2020 Luxoft Benefits Guide

For Employees in Luxoft USA and Intro Pro

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This Benefits Guide contains a very general description of the benefits to which you may be entitled as an employee of the Company. Please understand that this general explanation is not intended to, and does not, provide you with all the details of these benefits. Therefore, this Benefits Guide does not change or otherwise interpret the terms of the official plan documents. Your rights can be determined only be referring to the full text of the official plan documents, which are available for your examination from the Human Resource Department. Luxoft USA, Inc. reserves the right to cancel or change the benefits it offers to its employees. The Plan Document of each plan governs company-sponsored benefits, should conflict exist between the Employee Handbook and the Plan Document, the Plan Document will prevail.

Your Benefits. Your Choice.

At Luxoft USA, Inc. we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

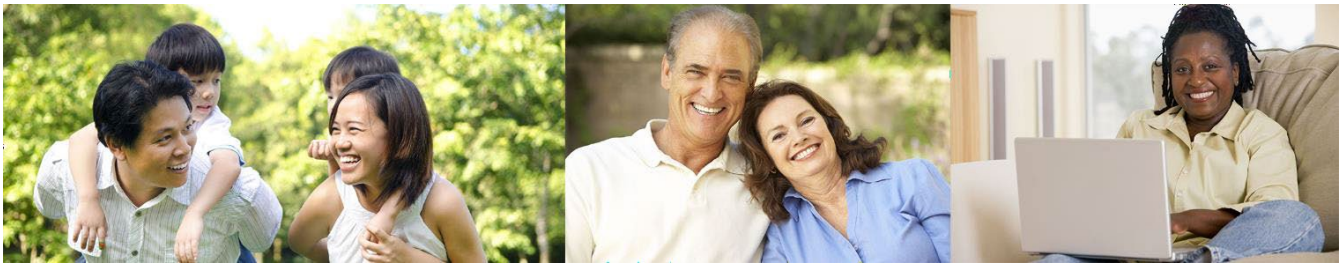
A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

January 1, 2020 - December 31, 2020

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices starting on Page 22 for more details.

Who Can You Cover?



WHO IS ELIGIBLE?

In general, Full-time employees working 30 or more hours per week are eligible for the benefits outlined in this overview. You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your same or opposite sex domestic partner OR domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your domestic partner's children):
    - Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of Luxoft USA, Inc. cannot also be covered as a dependent.
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new full-time employees begins on the 1st of the month following date of hire. After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify Human Resources within 31 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	Aetna PPO - Plan A		Aetna PPO - Plan B		Aetna PPO HDHP Plan	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible	$250 Individual $750 Family	$250 Individual $750 Family	$1,000 Individual $2,000 Family	$1,500 Individual $3,000 Family	$5,000 Individual $10,000 Family	$7,500 Individual $15,000 Family
Annual Out-of-Pocket Max	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$4,000 Individual $8,000 Family	$6,000 Individual $12,000 Family	$6,000 Individual $12,000 Family	$12,000 Individual $24,000 Family
Office Visit						
Primary Provider	$25 copay	plan pays 50% after deductible	$25 copay	plan pays 50% after deductible	Deductible then plan pays 100%	plan pays 50% after deductible
Specialist	$25 copay	plan pays 50% after deductible	$25 copay	plan pays 50% after deductible	Deductible then plan pays 100%	plan pays 50% after deductible
Preventive Services	plan pays 100%	plan pays 50% after deductible	plan pays 100%	plan pays 50% after deductible	plan pays 100%	plan pays 50% after deductible
Chiropractic Care	$25 copay up to 12 visits/year	plan pays 50% after deductible	$25 copay up to 12 visits/year	plan pays 50% after deductible	Deductible then plan pays 100% Up to 20 visits/year	plan pays 50% after deductible
Lab and X-ray	plan pays 90% after deductible	plan pays 50% after deductible	plan pays 80% after deductible	plan pays 50% after deductible	plan pays 100% after deductible	plan pays 50% after deductible
Inpatient Hospitalization	plan pays 90% after deductible	plan pays 50% after deductible	plan pays 80% after deductible	plan pays 50% after deductible	plan pays 100% after deductible	plan pays 50% after deductible
Outpatient Surgery	plan pays 90% after deductible	plan pays 50% after deductible	plan pays 80% after deductible	plan pays 50% after deductible	plan pays 100% after deductible	plan pays 50% after deductible
Urgent Care	$50 copay	plan pays 50% after deductible	$50 copay	plan pays 50% after deductible	plan pays 100% after deductible	plan pays 50% after deductible
ER (copay waived if admitted)	$150 copay then plan pays 90%	$150 copay then plan pays 90%	$150 copay then plan pays 80%	$150 copay then plan pays 80%	plan pays 100% after deductible	plan pays 50% after deductible
TelaDoc	$25 copay	N/A	$25 copay	N/A	$40 Copay	N/A

