

SHADY SIDE ACADEMY EMPLOYEE BENEFITS GUIDE 2023



MAINTENANCE 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 2023 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, 2023.

2023-2024 Payroll Deductions

Medical - Highmark BCBS

Enrollment Tier	Employee Cost
Single Coverage	\$0.00
Employee + Child(ren)	\$0.00
Employee + Spouse	\$0.00
Employee+ Family	\$0.00

Dental - UCCI

Enrollment Tier	Employee Cost
Single Coverage	\$0.00
Employee + 1	\$13.24
Family	\$19.21

Vision - VBA

Enrollment Tier	Employee Cost
Single Coverage	\$0.00
Employee + Family	\$3.50

Health Insurance Waivers

Cash Incentive	Per Month Cash Benefit (Semi-Monthly)
Employee who waves medical coverage	\$100.00

Cash Incentive	Per Month Cash Benefit (Semi-Monthly)
Employee who waves dental coverage	\$13.24

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:

Shady Side Academy offers 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.

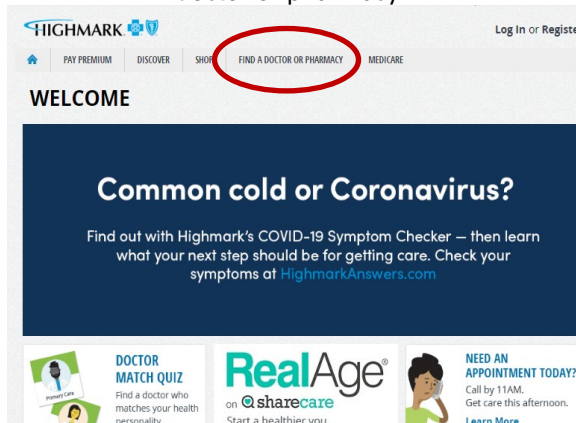
PPO Blue Choice Savings \$1,000		
Services	In-Network	Out-of-Network
Deductible -Individual -Family	\$1,000 \$2,000	\$5,000 \$10,000
Coinsurance	90% after deductible	60% after deductible
Out-of-Pocket (Limit) -Individual -Family	\$1,000 \$2,000	\$10,000 \$20,000
PCP Office Visit	\$20 copay	60% after 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

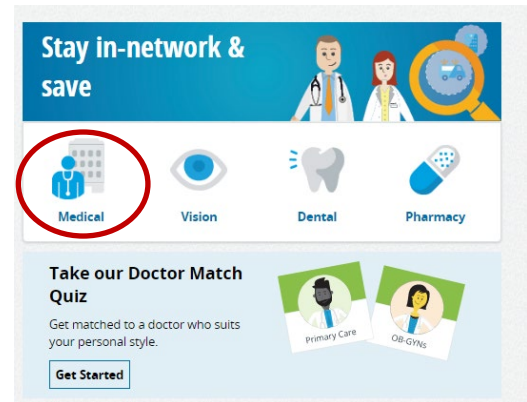


Follow the instructions below to locate a provider or facility participating with Highmark's PPO Blue network.

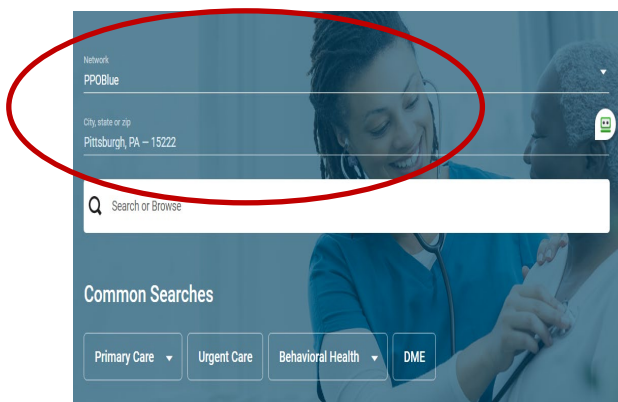
1. Visit www.highmarkbcbs.com and select find a doctor or pharmacy.



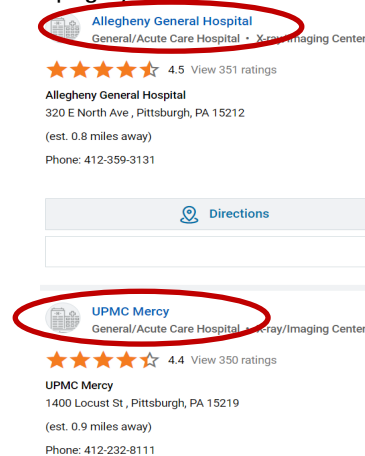
2. Select Medical



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.



Shady Side Academy Summary of Benefits PPO Blue \$1,000

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.

