EXL



2027
Benefits Guide

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Welcome to EXL's 2027 Benefits Guide!

This benefit plan guide has been designed to help you learn about the choices available to you and to help you make the selections that are best for you and your family.

Please carefully review the enclosed information so you can make the most informed decision for you and your family. If you have further questions, please contact the Human Resources and Talent Development Team.

Be Ready for Enrollment

EXL provides a full range of benefits that address your needs now and in the future.

To Your Health

- Medical & Prescription Insurance
- Dental Insurance
- Vision Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance

To Your Wealth

- Life Insurance
- Short-Term Disability Insurance
- Long-Term Disability Insurance
- Accident Insurance
- Retirement 401(k) Savings Plan

About Enrollment: First Things First

Things You Need To Know Before You Get Started:

Am I Eligible For Benefits?

You're eligible for benefits if you are a full-time employee working at least 30 hours per week.

When Does My Coverage Begin?

- Salary Employees (Exempt): Coverage begins on the first day of hire.
- Hourly Employees (Non-Exempt): Coverage begins on the first day of the month following 30 days of employment.

Do I Have To Enroll?

Yes! It is mandatory to enroll if you want to participate in the health care and/or dependent care flexible spending accounts (FSAs) or contribute to your Health Savings Account (HSA) as these elections do not roll-over. Since your family situation and the benefit coverage and cost can change each year, it is important that you enroll so you can review your options for 2027. New employees will need to register and set up credentials when accessing from home.

- Access Benefit Portal From Work
- Access Benefit Portal From Home

When Can I Enroll?

If you're a current employee, you must enroll during Annual Enrollment. This year, Annual Enrollment for 2027 runs from November 16, 2026 through November 25, 2026. If you're enrolling as a new employee, you must enroll within 30 days from the date you receive your benefit enrollment notice to have coverage for the rest of the current plan year. Also, watch for the next plan year's Annual Enrollment period for the opportunity to enroll or make changes to your benefits for the following plan year.

Annual enrollment is the only time you can enroll unless you experience a qualifying life event change. Contact Benefits if you have any question regarding your enrollment eligibility.

If you are an International Transfer without a Social Security Number at this time, you are still required to make your elections within this 30 day window. If you choose not to enroll at this time, regardless of your immigration status, your next opportunity to enroll or make changes to your benefits will be during the next Annual Enrollment (unless you experience a qualified life event). If you purchased International Travel Insurance it is not guaranteed that your EXL benefit coverage can coordinate with it when it terminates. Please review your offer letter to see when your benefits will begin.

How Do I Pay For My Benefits?

As an extension of your benefit package, EXL does pay a portion of the costs for various elected coverages. The remainder of your premium will be deducted through regular payroll processing, over 24 pay dates per year. Based on your benefit elections, some will be deducted on a pre-tax basis while others will be on a post-tax basis. You can see the amount of your contribution and the employer contribution when you enroll online.

Who Can I Cover?

Dependents eligible for coverage via the benefit plans include:

- Your spouse to whom you are legally married.
- Your or your spouse's married or unmarried child who is under age 26, including a natural child, a stepchild, a legally adopted child, a child placed for adoption, or a child for whom you or your spouse are the legal guardian.
- An unmarried child age 26 or older who becomes disabled and who is dependent upon you.
- A child for whom healthcare coverage is required through a qualified medical child support order, other court order, or administrative order.

Covering Dependents: You will be required to provide proof of eligibility for any new dependent you want to add to your coverage. You'll receive information about eligibility and documentation requirements after you enroll. EXL may conduct a dependent eligibility audit at any time.

Domestic Partner Coverage: Domestic partners are eligible to enroll as a dependent in the benefit plans if you and your partner meet the criteria for domestic partner coverage. In general, employee premium contributions for domestic partners must be deducted from your pay on an after-tax basis (not pre-tax). The premium value of coverage for domestic partners, less the premium amount you pay after-tax, will be shown as taxable benefits on your pay statement.

Dependent Verification Required for Covered Dependents

If you enroll a spouse, domestic partner, or child in medical, dental, vision, or other eligible benefits, you will be required to provide documentation verifying your dependent's eligibility for coverage. Eligible dependents and required documentation are reviewed through the Alight Dependent Verification Services (DVS) portal. Employees will be directed to the verification portal after enrollment and must upload supporting documentation directly through the portal for review.

Documentation requirements vary based on the dependent relationship being verified. Submitted documents should have Social Security numbers and financial information removed or obscured before upload. Documentation uploaded outside of the verification portal cannot be processed. Failure to complete the verification process by the required deadline may result in dependent coverage being denied or terminated.

Can I Make Changes During The Year?

Other than the Annual Enrollment period, the only time you can make changes to your benefits during the plan year is following a qualified status change that impacts the availability and/or need for benefits. Examples of a qualified status change are: marriage, divorce, birth, adoption, or a change in your or your spouse/domestic partner's employment. Make sure you enter your qualifying change through the EXL Benefit Portal within 31 days of your qualifying status change event. If you miss this, you'll have to wait until the next Annual Enrollment period. You will need to provide validating documentation of the Life Event in the Document Manager in the EXL Benefit Portal.

You must enroll in coverage prior to your benefits effective date or you will lose your opportunity to enroll until the next Open Enrollment period or until you experience a qualifying life event. Once you are enrolled, you must wait until the next Open Enrollment period to add or remove coverage for yourself or your dependents unless you experience a qualifying life event as defined by the IRS.

