SHADY SIDE ACADEMY
EMPLOYEE BENEFITS GUIDE
2021

FACULTY & STAFF

Welcome to Open Enrollment

Shady Side Academy strives to offer you and your eligible family members a comprehensive and diverse benefits program. The information contained within this guide is part of Shady Side Academy's 2021 Open Enrollment and aims to answer questions that you may have about the benefits to be offered by Shady Side Academy in the upcoming plan year. Please note: elections made during the open enrollment period will become effective July 1, 2021.

2021-2022 Payroll Deductions

Medical – Highmark BCBS

Enrollment Tier	Per Month Cash Benefit
Single Coverage	$0.00
Employee + Child(ren)	$366.67
Employee + Spouse	$391.67
Employee+ Family	$400.00

Dental - UCCI

Enrollment Tier	Per Month Cash Benefit (12 Months)
Single Coverage	$0.00
Employee + 1	$26.43
Family	$38.41

Vision - VBA

Enrollment Tier	Per Month Cash Benefit (12 Months)
Single Coverage	$0.00
Employee + Family	$7.00

Health Insurance Waivers

Cash Incentive	Per Month Cash Benefit (12 Months)
Employee who waves medical coverage	$200.00

Cash Incentive	Per Month Cash Benefit (12 Months)
Employee who waves dental coverage	$26.43

Medical Benefits

Who is Eligible and When?

You are eligible for Shady Side Academy's medical plan if you are a regular full-time employee or a part–time employee who works 50% of a full-time position. You may also enroll your dependent child(ren) who are under the age of 26 and your legally married spouse.

During open enrollment you can enroll, opt-out or make changes to your medical plan election. You can also make changes to your medical plan election during the plan year if you experience a family status change (a qualifying event).

Medical and RX Benefit You Receive:

New for 2021: Shady Side Academy is offering a medical and prescription drug plan to you and your eligible dependents through Highmark BCBS. This plan is written on Highmark's PPO Blue network platform. Under the PPO Blue network you will have access to Highmark's broadest provider network which includes all participating UPMC providers and facilities, Allegheny Health Network provides and facilities, in addition to other in-network community-based providers and facilities. This plan offers you a benefit in and out of network, however, to obtain the highest level of coverage you should always use in-network providers and facilities for your care whenever possible.

New for 2021: An HRA will no longer be provided with the health plan.

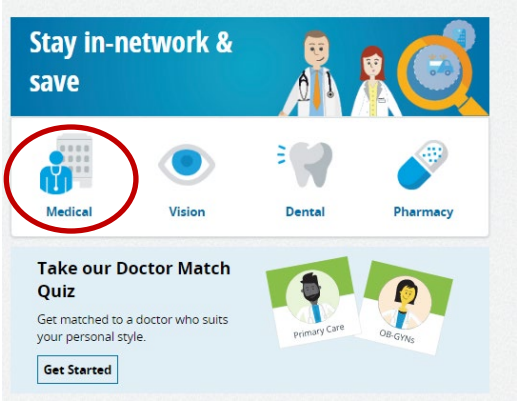
PPO Blue Choice Savings $1,000		
Services	In-Network	Out-of-Network
Deductible -Individual -Family	$1,000 $2,000	$5,000 $10,000
Coinsurance	90% after deductible	60% after deductible
Out-of-Pocket (Limit) -Individual -Family	$1,000 $2,000	$10,000 $20,000
PCP Office Visit	$20 copay	60% after deductible
Specialist Office Visit	$40 copay	60% after deductible
Preventive Care	100% (deductible does not apply)	60% after deductible
Telemedicine	$15 copay	Not covered
Emergency Room Copay	$150 copay	$150 copay
Hospital Services	90% after deductible	60% after deductible
Outpatient Therapies	$30 copay	60% after deductible
X-Ray and Lab Services	90% after deductible	60% after deductible
Prescription Drugs -Generic -Formulary Brand -Non-Formulary Brand	$8 copay $38 copay $76 copay	

Finding a Highmark Provider

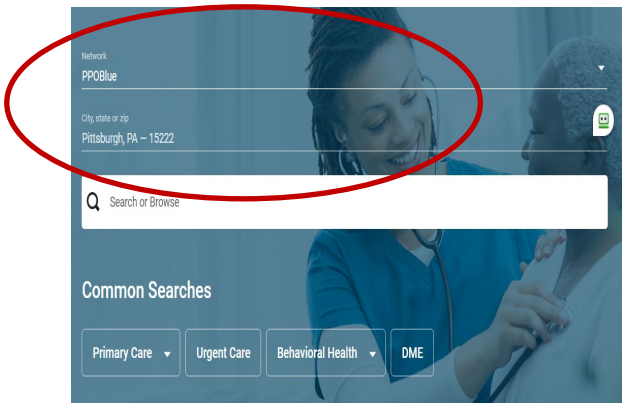
Follow the instructions below to locate a provider or facility participating with Highmark's PPO Blue network.