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	Aetna PPO - Plan A		Aetna PPO - Plan B		Aetna PPO HDHP Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Pharmacy						
Deductible	$50 Individual $100 Family	$50 Individual $100 Family	$100 Individual $200 Family	$100 Individual $200 Family	Plan Deductible	Plan Deductible
Generic	$15 copay	50% of submitted cost; after applicable copay	$15 copay	50% of submitted cost; after applicable copay	Deductible then $15 Copay	50% of submitted cost; after applicable copay
Preferred Brand	$35 copay	50% of submitted cost; after applicable copay	$35 copay	50% of submitted cost; after applicable copay	Deductible then $35 Copay	50% of submitted cost; after applicable copay
Non-preferred Brand	$60 copay	50% of submitted cost; after applicable copay	$60 copay	50% of submitted cost; after applicable copay	Deductible then $60 Copay	50% of submitted cost; after applicable copay
Supply Limit	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order						
Generic	$30 copay	Not covered	$30 copay	Not covered	Deductible then $30 Copay	Not covered
Preferred Brand	$70 copay	Not covered	$70 copay	Not covered	Deductible then $70 Copay	Not covered
Non-preferred Brand	$120 copay	Not covered	$120 copay	Not covered	Deductible then $120 Copay	Not covered
Supply Limit	90 days	Not applicable	90 days	Not applicable	90 days	Not applicable

Health Reimbursement Arrangement (HRA)

When you enroll in the Aetna HDHP Plan you are also provided with a Health Reimbursement Arrangement (HRA) through WageWorks. An HRA is an employer-funded account used to pay for designated healthcare expenses including your deductible and plan coinsurance. Please note that you cannot take the money with you when you leave the company or if you enroll in a different medical plan.

After you pay the first $500 (single) /$1,000 (family) of the deductible Luxoft will start contributing to your medical expenses through the HRA. Once your HRA balance has been used, you then pay any remaining deductible and coinsurance up to the plan's out-of-pocket limit.

	Luxoft Contribution
Employee Only Coverage	Employee pays first $500 then Luxoft pays $3,000 per year
Family Coverage	Employee pays first $1,000 then Luxoft pays $6,000 per year

MAXIMIZE YOUR DOLLARS

Spending your HRA wisely can leave money in your account for expenses down the road. **Stick with In-Network Providers.** It will limit the amount you have to pay because your cost will be capped at the negotiated rate for participating providers. It also ensures your costs are properly credited towards your deductible.

Going out of network can be more expensive. You are responsible for paying all the charge above what the insurance company will pay and there are no limits on what the out-of-network provider can charge.