Examples of qualifying life events include but are not limited to the following:

- Birth, legal adoption, or placement for adoption.
- Marriage, divorce, or legal separation.
- Dependent child reaches age 26.
- Spouse gains or loses employment or eligibility with current employer.
- Court-ordered change.
- Death of spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or SCHIP.

The IRS mandates that changes to your coverage due to a qualifying life event must be made within 31 days of that life event. Proof of the qualifying life event is required (marriage certificate, divorce decree, birth certificate, or loss of coverage letter).
NOTE: Any change you make to your coverage must be consistent with the change in status. Due to Affordable Care Act (ACA) reporting, please remember to add your Social Security number and the Social Security numbers of any dependents during enrollment.

Enrolling Is Easy!

How To Get to EXL Benefit Portal?

From your computer, tablet, or smartphone, go to: worklife.alight.com/exl.

The First Time You Visit

For your first visit, click on "Are you a new user?" Then follow the prompts to create your own username and password. If you have previously enrolled in benefits through the EXL benefit portal you will need to use the ID/Password you created to log in.

NOTE: International Transfers that do not have a SSN can still log into the benefit portal. During the verification step you can use the last 4 digits of the Social Security number showing in Dayforce. To view this go to your forms in Dayforce and then Confidential Information (USA) and it will list your National ID Number. Or you can call the customer service team at **1-877-319-8490**. You can still make your elections while you wait to obtain your Social Security Number. Enrollment is not dependent upon you receiving your Social Security Number; do not miss your enrollment window.

3 Simple Steps And You're Done

Don't worry. Enrolling for your benefits is pretty much like other shopping you do online. You'll log in to your account, review what's available to you, then make your choices, confirm them, and check out. You'll be prompted all along the way, and as you choose your benefits, they'll go into your online "shopping cart." You can open the shopping cart at any time to see the benefits you've chosen, as well as their costs. You can modify your choices in the shopping cart at any time before the enrollment window ends.

Make Smart Choices. Use The Tools.

The best way to make smart, confident decisions about your benefits is to take advantage of the online tools that can help you choose.

The tools available to you include:

- **BENEFIT COSTS:** You will be able to view the employee per pay period cost for benefits and the coverage level when you select the various benefit options in the benefit portal.
- **PLAN COMPARISON CHART:** Create a chart that compares key features for your available plans, including costs for specific services.
- **TOOLS TO HELP YOU CHOOSE:** The EXL Service Benefit Portal website is easy to use, and includes tools you can use to help you decide which plan is right for you and your family.
- **CUSTOMER SERVICE:** For assistance with the benefit enrollment portal you can call Customer Service at **1-877-319-8490**. They are available 8am to 8pm EST, Monday through Friday.
- **LIVE CHAT:** From the EXL Benefit Portal, click on the blue chat icon to speak live with a representative.

Medical and Prescription Drug Coverage

You can choose from different medical plan level options with Aetna. All options include prescription drug coverage with CVS. Focus on the features of the plans — there's no "better" or "worse" choice. Each plan has features that may be important to you depending on your health care needs and budget. Under all options, you'll typically save money when you use Aetna's in-network of providers Employees enrolled in EXL's medical plan are covered out of the United States for emergency/urgent care only. The member would pay out-of-pocket for emergency/urgent care treatment and then submit for reimbursement (minus the applicable in-network cost share) after he/she returns to the US.

Compare Medical Plan Features

This table is a summary of medical coverage only. For those employees that are interested in the HRA medical plan, the employer contribution of $500/$1,000 will help to offset your deductible. This money will be used by Aetna to directly pay for your medical claims until the balance is depleted. Any deductibles, copays, and coinsurance percentages shown in the chart are amounts for which you are responsible.

MEDICAL	HEALTH SAVINGS PLAN**		HRA*		PREMIUM (PPO)*	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Annual/Calendar Year Deductible (Non-embedded) (Individual/Family)	$2,000/$4,000 Non-Embedded	$4,000/$8,000 Non-Embedded	$1,500/$3,000 Embedded ***	$3,000/$6,000 Embedded ***	$250/$500 Embedded ***	$500/$1,000 Embedded ***
Employer Funding	N/A		$500/$1,000		N/A	
Coinsurance	30%	50%	20%	40%	20%	40%
Annual Out-of-Pocket Maximum (Includes Deductible) (Individual/Family)	$4,000/$8,000	$8,000/$16,000	$3,500/$7,000	$7,000/$14,000	$3,500/$7,000	$7,000/$14,000
Hospital Inpatient (Per Admission)	30%	50%	20%	40%	20%	40%
Emergency room	30%		20%		$150	
Urgent care	30%	50%	20%	40%	$30	40%
PCP Office Visit	30%	50%	20%	40%	$25	40%
Specialist Office Visit	30%	50%	20%	40%	$40	40%
PRESCRIPTION DRUGS (CVS) - Retail (30-day supply)						
Generic	$10 after deductible**		$10*		$10*	
Brand Formulary	$35 after deductible**		$35*		$35*	
Brand Non-Formulary	$75 after deductible**		$75*		$75*	
PRESCRIPTION DRUGS (CVS) - Mail Order (90-day supply)						
Generic	$20 after deductible**		$20		$20	
Brand Formulary	$70 after deductible**		$70		$70	
Brand Non-Formulary	$150 after deductible**		$150		$150	

NOTE: Coinsurance percentages shown above represent the portion you will pay after the deductible (if applicable) has been met.
** The pharmacy copays apply immediately as the Rx benefits are not integrated with the medical deductible.*
*** Members must meet the medical deductible before the copays will apply.*
**** An Embedded deductible means that if you are enrolled with dependents, no one person will have to pay more than the individual deductible.*

Please note the HRA Employer Funding is prorated based on date of hire according to the following schedule:

DATE	HRA EMPLOYER FUNDING
1/1	$500/$1,000
4/1	$350/$750
7/1 - 9/30	$250/$500
10/1 - 11/30	$125/$250
12/1 -12/31	No Contribution

Benefit Information At Your Fingertips!