1. Visit www.highmarkbcbs.com and select find a doctor or pharmacy.

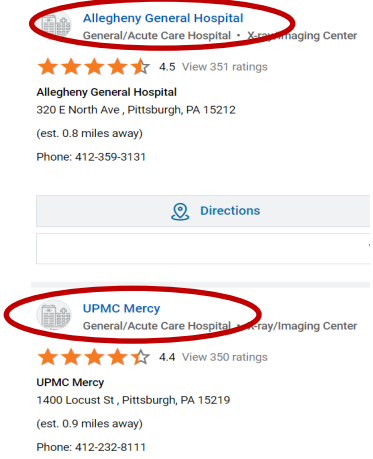
2. Select Medical



3. Under network select PPOBlue, then enter the city, state, or zip code of the area you wish to search within. You will also need to select whether you want to search or browse by a provider name or general category.



4. On the next page your search results will be displayed.



HIGHMARK. PPO Blue

Customized PPO Blue Choice Savings $1,000 90/60 $20/$40 with Rx Benefit Summary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Effective Date	July 1, 2021	
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $1,000 $2,000	 $5,000 $10,000
Plan Pays – payment based on the plan allowance	90% after deductible	60% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copay. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $1,000 $2,000	 $10,000 $20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only)(2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $2,000 $4,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $40 copay	60% after deductible
Virtual Visit Provider Originating Site Fee	90% after deductible	60% after deductible
Urgent Care Center Visits	100% after $50 copay	60% after deductible
Telemedicine Services(3)	100% after $15 copay	Not Covered
Preventive Care(4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 60% after deductible
Adult immunizations	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine	100% (deductible does not apply)	60% after deductible
Mammograms, medically necessary	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 60% after deductible
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services	100% after $150 copay (waived if admitted)	
Ambulance – Emergency	90% after network deductible	
Ambulance – Non-Emergency	90% after deductible	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	60% after deductible
Hospital Outpatient	90% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	90% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $30 copay Limit: 20 visits/benefit period	60% after deductible
Respiratory Therapy	90% after deductible	60% after deductible
Speech Therapy	100% after $30 copay Limit: 20 visits/benefit period	60% after deductible

Benefit	Network	Out-of-Network
Therapy and Rehabilitation Services (cont.)		
Occupational Therapy	100% after $30 copay	60% after deductible
	Limit: 20 visits/benefit period	
Spinal Manipulations	100% after $30 copay	60% after deductible
	Limit: 25 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	60% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	90% after deductible	60% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $20 copay	60% after deductible
Outpatient Substance Abuse Services	100% after $20 copay	60% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder(5)	90% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	90% after deductible	60% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	60% after deductible
Home Health Care	90% after deductible	60% after deductible
	Limit: 90 visits/benefit period	
Hospice	90% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment(6)	90% after deductible	60% after deductible
Private Duty Nursing	90% after deductible	60% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	90% after deductible	60% after deductible
	Limit: 100 days/benefit period	
Transplant Services	90% after deductible	60% after deductible
Precertification/Authorization Requirements(7)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program(8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design. **Select Specialty Drugs are limited to 31-day Supply**	**Retail Drugs (31/60/90-day Supply)** $8/$16/$24 generic copay after deductible $38/$76/$114 formulary brand copay after deductible $76/$152/$228 non-formulary brand copay after deductible **Specialty Drugs (Limited to a 31-day Supply)** $76 specialty copay after deductible **Maintenance Drugs through Mail Order (90-day Supply)** $16 generic copay after deductible $76 formulary brand copay after deductible $152 non-formulary brand copay after deductible **Specialty Drugs (Limited to a 31-day Supply)** $76 specialty copay after deductible	

Dental Benefits

Who is Eligible and When?

All full-time and part-time employees are eligible to receive company paid dental benefits for Individual coverage. Enrolled employees can then purchase dental coverage for their legally-married spouse and dependent children who are under the age of 26.