COMMON ELIGIBLE EXPENSES:

These include but are not limited to:

Medical Services:

- Coinsurance/copays
- Lab tests, x-rays, scans
- Ambulance
- Acupuncture
- Chiropractic

COMMON INELIGIBLE EXPENSES:

Dental & Vision

- Exams, cleaning and X-rays
- Extractions and filings
- Periodontal services
- Vision exams
- Prescription Glasses
- Cosmetic surgery or procedures
- Electrolysis
- Hair loss medication
- Teeth whitening
- Insurance premiums

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. Monies should be used in your account by the end of the plan year; however we do allow a grace period to submit claims incurred up to December 31st of each year by March 15th of the following year. You must re-enroll in this program each year. Wage Works administers this program

FSA HEALTHCARE ACCOUNT

Use before-tax dollars to pay for eligible health care expenses, including:

- Medical, dental and vision copays and coinsurance for you and your
- eligible dependents,
- Prescription or over-the-counter drugs with a doctor's prescription, and
- Glasses, contacts, contact lens solution, and/or LASIK surgery.

FSA DEPENDENT CARE ACCOUNT

Use before-tax dollars to pay for eligible dependent care expenses that allow you to go to work, such as:

- Day care or summer camp for dependent children under age 13
- Qualified elder care for an individual who resides in your home at least eight hours per day and is claimed as a dependent on your federal taxes
- Care providers for a disabled dependent

HOW FSAs WORK

1. During annual enrollment, you elect to set aside a certain amount of money for 2019, based on IRS guidelines.
   - **Health Care FSA** — contribute up to $2,750
   - **Dependent Care FSA** — contribute up to $5,000 (If you're married, your combined limit is $5,000 annually. If you file taxes separately, each of you is limited to a maximum of $2,500 annually.)
2. Your election amount is deducted from your Paychecks equally throughout the year.
3. You use the money in your FSA to pay yourself back for eligible health care and/or dependent day care expenses. You can also use your Wageworks FSA credit card to pay for eligible expenses.
4. You can manage your account on the www.wageworks.com

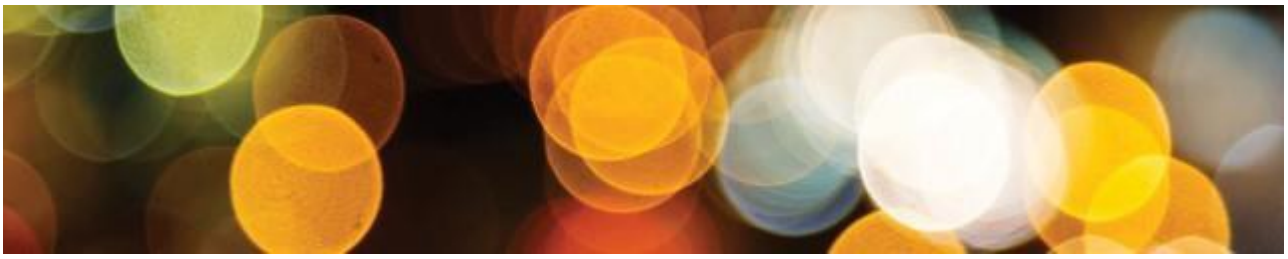
Important: Luxoft is required to test the Dependent Care FSA plan for compliance with IRS non-discrimination requirements. Luxoft will monitor the Dependent Care FSA and make any necessary adjustments to your contributions before the end of the 2020 plan year. If your account needs adjustment, you will be notified.

Important FSA Considerations

IMPORTANT MEDICAL FLEXIBLE SPENDING ACCOUNTS CONSIDERATIONS

- Expenses must be incurred between 01/01/20 and 12/31/2020 and submitted for reimbursement no later than 03/31/2021.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the Aetna health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep all of your receipts.
- You will forfeit remaining funds over $500 at the end of each year.

Getting Care When You Need It Now



WHEN TO USE THE EMERGENCY ROOM

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life threatening and do not require use of a hospital or emergency room. Urgent care conditions include, but are not limited to earache, sore throat, rashes, sprains, flu, and fevers.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms. Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

TELADOC

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency? Use Aetna Teladoc, the first and largest provider of telehealth medical consults in the United States giving you 24/7/365 access to quality medical care through phone and video consults. Talk to a doctor anytime for the price of a PCP copay.

You can now connect with board-certified doctors via secure video chat or phone without ever leaving your home or office.

