH Pharmacies	Navitus Pharmacies
Annual Out-of-Pocket Maximum	$1,600 individual / $3,200 employee and all covered dependents	
Generic	You pay 10% up to $5 max	You 20% up to $10 max
Brand Name	You pay 20%	You pay 30%
Non-Formulary	You pay 30%	You pay 50%

Healthcare Tips

COVID-19 Resources

- **Screening and testing -** The health plan will pay 100% for only medically necessary screening and testing of COVID-19. Beginning Saturday, Jan. 15, 2022, members covered by private health insurance or a group health plan are now able to purchase over-the-counter (OTC) COVID-19 tests authorized by the U.S. Food and Drug Administration (FDA) at no cost without a prescription. The reimbursement of OTC COVID-19 tests will remain in effect until the Public Health Emergency (PHE) is rescinded.
- Please see the Coronavirus FAQ and the Coronavirus member information.
- Your Anthem health plan will cover the care you receive if you're diagnosed with COVID-19. Anthem will also waive out-of-pocket expenses for the focused test used to diagnose COVID-19.
- Visit www.anthem.com/ca/blog or the CDC website at www.cdc.gov/coronavirus to learn more.

Getting the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Take Advantage of Preventive Care

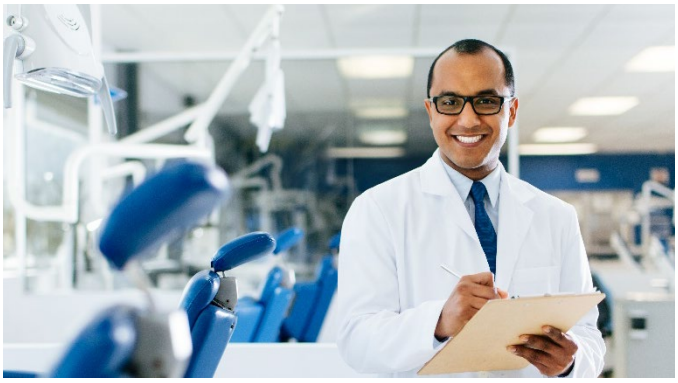
Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health.

The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Please review the full plan documents for details. *If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.*

Dental

Delta Dental | www.deltadentalins.com | (800) 765-6003



In addition to protecting your smile, dental insurance helps pay for dental care. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Dental	In-Network	Out-of-Network
Annual Deductible Individual / Family	$50 / $150	
Annual Benefit Max	$1500 per person per calendar year (maximum payments to an out-of-network provider: $1000)	
Lifetime Orthodontia Max (children only)	$1000 per person	
Services	**In-Network**	**Out-of-Network**
Preventive Care	100%*	80%**
Basic	80%	80%**
Major	50%	50%**
Orthodontia (children only)	50%	50%**

*Deductible waived
**Percent of the lesser of the fee actually charged, or the fee that satisfies the majority of Delta Dental dentists
[1]Only one copay applies for the exam, lenses and frames
[2]You automatically get an extra $20 to spend when you choose a featured frame brand. Visit www.vsp.com/specialoffers for details.

Vision

VSP | www.vsp.com | (800) 877-7195

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Vision	In-Network	Out-of-Network
Exam	100% after a $25 copay[1]	100% (up to $45) after a $25 copay[1]
Fit & Follow-up	100% after a copay up to $60	Not covered
Lenses	100% after a $25 copay[1]	100% after a $25 copay[1], up to a maximum of: $30 (single vision) $50 (lined bifocal) $65 (lined trifocal) Not covered (lenticular)
Frames**	100% (up to $110) after a $25 copay[1]	100% (up to $70) after a $25 copay[1]
Contact Lenses	100% (up to $110)	100% (up to $105)
Frequencies		
Exams	1 per 12 months	
Lenses	1 per 24 months	
Frames	1 per 24 months	
Contact Lenses	1 per 24 months in lieu of lenses/frames glasses	

Please **review the full plan documents for details.** If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Flexible Spending Accounts (FSA)

HealthComp | www.healthcomp.com | (800) 442-7247

USC offers two types of Flexible Spending Accounts (FSA) in which employees can participate. These accounts help employees save money by using tax-free dollars to pay for qualified expenses throughout the year. There are many benefits of using an FSA:

- **It saves you money**. You can set aside tax-free money to pay for qualified expenses.
- **It's a tax-saver**. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible**. You can use FSA funds at any time, even if it's the beginning of the plan year.*

FSA Money "Use It or Lose It" Rule

You cannot stockpile money in your FSA. You should only contribute the amount of money you expect to pay out of pocket that year. **If you do not use it, you lose it.**

Health FSA

Health FSAs allow you to pay for qualified health care expenses with pre-tax dollars.