During open enrollment you can enroll, opt-out or make changes to your dental plan election. You can also make changes to your dental plan election during the plan year if you experience a family status change (a qualifying event).

Dental Benefits You Receive:

Under Shady Side Academy's dental plan through United Concordia, preventative services are covered at 100% when you use an in-network provider and 70% if you use out-of-network provider. Preventative services include but are not limited to: exams, cleanings, x-ray and fluoride treatments.

The plan has a small annual deductible of $50 for an individual and $150 for a family. This deductible applies only to basic and major services. Preventative services are not subject to the deductible.

Basic restorative services are covered at 80% when an in-network provider is used and 50% when an out-of-network provider is used for services. Basic restorative services included but are not limited to: fillings, root canals and periodontal work.

Major restorative services are covered at 50% when an in-network provider is used and 40% when an out-of-network provider is used for services. Major restorative services include but are not limited to: crowns and dentures.

New for 2021 the plans calendar year maximum will be increased from $1,200 to $1,500 per individual covered under the plan for preventive, basic and major services. Coverage for child orthodontia will be added, the benefit will be covered at 50% up to a lifetime maximum of $1,000. This benefit is available for children up to 19 years of age.

Additional details about the plan can be found on United Concordia's website. You will need to log into United Concordia's website at www.unitedconcordia.com and then click on the Members tab to sign into My Dental Benefits. Through the site you have access to your benefits, claims and procedure history if you are already a member. If you are not a member, itis highly recommended that you register on the site. To find a participating dentist in your area,click on "Find a Dentist".

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Dental Benefits Summary for Shady Side Academy

Effective Date: July 1, 2021 **Network: Concordia Advantage**

Benefit Category[1]	CONCORDIA PREFERRED PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services		
Exams	100%	70%
Bitewing X-rays		
All Other X-rays		
Cleanings & Fluoride Treatments		
Sealants		
Palliative Treatment		
Class II – Basic Services		
Space Maintainers	100%	70%
Basic Restorative (Fillings)	80%	50%
Simple Extractions		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Consultations		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	50%	40%
Prosthetics (Bridges, Dentures)		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment	50%	50%
Included Plan Features		
The College Tuition Benefit® – College Savings Program [3]	• Earn Tuition Rewards® points redeemable for tuition discounts • Receive 2,000 at signup, then 2,000 points/year • Each child enrolled receives a one-time bonus of 500 Tuition Rewards points • One Tuition Rewards point = $1 reduction in full tuition • Use Tuition Rewards points at participating private colleges and universities	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Calendar Year Program Deductible (per member/per family)	$50/$150 Excludes Class I	
Calendar Year Program Maximum (per member)	$1,500 Excludes Class I & Orthodontics	
Lifetime Orthodontic Maximum (per dependent)	$1,000	
Reimbursement	**Advantage**	**Inside PA: Advantage Outside of PA: 90th Percentile**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

EEM-0160-0619

Dental plans are administered by United Concordia Companies, Inc., and underwritten by United Concordia Insurance Company. For more information please visit the “Disclaimers” link at www.UnitedConcordia.com. Administrative and claims offices located at 4401 Deer Path Road, Harrisburg, PA 17110 (1-800-332-0366).

These policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your account representative for specific provisions and details of availability.

1. Dependent children covered to age 26.
2. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee (also known as balance billing). United Concordia Dental’s standard exclusions and limitations apply.
3.Tuition Rewards® is a Registered Trademark of and administered by SAGE Scholars, Inc. Participation in the program is contingent upon enrollment with SAGE Scholars, Inc. Tuition Rewards are not an underwritten benefit but a value-added program. Tuition Rewards not available in all jurisdictions (SAGE). SAGE is not a subsidiary or affiliate of United Concordia Insurance Company (UCIC). Subject to eligibility requirements and terms and conditions. Tuition Rewards are a value-added program and not an insured benefit. Program participation subject to enrollment with SAGE. “Points” are credits that may be used to discount the cost of Tuition and have no cash value. UCCI does not provide services related to this program. Tuition Rewards not available in all jurisdictions. Program subject to change without notice.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos de ayuda lingüística gratuita. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。

Vision Benefits

Who is Eligible and When?

All full-time and part time employees are eligible to receive company paid vision benefits for Individual coverage. Enrolled employees can then purchase vision coverage for their legally married spouse and dependent children who are under the age of 26.