To learn more, visit the Resource section in the benefits website. Or you can call customer service at **1-877-319-8490** for assistance.

Dental Coverage

You can choose to enroll in one of the dental plan options. Both plans feature a network of dentists and specialists who have agreed to provide services at a discounted price. You'll pay less by using these network providers.

BENEFIT	CIGNA DENTAL PPO - CORE (In-Network/Out-of-Network)	CIGNA DENTAL PPO - PLUS (In-Network/Out-of-Network)
Annual/Calendar Year Maximum	$1,700 Combined In- and Out-of-Network	$2,250 Combined In and Out-of-Network
Annual/Calendar Year Deductible (Individual/Family)	$50/$150	$50/$150
Preventive Services (No Deductible)	$0; no deductible	$0; no deductible
Basic Services	20%	20%
Major Services	50%	50%
Orthodontia Lifetime Maximum	Not Covered	50%; no deductible; Adult and child coverage $2,000 Lifetime Maximum

NOTE: Out-of-network providers can determine their own charges. If the out-of-network provider charges more than the in-network allowable fee you will be responsible for paying the difference.

NOTE: Cigna Dental does not provide insurance cards. You only need to provide your name and social security number to your provider's office. If you want a copy of your Cigna card, you will need to log into Cigna and then you can print out a card.

Vision Coverage

EXL offers you and your dependents vision coverage through Eyemed. You must enroll to have vision coverage. This information is a summary of vision coverage only, visit www.eyemed.com for more information on the vision plan.

BENEFIT	EYEMED VISION	
	In-Network	Out-of-Network
Exam	$10 copay	Up to $50 reimbursement
Lenses	$15 copay	Up to $50-100 reimbursement
Lenses	Once every 12 months	
Frames	Once every 12 months	
Frames	Up to $170 Allowance; 20% off balance over $150	Up to $119 reimbursement
Conventional/Disposable	Up to $170 Allowance	Up to $147 reimbursement
Medically Necessary	$0 copay; paid in full	Up to $300 reimbursement

Supplemental Health Benefits

Critical Illness Coverage

Medical care for illnesses like cancer and heart disease can be expensive. But that's not everything. It can be financially challenging to provide the support and care beyond medical treatments. Critical Illness Insurance can help provide a financial cushion so you can stay on track financially and focus on your recovery. The Critical Illness benefit is paid in addition to any other medical coverage you may have. It pays a lump sum amount directly to you to use however you choose. Benefits can be used for medical and non-medical purposes. Critical Illness Insurance pays you for a variety of medical conditions including, but not limited to:

- Alzheimer's Disease
- Coma
- Coronary Artery Disease (severe)
- Heart Attack
- Major Organ Failure
- Cancer — Invasive or in situ
- Renal (Kidney) Failure
- Paralysis
- Stroke
- Health Screening Tests (performed as the result of preventive care)

The cost of the benefit will vary depending upon factors such as your age, whether you use tobacco, and the dependent coverage you choose. Child coverage under Critical Illness Insurance is covered at no additional cost. To learn more, visit the Resource section in the benefits website.

*DISCLAIMER: **If you reside in CA, MA, NJ, NY or D.C., in order to be eligible to enroll for Critical Illness insurance, you must be enrolled in a major medical plan.*

Hospital Indemnity

Many people are not financially prepared for an unexpected hospital stay. Hospital Indemnity Insurance can help provide a financial cushion so you can stay on track financially and focus on your recovery. Hospital Indemnity Insurance pays you for a variety of medical services including, but not limited to hospital admissions, daily In-Hospital stays, Intensive Care Unit admission and daily hospital Intensive Care Unit stays. Coverage under Hospital Indemnity Insurance includes a health screening benefit ($50) for tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

It pays a lump sum amount directly to you to use however you choose, like for out-of-pocket medical costs. Benefits can be used for medical and non-medical purposes. You can even use it to help pay for everyday living expenses, like babysitters and take-out food, making recovery a little easier and helping you to safeguard your savings.

To learn more, visit the Resource section in the benefits website.

Group Accident

An accident plan works to complement your medical coverage — paying in addition to what your health plan may or may not cover. It pays a lump sum amount directly to you to use however you choose, like for out-of-pocket medical costs such as deductibles, copays, or non-covered services. Benefits can be used for medical and non-medical purposes. You can even use it to help pay for everyday living expenses, like babysitters and take-out food, making recovery a little easier and helping you to safeguard your savings. Examples of injuries that can be covered, but are not limited to include:

- Fractures
- Broken Tooth
- Concussion
- Laceration
- Burns — 2nd and 3rd Degree

To learn more, visit the Resource section in the benefits website.

Life Insurance

Basic and Optional Life Insurance are benefits that provide a source of income to your beneficiary in the event of your death while employed by EXL. Your coverage includes an Accelerated Benefit Rider which generally pays 90% of your death benefits in advance of death in the event of a terminal illness.

