



maximus

OUR BENEFITS YOUR JOURNEY

YOUR 2026 BENEFITS GUIDE

SCA

Our Benefits Your Journey



For nearly 50 years, Maximus has moved forward through the dedication and contributions of our people. You are at the core of our success, and your wellbeing is an essential part of our future.

OUR BENEFITS are designed to travel with you, helping you stay healthy, protect what matters most, and prepare for the road ahead. From everyday care to long-term goals, Maximus is here to support you at every stage.

YOUR JOURNEY is uniquely yours. What works for someone else may not be right for you. This guide gives you the tools and information to choose the benefits that fit your life and your family in 2026.

Take time to explore your options and select the benefits that help you thrive today and in the years to come.



Your benefits at Maximus



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OUR BENEFITS. Maximus is dedicated to the health and financial wellbeing of our employees at every stage of life. We know that our benefits program is an important part of the total compensation package that helps us attract and retain a talented group of team members.

Our benefits program:

- Gives you choices, flexibility, and comprehensive coverage.
- Is competitive and generous with many benefits covered at 100% by Maximus.
- Provides you with high-quality provider networks so you and your family have access to the best available care.

YOUR JOURNEY. To make the best decisions about your benefits coverage:

- Carefully review this guide and our online materials on the [Maximus Benefits Center](#).
- Understand and evaluate your options.
- Think about your needs and goals as well as those of your family.
- Use the many available materials and tools to help you get the most out of your benefits.

This guide is intended as a summary of plans and coverages offered as part of your benefits package. In the event of disputed plan information, the plan documents govern.



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Full-time employees

If you are scheduled to work 30 hours per week or more, you are eligible for the following benefits:

Maximus pays:

- Employee-only Core HSA plan medical coverage
- Dental*
- Employee Assistance Program (EAP)
- Basic life insurance
- Basic accidental death & dismemberment (AD&D)
- Short-term disability (STD)
- Long-term disability (LTD)
- Sick leave (if eligible)
- Paid time off (PTO)
- Dependent care reimbursement account
- Health Reimbursement Account (HRA)
- Maximus GSA Retirement Plan
- 401(k) matching
- Health coaching
- Headspace and Wellbeats
- Wellbeing incentives

You pay:

- The difference between the Core HSA plan premiums and the PPO plan premium
- Dental*
- Vision
- Your HSA contributions
- Your Healthcare FSA contributions
- Supplemental life and AD&D insurance
- Dependent medical coverage
- Dependent life insurance
- Legal plan
- Critical illness insurance
- Accident insurance
- Hospital indemnity insurance
- Commuter benefits
- 401(k) contributions

*Maximus pays 50% of dental premiums.

Part-time employees

If you are scheduled to work less than 30 hours per week, you are eligible for the following benefits:

Maximus pays:

- Dental*
- Basic life insurance
- Sick leave (if eligible)
- Paid time off (PTO)
- Dependent care reimbursement account
- Maximus GSA retirement plan
- 401(k) matching
- Employee Assistance Program (EAP)
- Health coaching
- Headspace and Wellbeats

You pay:

- Dental*
- Vision
- Supplemental life insurance
- Dependent life insurance
- Legal plan
- Critical illness insurance
- Accident insurance
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- Commuter benefits
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*Maximus pays 50% of dental premiums.

Here’s what’s new for 2026

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Hello Heart will replace LiveHealth Online healthy blood pressure program

This digital cardiovascular wellness program replaces the Anthem Live Health Online blood pressure program. It includes an FDA-cleared blood pressure monitor and an easy-to-use app that offers personalized coaching, real-time insights, and tools to help you track and improve your heart health. Digital coaching offers a supportive community and detailed insights to support your health decisions.

SCA voluntary life enhancement

Voluntary life insurance options for **yourself** are increasing from increments of \$5,000 to \$10,000, up to 8x your salary (previously up to 5x your salary).

Voluntary life insurance options for your **spouse or domestic partner** are increasing from increments of \$5,000 to \$10,000, up to the lesser of 100% of your supplemental life benefit or \$150,000 (increased from \$100,000).

You can request voluntary life insurance coverage for your **child(ren)** in either a \$10,000 or \$20,000 policy for each child, instead of the previous limit of \$10,000.

Increase WIN fertility/adoption/surrogacy from \$10k to \$20k

Maximus families can receive reimbursement for adoption, surrogacy, and fertility expenses as part of a \$20,000 lifetime maximum benefit—a significant \$10,000 increase from the previous limit. WINFertility will provide comprehensive support throughout your journey, including education and claim processing.

Adoption and surrogacy benefits are available to all benefits-eligible employees, regardless of enrollment in medical plans. Fertility benefits are available to employees enrolled in an Anthem medical plan.

Basic Life and AD&D coverage update

All eligible employees receive basic life and AD&D insurance at no cost, which is equal to 1x your annual salary. This is an increase from the current flat \$20,000 benefit provided today. Coverage ends upon termination or retirement.

Higher HSA contribution limits for 2026

The IRS has raised annual limits to \$4,400 for individual coverage and \$8,750 for family coverage. If you’re age 55 or older, you can contribute an extra \$1,000.

How to enroll in your benefits

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To enroll in (or view) your benefits:

Navigate to [MyApps](#) and select the Benefits Portal app.
Or, visit the [Maximus Benefits Center](#).

- The first time you log in, you will be required to select “New User” to create your username and password.
- For subsequent logins, you can access the site through the [MyApps](#) single sign on.
- If need to change your login information, select “Forgot User ID or Password”.

If you have any questions, please visit the [Maximus Benefits Center](#) or call GSA National at 800.250.2741.



TIP: Save as you go

Your elections are saved as you enroll, so you can always come back later to finish. **If you don't finish, your elections will be automatically completed for you.** Please ensure you review your elections before your enrollment window closes.



CHART YOUR COURSE

Enrollment checklist

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Read about your benefits in this guide.



Enroll in your benefits in the [Maximus Benefits Center](#) during open enrollment or within **14 days** of your date of hire.*



If opting out of medical coverage, submit your proof of other acceptable coverage annually to [GSA National](#) within 14 days of your enrollment window. **Medical coverage will only be waived after acceptable proof of other coverage is reviewed and approved.**



If enrolling dependents, you must provide proof of dependent status and upload your documentation to the [Maximus Benefits Center](#) within 30 days of your enrollment window.



If you wish to make voluntary 401(k) contributions, go to [401k.com](#). 401(k) contributions can be changed at any time.

*Note: Although new hires have up to 30 days to elect benefits and submit documentation, we encourage you to submit your elections promptly, within 14 days, to avoid any delay in coverage. If you need additional time beyond 14 days, please notify GSA National via email or chat.



Questions? Contact GSA National
Monday - Friday
8:30 a.m. to 7 p.m. ET
800.250.2741
[gsanational.com](#)
[customersupport@gsanational.com](#)

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As a new employee, you will be given **14 days*** from your date of hire to select your benefits.

Your medical, dental, vision, life insurance, and voluntary coverages will become **effective on the first of the month following 30 days of employment**. For example, if your start date is February 8, your benefits will be effective April 1.

Short- and long-term disability are available to employees working at least 30 hours per week on the first of the month following six months of employment with Maximus.

*Note: Although new hires have up to 30 days to elect benefits and submit documentation, we encourage you to submit your elections promptly, within 14 days, to avoid any delay in coverage. If you need additional time beyond 14 days, please notify GSA National via email or chat.

To enroll in (or view) your benefits:

Navigate to [MyApps](#) and select the Benefits Portal app. Or, visit the [Maximus Benefits Center](#).

- The first time you log in, you will be required to select “New User” to create your username and password.
- For subsequent logins, you can access the site through the [MyApps](#) single sign on.
- If need to change your login information, select “Forgot User ID or Password”.

Changes made between October - December, 2025:

- Any elections or changes made to your 2025 benefits after October 20, 2025, won’t roll over into 2026.
- Employees newly hired during this time will receive an email about enrolling in both 2025 and 2026 benefits.



 **TIP: Save as you go**

Your elections are saved as you enroll, so you can always come back later to finish. **If you don’t finish, your elections will be automatically completed for you.** If you have any questions, please visit the [Maximus Benefits Center](#) or call GSA National at 800.250.2741.

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When can you change your benefits?

Sometimes life changes mean your benefits need to change too. These are called qualifying life events (QLEs), as defined by the IRS. If you have one, you’ll have 31 days from the event to update your benefits.

Examples of qualified life events include:

- Getting married
- Having a baby
- Losing other health coverage
- Experiencing a significant change in employment status

Most benefit changes take effect the first day of the month after your QLE. If you have a baby, coverage begins on the date of birth. The changes you can make depend on IRS rules and your specific situation.

You can visit the [Maximus Benefits Center](#) for more information on life events.



You must request changes to your benefits within 31 days of a QLE:

1. Visit the [Maximus Benefits Center](#) and log into your account.
2. Select “Change Your Coverage” to request a change.
3. Choose the event type and upload your documents. Your request will be reviewed and approved once documentation is verified.
4. Once approved, your enrollment window will open and you can make your benefit elections.

If you need assistance, contact GSA National at [800.250.2741](#).



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How to enroll eligible dependents

If you wish to enroll new dependents in our benefit programs, you will need to provide the following documents to the [Maximus Benefits Center](#):

- **For your legal spouse:** marriage certificate or last year's tax return verifying your marital status (financial data can be redacted).
- **For your domestic partner:** an affidavit and proof of financial interdependence issued in the last six months will be required.
- **For child(ren) under 26 years of age:** birth certificate, adoption paperwork, or proof of legal guardianship.

Note: Dependent child(ren) can be covered on the medical, dental, vision, and life insurance plans up to the end of the month they turn 26 (regardless of marital status).

Dependent verification documentation can be uploaded during your enrollment. Please follow the instructions outlined in the [Maximus Benefits Center](#) to ensure your dependent documentation is processed accurately.



You will need to submit your benefit elections within your eligibility window.

You must also provide any necessary dependent documentation (such as birth or marriage certificates) within the eligibility window.

Failure to complete the above will result in your dependents not being covered in any Maximus insurance plans.

Outside of an eligible election window, the only time you may make changes is during the next open enrollment period, unless you experience a QLE.

Legal spouses/domestic partners with access to employer-sponsored medical benefits are not eligible for coverage under the Maximus medical plans.



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Maximus extends domestic partners and their dependent children the same benefits and privileges afforded to spouses and dependent children of benefits-eligible employees.