During open enrollment you can enroll, opt-out or make changes to your vision plan election. You can also make changes to your vision plan election during the plan year if you experience a family status change (a qualifying event).

Vision Benefits You Receive:

Vision Benefits of America is a managed vision care program. You may select any vision provider for services; however, benefits are paid at a higher reimbursement level if a participating provider is used.

If you choose to use a non-participating provider, a set reimbursement amount is paid toward the cost of eligible services you receive from the provider. You may be responsible for the difference between this amount and the amount billed by the non-participating provider. The reimbursement amounts for a non-participating provider are shown on the Vision Benefits of America summary of benefits.

While a non-participating provider can be used for vision services, it is strongly recommended that you use a participating provider with Vision Benefits of America to maximize your benefits under the plan. You can find a participating provider or check the status of your provider on VBA's website www.visionbenefits.com or call 1-800-432-4966.

Expert Solutions. Exceptional Service.

Shady Side Academy

VBA# 3779
Effective: 7/1/21 – 6/30/23
$0 Exam / $20 Materials Copay

FREQUENCY OF SERVICE: Last Date of Service — **DEPENDENT AGE: 26**

	Employee	Spouse	Children (Up to age 19)
Vision Exam	24 Months	24 Months	12 Months
Lenses	24 Months	24 Months	12 Months
Frames	24 Months	24 Months	24 Months

BENEFITS: Employee can select either:

	VBA Participating Provider Amount Covered/Benefit (Less Copayment)*	Non-Participating Provider Amount Reimbursed (Zero Copayment)
Vision Exam (Glasses or Contacts)	100%	$40
Clear Standard Lenses (Pair):		
Single Vision	100%	$40
Bifocal	100%	$60
Blended Bifocal	100%	$60
Trifocal	100%	$80
Progressives	Partially Covered[A]	$80
Lenticular	100%	$120
Polycarbonate	100%[B]	N/A
Scratch Coat-1 Yr	100%	N/A
Frame	100%[C]	$50
-OR-		
Elective Contacts (in lieu of eyeglass benefits)		
Material Allowance	$110[D]	$110
Fitting Fee	15% off UCR[A]	N/A
-OR-		
Medically Necessary Contacts	100%[E]	$320
Low Vision Aids (Per 24 Months. No Lifetime Max)	$650	$650
-AND-		
Lasik Surgery (once every 8 years)	N/A	$125

A Participation may vary by location. Check with your Provider for details.
B Available In-Network at no charge for children under age 19.
C Up to the program's $50 wholesale allowance.
D The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.
E Requires prior approval. May only be selected in lieu of all other material benefits listed herein.
* A $20 copayment is applied to the total cost of the lenses and/or frames ordered from a VBA Member Doctor only. Copayment does not apply to the routine vision examination or the contact materials.

Limitations

This plan is designed to cover your visual needs rather than cosmetic options.

ADDITIONAL CHARGES

You may incur out-of-pocket charges when selecting any of the following:

- Tinted Lenses
- Photochromic/Polarized Lenses
- Polycarbonate (covered under age 19)
- Hi-index Lenses
- Progressive (available starting at $45)
- The coating of the lens or lenses (except 1 year scratch protection)
- A frame that costs more than the plan allowance
- Rimless Frames
- Anti-Reflective/Backside UV/Optifog

Additionally, costs for contact lenses/services in excess of the plan's scheduled reimbursement allowances are the responsibility of the patient.

NOT COVERED

The contract gives VBA the right to waive any of the plan limitations if, in the opinion of our optometric consultants, it is necessary for the patient's welfare. VBA provides no benefit for professional services or materials connected with the following:

- Orthoptics or vision training
- Non-prescription lenses
- Two pair of glasses in lieu of bifocals
- Medical or surgical treatment of the eyes
- Any eye examination, or corrective eyewear, required by an employer as a condition of employment
- Services or materials provided as a result of any Worker's Compensation Law or similar legislation
- Glasses and contacts during the same eligibility period

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

400 Lydia Street, Suite 300
Carnegie, PA 15106
1-800-432-4966
www.vbaplans.com

Flexible Spending Account (FSA)

Flexible Spending Account Program:

New for 2021 FSA and Dependent Care administration will be moved from UPMC Health Plan to P&A Group. Full-time and eligible part-time employees decide each year whether they want to participate in the spending accounts. The plan year begins on July 1, 2021 and will end on June 30, 2022. Your annual election is locked in for the plan year unless you experience a qualifying event in accordance with IRS code.