Group(s): 105554-00, -01

Benefit	In Network	Out of Network
General Provisions		
Effective Date	07/01/2023	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$1,000	\$5,000
Family	\$2,000	\$10,000
Plan Pays – payment based on the plan allowance	90% after deductible	60% after deductible
Out-of-Pocket Limit (Includes coinsurance, copays and prescription drug cost sharing. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$1,000	\$10,000
Family	\$2,000	\$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	\$2,000	Not Applicable
Family	\$4,000	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
	Copayment, if any, does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	
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	90% (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 (5)	100% after \$150 copay (waived if admitted)	
Ambulance – Emergency (6)	90% after deductible	90% after in-network deductible
Ambulance - Non-Emergency (6)	90% after deductible	60% after program deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
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	60% after deductible
	limit: 20 visits/benefit period- Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	90% after deductible	60% after deductible
Speech Therapy	100% after \$30 copay	60% after deductible
	limit: 20 visits/benefit period- Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Occupational Therapy	100% after \$30 copay	60% after deductible
	limit: 20 visits/benefit period- Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
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 (7)	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	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	
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 aggregate with visiting nurse	
Hospice	90% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment (8)	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 (9)	Yes	Yes

Prescription Drugs	
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible
Prescription Drug Program (10) 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 Formulary generic copay \$8 / \$16 / \$24 Non-Formulary generic copay \$38 / \$76 / \$114 Formulary brand copay \$76 / \$152 / \$228 Non-Formulary brand copay \$76 Formulary Specialty copay \$76 Non-Formulary Specialty copay Maintenance Drugs through Mail Order (90-day Supply) \$16 Formulary generic copay \$16 Non-Formulary generic copay \$76 Formulary brand copay \$152 Non-Formulary brand copay \$76 Formulary Specialty copay \$76 Non-Formulary Specialty copay

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
- (3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7), must be performed by a Highmark approved telemedicine vendor. Additional services provided by an approved telemedicine vendor are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP office visit benefit, behavioral health is eligible under outpatient mental health).
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
- (6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits
- (7) After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits
- (8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
- (10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield or Highmark Choice Company, which are independent licensees of the Blue Cross Blue Shield Association.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ou de w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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.

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, it is highly recommended that you register on the site. To find a participating dentist in your area, click on "Find a Dentist".

Dental Benefits Summary for Shady Side Academy

Effective Date: July 1, 2023

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	<ul style="list-style-type: none">• 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: 90 th Percentile

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

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).

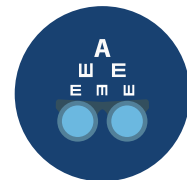
These policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your account representative for specific provisions and details of availability.

- 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.



Effective: 7/1/23 – 6/30/25
\$0 Exam / \$20 Materials Copay
Dependent Age: 26

Frequency Type: Last Date of Service	Employee	Spouse	Children (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 (After Applicable Copay)*	Out-of-Network Max Reimbursement (Zero Copay)
Vision Exam (Glasses or Contacts)	Covered in Full	\$40
Retinal Screening with Exam	Copay not to exceed \$39	N/A
Clear Standard Lenses (Pair):		
Single Vision	Covered in Full	\$40
Bifocal	Covered in Full	\$60
Blended Bifocal	Covered in Full	\$60
Trifocal	Covered in Full	\$80
Progressives	Partially-Covered	\$80
Lenticular	Covered in Full	\$120
Polycarbonate	Covered in Full for Persons Up to Age 19	N/A
Basic Scratch Coating	Covered in Full	N/A
Frame (Wholesale Allowance)	Up to \$50	\$50
-OR-		
Elective Contacts (in lieu of eyeglass benefits)		
Material Allowance	Up to \$110 ^A	\$110
Elective Fitting Fee and Evaluation	15% off UCR	N/A
-OR-		
Medically Necessary Contacts	Covered in Full ^B	\$320
Low Vision Aids (Per 24 Months. No Lifetime Max)	N/A	\$650
-AND-		
Lasik Surgery (once every 8 years)	N/A	\$125

Where an "allowance" is shown above, the Member is responsible for paying any charges in excess of the allowance less any applicable copay.

Benefits and participation may vary by location, including, but not limited to, Costco® Optical, Pearle Vision, LensCrafters®, Target Optical® and Boscov's™ Optical.

A 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.

B Requires prior approval. May only be selected in lieu of all other material benefits listed herein.

* A \$0 copayment is applied to the vision exam and a \$20 copayment is applied to the total cost of the lenses and/or frames ordered from a VBA Member Doctor only. Copayments do not apply to the contact materials.

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 \$29)
- The coating of the lens or lenses (except Basic Scratch Coating)
- A frame that costs more than the plan allowance
- Rimless Frames
- Anti-Reflective

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
- An eye examination, or corrective eyewear, required by an employer as a condition of employment
- Services of materials provided as 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.

Additional Terms and Conditions

Frame allowance is based on wholesale pricing at non-retail locations. Frame allowance, contact lens pricing and policies vary by location. Contact your provider before requesting services.