Defining a domestic partner

A domestic partner is a person of the same or opposite sex with whom an employee has a long-term and committed relationship:

- Must be 18 years of age, competent to legally enter into a contract and be each other’s only partner.
- May not be married to anyone else and cannot be blood-related to the degree that legally prohibits marriage.
- Must live together at the same permanent residence, be jointly responsible for each other’s common welfare, and be financially interdependent.

To qualify for benefits, you must have:

- Been in the relationship for twelve continuous months or more.
- Not signed a domestic partner affidavit with anyone else within the last twelve months.

Both you and your partner would need to complete an Affidavit of Domestic Partnership to this effect and be able to provide proof of a financially interdependent relationship such as a joint bank account, joint lease or mortgage, or joint ownership of property.

 How domestic partner coverage affects your taxes:

If you add a domestic partner (or their children) to your health, dental, or vision coverage, **your premium will be the same as the employee/spouse or family rate.**

However, the IRS does not recognize domestic partners for tax purposes.

This means:

- Your bi-weekly deductions for your domestic partner and their children are taken **after taxes.**
- The value of their coverage is **added** to your gross earnings as taxable income (called **imputed income**).

Example: If your domestic partner’s coverage is valued at \$200 per month, that \$200 will be added to your taxable income, and you’ll pay taxes on it—just like regular wages.

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What happens if I don't enroll?

- If you do not complete your enrollment within your new hire or open enrollment window, **you will be automatically enrolled in the Anthem Core HSA Plan.** This plan is free of cost at the employee-only level.
- All employees receive basic life and AD&D insurance and access to the Employee Assistance Program (EAP).
- Full-time employees receive short-term disability (STD) and long-term disability (LTD) coverage after meeting service requirements.

When will my deductions start?

- Your benefits as a SCA employee are pre-funded, meaning you pay for your benefits the month prior. For example, hours paid and deductions from January's paychecks are applicable to benefit coverage in February.
- **For new hires,** deductions will start the calendar month before your benefits become effective.
 - **For open enrollment elections,** deductions for the new plan year will begin in December of the previous year.

Based on the timing of payroll deadlines and when benefit elections are submitted, deductions may not be taken out of your paycheck when expected. In those situations, those deductions will be deducted from the next pay cycle as arrears deductions. If you have a balance due, benefit premiums will be taken at 1.5 times the regular rate until the full amount is covered.



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Can I opt out of medical coverage?

You will only be able to opt out of medical coverage if you have acceptable medical coverage that pays primary to Medicare from another source or person, such as your spouse.

- You must provide documentation showing coverage is current and effective on your start date **as well as yearly during benefits open enrollment. Copies of ID cards will not be accepted.**
- You are required to select a medical plan during your online enrollment until you have provided proof of other coverage, at which time your medical plan election will be canceled. Upload proof of other coverage to [GSA National](#) for secure transfer. New hires have 14 days from date of hire to submit the documentation.
- If you opt out of medical coverage and paperwork is not processed before your first month of coverage, the funds deducted from your Premium Reserve Account (PRA) will be corrected in the following month. See [page 16](#) for more information on PRAs.

Acceptable proof:

- ✓ TRICARE coverage
- ✓ CHAMPVA/VA insurance
- ✓ Letter from spouse's/partner's employer
- ✓ Indian Health insurance card

Note: If you have coverage through Indian Health Service, you are only required to provide proof of coverage during your initial enrollment period.

Unacceptable proof:

- ✗ Medicare, Medicaid, or Arizona Health Care Cost Containment System (AHCCCS) coverage
- ✗ Insurance ID cards (additional proof required)
- ✗ Discount (non-insurance) cards or letters (including Marketplace coverage)
- ✗ Short-term (gap coverage) insurance
- ✗ Insurance applications or temporary ID cards



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How are my benefits funded?

Your benefits are funded in full or in part by Maximus through an account set up just for you called a Premium Reserve Account (PRA).

- GSA National manages your PRA, which works like a bank account.
- Maximus makes contributions on your behalf and you “buy” benefits with the money deposited into your PRA.
- You also make your own contributions through payroll deductions to the PRA when you select benefits that cost more than what Maximus contributes (such as the PPO plans) or to fund other elected benefits.
- The funds in your account are used to pay monthly premiums not covered by Maximus. Depending on your account balance, PRA funds can also be used to contribute to dependent care reimbursement accounts or to fund your retirement plan.

What if I have surplus funds?

Surplus funds in your Premium Reserve Account (PRA) are transferred to your retirement account on a quarterly basis if you meet all of the following criteria:

- Your individual PRA balance exceeds six months of insurance premiums based on your current elections. You can access your retirement account at [netbenefits.com](#).
- You have been hired, rehired, or transferred to a position with GSA-administered benefits by the first day of the second month of the quarter.
- You are an active employee on the last day of the quarter.

If your employment is terminated, funds remaining in your PRA are forfeited.

For questions regarding your PRA balance, please contact GSA National directly at [800.250.2741](#) or email [customersupport@gsanational.com](#).





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READY FOR THE ROAD AHEAD. Maximus has partnered with Anthem Blue Cross Blue Shield to provide our medical insurance coverage.

Employees may choose from two Anthem medical plans:

 The Core HSA plan

 The PPO plan

The main differences between the plans are:

1. What you pay out of pocket for your medical services through your deductible and coinsurance (if applicable).
2. The funding method used to pay for your out-of-pocket expenses, including the deductible.
3. What you pay each pay period in premiums.

California employees have the option to choose either an Anthem plan or Kaiser coverage. Both Anthem plans cover the same services and use the same provider network.

Maximus medical plans provide the coverage, tools, and resources to help you take control of your health and spending by offering:

- Preventive care covered at 100% under all health plans for eligible services when using in-network providers.
- Real-time health support from a nurse advocate, when you call the Anthem Nurseline, available 24/7/365.
- Support from an Anthem Health Guide by phone or chat, Monday - Friday, 8 a.m. to 8 p.m. ET.
- Cost savings when using in-network providers.
- Access to 24/7 virtual care through LiveHealth Online telemedicine and virtual second opinion through My Medical Ally.
- Access to various health and wellbeing support programs.
- Wellbeing Coach Total: Support for lifestyle behavior changes, specifically weight loss (at no cost).



Video: Types of health plans at Maximus



Video: Understanding key terms

NO MATTER WHERE YOU ARE ON YOUR JOURNEY, check out the Maximus Wellbeing Program.

Note: The Core HSA plan offers affordable medical coverage with at least the minimum benefit value (called essential benefits) required under the Patient Protection and Affordable Care Act. You may also enroll in health plans through the Marketplace at [healthcare.gov](#). However, while some individuals with low incomes may qualify for subsidized coverage, Maximus employees generally will not qualify because of the cost and benefit value of our health plans.

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	Core HSA plan		PPO plan	
	IN-NETWORK	Out-of-network	IN-NETWORK	Out-of-network
Annual company contribution - Individual - Employee + child & spouse/DP	- N/A \$500		N/A	
	You pay:			
Annual deductible - Individual - Family	Aggregate deductible \$1,800 \$3,600	Aggregate deductible \$6,000 \$12,000	Embedded deductible \$700 \$1,400	Embedded deductible \$2,000 \$4,000
Coinsurance	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Annual out-of-pocket (OOP) limit (Includes deductible) - Individual - Family	\$6,000 \$12,000	\$10,000 \$20,000	\$3,000 \$6,000	\$7,000 \$14,000
Telehealth visits - LiveHealth Online (LHO) - Non-LiveHealth Online (Non-LHO)	\$0 20% after deductible	Not covered 50% after deductible	\$0 copay PCP: \$30 copay Specialist: \$60 copay	Not covered 40% after deductible
Preventive care services	\$0	50% after deductible	\$0	40% after deductible
PCP, non-preventive office visit	20% after deductible	50% after deductible	\$30; deductible doesn't apply	40% after deductible
Specialist office visit	20% after deductible	50% after deductible	\$60; deductible doesn't apply	40% after deductible
Urgent care	20% after deductible	50% after deductible	\$75; deductible doesn't apply	40% after deductible
Inpatient hospital/ outpatient surgical facility	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Emergency care	20% after deductible		\$500 copay	

Terms to know

Aggregate deductible and OOP limit: With an aggregate deductible or OOP limit, one family amount applies to everyone. When one or a combination of family members has expenses that meet the family deductible or out-of-pocket limit, it is considered to be met for all of you. Then, the plan will begin paying its share of eligible expenses for the whole family for the rest of the year.

Embedded deductible and OOP limit: With an embedded deductible or OOP limit, each person only needs to meet the individual deductible and out-of-pocket limit before the plan begins paying its share for that individual. (And, once two or more family members meet the family amounts, the plan begins paying its share for all covered family members.)

Out-of-network: Most providers are in-network. While most out-of-network services are covered, you will pay substantially more when you see a provider who is not in the Anthem network.

Out-of-pocket maximum: The most you will pay for covered services during the plan year before the plan begins to pay 100% of the allowed amount. Once you reach the out-of-pocket maximum, the plan will pay for 100% of your healthcare services for the rest of the year.

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Under the Core HSA plan, the employee-only medical premium is fully paid by Maximus with no additional cost to you. If you wish to add your dependents to your medical plan or if you wish to elect the PPO plan, the applicable premium below will be deducted from your paycheck each pay period.

	Bi-weekly payroll deductions	
	Core HSA plan	PPO plan
Employee	\$0.00	\$72.00
Employee + spouse/ domestic partner*	\$229.00	\$369.00
Employee + child(ren)	\$169.00	\$283.00
Employee + family*	\$372.00	\$569.00

*Working spouses who have access to medical/prescription drug insurance through their employer are not eligible for coverage under the Maximus medical/prescription plans. They remain eligible for dental, vision, and other benefits available to spouses.



Note

If you go out-of-network your expenses may exceed the coinsurance amount because the doctor may bill you for the charges not covered under the plan.

 (formerly Express Scripts) prescription drug coverage

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 **Express Scripts is currently rebranding its logo and external website to align with its parent organization, Evernorth Health Services. While you may notice changes to the look and feel, we will continue to refer to our partner as Express Scripts.**

Maximus partners with Express Scripts Inc. (ESI) to provide your prescription drug benefit. Express Scripts ensures that you have access to high-quality, cost-effective medicines through a network of retail pharmacies. Your copayments are based on the type of prescription you have filled, where you have it filled, and the medical plan you are enrolled in. After your plan deductible has been satisfied, prescription drug coverage is as follows.