Basic Term Life and Accidental Death & Dismemberment (AD&D)

EXL provides eligible employees with Basic Term Life and AD&D coverage at no cost to you and enrollment is automatic.

- **BASIC TERM LIFE AND AD&D COVERAGE:** Each benefit eligible employee is provided with Basic Life Insurance in an amount equal to 1.5 times your Annual Base Pay to a maximum of $500,000. There is no premium cost to the employee for this coverage. **Basic Life Insurance: At age 65, benefits are reduced to 65%; At age 70 benefits are reduced to 50%.**
- AD&D Insurance provides an additional source of income to your beneficiary in the event of your accidental death while employed by EXL. It also pays a benefit to you in the event you suffer certain severe injuries such as the loss of a limb or vision resulting from an accident.

Imputed Income

It is important for you to know that there is imputed income on any Employer Basic Life Insurance coverage over $50,000. This is required by government tax regulations. This calculated value is added to your income and you must pay taxes on this amount. This is reflected on your earnings statement as Group Term Life. Imputed income is not the cost of the life coverage but is the taxable amount for the value of the coverage over $50,000. The taxable portion varies by individual and is based on age and the total coverage amount. The company provided Basic Life Insurance and AD&D coverage is not a benefit that you can opt-out of the coverage.

Supplemental Life and Accidental Death & Dismemberment (AD&D)

You may also choose to purchase Supplemental Life Insurance coverage up to 5x Annual Base Pay in increments of $10,000 (maximum may not exceed $750,000) in addition to the company-paid benefit. You pay the total cost of this benefit through convenient payroll deduction.

- **SUPPLEMENTAL LIFE INSURANCE:** At age 65, benefits are reduced to 65%; At age 70, benefits are reduced to 50%.



Dependent Life Insurance

Dependent Life Insurance provides financial assistance and peace of mind at the time you least want to think about money — upon the death of your legal spouse or a dependent child. The Spouse Life Insurance benefit covers your legal spouse. The child/children Dependent Life Insurance benefit coverage is from live birth up to age 26 (if unmarried and dependent upon you for support). If both spouses work for EXL, you are not eligible to enroll each other in this benefit. In addition, only one of the spouses may carry the children under the Dependent Life Insurance benefit. You may select any option of coverage; however, the spouse amount can not be greater than 50% of your Employee Life Insurance benefit. Dependent Life Insurance is paid for with after-tax dollars, unlike the other benefits available.

PLAN FEATURES	PLAN BENEFITS
Spouse Life Insurance Options At age 65, benefits are reduced by 65%; benefits are reduced again at 70 or older by 50%.	May elect coverage up to 50% of employee coverage amount in increments of $5,000 (maximum may not exceed $250,000). You must be enrolled in Employee Life Insurance in order to elect this benefit.
Child Life Insurance Options	May elect either $5,000 or $10,000 of coverage. You must be enrolled in Employee Life Insurance in order to elect this benefit.

NOTE: Elected spouse or child amounts may not exceed 50% of total elected employee amount.

Evidence of Insurability

Employees hired within the past 30 days are eligible to enroll in any coverage increment up to $250,000 for yourself and up to $50,000 for your spouse without having to complete an evidence of insurability form. Coverage amounts over the Guarantee Issue will require additional approval. Additionally, any employee enrolling after their initial 30 day enrollment window will require evidence of insurability.

Mental Health Benefit

Get started today!

Website: exl.springhealth.com

Spring Health mobile app

Contact Spring Health

Website: springhealth.com/support

1-855-629-0554

Spring Health

Spring Health is a mental health and wellness benefit available at no cost to EXL medical enrolled employees and dependents. Employees and their dependents can receive up to 6 free therapy sessions every year and 6 free coaching sessions per year. Spring Health also provides the following:

- PERSONALIZED CARE: Take a short online assessment to gett a care plan designed just for you. Based on your immediate needs and long term goals.
- CARE FOR YOUR WHOLE FAMILY: Families need mental health support too. Spring Health offers fast access to providers who specialize in working with couples, families, children, and teenagers.
- DIVERSE PROVIDERS: Find a therapist you can relate to. Search by condition, specialty, gender, race, language, and more.
- WELLNESS EXERCISES: Get on-demand access to a digital library of self-guided exercises designed to improve your mental wellbeing.
- MEDICATION MANAGEMENT: Meet with prescriber's who can manage many of your medications during care as needed.
- COACHING: Connect with a professional coach to help you set and achieve tangible goals, build new skills, and develop healthier habits.
- A WORK/LIFE SERVICE: Access to Work/Life services to match you with financial and legal services when appropriate.

CVS Virtual Visits

A convenient way to access quality care

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit.

CVS Virtual Care is here for:

- **24/7 Care -** Virtually connect quickly and easily with a licensed provider for minor illnesses and injuries.
- **Mental health services -** Talk with a therapist about your anxiety or stress. Or schedule with a psychiatric mental health nurse practitioner (PMHNP) for diagnosis, treatment and medication management.
- **Primary care services -** Book a new patient visit within days with your selected provider.



It's your care, your way

You can access 24/7 care (available to adults and children over 18 months) in minutes through the CVS virtual clinic. Mental health appointments are available within a week.

Get care for things like:

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

All CVS Health virtual visits are covered at 100%—no cost to you—regardless of your health plan or deductible.

Schedule a virtual primary care visit quickly and easily

You get to choose your provider and enjoy flexible appointments that work with your busy lifestyle.

Get started today
Scan the QR code or go to CVS.com/virtual-care to register and schedule an appointment.