What can a Health FSA be used for?

- Medical plan deductibles
- Most insurance copays
- Prescription drugs
- Some OTC medications – with a prescription
- Vision exams, eyeglasses and contact lenses
- Laser eye surgery
- And More!

See *www.irs.gov* regarding eligible expenses.

Health FSA	2023	2024
Annual Contribution Limit	$3,050	$3,200

Dependent Care FSA

Dependent care FSAs allow you to pay for qualified dependent care expenses with pre-tax dollars.

What can a Dependent Care FSA be used for?

- Daycare
- Before and after school care.
- Elder care
- Day camp

Dependent Care FSA	2023	2024
Annual Contribution Limit		
Married and filing separately	$2,500	$2,500
Single or married and filing jointly	$5,000	$5,000

*Does not apply to Dependent Care FSA funds.

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

You cannot transfer funds between the Healthcare FSA and Dependent Care FSA

The Health Care FSA option allows continuation through COBRA if you have contributed more than you have withdrawn at the time of termination.

Life/AD&D

MetLife | www.metlife.com/USC/life-insurance/

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if your die or become dismembered due to a specially covered accident.

Basic Life/AD&D	
Benefit Amount	Employee: $50,000
Benefit Cost	100% company-paid

Voluntary Life/AD&D	
For You	$10,000 to $2,500,000 in $10,000 increments
For Your Spouse / Domestic Partner	$5,000 to $250,000 in $5,000 increments, the lesser of 100% of your coverage amount or $250,000
For Your Dependent Children*	$5,000 to $25,000 in $5,000 increments, the lesser of 100% of your coverage amount or $25,000
Benefit Cost	Employee-paid

Definition of "Eligible Dependents"

- Spouse – eligibility may terminate at Spouse age 70.
- Child – dependent children ages from birth to 26 years old, are eligible for coverage. In TX, regardless of student status, child(ren) are covered until age 25.

Important – Please Read!

- New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active at Work/eligible status.
- Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.
- It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or HR for more information.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Benefits may be reduced for employees over age 65 per ADEA.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

*How to Apply**

You may apply for life insurance coverage quickly and securely online using Workday. Click the Workday icon on the Employee Gateway at employees.usc.edu.

Note: If you do not wish to make a change to your coverage, you do not need to do anything

*All applications are subject to review and approval by Metropolitan Life Insurance Company. Based on the plan design and the amount of coverage requested, a Statement of Health may need to be submitted to complete your application.

AD&D pays a benefit for loss of life or dismemberment resulting from a covered accidental bodily injury. Your beneficiary may receive up to 100% of the AD&D amount if you die as the result of a covered accidental injury. You may receive an accidental dismemberment benefit for losses to a hand, a foot, or the sight of an eye due to an accidental injury. See the policy for exact schedule of losses and benefits.

If you enroll when first offered, you receive up to the guaranteed issue amount without having to answer medical questions.

Voluntary Benefits

Accident, Critical Illness, Hospital Indemnity, and Legal Plans through MetLife

Your financial confidence goes well beyond health coverage, which is why we have made various enhanced coverage options available to you through MetLife. You can enjoy the same feeling of confidence provided by health insurance to other aspects of your life. Together, the complementary benefits you choose helps provide protection for what matters most to you.

Accident Insurance

Be better prepared when the unexpected happens

Accidents can happen at any time, and treatment can knock a household budget off course. MetLife accident insurance payments are made directly to you, not your healthcare provider, so you can use the money however you want. More than 150 events are covered under this plan, in addition to any benefits your medical plan may pay. This plan includes a wellness benefit that pays you $60 for completing one of a number of preventive health care activities (completing USC's health assessment is one of them).