	Core HSA plan	PPO plan
	IN-NETWORK	IN-NETWORK
Deductible • Individual • Family	Aggregate deductible \$1,800 \$3,600	None
Generic	\$10	\$10
Formulary	\$30	\$30
Non-formulary	\$60	\$60
Mail order - generic	\$20	\$20
Mail order - formulary	\$60	\$60
Mail order - non-formulary	\$120	\$120
Mail order - specialty • 1- to 30-day supply • 31- to 90-day supply	Applicable copay applies	Applicable copay applies

You can enjoy additional savings by using ESI’s medication home delivery service. In most cases, your prescriptions are covered only if they are filled at a participating retail pharmacy or through our home delivery pharmacy service. To find an in-network pharmacy, visit [express-scripts.com/maximus](#). For out-of-network benefits, contact Express Scripts using the toll-free number on the back of your member ID card or call **800.282.2881**.

Express Scripts has developed a list of drugs covered under your plan referred to as your “formulary.” Your formulary offers a wide selection of generic and brand-name prescription drugs chosen to help keep prescription drug costs down. You can find the complete formulary at [express-scripts.com](#).

A prior authorization may be needed for some of the medication prescribed by your physician. To find out if your medicine requires a prior authorization, log in to [express-scripts.com](#) and select “Price a Medication” from the drop-down menu under “Manage Prescriptions.”

Specialty medications will be covered under the appropriate plan copay for preferred or non-preferred drugs.

EVERNORTH

HEALTH SERVICES

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Maintenance medication – Smart90 Program

Smart90 Program members are allowed 2 maintenance medication fills from a 30-day retail pharmacy (for example, drugs used to treat high blood pressure or diabetes). With Smart90, a member can choose to fill a 90-day supply at a CVS pharmacy or through the Express Scripts mail order pharmacy. Members continuing to use 30-day supplies of maintenance medication, or filling out-of-network, pay 100% of prescription cost.

Preventive pharmacy program

Members receive free or discounted preventive medications for many conditions including diabetes, heart disease, and high blood pressure. This program helps you adhere to your medication regimen and stay healthy. Be sure to speak with your doctor about this benefit and discuss choosing the most cost-effective option for you. Sign in at [express-scripts.com](#) to see all of the medications included in the preventive medication list that are not subject to your deductible. All preventive generic drugs are available at no cost to you.

Specialty pharmacy – Accredo

Accredo, the full-service Express Scripts specialty pharmacy, provides personalized care to patients with chronic, complex health conditions. Accredo offers several comprehensive disease-specific patient care management programs:

- **Patient counseling and education:** convenient access to highly trained specialty experts, including pharmacists, nurses, and patient care coordinators who provide support to manage your condition.
- **Convenient medication delivery:** coordinated delivery to your home, doctor’s office, or any other approved location.
- **Refill reminders:** ongoing refill reminders from a patient care coordinator.
- **Language assistance:** translation services for non-English-speaking patients.
- **Mobile app:** makes it easy for your to refill medications.

For additional information about the services available to you through Accredo, please call [800.987.5254](#).



Contact Express Scripts

Register today at [express-scripts.com](#) or call [800.224.5513](#). To access TTY service for hearing-impaired members, call [800.899.2114](#).

All services listed are available 24 hours a day, 7 days a week.

Your doctor may fax your prescriptions to the Express Scripts Pharmacy at [800.837.0959](#).

FOR EMPLOYEES IN CALIFORNIA AND HAWAII ONLY

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California employees have the option to choose either an Anthem plan or Kaiser coverage. Hawaii employees are offered the Hawaii Kaiser plan. Employees in Hawaii who wish to opt-out of employer medical coverage will be required to complete the HC-5 Form yearly as required by the Hawaii Department of Labor (DOL). You can locate this form in the [Maximus Benefits Center](#).

	Northern and Southern California Plan	Hawaii Plan
	IN-NETWORK ONLY	IN-NETWORK ONLY
	You pay:	
Annual deductible - Individual - Family	Aggregate deductible \$0 \$0	Embedded deductible \$0 \$0
Coinsurance	20% after deductible	Varies depending on service
Annual out-of-pocket (OOP) limit (Includes deductible) - Individual - Family	\$1,500 \$3,000	\$2,500 \$7,500
Preventive care services	\$0	\$0
Office visit (PCP, non-preventive)	\$35	\$15
Office visit (Specialist)	\$35	\$15
Urgent care	\$35	\$15 per visit (20% coinsurance for out of area urgent care)
Emergency care	\$100	\$100
Inpatient hospital	\$500 per admission	10% coinsurance
Outpatient surgical facility	\$35 per visit	10% coinsurance
Lab work & X-rays	No charge	\$15



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	Bi-weekly payroll deductions		
	Northern California Plan	Southern California Plan	Hawaii Plan
Employee	\$155.60	\$155.60	\$25.11
Employee + spouse/ domestic partner*	\$787.85	\$787.85	\$376.25
Employee + child(ren)	\$703.55	\$703.55	\$317.73
Employee + family	\$1,209.36	\$1,209.36	\$560.60



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	Northern and Southern California Plan	Hawaii Plan
Retail Pharmacy	You pay:	
Generic	\$15.00	\$10.00
Formulary	\$35.00	\$45.00
Non-formulary	\$35.00	\$45.00
Specialty	\$35.00	\$200.00
Mail Order Pharmacy		
Generic	\$30.00	\$20.00
Formulary	\$70.00	\$90.00
Non-formulary	\$70.00	\$90.00



Be prepared: know when and where to get care



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Primary care physician		Virtual care						Retail health clinic		Urgent care center		Emergency room			
		24/7 Nurseline		Anthem LiveHealth Online		Telehealth with a doctor									
Usually available during normal business hours and may also provide medical advice by phone after hours.		24/7/365 access to a nurse to triage health issues and answer health concerns		MEDICAL Access to LiveHealth Online doctors from the comfort of your home		BEHAVIORAL HEALTH Access to LiveHealth Online behavioral health therapists from the comfort of your home		Virtual visits with your provider using visual and audio (computer, smart phone, tablet)		Walk-in care clinics located in certain drugstores and major retailers		Urgent care centers are for serious but non-life-threatening issues. Many are open 7 days a week with extended hours, and they usually offer X-ray and lab services.		ERs are open 24/7/365 and are for life-threatening emergencies only. Using the ER for non-life-threatening issues can cost you a lot in time and money.	
COST	AVG WAIT	COST	AVG WAIT	COST	AVG WAIT	COST	AVG WAIT	COST	AVG WAIT	COST	AVG WAIT	COST	AVG WAIT	COST	AVG WAIT
\$\$	20 min	FREE	0 min	FREE*	10 min	FREE*	Psychology: 7 days Psychiatry: 28 days	\$\$	20 min	\$	30 min	\$\$\$	30 min	\$\$\$\$	90 min
• Allergies • Cold, flu and COVID-19 symptoms • Sinus issues • Ear and eye infections • Headaches or migraines • Sore or strep throat • Urinary tract infections • Preventive exams and vaccination • Ongoing care support		Questions about: • Medical conditions • Pre- or post-op care • Symptoms you're experiencing • Where to get care		• Allergies • Cold, flu and COVID-19 symptoms • Sinus issues • Ear and eye infections • Sore or strep throat • Acute dermatology		• Anxiety • Depression • ADD/ADHD		• Allergies • Cold, flu and COVID-19 symptoms • Sinus issues • Ear and eye infections • Sore or strep throat • Behavioral health visits		• Allergies • Cold, flu and COVID-19 symptoms • Sinus issues • Ear and eye infections • Headaches or migraines • Sore or strep throat • Urinary tract infections		• Back and neck pain • Sprains and fractures • Minor allergic reactions • Cuts, scrapes, and minor burns • Respiratory issues • Infections		• Chest pain or trouble breathing • Severe abdominal pain • Uncontrollable bleeding • Symptoms you think may put your life at risk	

* All LiveHealth Online services \$0 cost share for 2026 on all Anthem health plans

Health Savings Account (HSA)

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A health savings account (HSA) is a powerful tool that allows you to pay for qualified health expenses (as determined by the IRS) during the year. The money in your HSA is yours to keep and use forever, even if you leave the company or are no longer enrolled in the Core HSA plan.

You must enroll in the Core HSA plan to contribute to an HSA, but you can use the funds regardless. You are not eligible to contribute or receive employer funds if you are enrolled in Medicare or TRICARE.

Maximus’ HSA wellbeing incentive contributions

- You can earn up to \$500 by completing different wellbeing incentives.
- Employees enrolling in spouse/domestic partner, child/children, or family coverage will receive an annual employer contribution of \$500 towards your HSA account. This amount is pro-rated and added to your HSA on a per-pay-period basis. This means each pay period you will see a deposit into your HSA from Maximus, in addition to any contributions you elect to make into the account.
- Any earned wellbeing incentives will be deposited into your HSA account.

Your HSA contributions

Contributions to your HSA (up to the 2026 IRS maximum, minus any Maximus HSA wellbeing incentive contributions) can be made via pre-tax payroll deductions and can be changed at any time.

OUR BENEFITS, YOUR JOURNEY

For 2026, you can contribute:

- **\$4,400 per year for single coverage** (inclusive of wellness incentive).
- **\$8,750 per year for family coverage** (inclusive of wellness incentive). Dependents must be approved via dependent verification process in order to elect the family HSA contribution.
- **\$1,000 per year catch-up contribution** option for employees age 55+.

For information about your HealthEquity account log into your HealthEquity member portal at [myhealthequity.com](#) or call HealthEquity Member Services at 866.346.5800.



Video: [HSA: Spend. Save. Invest.](#)

How your HSA works

-  1. Enroll in the Core HSA plan.
-  2. Elect payroll contribution amount.
-  3. Get tax breaks.
-  4. Pay for qualified health expenses with your HSA debit card, or online payment options.
-  5. Let your money grow.
-  6. Roll contributions over year to year.
-  7. Retire with more.

Health Reimbursement Account (HRA)

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If you are enrolled in the PPO plan, you will automatically be enrolled in a Health Reimbursement Account (HRA).

Maximus funds your HRA by providing up to \$500 for completing wellbeing activities as identified by our [wellbeing program](#).

You will receive a debit card with this plan that allows flexibility in the way your earned HRA dollars are used. You may use the debit card to pay your cost share at the point of service at a doctor’s office or the pharmacy. You may also pay up front using another source of payment and then request reimbursement through the [anthem.com](#) portal or [Engage](#).



The funds up to your out-of-pocket maximum are yours to keep the following year if you re-enroll in the PPO plan.

For information about your HealthEquity account log into your HealthEquity member portal at [myhealthequity.com](#) or call HealthEquity Member Services at 866.346.5800.

How your HRA works

-  1. Enroll in the PPO plan.
-  2. Maximus makes contributions to the account when you complete wellbeing activities.
-  3. Once you have a balance from completing activities, you will receive your HRA debit card.
-  4. Pay for qualified medical or prescription expenses by using your HRA debit card or through a reimbursement request.
-  5. Get reimbursed.