Choose When: Day or night, weekdays, weekends or holiday
Choose Where: Home, work or on the go
Choose How: Phone or Video Chat

Setting up your account is a quick and easy process online. Visit the Teladoc website and click "Set Up Account". The follow the online instructions to connect with a doctor to help with symptoms such as:

- Sore throat
- Headache
- Fever
- Cold and flu
- Allergies
- Rash
- Etc.

Register for one or both today so you will be ready to use Teladoc service when and where you need it!

Online: **www.teledoc.com/Aetna**

Phone: 1-855-Teladoc (835-2362)

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Luxoft USA, Inc. provides you with a comprehensive coverage through Aetna.

Aetna Dental PPO Plan - Luxoft

	In-Network	Out-Of-Network
Calendar Year Deductible	$50 per individual $150 per family	$50 per individual (combined with in-network) $150 per family (combined with in- network)
Annual Plan Maximum	$2,000	$2,000 (combined with in-network)
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%
Basic Services		
Fillings	plan pays 80% after deductible	plan pays 80% after deductible
Root Canals	plan pays 80% after deductible	plan pays 80% after deductible
Periodontics	plan pays 80% after deductible	plan pays 80% after deductible
Major Services	plan pays 50% after deductible	plan pays 50% after deductible
Orthodontic Services		
Orthodontia (Adult & Child)	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$1,500	$1,500 (combined with in-network)
Dependent Children up to age 26	Covered	Covered

aetna

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through Vision Service Plan

VSP Vision Plan

	In-Network	Out-Of-Network
Examination		
Benefit	$20 copay then plan pays 100%	plan pays 100% (reimbursed up to $50)
Frequency	One visit every calendar year	In-network limitations apply
Materials	$20 copay then plan pays 100%	See schedule below
Eyeglass Lenses		
Single Vision Lens	plan pays 100% of basic lens (material copay applies)	Reimbursed up to $50
Bifocal Lens	plan pays 100% of basic lens (material copay applies)	Reimbursed up to $75
Trifocal Lens	plan pays 100% of basic lens (material copay applies)	Reimbursed up to $100
Frequency	One visit every calendar year	In-network limitations apply
Frames		
Benefit	Up to $130 plus a plan pays 20% discount from the remaining balance	Reimbursed up to $70
Frequency	One visit every other calendar year	In-network limitations apply
Contacts (Elective)		
Benefit	Reimbursed up to $130 (copay waived; instead of eyeglasses)	Reimbursed up to $105 (in-network limitations apply)
Frequency	One visit every calendar year	In-network limitations apply

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by First Reliance Standard.

Basic Life Amount	3 x Earnings Maximum of $400,000
Basic AD&D Amount	3 x Earnings Maximum of $400,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Evidence of Insurability: If you select a coverage amount above $200,000, you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage.

Taxes: A life insurance benefit of $50,000 or more is a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability (STD) coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other income sources such as paid time off. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition. Coverage is provided by Reliance Standard.

Weekly Benefit Amount	Plan pays 60% of covered weekly earnings
Maximum Weekly Benefit	$2,000
Benefits Begin After:	
Accident	7 days of disability
Sickness	7 days of disability
Benefit Duration*	25th week of disability

*Total number of paid weeks of the benefit duration.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

LONG-TERM DISABILITY INSURANCE

Long-Term Disability (LTD) coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by Reliance Standard.

Monthly Benefit Amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	Manager & Executives: $10,000 All other employees: $5,000
Benefits Begin After:	
Accident	180 days of disability
Sickness	180 days of disability
Maximum Payment Period*	Prior to age 62: to age 65, Age 62: 42 months, Age 63: 36 months, Age 64: 30 months, Age 65: 24 months, Age 66: 21 months, Age 67: 18 months, Age 68: 15 months, Age 69 and over: 12 months

*The age at which the disability begins may affect the duration of the benefits.

Ancillary Benefits

UNUM ACCIDENT INSURANCE

You can't predict when or where an accident will strike. But you can make sure you have a safety net of financial protection to help if an accidental injury occurs.