Health Savings Account (HSA)

An HSA is a personal healthcare bank account you can use to pay out-of-pocket medical expenses with pretax dollars. If you enroll in a high-deductible health plan, you may be eligible to open an HSA.

You own and administer your HSA. You determine how much you contribute to your account, when to use your money to pay for qualified medical expenses, and when to reimburse yourself. Remember, this is a bank account; you must have money in the account before you can spend it.

HSAs offer you the following advantages:

TAX SAVINGS: You contribute pretax dollars to the HSA. Interest accumulates tax-free, and funds are withdrawn tax-free to pay for medical expenses.

REDUCED OUT-OF-POCKET COSTS: You can use the money in your HSA to pay for eligible medical, dental and vision expenses and prescriptions. The HSA funds you use can help you meet your plan's annual deductible.

A LONG-TERM INVESTMENT THAT STAYS WITH YOU: Unused account dollars are yours to keep even if you retire or leave the company. Also, you can invest your HSA funds, so your available healthcare dollars can grow over time.

THE OPPORTUNITY FOR LONG-TERM SAVINGS: Save unused HSA funds from year to year — you can use this money to reduce future out-of-pocket health expenses. You can even save HSA dollars to use after you retire.

IMPORTANT! How Much You Can Deposit Into An HSA in 2027

These limits apply for participants entering the plan midyear. Prior-year contributions may be made through April 15 of the following year.

IRS LIMITS SUBJECT TO CHANGE	UNDER AGE 55	AGE 55 AND OLDER (AND NOT ENROLLED IN MEDICARE)
Individual	$4,500	$5,500 (includes $1,000 "catch-up" contribution)
Family	$9,000	$10,000 (includes $1,000 "catch-up" contribution)

You are eligible to open and fund an HSA if:

- You are not enrolled in any other non-HSA qualified health insurance plan.
- You are not covered by your spouse's health plan (unless it is a qualified HDHP), flexible spending account (FSA) or health reimbursement arrangement (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, TRICARE or TRICARE For Life.
- Care received through the VA in the preceding three calendar months was dental, vision or preventive care or was provided to a veteran who has a disability rating from the VA.



Flexible Spending Account (FSA)

A great way to plan ahead and save money over the course of a year is to participate in an FSA. An FSA lets you redirect a portion of your salary on a pretax basis into a reimbursement account, saving you money on taxes. Each year that you would like to participate in the FSAs, you must elect the amount you want to contribute.

	2027 ANNUAL CONTRIBUTION LIMITS
Healthcare flexible spending account	$3,500 per household
Dependent care flexible spending account	$7,500 filed jointly / $3,750 filed individually
Limited-purpose flexible spending account	$3,500 per household

EXL offers three types of FSAs that can help you save on a pretax basis for out-of-pocket expenses.

Healthcare Flexible Spending Account

The healthcare FSA can be used to pay for eligible out-of-pocket medical, dental, vision and prescription drug expenses.

Funds in the healthcare FSA are available at the beginning of the plan year and can be used for your expenses and those of your spouse and dependents, even if you and your family aren't covered by our healthcare plan.

Contribute up to your plan's limit in pretax dollars from your paycheck. Your full contribution is available to use at the start of the plan year to pay for eligible health care expenses, such as:

- Copays, coinsurance and deductibles
- Dental and vision expenses
- Prescription medicine and over-the-counter items

Carryover Benefit

The maximum contribution in 2027 for the healthcare flexible spending account is $3,500 per household. This is a use-it-or-lose-it account, meaning any funds remaining in the account following the close of the plan year will be forfeited. All services must be incurred from Jan. 1, 2026, through Dec. 31, 2026. Claims must be submitted by March 31, 2027. Our plan has a carryover feature that allows up to $680 of your unused 2026 funds to be carried forward to 2027 and $700 of your unused 2027 funds to be carried forward to 2028. These carryover dollars can be used for expenses incurred at any point within the new plan year. Any unused amount over the carryover limit will be lost.

Inspira FSAs

Pay yourself back

Pay for eligible expenses with cash, a check or your personal credit card. Then withdraw funds from your FSA to pay yourself back and have your payment deposited.

Pay your provider

You may pay your provider directly from your account.

Pay with your Inspira Card®

When you use it, your expense is automatically paid from your account.

Keep it simple with the Inspira Mobile app

- Manage your account and view alerts.
- Snap a photo of your receipts to submit claims.
- Use our barcode scanner to verify eligible items in-store.

Dependent Care Flexible Spending Account

Dependent care FSAs allow you to set aside money pretax to pay eligible out-of-pocket day care expenses so that you or your spouse can work or attend school full-time. You must contribute money through your payroll deduction to your dependent care FSA before you can spend it.

During open enrollment, you must decide how much to set aside for this account in 2027. You may contribute up to $7,500, or up to $3,750 if you are married and file separate tax returns.

Eligible Expenses

- Adult day care
- Child day care
- After-school care
- Babysitting (work-related, in your home or someone else's home)
- Babysitting by your relative who is not a tax dependent (work-related)
- Nanny or au pair
- Custodial elder care
- Transportation to and from eligible care (provided by your care provider)

Ineligible Expenses

- Babysitting (not work-related, for other purpose)
- Babysitting by your tax dependent (work-related or for other purpose)
- Custodial elder care (not work-related, for other purpose)
- Dance lessons, piano lessons or sports lessons
- Educational, learning or study skills services for child(ren)
- Household services (housekeeper, maid, cook, etc.)

Remember

Changes to your FSA elections can be made only during open enrollment or if you experience a qualifying life event.