Healthcare Flexible Spending Account (FSA)

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If you enroll in the PPO plan or do not elect medical coverage through Maximus, you can enroll in a healthcare flexible spending account (FSA).

A healthcare flexible spending account (FSA) allows you to set aside pre-tax funds from your paycheck to pay for eligible expenses (as determined by the IRS) during the year. You can change your pre-tax payroll contributions at open enrollment or if you experience a qualifying life event. FSAs also reduce your taxable income since your contributions are subtracted from your gross pay.



Any unused money remaining in your account at the end of the year will be forfeited, so plan your contributions carefully. This is known as the “use-it-or-lose-it” rule and it is governed by IRS regulations.

For information about your HealthEquity account log into your HealthEquity member portal at myhealthequity.com or call HealthEquity Member Services at 866.346.5800.

OUR BENEFITS, YOUR JOURNEY

For 2026, you can contribute up to \$3,400 on a pre-tax basis to your healthcare FSA.

How your FSAs work

- 
1. Enroll in the PPO plan or elect no medical coverage.
- 
2. Elect your payroll contribution amount (the full amount is available on day 1).
- 
3. Save on taxes.
- 
4. Pay for eligible healthcare expenses.



Video: [FSA: Surprising tax savings](#)

HSA, HRA, and FSA compared



Use your HealthEquity card to shop on Amazon!
[Click here](#) to shop for eligible products!

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	Health savings account (HSA)	Health reimbursement account (HRA)	Flexible spending account (FSA)
Purpose	Long-term savings account for healthcare	Maximus-funded savings account that reimburses you for healthcare expenses	Short-term savings account for healthcare
Eligibility	Must be enrolled in the HSA health plan	Must be enrolled in the PPO health plan	Must be enrolled in the PPO health plan or have waived coverage
Ownership	You own the account	Maximus owns the account	Maximus owns the account
Opening the account	Automatic opening when enrolling in the Core HSA Plan.	Maximus opens the account for you	Enroll during Open Enrollment
Funding the account	Both you and Maximus fund this account	Funded by Maximus	You fund the account
Using the account	HSA debit card or reimbursement	HRA debit card or reimbursement	FSA debit card or reimbursement
Eligible expenses	Eligible healthcare expenses such as doctor visits, prescriptions, dental cleanings, eye exams, and much more	Eligible healthcare expenses such as doctor visits, prescriptions, and much more	Eligible healthcare expenses such as doctor visits, prescriptions, dental cleanings, eye exams, and much more
Rollover of funds	Unused funds roll over year to year	Unused funds roll over (up to your out-of-pocket maximum) if you re-enroll in the HRA	Unused funds do not roll over
Portability	You keep the account and the funds if you change employers or health plans	You lose any funds in the account if you leave your job	You lose any unused funds in the account (use-it-or-lose-it)

Visit the [HealthEquity Education Center](#) to learn more about spending accounts.

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Regardless of the plan you choose, here are a few easy ways you can save on out-of-pocket healthcare expenses, if you enroll in a health plan.

- 1. SAVE IN THE NETWORK.** Save big when you use a doctor, hospital, or facility that is part of your plan’s network. Chances are there is a network doctor or facility right in your neighborhood. It’s easy to find high-quality, cost-effective care right where you need it.
- 2. Use telehealth for 24/7 care.** Anthem LiveHealth Online lets you get the care you need – including most prescriptions (if appropriate) – for a wide range of minor medical conditions at no cost. You can connect with a board-certified provider via video chat or phone.
- 3. Consider using an urgent care center.** If you need immediate medical attention, but it’s not serious or life-threatening, you may not have to go to an emergency room (ER). An urgent care center provides care like you would receive in the ER, but offers lower costs, shorter wait times, and extended hours. An urgent care center can treat things like minor cuts, burns and sprains, fever and flu symptoms, or lower back pain.
- 4. Consider using a convenience care clinic such as CVS MinuteClinics.** When you need face-to-face routine medical care but can’t wait for an appointment, consider using a convenience care clinic. You will get quick access to quality and affordable medical care. A convenience care clinician can treat you for a range of routine medical conditions such as sinus infections, earaches, and rashes and can provide immunizations. You can find convenience care clinics in grocery stores, pharmacies, and other retail stores.



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FOR BETTER HEALTH, THROUGHOUT YOUR JOURNEY.

The **physical, financial, emotional,** and **social** wellbeing of you and your family are significant parts of what allow you to be successful at work and at home.

Employee Assistance Program (EAP)

The EAP, provided through TELUS Health, can help employees with everyday challenges both large and small, including personal, work, and family issues. **It is a free and confidential service provided to all employees and everyone who lives in their household.** Services include help with daily work and life challenges, free counseling sessions with a licensed counselor, webcasts, and online resources.

Employees have **unlimited access** to the EAP by phone or by visiting [maximus.com/eap](#) (Username: maximuseap, password: maximus).

Our wellbeing program has even more resources for all employees regardless of whether you are enrolled in a Maximus medical plan, such as:

- **Engage:** A wellbeing platform that is your single stop to access all of your Maximus wellbeing benefits. Earn points by completing healthy activities to win prizes.
- **Mental Health in the Workplace** training for all employees.
- **Weight management and tobacco cessation coaching** by phone.
- **Free wellbeing apps**, such as Headspace and Wellbeats.
- Fairs and on-site activities.
- Employee perks and discounts.

Visit [mywellness-maximus.com](#) or [engage-wellbeing.com](#) to access these resources to maintain healthy habits that lead to healthier, more fulfilling lives.

Employees and covered dependents enrolled in an Anthem medical plan have access to other wellbeing support programs such as:

- Chronic condition support (pre-diabetes, diabetes, hypertension, joint/back pain, and pelvic floor health).
- Health coaching.
- Healthy families program with incentive.
- Free biometric screening.
- Wellbeing Rewards (up to \$500).

Wellbeing rewards

10 points earned = \$1
Total points you can earn = 5,000*

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Employees enrolled in a Maximus medical plan can earn up to \$500 for taking healthy actions, such as completing an annual physical or getting routine screenings. Incentives will be paid directly into your HSA or HRA.

Employees not enrolled in a Maximus medical plan can also earn points for completing healthy activities and can use the points to be entered into quarterly sweepstakes for a chance to win prizes.

Visit [engage-wellbeing.com](#) to learn more about your wellbeing rewards.

Program name	Program activities	Frequency	Points earned for Anthem medical plan participants	Maximum incentive allowed	Points earned for non-Anthem medical plan participants**
Explore and earn	Understand your plan	Once annually	25	\$2.50	N/A
	See your claims	Once annually	25	\$2.50	N/A
	Search for care	Once annually	25	\$2.50	N/A
	Rate a doctor	Once annually	25	\$2.50	N/A
	Build a care team	Once annually	25	\$2.50	N/A
	Take health assessment	Once annually	50	\$5.00	250
Get active	Walk 5,000 steps	Once daily	5	\$182.50	5
	Walk 10,000 steps	Once daily	10	\$365.00	10
Eat smart	Track 800+ Calories	Once daily	10	\$500.00	10
Engage with an Anthem Case Manager	Engage with an Anthem Case Manager telephonically	Once monthly	250	\$300.00	N/A
Anthem preventive care & cancer screenings Not all services under the Preventive Care incentive category are fully covered under the health plan. Please consult your provider prior to service to understand your potential cost share.	Breast cancer screening	Once annually	2,000	\$200.00	N/A
	Prostate cancer screening	Once annually	2,000	\$200.00	N/A
	Skin cancer screening	Once annually	2,000	\$200.00	N/A
	Well-woman visit	Once annually	2,000	\$200.00	N/A
	Colon cancer screening	Once annually	2,000	\$200.00	N/A
	Annual physical	Once annually	2,000	\$200.00	N/A
	Bone density	Once annually	2,000	\$200.00	N/A
Anthem Wellbeing Coach Total	Complete 30 digital daily check-ins	Once annually	1,000	\$100.00	N/A
	Complete 3 health coaching calls	Once annually	1,000	\$100.00	N/A
LiveHealth Online Sword Digital PhysicalTherapy	Complete 9 digital physical therapy sessions	Once annually	2000	\$200.00	N/A
Hello Heart Healthy Blood Pressure	Blood pressure reading and coaching interaction once a week	Once weekly	40	\$208.00	N/A
LiveHealth Online Healthy Weight	Complete 3 sessions with the coach	Once annually	N/A	N/A	50
Employees enrolled in an Anthem medical plan may access a weight management program through Athem Wellbeing Coach Total.					
Omada Health	Build healthy habits	Once weekly	40	\$208.00	N/A
Quest Diagnostics	Complete screening	Once annually	1,000	\$100.00	N/A
Quest Diagnostics	View results	Once annually	100	\$5.00	N/A
Dental cleaning	Self report dental cleaning	Once every 6 months	250	\$50.00	250
Healthy Habits	Complete a Healthy Habit challenge	Once daily	2	\$73.00	2

* Anthem medical plan participants who earn over 5,000 points may use additional points to enter quarterly sweepstakes for prizes in Engage.
** Points earned for non-Anthem participants do not translate to dollar amounts. These points are used for entry into quarterly sweepstakes for prizes in Engage.

Redeeming wellbeing rewards

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Your health is worth rewarding. When you complete wellbeing activities through Engage, you'll earn employer-paid contributions to your Health Savings Account (HSA) or Health Reimbursement Account (HRA).

How it works:

- Log in to [Engage-Wellbeing.com](#) or use the Engage app to see eligible activities.
- Visit [MyWellness-Maximus.com](#) for program details.
- Complete activities like preventive care visits, screenings, or wellness challenges.
- Rewards earned in one month are deposited into your HSA or HRA on the second paycheck of the following month.

What you'll see:

- Contributions are listed as both an earning and a deduction on your pay statement. This has no impact on your take-home pay.
- Deposits go directly into your HealthEquity HSA or HRA account.
- Employer contributions count toward the IRS annual HSA limit, so be sure to track your balance at [my.healthequity.com](#).

Why it matters:

These contributions help you pay for eligible medical expenses tax-free, while rewarding you for taking steps toward better health.

Learn more at [Health Equity Education Center](#). If you have additional questions, please contact GSA National at 800.250.2741 or email customersupport@gsanational.com.



Find more information on the [My Maximus Benefits page](#).