A set amount is payable based on the injury you suffer and the treatment you receive. Employees do not need to answer medical questions or have a physical exam to get basic coverage. Unlike workers' compensation, which only covers on-the-job injuries, accident insurance covers injuries that happen on or off the job. Coverage is available for you, your spouse and eligible dependent children.

Accident can happen anytime, anywhere – at home or at work, on the playground or on the road. Some of the most common injuries include:

- Broken bones
- Burns
- Concussions
- Lacerations
- Back or knee injuries
- Accidental injuries that send you to the Emergency Room or Urgent Care

How much does it cost?

Your monthly premium	Plan 1
You	$7.91
You and your spouse	$13.63
You and your children	$19.23
Family	$24.95

UNUM CRITICAL ILLNESS PLAN - SPECIFIED DISEASE INSURANCE

If you're diagnosed with a covered critical illness or cancer, group critical illness insurance* from UNUM to help supplement your major medical coverage by providing a lump-sum benefit that you can use to pay the direct or indirect costs related to a covered critical illness.

What's covered?

Specified Diseases
• Heart attack • Stroke • Major organ failure • Coronary artery disease (50%) • Alzheimer's disease

Cancer conditions	
• Invasive cancer — all breast cancer is considered invasive	• Non-invasive cancer (25%) • Skin cancer — $500

UNUM CRITICAL ILLNESS PLAN – SPECIFIED DISEASE INSURANCE

Be Well Benefit

Be Well Benefit

Every year, each family member who has Specified Disease coverage can also receive $50 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician (including sports physicals) for adults, and well-child visits
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

How much does it cost?

Monthly costs		
Age	Employee coverage: $10,000 Spouse coverage: $5,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$3.77	$1.75
25 - 29	$4.17	$1.95
30 - 34	$4.87	$2.30
35 - 39	$5.87	$2.80
40 - 44	$7.47	$3.60
45 - 49	$10.27	$5.00
50 - 54	$14.57	$7.15
55 - 59	$19.97	$9.85
60 - 64	$28.27	$14.00
65 - 69	$40.07	$19.90
70 - 74	$57.87	$28.80
75 - 79	$76.47	$38.10
80 - 84	$95.87	$47.80
85+	$136.17	$67.95

Monthly costs		
Age	Employee coverage: $20,000 Spouse coverage: $10,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$4.47	$2.10
25 - 29	$5.27	$2.50
30 - 34	$6.67	$3.20
35 - 39	$8.67	$4.20
40 - 44	$11.87	$5.80
45 - 49	$17.47	$8.60
50 - 54	$26.07	$12.90
55 - 59	$36.87	$18.30
60 - 64	$53.47	$26.60
65 - 69	$77.07	$38.40
70 - 74	$112.67	$56.20
75 - 79	$149.87	$74.80
80 - 84	$188.67	$94.20
85+	$269.27	$134.50

For additional detail on these programs – visit [Unum Insurance Information]

Cost of Coverage

Aetna PPO – Plan A	Monthly Cost	Semi-Monthly Cost (24 pay periods)
Employee Only	$130.00	$65.00
Employee + Spouse	$325.00	$162.50
Employee + Children	$311.00	$155.50
Employee + Family	$486.00	$243.00
Aetna PPO – Plan B	**Monthly Cost**	**Semi-Monthly Cost (24 pay periods)**
Employee Only	$96.00	$48.00
Employee + Spouse	$240.00	$120.00
Employee + Children	$230.00	$115.00
Employee + Family	$400.00	$200.00
Aetna PPO HDHP Plan	**Monthly Cost**	**Semi-Monthly Cost (24 pay periods)**
Employee Only	$27.00	$13.50
Employee + Spouse	$61.00	$30.50
Employee + Children	$59.00	$29.50
Employee + Family	$79.00	$39.50
VSP Vision	**Monthly Cost**	**Semi-Monthly Cost (24 pay periods)**
Employee Only	$5.03	$2.52
Employee + Spouse	$8.04	$4.02
Employee + Children	$8.21	$4.11
Employee + Family	$13.24	$6.62
Aetna Dental	**Monthly Cost**	**Semi-Monthly Cost (24 pay periods)**
Employee Only	$0	$0
Employee + Spouse	$0	$0
Employee + Children	$0	$0
Employee + Family	$0	$0

Commuter Benefits & Retirement Plans

401(K) RETIREMENT

One of the best ways you can prepare for retirement is by contributing to Luxoft's retirement plan. You can contribute 1-99% of your eligible compensation up to the IRS Maximum for 2020.