Benefits may only be used for contact lenses when selected in lieu of eyeglasses (spectacle lenses and frames). If purchased at the same time from a single provider, your plan will cover up to \$110 towards the cost of contact fitting fees and contact lenses. Any provider contact lens charges that exceed this amount shall be the responsibility of the member. Members may be required to pay contact fitting fees out of pocket at some locations.

Benefits and participation may vary by location and where prohibited by state law.

LASIK benefits may be limited to no more than 50% per eye.

Exam copay is not required if benefits are used to purchase contact lenses from a single provider on the same day of the member's exam. Material copays do not apply to contact lenses.

A 15% discount off the provider's usual, customary and reasonable contact lens fitting fee may be available in some locations. Void where prohibited by law.

Benefits may only be used for medically necessary contact lenses when selected in lieu of all other materials.

Additional terms and conditions apply. Contact VBA at 412-881-4900 for more information.

Flexible Spending Account (FSA)



Flexible Spending Account Program:

The FSA and Dependent Care administration are administered by 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, 2023 and will end on June 30, 2024. 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 \$610 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.

Spending Account Maximums:

Medical Plan Election Annual Limit: \$3,050

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?

A. The IRS states an individual is able to carryover up to \$610. If you have more than \$610 in your account, only \$610 will be available after the run-out period.

Q. How long is the run-out period?

A. 90 days following the last day of the current plan year.

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.

Q. Why do I need to wait until the end of my run out period before I can access my funds?

A. P&A Group 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 be available for use in the new plan year up to the maximum carryover amount of \$610.

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:

Shady Side Academy provides employees with a Life and Accidental Death and Dismemberment (AD&D) benefit of 1x salary to a maximum of \$350,000 with a minimum benefit of \$50,000.

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.

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.

The plan will pay 60% of your monthly income to a maximum benefit of \$7,000 per month. There is an elimination period of 180 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.



Employee Assistance Program

LifeSolutions' employee assistance program (EAP) can help you balance work and personal needs to become healthier, happier, and more productive. Our private and confidential resources and support are inclusive of all populations, including older adults, new parents, diverse individuals, LGBTQIA+, veterans, disabled persons, and others.

Our trained professionals can help with:

- Stress, anxiety, or depression.
- Parenting resources.
- Caregiving support.
- Financial and legal worries.
- Overuse of alcohol.
- Grief and loss.
- Work-related challenges.
- Making healthy lifestyle changes.

Our consultation and problem-solving services include:

- Short-term coaching and counseling in person, by telephone, or via video.
- Parenting resources and options for children.
- Support for individuals caring for older loved ones.
- Community referrals and information to address everyday concerns.
- 24/7 phone support for immediate help.
- RxWell, an app that can help you improve your mental and physical health.

You have access to free, 30-minute consultations with a licensed attorney and/or a certified financial adviser. During these consultations, you can address:

- Legal concerns, such as landlord/tenant issues, real estate transactions, bankruptcy, child custody and other family matters, estate planning, immigration issues, and criminal matters.
- Debt management, credit concerns, student loans, mortgages, retirement planning, and financial hardships.

Our interactive website includes thousands of tools to help you and your family address most major life issues. Available resources include:

- Skill Builder courses and articles.
- Wellness, fitness, nutrition, and emotional well-being materials.
- Expert-led webinars on personal development, health topics, and caregiving.
- Financial education tools and legal forms, educational information, and discount offers.

(EAP) services are available to you and members of your household at no cost.

To access the Work-Life section of our website, go to www.lifesolutionsforyou.com, click Login, and enter your company code: **SSA**. Click on the Work-Life Resource Portal under Featured resources. You may also contact 1-800-647-3327 or Lifesolutions@upmc.edu for additional information.

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 to \$20,500 in 2022. Employee's age 50 or older may contribute up to an additional \$6,500 for a total of \$27,000.

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 monet 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 funeral 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

Limited COVID Relief for Certain Benefit Deadlines

The national COVID emergency declared by Presidential proclamation has not ended. As a result, relief that extends the applicable deadline for when a member experiences an event, such as a COBRA qualifying event, receipt of a COBRA election notice, a Special Enrollment Event, or an adverse benefit determination, etc. will continue until the earlier of one year from the original deadline or 60 days after the emergency ends. The extensions available to employees and other qualified beneficiaries apply separately to each deadline and in no event will exceed one year. Please contact Human Resources if you have any questions about how this extension on certain benefit deadlines may apply to you.

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.

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.

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

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 employee 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. 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. 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.

---- Continued on Next page ---

**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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	MINNESOTA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	MISSOURI – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	MONTANA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov
KENTUCKY – Medicaid	NEBRASKA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	NEVADA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	TEXAS – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	VERMONT– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	WASHINGTON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)