Dental

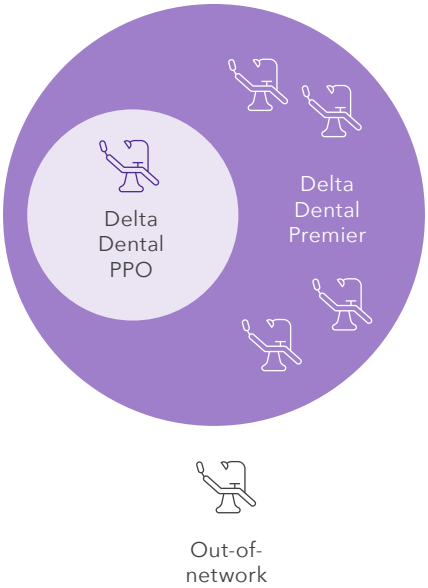
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Maximus offers dental insurance through Delta Dental at a small cost to you and your dependents. Our plan focuses on prevention by providing full coverage for routine dental visits and cleanings, as well as coinsurance benefits for more complex care such as fillings, root canals, and crowns.

To get the full advantage of your Delta Dental coverage, we recommend that you choose a dentist who participates in the Delta Dental network(s) covered by your plan.

- **Delta Dental PPO:** offers the deepest discounts and lowest out-of-pocket costs.
- **Delta Dental Premier:** offers expanded access to care.
- **Out-of-network:** offers dental services, but may have higher out-of-pocket costs.



PREPARE FOR BETTER ORAL HEALTH

Delta Dental programs and services

Prevention first: Visits to the dentist for diagnostic and preventive services will not count against the annual maximum.

Healthy Smile, Healthy You Program®: Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, or high-risk cardiac conditions, or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the Healthy Smile, Healthy You Program is simple. Log in to [deltadentalva.com](#) to print an enrollment form.

Orthodontic services: Your plan offers coverage for adult and child orthodontic services up to a \$2,000 lifetime maximum per covered individual.

Learn more

Contact Delta Dental by calling [800.237.6060](#) or visit [deltadentalva.com](#). You can also download the mobile app to obtain information about dental coverage benefits, coverage levels, claims status, find a participating dentist in your area, and more.

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	Delta Dental PPO/Premier (IN-NETWORK)	Out-of-network*	Frequency of benefit
Annual deductible - Individual - Family	\$100 \$200	\$100 \$200	Per calendar year
Annual benefit maximum (Per person)	\$2,000	\$2,000	Per calendar year
The plan pays:			
Orthodontic lifetime maximum (Per person)	\$2,000	\$2,000	Lifetime
You pay:			
Diagnostic and preventive services	0% after deductible		N/A
Basic services	0% after deductible		N/A
Major services	30% after deductible		N/A
Orthodontic services (For subscribers and covered dependents)	50% after deductible		N/A

We understand how important dental and orthodontic care is. After you meet your deductible, Maximus will cover 50% of your orthodontic expenses, up to a total of \$2,000. You will be responsible for paying the remaining 50% of the costs as they progress toward the \$2,000 limit, as well as any expenses that exceed that amount.

*Out-of-network care may result in higher out-of-pocket costs.

Your contributions

Bi-weekly payroll deductions	
Employee only	\$8.18
Employee + spouse/domestic partner*	\$17.17
Employee + child(ren)	\$15.53
Family	\$24.53



Maximus pays half of the total premium for all coverage levels – so you pay less for Delta Dental coverage!

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Vision insurance is provided through VSP, which gives you access to the largest provider network in the industry. You have two vision plan options – **the Base plan and the Enhanced plan (VSP EasyOptions)** – that cover a wide range of services including exams, lenses, frames, contact lenses and more.

The Base plan covers:

- **KidsCare:** Children have two fully covered WellVision exams per year, if needed. Frames for children are covered every 12 months.
- **Computer VisionCare:** (\$100 allowance) This enhancement allows you to obtain corrective eyewear that is designed to meet the specific health and vision needs of computer users. Lenses and frames for those supplemental glasses are available at the same service frequency as your core plan.
- **Value and savings:** Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of exclusive member extras for additional savings.
- **Vast network of providers to you choose from:** With an average of five VSP network doctors within six miles of you, it’s easy to find a nearby in-network doctor or retail chain. Maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

The Enhanced plan (VSP EasyOptions) covers everything in the Base plan plus an additional level of personalization that gives every family member the ability to personalize their benefits by choosing one of these at the time of service:

- + \$100 additional frame allowance **OR**
- + \$100 additional contact lens allowance **OR**
- + Anti-glare coating **OR** progressive lenses **OR** light-reactive lenses

Each member can wait until they’ve met with their doctor to decide which upgrade is best for them (instead of having to guess when they enroll).

Learn more

Create an account on [vsp.com](#) to view your in-network coverage, find the VSP network doctor who’s right for you, and discover savings with exclusive member extras.

VSP does not mail insurance ID cards.
You can print an ID card on the VSP website or you may simply tell your provider that you have coverage through VSP.

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	Base plan		Enhanced plan	
	Copay	Frequency of benefit	Copay	Frequency of benefit
Annual exam	\$10	Per calendar year	\$10	Per calendar year
Prescription glasses	\$25	Per calendar year	\$25	Per calendar year
Lenses	Included in prescription glasses	Per calendar year	Included in prescription glasses	Per calendar year
Frames	\$200 allowance; \$220 featured frame allowance 20% discount off any amount above the allowance	Every other calendar year	\$250 allowance; \$270 featured frame allowance 20% discount off any amount above the allowance	Per calendar year
Lens enhancements Standard progressive lenses Premium progressive lenses Custom progressive lenses	\$0 \$80-\$90 \$120-\$160	Per calendar year	\$0 \$80-\$90 \$120-\$160	Per calendar year
Contacts* (Instead of glasses)	Up to \$60 contact fitting fee \$200 allowance for contacts; copay does not apply to contact lens exam (fitting and evaluation)	Per calendar year	Up to \$60 contact fitting fee \$250 allowance for contacts; copay does not apply to contact lens exam (fitting and evaluation)	Per calendar year
Diabetic Eyecare Plus	\$20	As needed	\$20	As needed
Upgrades	N/A		Choose ONE of these upgrades at time of service: + Additional \$100 frame allowance + Fully-covered premium or custom progressive lense + Fully-covered light-reactive lenses + Fully covered anti-glare coating + An additional \$100 contact lens allowance	

*You can have either glasses or contacts during the 12-month plan year.

Your contributions

Bi-weekly payroll deductions	Base plan	Enhanced plan
Employee only	\$4.20	\$6.40
Employee + spouse/domestic partner*	\$6.14	\$9.34
Employee + child(ren)	\$6.54	\$9.95
Family	\$10.06	\$15.32

Hearing aids

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP Vision Care members. You and your family can save up to 60% on a pair of hearing aids. Other program benefits include:

- Access to a national network of more than 6,000 hearing healthcare providers.
- Discounted pricing on a wide selection of the latest brand name hearing aids.
- Three provider visits for fitting and adjustments.
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement.
- 48 free batteries per hearing aid for non-rechargeable models.



Financial security

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Helping you plan for the future is important to Maximus, which is the reason we offer the Maximus GSA Retirement Plan. This account is funded through excess contributions and growth in your Premium Reserve Account. The amount of contributions will depend on the number of hours you work and your benefit elections. Transfers occur the month following the end of each fiscal quarter, and you must be actively employed on the last day of the quarter to be eligible.

The GSA Retirement Plan:

- Allows employees to use pre-tax employer funds (H&W funds) to save for retirement.
- Vests immediately at 100%.
- Provides a variety of investment options through Fidelity, including money markets and global funds.
- Offers 24/7 access to online account info at [401k.com](#).
- Is portable upon separation from the company. To initiate a rollover, or to cash out funds, contact Fidelity at 800.890.4015 or [401k.com](#).



Maximus 401(k) Plan

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YOUR JOURNEY TO RETIREMENT. It’s never too early to start thinking about and planning for your retirement. The Maximus 401(k) Plan helps you build a solid foundation for your financial future.

How do I enroll?

Employees call Fidelity directly at [800.890.4015](tel:800.890.4015) or access online at 401k.com. **You can enroll in a 401(k) and modify your deductions at any time throughout the year.** Changes towards your contributions will be reflected within one to two payroll cycles.

What is the maximum annual contribution I can make?

- IRS annual contribution limit: \$24,000*
- Catch-up contribution limit (over age 50): \$8,000*
- Super catch-up contribution limit (age 60-63): \$12,000*

*The above 2026 contribution maximums are the projected IRS 2026 amounts, but the actual amounts have not been released yet.

What is the company match?

Maximus will match 100% of the first 3% of your eligible compensation and 50% of the next 2% that you contribute. The total maximum match is 4% of your eligible compensation.



Disability plans

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SUPPORT AT EVERY MILE. Disability insurance is an important coverage for financial protection and peace of mind. These plans offer salary continuation if you are absent from work due to a covered illness or disability.

Disability insurance is available to regular full-time employees scheduled to work at least 30 hours per week and begins the first of the month following 6 months of service.

Important: Long-term disability (LTD) coverage is subject to a pre-existing condition clause that may exclude you from becoming eligible for benefits for a period of time, due to a medical condition that you had or for which you received treatment prior to filing a disability claim. Please refer to the plan document at gsanational.com for more information.

Short-term disability (STD)

- The premium is paid by Maximus and pays a weekly benefit.
- The plan pays 70% of your pre-disability weekly earnings (subject to the plan’s maximum weekly benefit of \$1,000).
- 7-day elimination period which may be paid using available paid time off or taken as unpaid leave of absence.
- Maximum duration of 26 weeks.

Long-term disability (LTD)

- The premium is paid by Maximus and pays a monthly benefit.
- Plan pays 50% of your pre-disability monthly earnings (subject to the plan’s maximum monthly benefit of \$2,500).
- Elimination period for LTD is the greater of the STD maximum benefit period or 180 days.
- Up to age 65 if you continue to meet the definition of disability under the plan.
- Pre-existing condition review applies when you have been covered for less than 12 consecutive months from the date of disability.

Pre-existing condition exclusion period

The pre-existing condition exclusion period is a benefit eligibility provision that may exclude you from becoming eligible for benefits for a period of time, due to a medical condition that you had or for which you received treatment prior to filing a disability claim.

A pre-existing condition review will take place when a disability claim is filed before your coverage has been in effect for 12 consecutive months from your benefit eligibility date.

This review will take into consideration any conditions believed to exist three months prior to the effective date of disability coverage. When the review determines that the disability is a result of a pre-existing condition, benefits will not be paid.

For further information on what is considered a pre-existing condition or how it applies to disability coverage, please review the plan document or call MetLife.