- The maximum contribution for 2020 is $19,000.
- For employees over age 50 the contribution maximum is $25,000.

Luxoft also offers an employer matching contribution, which will be a 100% (dollar-for-dollar) matching contribution on your salary deferrals up to 3% compensation, plus a 50% matching contribution on any deferrals 3% up to 5% of compensation.

Deferrals are made on each payroll during the plan year. You are eligible to enroll in 401(k) on the first of the month following 30 days of employment.

COMMUTER BENEFITS

Commuter benefits allow you to use pre-tax income to pay for your commute to and from work. By enrolling in the program offered by WageWorks, you get to take home more money each month, which can add up to big annuals savings. Pre-tax payroll deductions mean that money comes out of your paycheck before federal, state and local taxes are calculated. You are eligible to enroll on the first day of the month following your date of hire.

2020 Allowable Limits:

- $270 for Parking
- $270 for Transit

Elections are made before the 6th of every month for the next month.

You can make recurring elections on the WageWorks site so that you do not have to set up elections each month. You can elect more than the allowable limit shown above, anything above the 2020 allowable limits will be deducted on a post-tax basis.

Visit www.wageworks.com for more information.

For Assistance

YOUR BENEFIT ADVOCATE

Benefit Advocates are highly trained professionals with extensive insurance industry experience. They are available to assist you with your benefit needs.

How can a benefit advocate help me?

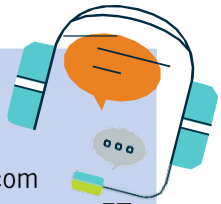
Call you Benefit Advocate for:

- Insurance claim questions
- Denied claim appeals
- Benefit questions or clarifications
- Prescription problems
- Flexible Spending Account questions
- COBRA inquiries
- General questions

Benefit Advocates cannot answer questions on Worker's Compensation claims, Medicare, or Medicaid.

What do I need to provide the Benefit Advocate for assistance?

- Member ID Number or Social Security Number
- Date of birth
- Employer's name
- Itemized bill of service from your provider or an explanation of benefits (EOB) from the carrier



Phone: (877) 819-9413
Fax: (203) 568-8395
Email: benefithelpteam@alliant.com
Hours: Monday - Friday, 8 a.m. to 8 p.m. ET

Benefit Advocate Contact Information

All calls are kept confidential and are tacked and monitored to resolution. Benefit Advocates also work with an interpretation service that supports 125 different languages. If you are in need of this service, please be prepared to tell the Benefit Advocate what language you need when you call.

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Aetna	800-238-6716	www.aetna.com	#568452
Dental	Aetna	877-238-6200	www.aetna.com	#568452
Life & Disability	Reliance Standard	800-351-7500	www.reliancestandard.com	Life #161383 STD #167243 LTD #131462 DBL #252452 TDB #151381
Vision	VSP	800-877-7195	www.vsp.com	#30024298
Individual Products	UNUM	866-679-3054	www.unum.com	Accident # 634062 CI # 634063

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST –

A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an FSA or HRA.

DEDUCTIBLE

The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE –

After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY –

A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK –

Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of- network providers are not covered at all.

OUT-OF-POCKET MAXIMUM –

The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME –

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG –

A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

You generally pay a lower copay for generic drugs.