Why Participate?

Participants contribute pre-tax money into the accounts via payroll deduction. Employees save taxes when they request reimbursement from the plan for eligible expenses. Your FSA plan also includes a carryover feature. You can carry over up to $550 of unused funds remaining in your Healthcare FSA at the end of the plan year, to be paid or reimbursed on qualified medical expenses incurred during the new plan year.

Soon after enrolling, you will receive your P&A FSA card loaded with your Healthcare FSA annual election amount. Use it to pay at the point of sale for all of your eligible expenses. The amount paid will automatically be deducted from your Healthcare FSA account. Remember to save your receipts. In some instances, you may be asked to submit your receipt to verify eligibility of the expense. With P&A you will also have the ability to submit claims online or through P&A's mobile compatible site at www.padmin.com for reimbursement from the FSA account. You can also register under this site to view your account information and check the status of a claim.

Please see the next page for an FAQ section on how the runout and carryover provisions of the FSA will work during the transition from UPMC Health Plan to P&A.

Spending Account Maximums:

Medical Plan Election Annual Limit: $2,750

Dependent Care Election Annual Limit: $5,000*

*Limit subject to IRC regulations based on tax filing status.

Flexible Spending Account (FSA) FAQ's

Q. What is a carryover for my FSA account?
A. Per IRS regulations your employer has opted to offer a carryover feature of your healthcare FSA account.

Q. How much money can I carryover from the prior year? The IRS states an individual is able to carryover up to $550. If you have more than $550 in your account, only $550 will be available after the run-out period. Due to legislation passed through the Consolidated Appropriations Act you will be able to carryover up to $2,750 from the 2020-2021 plan year into the 2021-2022 plan year. The amount you carryover will not impact how much can elect to put into your FSA for the new plan year.

Q. How long is the run-out period?
A. 90 days following the last day of the current plan year. The run-out period will be administered by UPMC Health Plan FSA, any claims you incurred during the 2020-2021 plan year can be submitted to UPMC for reimbursement through the run-out period.

Q. What is the purpose of the run-out period?
A. The run-out period allows you time after the plan year ends to submit expenses incurred during the plan year for reimbursement.

Q. When will my carryover funds be available in the new plan year?
A. The carryover funds will be available following your run out period. The run-out period is a designated amount of time set by your employer to allow you to submit claims from the previous year for reimbursement. Once the run-out period is complete, your carryover funds will be transferred to your new FSA with P&A Group.

Q. What if I don't want to participate in the FSA for the 2021-2022 plan year, what will happen to my carryover funds?
A. Even if you do not elect to participate in the FSA in the new plan year an account will still be established for you with P&A after the run-out period so that you have access to the carryover funds.

Q. Why do I need to wait until the end of my run out period before I can access my funds?
A. UPMC Health Plan FSA will use your remaining funds to process your claims submitted during your run out period. Once the run-out period is complete and your previous year claims have been paid out with the correct funds, your remaining balance will transfer over to P&A Group.

Q. What if I incur a new eligible expense during the runout period when I don't have access to my carryover funds and I haven't elected the participate in the FSA in the 2021-2022 plan year, can I be reimbursed?
A. Yes, once the run-out period ends an FSA will be established for you with P&A Group using your carryover funds. Once that account is opened you can submit a claim for reimbursement against your carryover funds for an eligible expense you incurred during the run-out period.

Life / AD&D / Optional Life Insurance

Who is Eligible and When?

Every eligible employee is eligible to receive Life and Accidental Death & Dismemberment Insurance. Shady Side Academy pays 100% of premium for Life and Accidental Death & Dismemberment Insurance. Additional Life Insurance can be purchased by employees through payroll deductions.

Benefits You Receive:

New for 2021: Shady Side Academy will now provide employees with a Life and Accidental Death and Dismemberment(AD&D) benefit of 1x salary to a maximum of $350,000.

Optional Life / AD&D Benefits You Can Purchase:

Shady Side Academy gives you the ability to purchase term Life / AD&D coverage on a voluntary basis through MetLife.

New for 2021:
The voluntary life plan will move to a multiple of salary, employees can elect between one and five times their annual salary to a maximum of $500,000. The guarantee issue amount for employees is the lesser or three times annual salary or $100,000.