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Critical illness insurance

In the event that you or a covered family member has a verified diagnosis, you receive a lump-sum benefit paid directly to you by MetLife. Payment(s) that you receive will be made in addition to any other insurance you may have, and may be spent as you see fit. They can be used to help pay for medical plan deductibles and copays, for out-of-network stays, for your family’s everyday living expenses, or for whatever else you need while recovering. **The benefit maximum has increased from 500% to unlimited, giving you expanded coverage when you need it most. The recurrence separation period and treatment-free period for cancers and tumors have both been reduced from 180 days to 30 days—meaning you can access benefits faster if a condition returns.**

Hospital indemnity insurance

This coverage provides you with a payment when you are admitted or confined to a hospital due to a covered accident or illness. Typically, a flat amount is paid for admission and a daily amount is paid for each day of a hospital stay. It also pays extra benefits for admission to, or confinement in, an intensive care unit and for other benefits and services. Payments are made directly to you to use as you see fit. **Hospital and Intensive Care Unit (ICU) stay durations have increased from 31 days to 365 days, giving you extended coverage for longer hospitalizations and intensive care stays.**

Accident insurance

This coverage provides you with payment for any care related to a covered accident. This care may include diagnostic testing, medical treatment, and hospitalization. Payments are made directly to you to use as you see fit. **Reimbursements have increased across key services—now providing \$1,500 for hospital admission, \$300 for confinement, \$150 for emergency room visits, and \$100 for urgent care, physician office, or follow-up visits.**



Enroll for these benefits* on the [Maximus Benefits Center](#) at any time of the year. Learn more at [metlife.com/mybenefits](https://www.metlife.com/mybenefits).

*Critical illness insurance is subject to proof of insurability if you enroll outside of initial eligibility period.

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Enhanced basic term life and accidental death & dismemberment (AD&D) coverage

Maximus provides all eligible employees with basic term life and basic term AD&D coverage at no cost to you in the amount of 1x your annual salary (up to a maximum of \$350,000) for each coverage. Benefits end upon termination or retirement.

Voluntary life and enhanced AD&D insurance

For many employees, the basic life coverage will help provide financial support for elected beneficiaries but may not be enough to cover all of your expenses after you pass away. For that reason, Maximus offers voluntary life insurance coverages.

- **Coverage for you:** You can request voluntary coverage in \$10,000 increments up to 8x your salary rounded to the next higher \$10,000 or \$1,000,000, whichever is less. You will need to provide evidence of insurability if you want to elect more than your salary rounded to the next higher \$10,000 or \$200,000, during your initial enrollment (this is called a Guaranteed Issue amount).
- **Coverage for your spouse/domestic partner:** You can request voluntary coverage for your spouse or domestic partner in increments of \$10,000, up to the lesser of 100% of your supplemental life benefit or \$150,000 of coverage. You will need to provide evidence of insurability if you want to elect more than \$50,000, during your initial enrollment.
- **Coverage for your child(ren):** You can request voluntary coverage for your child(ren) in either a \$10,000 or \$20,000 policy for each child. Children under 6 months of age are eligible for a maximum of \$500. You pay one rate for all covered children. Children are eligible up to the age of 26.

Note

You cannot elect coverage for your spouse or child(ren) if you do not elect coverage for yourself. You also cannot elect more coverage for your spouse than you carry for yourself.

Evidence of insurability (EOI)

Anytime you enroll in coverage or increase your coverage amount outside of the initial enrollment window, EOI will be required. In cases where EOI is required, your new coverage and contributions will not begin until you receive written approval from the insurance company.

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Voluntary accidental death & dismemberment (AD&D) insurance

Accidental death & dismemberment covers you in the event that your death is an accident or if you suffer a covered loss such as loss of limb, paralysis, or loss of sight or hearing due to an accident.

- **Coverage for you:** You can request voluntary coverage in \$10,000 increments up to 5x your salary rounded to the next higher \$10,000 or \$500,000, whichever is less. AD&D coverage does not require evidence of insurability.
- **Coverage for your family:** Your family’s coverage, if elected, is a percentage of your own coverage as outlined below:
 - **Spouse coverage/domestic partner:** 50% of employee coverage
 - **Child(ren) coverage:** 15% of employee coverage
 - **Family coverage:** 40% spouse, 10% child(ren) of employee coverage

Note

You cannot elect coverage for your spouse or child(ren) if you do not elect coverage for yourself. You also cannot elect more coverage for your spouse than you carry for yourself.

Evidence of insurability (EOI)

Anytime you enroll in coverage or increase your coverage amount outside of the initial enrollment window, EOI will be required. In cases where EOI is required, your new coverage and contributions will not begin until you receive written approval from the insurance company.

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EDUCATION THAT MOVES YOU FORWARD. At Maximus, we value your growth and development. We want to support you as you pursue further education, obtain certifications, and contribute to our collective success. One of the ways we do this is through our Tuition Reimbursement program which offers an **annual reimbursement of up to \$5,250.**

Eligibility requirements

Full-time, regular employees with a minimum of one year of service are eligible to apply.

Eligible classes and certifications

Courses or certifications are available to help you advance in your career. You have three programs to chose from:

- **Degree programs:** Courses leading to an associate, bachelor’s, master’s, or PhD degrees from accredited educational institutions.
- **Non-degree-seeking courses:** College level courses from accredited educational institutions related to a Maximus career path, but not taken in pursuit of a degree.
- **Professional certifications:** Relevant professional certifications that will enhance skills and expertise in your current or potential future roles.

Reimbursement requirements

- **Academic performance:** For college courses, you must achieve a passing grade of C or better. For certifications, you must provide proof of passing the certification exam, or attaining the certification.
- **Timely submission:** You must submit the reimbursement requests within 45 days of completing the course or obtaining the certification.

Where to start

- **Talk with your manager:** Have a conversation with your manager about your career development and how this benefit can be a critical component of your future at maximus.
- **Visit the portal:** To learn more and apply for this benefit, visit [maximus.tuition.io](#).
- **Connect with a career counselor:** Schedule a meeting with the Employee Career Development Team to move your career forward on the [Career Development page](#).



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A dependent care reimbursement account is funded by Maximus and allows you to reimburse yourself for eligible day care costs and other qualifying, non-healthcare child or elder care expenses.

To initiate a reimbursement claim or for account information, visit flexfacts.com or call 877.94.FACTS (877.943.2287).



How it works

-  1. Enrollment in this account can take place at any time and must be renewed from year to year.
-  2. Participation requires a minimum Premium Reserve Account balance of \$50, with transfers limited to 50% of the Premium Reserve Account balance.
-  3. Fund transfers take place at the end of each fiscal quarter. If you want to make changes to the quarterly transfers, you must complete it by the last day of the quarter. You must also be actively employed on the last day of the quarter to be eligible for the transfer.



Benefits for better work/life balance

IN THIS SECTION:

[Dependent care reimbursement account](#)

[Legal plan](#)

[Transit/parking commuter benefits](#)

[Auto, home, and renter's insurance discounts](#)

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MetLife legal plan

Maximus has partnered with MetLife to offer assistance with legal matters such as wills and codicils, powers of attorney, protection from domestic violence, deeds, mortgages and notes, document preparation, eviction/tenant problems, small claims, bankruptcy, and adoption/guardianship. The MetLife legal plan now includes four hours of attorney work for non-covered matters not expressly excluded. To use the legal plan, visit [legalplans.com](#) or call MetLife's Client Service Center at 800.821.6400.

Transit/parking commuter benefits

Maximus partners with HealthEquity to give you an opportunity to purchase transit or parking passes at work directly from your paycheck, on a pre-tax basis. This is a great way to make your dollars work harder for you, by reducing your taxable income while paying for commuting expenses. To learn more, visit [healthequity.com/learn/commuter](#) call HealthEquity at 877-924-3967.

Auto, home, and renter's discounts

MetLife/Farmers GroupSelectSM home, auto and renter's coverage is available to eligible employees and offers special savings and a wide range of policies to suit your needs. For more information, call 800.GET.MET8 (800.438.6388) or visit [mybenefits.metlife.com](#) (enter employer: Maximus Services, LLC). You can enroll or cancel coverage at any time during the year.

Pet insurance discount

MetLife pet insurance is available to eligible employees and helps to cover the costs of vet visits, accidents, illness, and more. For more information, call 800.GET.MET8 (800.438.6388) or visit [mybenefits.metlife.com](#) (enter employer: Maximus Services, LLC). You can enroll or cancel coverage at any time during the year.



Benefits for better work/life balance

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Paid time off

Maximus provides paid time off (PTO) to full-time and part-time employees for vacation, personal time, illness or injury, or to care for a family member. PTO is accrued weekly based on a 40-hour work week.

Accrued PTO is paid at your hourly rate during the time your leave is taken. Any unused PTO will carry over into the following year, up to the maximum balance shown below. Annual PTO is based on the calendar year (January 1 – December 31).

Years of service	Annual hours accrued	Annual days accrued	Maximum balance
Less than 1 year	96 hours	12 days	96 hours
1 year	120 hours	15 days	120 hours
2 to 7 years	160 hours	20 days	160 hours
8+ years	200 hours	25 days	200 hours

If you transfer between SCA-covered and Non-SCA positions, you can carry over your PTO balance up to the applicable maximum balance. SCA employees may be eligible for PTO payout upon separating with Maximus for any unused hours. For further details, please refer to the paid time off policy available on the [My Maximus Policies and Procedures page](#).

Holidays

We realize the importance of having a good work/life balance. Each year, employees receive paid company holidays listed in the Employee Handbook. Please note that if you work at a project site, then your holiday schedule may vary slightly. All full-time and part-time SCA employees are eligible for holiday time off immediately upon hire. Check with your supervisor or local human resources representative for the holiday schedule for your project.



Maximus Foundation

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- [Maximus Foundation](#)
- [Employee Assistance Fund \(EAF\)](#)

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BENEFITING OUR COMMUNITIES. Maximus Foundation

IN THIS SECTION:

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Giving back with purpose, partnership, and care

Since 1975, Maximus has been committed to improving lives through health and human services. The Maximus Foundation, established in 2000 as our colleague-led 501(c)(3) nonprofit, extends that impact by supporting community-based organizations across the U.S.

As the philanthropic arm of Maximus, the Foundation brings our values to life: respect, accountability, compassion, collaboration, customer focus, and innovation. We fund nonprofits that are building stronger communities, advancing health access, and supporting individuals and families.

Our mission is to promote community-led change through strategic partnerships that drive meaningful impact. We are guided by a vision of a world transformed by collaboration, where nonprofits and communities thrive together.

Led by employees, rooted in care

The Foundation is powered by Maximus employees and contingent staff who nominate and vote for nonprofit partners. Recent changes introduced Impact Grants for food access and Community Choice Grants for broader community needs. All staff can now participate, reinforcing our commitment to shared leadership and community-driven change.