PREFERRED DRUG –

Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES –

Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES –

Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES –

Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays

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Qualifying Events

CHANGES TO ELECTIONS DUE TO STATUS CHANGES

The benefits you select at the time of your eligibility must remain in effect until unless you experience a Qualifying Life Event during the year. You must request a coverage change within 31 days following the event. Qualifying Life Events generally include the following:

- Marriage, divorce, legal separation, annulment, certification of a domestic partner or death of a spouse.
- Birth, adoption, placement for adoption or death of a dependent.
- Change in employment status that impacts benefits coverage such as termination of employment, loss of eligibility or an unpaid leave of absence.
- A change in the place of residence or work for you, your spouse or your dependent.
- Significant change in your spouse's coverage through his/her employer,such as the loss or addition of health insurance.
- **Other Events.** A corresponding election change may be made if the plan receives a Qualified Medical Child Support Order. In addition, if you, your spouse or your dependent becomes entitled to Medicaid, a corresponding election change is permitted.

Any change in benefits must be consistent with the change in status. For example, if you get married, you may add your spouse (and any eligible dependent children) to your medical plan or cancel coverage to join your spouse's plan.

Other Important Information

KEEP YOUR INFORMATION UP TO DATE!

Open Enrollment is a great time to update your beneficiary designations under these plans.

- Company paid Life Insurance and AD&D
- Supplemental Insurance if you decide to purchase this.

Important: For life insurance, there are different types of beneficiaries — primary and contingent. If your primary beneficiary(ies) predeceases you, your contingent beneficiary(ies) will become your primary beneficiary, unless you name another primary beneficiary.

Your Address
Have you moved recently? If so, remember to let Luxoft know your new address. Keeping your information up to date with your company ensures that important tax documentation and other materials get to you in time and when you need them. Update your address at

Annual Notices

Continuation Coverage Rights Under COBRA

This section contains important information about your right to a temporary continuation of benefits coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The following explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's summary plan description or contact the plan administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a Qualifying Life Event. Specific Qualifying Life Events are listed later in this notice. After a Qualifying Life Event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the Qualifying Life Event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following Qualifying Life Events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following Qualifying Life Events happen:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following Qualifying Life Events happen:

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

WHEN IS COBRA COVERAGE AVAILABLE?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a Qualifying Life Event has occurred. When the Qualifying Life Event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the plan administrator of the Qualifying Life Event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING LIFE EVENTS

For the other Qualifying Life Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the Qualifying Life Event occurs.

HOW IS COBRA COVERAGE PROVIDED?

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

IF YOU HAVE QUESTIONS

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

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Life Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Life Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Life Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Life Event (36 months minus eight months). Otherwise, when the Qualifying Life Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended: disability extension and second Qualifying Life Event extension.

DISABILITY EXTENSION

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

SECOND QUALIFYING LIFE EVENT EXTENSION

If your family experiences another Qualifying Life Event while receiving 18 months of continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Life Event is properly given to the plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first Qualifying Life Event not occurred.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

Medicare Part D Notice

IMPORTANT NOTICE FROM LUXOFT USA, INC. 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 Luxoft USA, Inc. 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. Luxoft USA, Inc. has determined that the prescription drug coverage offered by the Luxoft Medical Plan 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 Luxoft USA, Inc. 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 Luxoft Medical Plan 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 Luxoft USA, Inc. 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 Luxoft USA, Inc. 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 Sara Hutchins at shutchins@luxoft.com 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 Luxoft USA, Inc. 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:	November 8, 2019
Name of Entity/Sender:	Luxoft USA, Inc.
Contact-Position/Office:	Plan Administrator
Address:	1 Rockefeller Plaza #27th Floor New York, NY 10020
Phone Number:	(201-621-4797) x6242

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy was performed;
- Any necessary surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical conditions related to the mastectomy, including lymphedema.

Our medical plans comply with these requirements. Benefits for these items are similar to those provided under the plan for similar types of medical services and supplies.

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 at (425) 452-1001 x2191.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Luxoft USA'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 Luxoft USA'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 30 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 30 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 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Luxoft USA'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.

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, 2018. Contact your State for more information on eligibility

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: https://dhs.iowa.gov/hawk-iPhone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 / Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.