Limited-Purpose Flexible Spending Account

If you are enrolled in the HSA plan, you are eligible to enroll in the limited-purpose flexible spending account. IRS rules state that you cannot have both an HSA and healthcare FSA since both apply funds toward your medical expenses. A limited-purpose FSA allows you to continue to contribute to an HSA. A limited-purpose FSA is much like a general healthcare FSA. The main difference is that the limited-purpose account is set up to reimburse only eligible FSA dental and vision expenses. Visit inspirafinancial.com for a current list of eligible expenses, claims filing deadlines and other information about your account. The annual contribution limit for limited-purpose flexible spending accounts is $3,500.

**These are 2027 projected limits. IRS limits subject to change*

Please note EXL performs annual non-discrimination testing on the DCFSA plan per IRS regulations. This ensures that the plan does not disproportionately benefit highly compensated employees over other employees. In the event of non-compliance, contributions may need to be adjusted during the year.

Commuter Benefits

Save on Your Commuting Costs

The EXL Commuter Benefits Program allows you to pay for eligible commuting expenses with pre-tax dollars, helping reduce your taxable income and stretch your paycheck further. You may use pre-tax payroll deductions to pay for eligible:

- Public transportation expenses, including train, subway, bus, and ferry fares
- Qualified parking expenses at or near your workplace or at a location from which you commute by mass transit

How It Works

- Elect a monthly contribution during Annual Enrollment or when first eligible. (bold) The 2027 IRS limits for parking expenses and mass transit expenses is $350 per month.
- Contributions are deducted from your paycheck before taxes.
- Use your commuter account to pay for eligible transit and parking expenses.

**These are 2027 projected limits. IRS limits subject to change*

Disability Insurance

If you are out of work for an extended period of time due to a disabling injury or illness, disability insurance is designed to replace a portion of your income, and help you maintain your lifestyle.

Short-Term Disability (STD)

Short-Term Disability Insurance provides the security of a continuing income in the event you are sick or injured and unable to work for a short period of time. This is provided at no cost.

Benefits Begin	After 7 calendar days
Benefit Amount for All Employees	66.67% of your weekly pay up to a maximum benefit of $3,000 per week
Benefit Duration	25 weeks

Long-Term Disability (LTD)

Long-Term Disability Insurance through Prudential provides the security of a continuing income in the event you are disabled and unable to work for an extended period of time. This is provided at no cost.

Benefits Begin	After 180 days of disability
Benefit Amount for All Employees	60% of your monthly earnings to a maximum of $14,000 per month, taxable income benefit (minimum monthly benefit of $100)
Benefit Duration	Generally benefits can continue until age 65

Long-Term Disability (LTD) is a core benefit for all benefit eligible employees. LTD insurance benefits are payable after 180 days of disability and will continue until age 65, the date upon which you return to work, or die, whichever comes first. In accordance with the provisions of the policy, your benefit payable is offset by any benefit received under a EXL defined benefit pension plan, Social Security, or other statutory benefit program. If your disability is due strictly to a work related injury, Workers' Compensation benefits are an offset to the LTD benefit. Disability benefits are not automatic. All claims are subject to approval by the insurance carrier.



Additional Benefits

Legal Plan

This is a service through LegalEASE that offers a network of attorneys who can help with life's most common personal legal needs. It represents you, your spouse and dependents. Below are some of what the plan has to offer.

- An attorney with expertise specific to your personal legal matter
- Access to a national network of attorneys with exceptional experience that are matched to meet your needs
- In and out-of-network coverage
- Concierge help navigating common individual or family legal issues

To view more details visit https://www.legaleaseplan.com/exlservice for more information.

Identity Theft

LifeLock™ with Norton™ Benefit Plans help provide employees peace of mind with comprehensive all-in-one protection for your identity, personal information and connected devices. Everyday things like online shopping, banking and even browsing can expose personal information and make you vulnerable to cybercriminals and identity theft. LifeLock helps monitor your personal accounts and sends you alerts† if they detect potential threats to your identity. If you should become a victim of identity theft, they will work to resolve it. Norton's multi-layered, advanced security helps protect against existing and emerging malware threats to your devices and helps protect your private and financial information when you go online.

For a low cost, you can get the protection you need for yourself and your eligible dependents. It is more important now, than ever before, to protect your identity.

Identity theft is a very real threat these days. You can learn more about this benefit at 1-800-607-9174.

† No one can prevent all identity theft or cyber crime. We do not monitor all transactions at all businesses.



Employee Assistance Program

Trying to juggle work, kids, family, and life can be challenging. It can be frustrating when you don't know where to go for help, support, or just a listening ear. That's why EXL provides the Employee Assistance Program (EAP) with Guidance Resources. There's no enrollment required — EXL pays the full cost for this program.

Through the EAP, you and eligible members of your household have 24/7 access to confidential counseling to help you address issues such as relationships, drug and alcohol abuse, financial hardship, and general stress or depression. Many issues can be addressed directly with your EAP professional; in some cases, you may be referred to other resources. The EAP is available 24 hours a day, 7 days a week by calling **1-800-311-4327** or visiting www.guidanceresources.com, Web ID GEN311.

Automobile and Homeowners Insurance

Here is an opportunity to obtain competitive quotes for your automobile and/or homeowners coverage from one of the top group automobile and homeowners insurance carriers — Farmers GroupSelect. In many cases group automobile and homeowners insurance is less expensive than buying this insurance the traditional way. To obtain a competitive quote simply call the Toll Free number shown and visit with a Farmers GroupSelect underwriter at **1-800-438-6381**, GPC Code: **DUA**.