Double your impact, amplify your voice

Maximus matches 100% of every dollar you donate to the Foundation’s grantmaking program to award eligible nonprofits. While donations are not required to participate, every contribution helps us support more organizations and deepen our collective impact.

Your voice matters. All Maximus employees and contingent staff are invited to nominate and vote for future grantee partners. By participating, you help elevate organizations that tackle root causes and build lasting change in the communities where we live and work. Visit maximus.com/foundation to learn more, donate, or get involved.



BETTER TOGETHER. Employee Assistance Fund (EAF)

IN THIS SECTION:

[Maximus Foundation](#)

[Employee Assistance Fund \(EAF\)](#)

Supporting employees through crisis and hardship

The Employee Assistance Fund (EAF) is a shared fund supported by Maximus and our U.S. colleagues to help employees facing financial hardship due to a personal crisis or disaster. Whether it’s an unexpected emergency, a climate-related event, or another hardship, the EAF offers confidential financial relief when support is needed most.

Maximus partners with America’s Charities to manage the application process and ensure impartial, confidential review. All funding decisions are made by America’s Charities to protect employee privacy and ensure fairness.

To apply or donate, visit maximus.com/EAF
Need help with your application? Email maximus@charities.org
General questions? Email maximuscharitablefoundation@maximus.com



Contacts

Benefit	Contact	Website	Group number
GSA National	800.250.2741	gsanational.com	N/A
Anthem Medical	833.371.1223	anthem.com	201080
Kaiser Medical (Northern California)	800.390.3510	kp.org	32230
Kaiser Medical (Southern California)			105475
Kaiser Medical (Hawaii)			18113
HealthEquity HSA	866.346.5800	my.healthequity.com	N/A
HealthEquity HRA, FSA, and Commuter	877.924.3967		
Flex Facts Dependent Care Reimbursement Account	877.943.2287	flexfacts.com	N/A
Express Scripts (ESI) Prescription Drugs	800.224.5513	express-scripts.com	KK8A
Delta Dental	800.237.6060	deltadentalva.com	2500879
VSP Vision	800.877.7195	vsp.com	12098598
GSA Retirement Plan	800.890.4015	401k.com	Use your SSN
Fidelity 401(k) Retirement Plan	800.890.4015	401k.com	Use your SSN
MetLife Disability	866.729.9201	metlife.com	Use your SSN
MetLife Life Insurance	800.638.6420	metlife.com	Use your SSN
MetLife Critical Illness, Group Accident, Hospital Indemnity	Information: 800.GET.MET8 Claims: 866.626.3705	metlife.com/mybenefits	N/A
MetLife Legal Plan	800.821.6400	legalplans.com	N/A
MetLife Auto, Home, Pet Insurance	800.GET.MET8 (800.438.6388)	metlife.com/mybenefits	118608
Maximus Accommodations and Leave Team (MALT)	833.255.6258	Leave request application portal	N/A
Employee Assistance Program (EAP)	855.522.1310	maximus.com/eap Username: maximuseap Password: maximus	N/A
Employee Assistance Fund (EAF)	maximus@charities.org	maximus.com/EAF	N/A
Maximus Foundation	MaximusCharitableFoundation@maximus.com	maximus.com/foundation	N/A

Benefit Terms Glossary

Aggregate deductible: For family coverage, family as the whole deductible or out-of-pocket amounts must be met before copayments or coinsurance are applied for each family member.

Arrears: Unpaid or overdue debts or obligations toward benefits

Beneficiary: The person(s) named by you to receive any benefits provided by a life insurance and/or accidental death & dismemberment (AD&D) plan if you die. Benefits will be paid to the primary beneficiaries unless they have died before or at the same time or are unavailable. In this case, benefits will be paid to the contingent beneficiaries.

Brand-name drug: Drugs are developed and produced exclusively by a single pharmaceutical company. The formula for these drugs is protected by patent for several years before a generic can be developed.

Claim: A formal request submitted by you or your healthcare provider to your health insurer or plan, seeking payment or reimbursement for medical services, treatments, or expenses that are covered under your policy.

Co-insurance: A percentage of a health care cost (for example 20 percent) that the covered employee pays after meeting the deductible.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law that may allow you to keep healthcare coverage after your employment ends temporarily, you lose coverage as a dependent of the covered employee or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Copay/copayment: The fixed dollar amount you pay directly to the medical service provider or pharmacy at the time of service. Copays do not accumulate toward your deductible but are applied to your in-network out-of-pocket maximum.

Deductible: A fixed dollar amount that the covered employee must pay out of pocket each calendar year before the plan will begin reimbursing for non-preventative health expenses. Plans usually require separate limits per person and per family.

Dependent: A person who is eligible for coverage under a policyholder’s health insurance coverage

Embedded deductible: This means each covered family member only needs to satisfy their individual out-of-pocket maximum, not the entire family’s out-of-pocket amounts. This can apply to the deductible and/or out-of-pocket maximum.

Evidence of insurability (EOI): An application process in which information on one’s health or a dependent’s health is provided to be considered for certain types of insurance coverage.

Benefit Terms Glossary

Explanation of benefits (EOB): A statement provided by a health insurer to the plan participant that explains how their claim was paid. The EOB typically includes the date of service, type of service rendered, eligible expense, amount paid by the plan, and the balance to be paid by the plan participant. If applicable, it will also provide any reason(s) the plan did not cover the service or supply.

Flexible spending account (FSA): Funded through pre-tax payroll deductions, an FSA is a costsavings tool that allows you to pay for qualified healthcare-related expenses with pre-tax dollars. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as “use it or lose it.”

Formulary: A list of prescription drugs covered by the health plan that is often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic drug: A prescription drug chemically equivalent to a brand-name drug dispensed under its generic chemical name. Generic drugs are cheaper versions of expensive brand-name drugs with the same active ingredients, strength, and dosage form.

Guaranteed issue: A feature of certain insured benefits that permits you to enroll regardless of health status, age, gender, or other factors that might predict the use of the benefit.

Health reimbursement account (HRA): Unlike HSAs, only an employer may fund an HRA, and the funds revert to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs and may be paired with either high-deductible or traditional health plans.

Health savings account (HSA): A type of savings account that lets you set aside money on a pretax basis to pay for qualified medical expenses. You can reduce your overall healthcare costs by using untaxed dollars in a HSA to pay for deductibles, copayments, coinsurance, and some other expenses. An HSA can be used only if you have a high deductible health plan (HDHP).

High-deductible health plan (HDHP): An HDHP features higher annual deductibles than traditional health plans, such as a preferred provider organization (PPO). Except for preventive care, covered employees must meet the yearly deductible before the plan pays benefits. However, HDHPs may have significantly lower premiums than a PPO, HMO, or another traditional plan. Imputed income: This is the reasonable value of the additional benefit coverage for domestic partners and, under IRS regulations, is treated as taxable income to the employee. Imputed income is separate from and in addition to, your bi-weekly plan cost. For instance, if you include a domestic partner in your coverage (which is not defined as a dependent by the IRS), you will be responsible for paying imputed income tax based on the value of that coverage.

Benefit Terms Glossary

In-network: Doctors, clinics, hospitals, and other providers with whom the health plan agrees to care for its members. Health plans cover a greater, more significant share of the cost for in-network providers than for out-of-network providers.

Maximum out-of-pocket limit: The federal government sets the maximum each individual or family can be required to pay in cost-sharing during the plan year for covered, in-network services. This limit applies to most types of health plans and insurance. It may be higher than the out-of-pocket limits stated for your plan.

Medicaid: A medical benefits plan available for low-income persons, paid by federal and state government but administered by the state.

Medicare: A federal health insurance program for people 65 or older, certain younger people with disabilities, and people with end-stage renal disease.

Non-formulary drug: Any brand-name prescription drug not included in a particular health plan’s list of approved formulary drugs.

Open enrollment period: The yearly period when you can enroll in health insurance plans for yourself and your dependent(s). Outside the Open Enrollment period, you are eligible if you have certain life events, such as getting married, having a baby, or losing other health coverage.

Out-of-network: A health plan will cover treatment for doctors, clinics, hospitals, and other out-of-network providers, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-of-pocket limit: The most an employee could pay during a coverage period (usually one year) for their share of the costs of covered services, including co-payments and co-insurance.

Over-the-counter drugs: Drugs that do not require a prescription. They can be bought at a pharmacy or drugstore and be dispensed to patients while at the hospital or doctor’s office.

Plan year: The 12 months of coverage offered by a plan, like a subscription for your benefits that renews annually. The plan year for care and most other benefits is based on the calendar year (January 1 through December 31).

Pre-existing condition: A medical condition for which the patient has received treatment during a specific period of time prior to enrolling in a new insurance plan.

Preferred brand name drug: These are medications for which generic equivalents are unavailable. They have been in the market for some time and are widely accepted. They cost more than generic drugs but less than non-preferred brand-name drugs.

Preferred provider organization (PPO): An organization of participating providers that have agreed to provide their services at negotiated discount fees in exchange for prompt payment and increased patient volume.

Premium: The amount that must be paid via payroll deductions for insurance coverage.

Prescription drugs: Drugs and medications that by law require a prescription.

Benefit Terms Glossary

Pre-tax deductions: With pre-tax benefits, the benefit-cost is deducted from an employee’s paycheck before income and employment taxes are applied. This lowers the total income amount that is taxed, which reduces the income taxes the employee is responsible for paying.

Preventive services: Routine healthcare, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary care physician: A physician, including a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.), who provides or coordinates a range of healthcare services for patients.

Qualifying life event (QLE): When changes happen in your work or personal life, your benefits may need to change too. If you’re eligible to make changes, you must make the change within 31 days of the date of your qualifying life event (e.g., gain a dependent child through birth, adoption, or legal custody, spouse/partner loses coverage due to loss of job and now needs coverage through you). If you miss the 31-day deadline, you will have to wait until the next open enrollment period.

Retro deductions: Created when there is a benefit plan change, or enrollment and the deduction begin date associated with the plan was in a pay period that has already been confirmed.

Specialist: A doctor not categorized as a general practitioner, family practitioner, pediatrician, internist, or OB/GYN. Examples of a specialist would include a dermatologist or cardiologist.

Specialty drug: A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional or is difficult to dispense. Specialty drugs are the most expensive drugs on a formulary.

Summary of benefits: This outlines what your plan covers, including deductible, copay, and coinsurance amounts. However, it is less detailed than a summary plan description (SPD) or evidence of coverage (EOC).