A spousal benefit of 50% of the employee amount up to $150,000 can be elected and will be offered with a guaranteed issue amount of $50,000.

A dependent benefit of $250 for children under 6 months and a flat $10,000 benefit for children 6 months and older can be elected.

An open enrollment will be offered this year, this allows anyone who previously declined coverage to enroll in the optional life benefit during open enrollment up to the guaranteed issue amount without having to provide medical evidence of insurability.

Beneficiaries:

It is extremely important that the individual that we have on file as your beneficiary is the individual that you intend to receive your Life / AD&D benefit in the event of your passing.

Please contact Human Resources to update your beneficiary today!

Long Term Disability Benefits

Who is Eligible and When?

All full-time employees are eligible to receive Long Term Disability benefits. Shady Side Academy pays 100% of the premium for this benefit.

Long Term Disability:

In the event you are deemed disabled and are unable to continue to work, long-term disability income benefits are provided as a source of income. Long-Term disability benefits are provided for non-work-related disabilities. Long Term Disability benefits are offset by other sources of income, including social security benefits.

New for 2021: The plan will pay 60% of your monthly income to a maximum benefit of $7,000 per month, this is an increase from the current monthly maximum of $3,000. There is an elimination period of 90 days before benefits begin. The maximum duration of Long-Term Disability benefits is determined by your age when the disability began. Please read the important details below regard the pre-existing condition clause that is a part of your long-term disability coverage.

Long Term Disability Pre-Existing Condition Clause:

Shadyside Academy's long-term disability policy contains a pre-existing condition clause. A pre-existing condition is defined as any sickness or injury that an individual receives medical advice or treatment for within 3-months of their coverage taking effect or an increase in benefit being made.

Coverage for a disability related to the sickness or injury for which an individual receives medical advice or is treated during the 3-month look-back period is excluded for a period of 12 months. Disabilities that occur that are unrelated to medical advice or treatment received during the 3-month look-back period will be covered at the full-benefit.

Example:

Employee A earns an annual salary of $85K per year. Employee A is eligible for the maximum benefit of $3,000 per month under Shadyside's current long-term disability plan. Shadyside increases the monthly maximum under their long-term disability plan from $3,000 per month to $7,000 per month on July 1st. Under the new plan Employee A is now eligible for a monthly maximum benefit of $4,250.

Employee A is an insulin dependent diabetic who see their physician regularly for their diabetic condition and was treated within the 3-month period prior to the increase in benefit being made. Shortly after the monthly maximum under the long-term disability plan is put in place (within the first 12 months), Employee A goes out on disability for a condition related to their diabetic condition. Employee A applies for and qualifies for a long-term disability; however, they are only eligible for a maximum benefit of $3,000 per month due to the pre-existing condition clause. Once the 12-month period from the effective date of the change has past, if Employee A goes out on disability for any medical conditions (including their diabetes), he / she will be eligible for their full benefit of $4,250 per month.

It should be noted that if Employee A goes out on disability due to a sickness or injury that is unrelated to their diabetes, regardless of the time period the sickness or injury occurs, the full long-term disability benefit of $4,250 will be paid.

403(b) Retirement Plan

To help you prepare for the future, Shady Side Academy sponsors a 403(b) retirement savings plan as part of its benefits package. There are two options: - Salary Reduction Before Tax contributions or Roth contributions.

1. Salary reduction reduces current income taxes. The money that goes into your plan comes out before federal taxes do. Because your gross salary is reduced by the amount of your contribution, your taxable income is lowered. That means that more goes into your plan than comes out of your paycheck. The money in your account, including any earnings accumulates tax deferred. This may afford your account the opportunity to grow more than if it were subject to taxation.

2. Roth (salary deduction) contribution deductions are made from your gross salary after it has been taxed. You are paying taxes now rather than later.

Who can participate? All employees are eligible to participate except independent contractors. Based on your years of service you may receive an employer matching contribution. You are eligible to receive matching contributions if you have attained age 21 and have 1 year of service.

When can I join? You may join the plan on the first month following your hire date, or at the beginning of any quarter.

How do I contribute to the plan? Through payroll deduction, you can make elective deferrals up to the maximum allowed by law. The annual elective deferral limit for 403(b) plan employees
contributions increased from $19,000 to $19,500 in 2020. Employee's age 50 or older may contributeup to an additional $6,500 for a total of $26,000.