Pet Insurance

Nationwide pet insurance offers My Pet Protection which features budget-friendly options to protect your pet.

- Get cash back on eligible vet bills: Choose your reimbursement level of 50% or 70% with an optional $500 wellness benefit
- Available exclusively for employees: Plans with preferred pricing only offered through your company
- Use any vet, anywhere: No networks, no pre-approvals

For more information, visit petinsurance.com/exl

Active & Fit

Stay active and support your well-being with Active&Fit Direct, which provides access to a nationwide network of fitness centers and wellness resources.

Program Highlights

- Access to 11,900+ participating gyms and fitness centers
- Over 9,000 on-demand workout videos available anytime, anywhere
- One-on-one well-being coaching to help support your health goals

Getting Started

- Step 1: Visit the enrollment experience section in the Benefit Portal to access the Active&Fit Direct website
- Step 2: Search for participating fitness centers near you using your ZIP code or city and state.
- Step 3: Choose your preferred gym, create an account, and complete your enrollment.
- Step 4: Download or print your fitness membership card and present it at your selected fitness center.
- Step 5: Begin using your membership and enjoy immediate access to thousands of digital workout videos.
- Step 6: Eligible spouses or domestic partners may be added directly through the Active&Fit Direct member portal.

Eligible Dependents

Medical/RX Plan

An eligible dependent is a person who meets one of the following criteria:

- The Employee's dependent children until attaining age 26, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee's children (or children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the Employee for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan or have prior Creditable Coverage prior to reaching age 26. Certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.

Spouse:

Your opposite-sex or same-sex spouse as determined under applicable state law at the time and location that the marriage was entered into irrespective of the state in which the employee resides.

Dependent:

The spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree. Intellectual disable or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or your employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective. Term ends the month dependent turns 26.

Dental, Voluntary Vision and Voluntary Critical Illness

Spouse Means The Following:

Your opposite-sex or same-sex spouse as determined under applicable state law at the time and location that the marriage was entered into irrespective of the state in which the employee resides.

Child Means The Following:

- Your natural or adopted child or your stepchild; or a child who resides with and is fully supported by you; and who, in each case, is under age 26;
- Your grandchild; a child who is your blood relative; or a child for whom you are the legally appointed guardian; and who, in each case, is under age 26 and is dependent upon you for 50% of their support.



Life, Voluntary Life, Dependent Life, and EAP

Spouse:

Your opposite-sex or same-sex spouse as determined under applicable state law at the time and location that the marriage was entered into irrespective of the state in which the employee resides.

Child:

- Your natural or adopted child
- A child for whom you have legal obligation for purposes of adoption
- A child who is primarily dependent on you for support and lives with you in a permanent parent-child relationship and who is your stepchild, your foster child or a child for whom you are a legal guardian.
- A child who is your stepchild, your foster child or a child for whom you are a legal guardian

Dependent:

- Your lawful spouse
- Your unmarried child from birth to 26 years of age

Does NOT Include:

- A married child
- A spouse or child living outside the United States
- A spouse or child eligible for Employee's Insurance under the group policy
- A spouse or child on active military duty
- A parent of you or your spouse
- A spouse who does not give proof of good health when requested, or when proof is not approved.

Voluntary Critical Accident

Eligible Dependents Are:

- Your legal spouse; and
- Your children

A Child Is A Person Under Age 26 Who Is:

- Your natural or adopted son or daughter, stepson or stepdaughter; or
- A foster child who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

A Spouse Is:

- Your opposite-sex or same-sex spouse as determined under applicable state law at the time and location that the marriage was entered into irrespective of the state in which the employee resides.

Who To Contact?

For general questions about your benefits and enrolling, logon to the EXL Benefits Portal at worklife.alight.com/exl to chat live with a customer service representative. Or, you may call the EXL Benefits Service Center at **1-877-319-8490** to speak with a representative. Call center hours are Monday - Friday, 8 am to 8 pm ET.

BENEFIT	CONTACT	CALL	VISIT/EMAIL
Medical	Aetna — Plan # 847788	1-800-962-6842	aetna.com
Prescription Drug	CVS — Plan # RX3630	1-888-626-1132	caremark.com
Dental	Cigna — Plan # 3339520	1-800-244-6224	cigna.com
Vision	Eyemed — Plan # 1025201	1-866-800-5457	eyemed.com
Life Insurance	Prudential — Plan # 51937	1-800-524-0542	prudential.com/mybenefits
Disability	Prudential — Plan # 51937	1-800-842-1718	prudential.com/mybenefits
Flexible Spending Accounts, HSA and Commuter Benefits	Inspira Financial	1-888-678-8242	inspirafinancial.com
Employee Assistance Program	Guidance Resources — Web ID: GEN311	1-800-311-4327	guidanceresources.com
Mental Health Benefit	Spring Health	1-855-629-0554	springhealth.com/support
401(k)	Fidelity Investments	Customer Service 1-888-503-7526 Investor Guidance 1-800-835-5095	401k.com
Critical Illness	Aflac	1-800-433-3036	aflacgroupinsurance.com
Hospital Indemnity	Aflac	1-800-433-3036	aflacgroupinsurance.com
Group Accident	Prudential	1-844-455-1002	mybenefits.prudential.com
Group Legal	LegalEASE Member Services Team	1-800-248-9000	legaleaseplan.com/exlservice
Auto and Home Insurance	Farmers	1-800-438-6381, GPC Code: **DUA**	myautohome.farmers.com
Pet Insurance	Nationwide	1-877-738-7874	petinsurance.com/exl
Identity Theft	Norton LifeLock	1-800-607-9174	NortonLifeLock.com
Service Center	EXL Benefit Service Center	1-877-319-8490	worklife.alight.com/exl

ABOUT THIS GUIDE: This guide highlights all employee benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary Plan Description (SPD), plan document or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-Deductible Health Plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a Health Savings Account (HSA).