Visit the accident coverage page

Critical Illness Insurance

Help protect your family's finances

A critical illness in the family can be a scary and uncertain time. A lump-sum payment – one convenient payment all at once – paid directly to you, when it matters, means one less worry. What's more, covered conditions include heart attack, cancer, and stroke, among others. This plan includes a wellness benefit that pays you $50 for completing one of a number of preventive health care activities, but if you have critical illness insurance only, and complete a mammogram, the plan pays you $200.

Visit the critical illness coverage page

Hospital Indemnity Insurance

Protect yourself from expensive hospital stays

Hospitalization can be expensive, and hospital indemnity insurance provides a direct lump-sum payment – one convenient payment all at once – if you or a family member are hospitalized. Because MetLife makes the payment to you, not your healthcare provider, you can use the money any way you see fit. This plan includes a wellness benefit that pays you $50 for completing one of a number of preventive health care activities (completing USC's health assessment is one of them).

Visit the hospital indemnity coverage page

Identity Theft and Fraud Protection

Make the internet a safer place for you and your family

Identity Theft Protection

Keep your identity secure with proactive monitoring and alerts if threats to your personal info—like your bank accounts, credit, Social Security Number, IDs and more—are detected.

Financial Fraud Protection

Get alerted to new inquiries to your credit, suspicious transactions on your bank accounts, and changes to your car or home title.

Digital Security

Shop, bank, and work online more privately with safety tools including VPN/Wi-Fi security, antivirus, and password manager.

Privacy

Aura requests removal of your personal info from data broker lists to help reduce spam like robocalls, robotexts, and more.

Visit the Identity Theft & Fraud coverage page

Pet Insurance

Make sure your four-legged family members are protected in case of an accident or illness

Pet Insurance offered by MetLife can give you the confidence that you can care for your pet when an unexpected accident or illness occurs.

Coverage is purchased directly through MetLife at the Pet Insurance coverage page link.

Visit the Pet Insurance coverage page

Legal Insurance

Low-cost access to legal coverage is available from MetLife Legal Plans. Fully covered legal services are free when you enroll and pay the small monthly premium of $15.74. You must enroll in the plan within 30 days of your employment at USC or wait until the next open enrollment. The plan provides unlimited, confidential telephone advice and office consultation, giving you the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded matters, even if the matter is not fully covered under the plan.

During the consultation, the attorney will explain your rights, point out your options and, if needed, recommend a course of action. The attorney will identify any further coverage available under the plan and will undertake representation if you wish. If representation is covered by the plan, you will not be charged for the network attorney's services. If representation is recommended, but is not covered by the plan, the network attorney will provide a written fee statement in advance.

Some of the services provided include:

- Purchase, sale or refinancing of a primary residence
- Wills and estate planning
- Deed preparation and immigration assistance
- Debt matters and identity theft defense
- Civil litigation defense

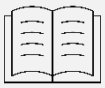
Additional Benefits

Employee Assistance Program | Life Works

This program is here for you and can help you and your family find solutions and restore your peace of mind. To access services, visit the LifeWorks for USC website and log in with username "USC" and password "workwell"

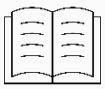
Retirement | Fidelity Investments

USC will match 100% of your before-tax or Roth contributions up to a maximum of 4% of your eligible earnings on a paycheck by paycheck basis. Your contributions begin with the pay period following enrollment. Review the USC Hospital Summary Plan Description (SPD) for more information.



Tuition Assistance (For Family) | USC

After a two-year waiting period, if eligible, children of Keck Community Medical Group employees who are admitted to USC may attend 50% tuition free. After a two-year waiting period, spouses of Keck Community Medical Group employees may attend at a 25% discount. Families are still responsible for all other fees, including housing and meal costs, books, etc. *Please note that if both parents of an eligible child are USC employees, that does not change the child's eligibility for Tuition Assistance.*
The most comprehensive information on Tuition Assistance is contained in the Tuition Assistance Benefit policy, which should be read carefully.



Tuition Assistance (For Employees) | USC

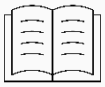
Faculty or staff who wish to be accepted into a degree program should consult with the Office of Admissions, or an academic advisor in the school where they would like to enroll. Faculty should also consult with their dean of faculty or dean.

Staff of Keck Community Medical Group may attend USC 50% tuition free.