Can I make catch-up contributions to the plan? If you are age 50 or older and make the maximum allowable deferral to the plan, you are entitled to contribute an additional "catch-up contribution." The catch-up contribution is intended to help eligible employees make up for smaller contributions made earlier in their careers. The maximum catch-up contribution is $6,000 for 2019.

Can I stop or change my contributions? You may stop your contributions on a quarterly basis upon written notice to your employer. You may increase or decrease the amount of your contribution on a quarterly basis upon written notice to your employer.

How does my employer contribute to the plan? The plan allows your employer to make contributions based on the following schedule:

Year of Service	Employee Contributions	Employer Contributions
Less than 3 Years	4%	6%
More than 3 Years	4%	7%

The age and service requirement are waived if the employee has established a 403b account with a previous employer.

How do I become "vested"? Vesting refers to "ownership" of a benefit from the plan. You are

always 100% vested in your plan contributions, rollover contributions, and your employer matching contributions.

403(b) Retirement Plan (Cont.)

When can money be withdrawn from my account? Money can be withdrawn from your account in the event of:

- Your attaining age of 59.5
- Death
- Disability
- Termination of employment

May I withdraw money in case of financial hardship? If you have an immediate financial need created by serve hardship and you lack other reasonable resources to meet that need, you may be eligible to receive a hardship withdrawal from your account. A hardship, as defined by the government, can include:

- Buying a principal residence
- Paying for your or dependent's college education
- Paying certain medical expenses
- Preventing eviction from or foreclosure on your principal residence
- Paying for funeral expenses
- Paying for qualified repairs to your principal residence, within tax limits

May I borrow money from my account? The plan is intended to help you put aside money for your retirement. However, your employer has included a feature that lets you borrow money from the plan if you meet one of the hardship requirements below:

- Buying a principal residence
- Paying for your or dependent's college education
- Paying certain medical expenses
- Preventing eviction from or foreclosure on your principal residence
- Paying for funereal expenses
- Paying for qualified repairs to your principal residence, within tax limits

Summary Plan Description:

The above highlights are only a brief overview of the plan's features and are not a legally binding document. A more detailed summary plan description is available upon request. Your employer does not attempt to provide you with tax or investment advice. Please consult with certified professionals for answers to your specific questions.

Sign-Up:

Please see your benefits administrator for an enrollment guide and the available investment options in your plan.

IMPORTANT DISCLOSURES ABOUT OUR PLAN

Rights under the Women's Health and Cancer Rights Act

Under Federal law, group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must provide certain benefits to a participant or beneficiary who is receiving benefits in connection with mastectomy and who elects breast reconstruction.

Specifically, the group health plan and issuer must provide coverage in a manner determined in consultation with the attending physician and the patient, for (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications during all stages of mastectomy, including lymphedemas. This coverage may be subject to annual deductibles and coinsurance provisions, consistent with other benefits under the medical coverage option.

Genetic Information Nondiscrimination Act

The Shady Side Academy Plan is intended to comply with the Genetic Information Nondiscrimination Act of 2009. What that means to you generally is that you will not be asked or required to provide any genetic information in connection with the medical benefits before enrolling in the Plan and your genetic information will not be used for underwriting purposes. It is important that you refer to the insurance booklet for the medical benefits to more fully understand how the Genetic Information Nondiscrimination Act applies to you.

Newborns' & Mothers Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. Our group health plan generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

Summary of Privacy Practices

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by the Company or others in the administration of your claims, and certain rights that you have.

We are committed to protecting your personal health information. We are required by law to (1) make sure that any medical information that identifies you is kept private; (2) provide you with certain rights with respect to your medical information; (3) make certain you are notified of our legal duties and privacy practices; and (4) follow all privacy practices and procedures currently in effect.

In the course of providing health, dental, vision, and flexible spending account benefits we may use and disclose health information about you and your participating dependents without your permission for the administration of these plans and for any other health care operation as allowed or required by law. The Company's employees who are responsible for maintaining eligibility for these benefit programs may not share your information for employment-related purposes. Otherwise, we must obtain your written authorization for any other use and disclosure of your medical information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

You have the right to inspect and copy your protected health information, to request corrections of your medical information, and to obtain an accounting of certain disclosures of your medical information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your protected health information, or that communications about your protected health information be made in different ways or at different locations.

If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the Office for Civil Rights. We will not retaliate against you for making a complaint.

Notice of Special Enrollment Rights

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of a 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, or placement for adoption.

Additionally, if you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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