Health Savings Account (HSA)

A Health Savings Account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a High-Deductible Health Plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preventive Care

Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.



EXL Solutions

HEALTH PLAN NOTICES

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6. Women's Health and Cancer Rights Notice
7. Michelle's Law Notice
    - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.
8. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From EXL Solutions About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM EXL SOLUTIONS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with EXL Solutions and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. EXL Solutions has determined that the prescription drug coverage offered by the EXL Solutions Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the EXL Solutions Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the EXL Solutions Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the EXL Solutions Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your EXL Solutions prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 201-748-4700. **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 EXL Solutions changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	October 1, 2026
Name of Entity/Sender:	EXL Solutions
Contact—Position/Office:	Benefits Team
Address:	10 Exchange Place Ste 2200 Jersey City, New Jersey 0732-4934
Phone Number:	201-748-4700

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

EXL SOLUTIONS
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

EXL Service Welfare Benefits Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, EXL Solutions is referred to as Company.

1. **Introduction**: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. **General Rule**: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. **Protected Health Information**: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. **Use and Disclosure for Treatment, Payment and Health Care Operations**: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. **Disclosure for Underwriting Purposes**. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. **Uses and Disclosures Requiring Written Authorization**: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. **Special Rule for Mental Health Information**: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. **Uses and Disclosures for which Authorization or Opportunity to Object is not Required**: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. **Minimum Necessary Standard**: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. **Disclosures of Summary Health Information**: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. **Disclosures of Enrollment Information**: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. **Disclosure to the Department of Health and Human Services**: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. **Disclosures to Family Members, other Relations and Close Personal Friends**: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if

he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might choose to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. **Appointment of a Personal Representative**: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. **Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information**: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. **Individual Right to Request Alternative Communications**: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. **Individual Right to Inspect and Copy Protected Health Information**: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health plan to make decisions about individuals.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. **Individual Right to Amend Protected Health Information**: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. **Right to Receive an Accounting of Protected Health Information Disclosures**: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your

request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. **The Right to Receive a Paper Copy of This Notice Upon Request**: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. **Changes in the Privacy Practice**. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. **Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services**: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 23). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. **Person to Contact at the Group Health Plan for More Information**: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

24. **Substance Use Disorder Treatment:** The group health plan may receive certain substance use disorder (SUD) treatment records that are protected by Federal law under 42 C.F.R. Part 2 ("Part 2"). These records are subject to privacy protections that are more stringent than the HIPAA privacy rules. The group health plan will follow all applicable Part 2 requirements for safeguarding, maintaining, using, and disclosing any SUD treatment information it receives.

If the group health plan receives or maintains SUD information protected by Part 2, the group health plan may not use or disclose Part 2 records unless: (i) the plan has your written consent that meets the requirements of Part 2; (ii) the disclosure is expressly permitted by Part 2 regulations; or (iii) a court issues an order that complies with Part 2. Examples of permitted disclosures include medical emergencies, certain audit or evaluation activities by authorized agencies, or other limited circumstances allowed under Part 2.

Part 2 records generally may not be used or disclosed in any civil, criminal, administrative, or legislative proceeding to which you are a party unless you provide written consent in accordance with requirements of Part 2; or a court orders the disclosure after following the procedures required under Part 2.

The group health plan will not disclose any Part 2 records for fundraising purposes unless you are first provided with a clear and conspicuous opportunity to opt out of receiving fundraising communications. If Part 2 records are disclosed to another party, federal law may prohibit the recipient from redisclosing that information unless further disclosure is expressly permitted by Part 2.

As applicable, you have the right to: (i) request access to your Part 2 records maintained by the plan; (ii) request restrictions on disclosures, including those permitted under Part 2; and (iii) revoke your consent to disclosures permitted under Part 2, except to the extent we have already relied on it.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

EXL Solutions
Benefits Team
201-748-4700

Effective Date
The effective date of this notice is: October 1, 2026.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

EXL SOLUTIONS EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within ***30*** *days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within ***30*** *days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

EXL Solutions
Benefits Team
201-748-4700

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

EXL Solutions
Benefits Team
10 Exchange Place Ste 2200
Jersey City, New Jersey 0732-4934
201-748-4700

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

EXL Solutions Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 201-748-4700.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from EXL Solutions Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the EXL Solutions Employee Health Care Plan at:

EXL Solutions
Benefits Team
201-748-4700

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

EXL Solutions Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The EXL Solutions Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

PPO	In-Network	Out-of-Network
Individual Deductible	$250	$500
Family Deductible	$500	$1,000
Coinsurance	20%	40%
HRA	In-Network	Out-of-Network
Individual Deductible	$1,500	$3,000
Family Deductible	$3,000	$6,000
Coinsurance	20%	40%

HSA	In-Network	Out-of-Network
Individual Deductible	$2,000	$4,000
Family Deductible	$4,000	$8,000
Coinsurance	30%	50%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

EXL Solutions
Benefits Team
201-748-4700

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

EXL

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