Vesting: A permanent right of ownership. This means that each employee will vest or own a certain percentage of their account in the plan each year. An employee who is 100% vested in his or her account balance owns 100% of it.

Disclosure notices

Newborn’s and Mother’s 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act Notices

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.
- 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.

Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Maximus 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. Maximus has determined that the prescription drug coverage offered through the company-sponsored Medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 current Maximus coverage will not be affected.

You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at [cms.hhs.gov/CreditableCoverage](https://www.cms.gov/CreditableCoverage)), which outlines the prescription drug plan provisions/options that Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.

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

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

You should also know that if you drop or lose your current coverage with Maximus 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...

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 Maximus changes. You also may request a copy of this notice at any time.

GINA Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual’s current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellbeing programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information, and includes a warning against providing genetic information in any responses.

Notice of Privacy Practices for Maximus Employee Health and Welfare Benefit Plan

EFFECTIVE DATE: APRIL 4, 2025

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You are receiving this Notice of Privacy Practices (“Notice”) because you participate in a Maximus Employee Health and Welfare Benefit Plan. This Notice applies to the Maximus Group Health Plans subject to HIPAA (collectively referred to in this Notice as the “Plan”). For a full and current list of participating health plans to which this Notice applies, please contact the Privacy Officer using the contact information at the end of this Notice. This Notice applies only to the Plan, and does not apply to health information that Maximus creates, receives, uses, discloses, maintains, or requests in its capacity as an employer or plan sponsor in accordance with applicable law and the Plan documents.

Summary

This Notice provides a short summary of some of the key parts of the Notice up front. More specific detail about the information included in the summary follows.

Your Rights

Subject to certain limitations and requirements, you may have the right to:

- Request a copy of your health and claims records
- Request that we correct your health and claims records
- Request communication with you through certain means or locations
- Ask us to limit the information we share
- Get a list of certain disclosures of your information that we have made
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You may have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

Subject to certain requirements, we may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. If you would like to exercise any of the rights discussed, you may contact us using the information at the end of this notice.

Request a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you that may be used to make decisions about you or your benefits. You must submit your request in writing.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Request that we correct health and claims records

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Your request must be submitted in writing and describe the reason(s) for your proposed correction. In certain cases, we may deny your request. For example, we may deny your request if the information you want to amend is accurate and complete or was not created by us. If we deny your request, you have the right to file a statement of disagreement. Your statement of disagreement may be linked with the disputed information.

Request communication with you through certain means or locations

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Your request must be in writing and specify how you’d like us to contact you. It also must state whether the disclosure of all or part of the health information in a manner inconsistent with your instructions could put you in danger. We will accommodate a request for confidential communications that is reasonable and where the disclosure of all or part of your health information could endanger you.

Ask us to limit what we use or share

You can ask us to restrict our uses and disclosures of your health information for treatment, payment, or our operations. You can ask us to limit our disclosures of your health information to family members or friends who are involved in your care or the payment for your care. In most circumstances, we are not required to agree to a requested restriction. If we agree to the restriction, we can stop complying with the restriction upon providing notice to you. Your request must describe the health information you wish to limit, whether you want to limit our use, disclosure, or both, and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse). If we have agreed to a requested restriction, but you are in need of emergency treatment and the restricted health information is needed to provide the emergency treatment, we may disclose such information to a health care provider to provide such treatment to you.

Get a list of certain disclosures of your information that we have made

You can ask for a list (accounting) of certain disclosures we’ve made of your health information for six years prior to the date of your request. We are not required to include information about disclosures made for treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within the same 12-month period. We will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.

Get a copy of this privacy notice

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

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will request documentation or verification that the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your privacy rights by contacting us using the information at the end of this notice.
- You can also file a complaint with the Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, let us know by using the contact information at the end of this Notice, and we will follow your instructions.

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

- Share information with your family, close friends, or others involved in your care or payment for your care
- Share information in a disaster relief situation
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information in certain cases, for example, if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Notice of Privacy Practices for Maximus Employee Health and Welfare Benefit Plan

Our Uses and Disclosures

How do we typically use or share your health information?

In certain circumstances, we are permitted or required to use or disclose your health information without obtaining your authorization. These circumstances include each of the circumstances listed below. This Notice does not describe in detail every permitted use or disclosure that we may make. However, all uses or disclosures of health information without your authorization will fall within one of the categories below. State laws and regulations may impose further limits or requirements on our ability to use or disclose your PHI or certain categories of your PHI. We will follow more stringent state laws and regulations that apply to the Plan.

Help manage the health care treatment you receive

We may use your health information to help manage and coordinate your care and share it with professionals who are treating you.

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

Run our organization

- We may use and disclose your information to run our organization and contact you when necessary, and for certain other health care operations. Health care operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts for insurance benefits; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Plan.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We may use health information about you to develop better services for you, such as responding to a customer service inquiry from you. The Plan also may use and disclose information about your claims to refer you to a disease management program, project future benefit costs, or audit the accuracy of its claims processing functions.

Pay for your health services

We may use and disclose your health information as we pay for your health services and for other payment activities, such as, determining eligibility for coverage and plan benefits, obtaining premiums, facilitating payment for the treatment and services you receive from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans.

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

Administer your plan

We may use and disclose your health information to Maximus as health plan sponsor for plan administration activities. The Plan may also disclose enrollment and disenrollment information to Maximus as plan sponsor and may disclose certain “Summary Health information” for the purpose of obtaining premium bids or modifying or terminating the Plan.

Example: We may provide Maximus with certain statistics to explain the premiums we charge. Additionally, we may disclose your health information to certain individuals at Maximus to handle high-level claims appeals and to assist with the Plan’s HIPAA compliance.

How else can we use or share your health information?

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

Help with public health and safety issues

We may use and share health information about you with public health authorities or certain regulated entities for certain public health and safety situations such as:

- Preventing or controlling disease, injury or disability
- Reporting disease or infection exposure
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence to a government authority that is authorized by law to receive such information
- Preventing or reducing a serious and imminent threat to someone’s health or safety as consistent with applicable laws and if disclosure is necessary to prevent or lessen such threat

Do research

We may use and share your information for research purposes subject to certain requirements, including pursuant to a waiver of authorization by an institutional review board or privacy board, or through the removal of direct identifiers from the research data.

Comply with the law

We will use and share information about you if applicable state or federal laws require it, including with the Secretary of the Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

Organ and tissue donation and procurement organizations, medical examiners, and funeral directors

- We may use and share health information about you with organizations that handle organ, eye or tissue donation, procurement, and transplantation.
- We may use and share health information with a coroner or medical examiner when necessary for identifying a deceased person or determining a cause of death, or with a funeral director as necessary to carry out their duties.

For purposes of workers’ compensation, law enforcement, and other government activities

We may use and share health information about you:

- For workers’ compensation and similar programs
- For law enforcement purposes or with a law enforcement official under certain circumstances, for example in response to a request from law enforcement personnel to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime under certain circumstances; about a death the Plan believes may be the result of criminal conduct; about criminal conduct on our premises; and in response to a court order, subpoena, warrant, summons or similar process permitted by law
- With health oversight agencies for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking information include government agencies that ensure compliance with civil rights laws and that oversee the health care system, government benefit programs, and other government regulatory programs.
- For special government functions such as military, national security, and presidential protective services. For example, under certain conditions, the Plan may use and disclose your health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, the Plan may disclose your health information to the foreign military authority in certain circumstances. The Plan also may use and disclose your health information to authorized federal officials for conducting national security and intelligence activities and for the protection of the President, other authorized persons, or heads of state.

Respond to lawsuits and legal actions

If certain conditions are met, we may use and share health information about you in response to a court or administrative order, or in response to a subpoena.

To correctional institutions

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the correctional institution.

Notice of Privacy Practices for Maximus Employee Health and Welfare Benefit Plan

To individuals involved in your care or payment

In certain circumstances, we may use and disclose to your family member, other relative, or close personal friend, or any other person identified by you, your health information that is directly relevant to such person’s involvement with your health care or payment related to your health care. In addition, we may use or disclose your health information to notify (or assist in the notification of) your family member, personal representative, or another person responsible for your care of your location, general condition, or death. In both cases, when you are present, we will obtain your agreement to the disclosure, provide you with an opportunity to object to the disclosure, or exercise our professional judgment to infer that you do not object to the disclosure. If you are not present, we will disclose your health information only if we determine that such disclosure is in your best interests in the exercise of our professional judgment.

Other Uses and Disclosures

Generally, other uses and disclosures of your health information that are not described above will be made only with your written authorization or that of your legal representative. You may revoke such authorization in writing at any time. However, the revocation will not be effective for information that we have used or disclosed in reliance on the authorization and prior to receiving your written revocation. Most uses and disclosures of psychotherapy notes, and of health information for marketing purposes, or that constitute a sale of health information require your authorization.

Our Responsibilities

- We are required by law to maintain the privacy of your protected health information.
- We will let you know if a breach occurs of your unsecured protected health information, as required under HIPAA.
- We are required to provide you with a copy of this Notice setting forth our legal duties and our privacy practices with respect to your protected health information.

Changes to the Terms of this Notice

We are required to abide by the terms of the current Notice in effect. We reserve the right to change the terms of this Notice, and to make the changes apply to all information we have about you, even information obtained prior to the effective date of the changes. If we revise this Notice, the new Notice will be available upon request and on our web site.

If You Have Questions

If you have any questions about this Notice or its contents, or would like to exercise any of the rights discussed in this Notice, you may reach the Maximus Privacy Officer at:

Phone: 1-833-953-3696
Email: privacy@maximus.com

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

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA - Medicaid
Website: myalhipp.com
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS - Medicaid
Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program Website: 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: healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website: flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA - Medicaid
GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA - Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: in.gov/fssa/hip
Phone: 1-877-438-4479
All other Medicaid
Website: in.gov/medicaid
Phone: 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki)
Medicaid Website: dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS - Medicaid
Website: kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA - Medicaid
Website: medicaid.la.gov or ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid
Enrollment Website: mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS - Medicaid and CHIP
Website: mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - Medicaid
Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI - Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA - Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HSHHIPPProgram@mt.gov

NEBRASKA - Medicaid
Website: ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - Medicaid
Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY - Medicaid and CHIP
Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid
Website: health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA - Medicaid
Website: hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: insureoklahoma.org
Phone: 1-888-365-3742

OREGON - Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid and CHIP
Website: 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: eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA - Medicaid
Website: scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH - Medicaid and CHIP
Medicaid Website: medicaid.utah.gov
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT- Medicaid
Website: dyha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - Medicaid
Website: hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP
Website: dhhr.wv.gov/bms or mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: 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, 2025, 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.

OMB Control Number 1210-0137 (expires 1/31/2026)