Staff must complete two years of service before enrolling in a degree program; they must also stay actively employed by USC for two additional years (total four years of service) to avoid having to repay tuition. Staff must be actively employed (not on leave) to use the tuition assistance benefit.

Staff wishing to earn an undergraduate degree might consider beginning their collegiate studies at a community college and apply as a transfer student to USC. More information is available at the Transfer Applicants website.

Employees wishing to earn a graduate degree should consult the Graduate Admission website.



Tuition Exchange

Your university employment may provide your child an alternative to a USC degree. Every child who is eligible for Tuition Assistance is also eligible to compete for scholarships in the Tuition Exchange program, which is not a benefit, strictly speaking, but a selective and competitive scholarship program that allows children to earn their undergraduate degree from one of more than 600+ Tuition Exchange member schools worldwide – at greatly reduced cost.

USC / Keck Community Medical Group Perks | USC

Keck Community Medical Group employees are also entitled to: free onsite annual certification renewals, free onsite parking, and employee discounts in cafeterias, gift shop, pharmacy, and entertainment activities.

Time Off | Keck Community Medical Group

Physicians

Vacation Time
KCMG physicians are entitled to 20 working days annual vacation. The maximum amount of vacation that can accrue at any time is 35 working days.

Sick Time
KCMG physicians accrue sick time at the rate of 5.78 hours for every month of 100% work to a maximum of 72 hours. For KCMG physicians working less than 100%, accruals are prorated based on the percentage of time worked. Sick time is only accrued during contract period.
Complete information can be found here

Staff

Vacation Time
The university's official system of record for the calculation of vacation accruals is Workday. Vacation is accrued based on cumulative years of university service as a benefits-eligible employee as follows:

- Upon hire, staff accrue vacation equivalent to 12 working days per year, with a maximum of 24 working days (applies through the first 4 years of cumulative service)
- At the start of the 5th year of employment, staff accrue vacation equivalent to 18 working days per year, to a maximum of 36 working days (applies after 4 years and through the first 9 years of cumulative service)
- At the start of the 10th year of employment, staff accrue vacation equivalent to 24 working days per year, to a maximum of 48 working days (applies after 9 years of cumulative service)

Complete information can be found here

Sick Time
For benefits-eligible employees working less than 100%, accruals are prorated based on the percentage of time worked. When a new employee begins work other than on the first day of a pay period, accruals are prorated for the first pay period. Below are the accruals for 100% effort.

Biweekly Pay Cycle:

Workweek Hours	Accrual	Maximum Hours Accrued
37.5	3.47	90
40	3.70	96
36 (3/12 alternative schedule)	3.33	86.4

Complete information can be found here

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.

- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Annual Notices and Important Plan Information

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located {describe Annual Notices location}:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

Plan Documents

Important documents for our health plan and retirement plan are available on the **Employee Gateway.** Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Keck Medicine of USC

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on the **Employee Gateway**.

- Keck Medicine of USC / USC Care Medical Group
- Anthem Blue Cross Prudent Buyer
- Delta Dental PPO

Medicare Part D Notice

Important Notice from Keck Medicine of USC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Keck Medicine of USC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the

coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Keck Medicine of USC has determined that the prescription drug coverage offered by the Anthem Blue Cross Prudent Buyer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your USC-Verdugo Hills Hospital coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Anthem Blue Cross Prudent Buyer is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Keck Medicine of USC prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with USC-Verdugo Hills Hospital and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through USC-Verdugo Hills Hospital changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2024
Name of Entity/Sender:	Keck Medicine of USC
Contact-Position/Office:	Human Resources
Address:	3500 S Figeroa St. Unit 105
Phone Number:	(213) 821-8100

Women's Health and Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 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. Therefore, the deductibles and coinsurances in Keck Medicine of USC's medical plans apply. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

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, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Keck Medicine of USC'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 Keck Medicine of USC's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- 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 the loss of such coverage.

If you request a change due to a special enrollment event within the 31-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 Keck Medicine of USC's health 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 a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Keck Medicine of USC describing how health information about you may be used and disclosed.

Michelle's Law

The Anthem Blue Cross Prudent Buyer plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Keck Medicine of USC's LLC's Human Resources Department in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 of your modified adjusted household income.

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, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://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
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org	Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx	Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx	Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)	CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/	Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov	Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov	Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services	Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/	CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/	Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700	CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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