Your 2025 Benefits Enrollment Guide

ALLEGHENY COLLEGE

NON GRANDFATHERED EMPLOYEES

HIRED AFTER 9/1/2019

ALLEGHENY COLLEGE

Table of Contents

Welcome to Open Enrollment

Allegheny College is committed to offering a competitive benefits package which provides options for you and your family's long-term, wellness and financial well-being.

For the 2025 plan year, one (1) Medical/Prescription Drug plan, a Health Savings Account (HSA), Flexible Spending Account (FSA) as well as Dental, Vision, Basic Life coverage, Short-Term Disability coverage, Long-Term Disability coverage, and Voluntary Life Insurance will be offered to all full-time eligible employees. The benefit package offering is robust and may be personalized based on your specific and unique needs. Employees and their spouses are encouraged to take active roles in their health and wellness choices. Additionally, now is a good time to be informed consumers who understand how their money is spent each time they seek treatment or care.

Allegheny College pays a large portion of the annual cost of Medical/Prescription Drug premiums for you and your eligible dependents.

Open Enrollment is May 19, 2025 through June 6, 2025!

This is your annual opportunity to review and make changes to your benefit elections for the upcoming plan year, which will be in effect from July 1, 2025, through June 30, 2026. **All Employees** must elect benefits, or waive coverages, and submit enrollment form to Human Resources **by June 6, 2025**.

Human Resources will be available to answer questions and assist you with enrolling in coverage!

Benefits Eligibility

Eligibility

You are eligible for Allegheny College's benefits if you are a regular full-time employee who works more than 33 3/4 hours per week. For medical benefits specifically, you must work 30 hours per week due to ACA regulations. Certain family members may also be eligible if they meet the following criteria:

- They are your legally married spouse or domestic partner.
- They are your dependent child(ren) under the age of 26.

When Coverage Begins

- You must complete the enrollment process within 14 days of your date of hire.
- If you enroll on time, coverage is effective on the first of the month following date of hire.
- If you fail to enroll on time, you will NOT have benefits coverage (except for company- paid benefits).

Choose Carefully!

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualified life event during the year. The following are examples of the most common qualified life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse or child
- You lose coverage under your spouse's plan
- You gain access to state coverage under Medicaid or CHIP

Making Changes

To make changes to your benefit elections, you must contact Human Resources within 31 days of the qualified life event (including newborns). Be prepared to show documentation of the event, such as a marriage license, birth certificate, or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

Spousal Affidavit Form

If you are enrolling a spouse, you **MUST** complete the Spousal Affidavit Form. Please contact Human Resources for more information, or to recieve a copy of the form.

Benefits Terms You Need to Know

Insurance Terms You Should Know:

Contribution	The amount of the premium YOU must pay toward the cost of your insurance. This amount is typically paid on a per pay basis and is deducted pre-tax.
Deduction	The amount of money YOU must pay first before the insurance company begins paying their portion of a claim.
Coinsurance	The percentage of a bill that YOU are responsible for paying once YOU have satisfied your deductible.
Out-of-Pocket Maximum	The total amount that YOU are responsible for paying out of your pocket during the plan year. This amount typically includes the deductible and coinsurance amounts. Once this amount is met, the plan pays 100% of covered services for the remainder of the plan year.

Medical Plan Information

Allegheny College offers you a medical plan with Highmark Blue Cross Blue Shield.

In-Network Benefits	QHDHP PPO Blue $1,750Q Plan
Deductible ***Employee/Family***	$1,750/$3,500
Plan Pays	90% after deductible
Out-of-Pocket (OOP)	$1,500/$3,000
Office Visit Copay	90% after deductible
Specialist Copay / Virtual Visits	90% after deductible
Urgent Care Copay	90% after deductible
Telemedicine	90% after deductible
ER Copay	90% after in-network deductible
Prescription Drug Coverage **Retail Drugs (31/60/90-day Supply)** *Rx copays applied after in-network Medical Deductible is met*	90% after deductible
Maintenance Drugs through Mail Order (90-day Supply)	90% after deductible
Specialty Drugs through Mail Order (90-day Supply)	90% after deductible

*****IMPORTANT***** ***To view a list of participating providers, please view "Find a Provider" instructions on the following page.***

Please note: The costs shown above are for In-Network services only. To view a full list of network benefits for the medical/Rx plan, please view the Benefit Summary located in the Resources Section of this guide.

Medical Plan Information (Continued)

Highmark Member Website:

You can check the status of a claim, view your explanation of benefits, request ID cards, locate providers, review your medical and prescription benefits, check the balance of your HSA, and more on the Highmark member website.

How to register on the Highmark member website:

1. Go to https://www.highmark.com/member/member-guide.
2. Click on **Register**.
3. Enter the numeric portion of your ID number (no letters or spaces).
4. Enter your first and last name, your date of birth, and email address.
5. You will be asked to create a login ID and password.

Finding a Medical Provider:

Our Highmark medical plans have a robust network of medical physicians and facilities. With your coverage, you get access to 96% of hospitals and 95% of doctors across the country. However, it is recommended that you verify your provider's network status prior to a non-emergent medical appointment. For emergency situations, go to the nearest hospital to receive care. When you travel globally, you're covered in 190 countries through the Blue Cross Blue Shield Global Core program. Many Highmark doctors and hospitals have earned Blue Distinction status for their exceptional safety and superior results.

Please follow these steps to determine if your provider is in-network:

To search for in-network providers:

1. Visit https://www.highmark.com/western-pennsylvania/individual-families/doctors-drugs.
2. Select Find a Doctor, Hospital or other Medical Provider, then click Medical and select Continue.
3. Enter your zip code or the zip code you are searching. When searching for providers either in or out-of-state, select theVisit https://www.highmark.com/western-pennsylvania/individual-families/doctors-drugs.
4. Click on the **Let's Get Started** button.
5. On the next page you can either click on the **Get Started** link under the Find a Doctor section or you can click on the **National Network Pharmacy** link under the Find a Pharmacy section.
6. Click on the **Continue** button under "Just Browsing".
7. Enter your zip code or the zip code you are searching. When searching for providers either in or out-of-state, select the **PPO (Blue Access)** option under the network tab.
8. Select an option in **Browse by Category** or type a name or specialty in the search window. PPO Blue option*.
9. Select an option in Browse by Category or type a name or specialty in the search window.

Medical Plan Information (Continued)

Preventive Care is covered at 100%.

Preventive care includes services, such as but not limited to:

- Annual physical and well-woman exam
- Children's check-ups / well-baby exams
- Recommended immunizations (including the flu vaccine) for both children and adults
- A1C Testing
- Colonoscopy / colorectal cancer screenings
- Mammograms
- Smoking deterrents, including prescription drugs
- All FDA-approved contraception

A list of all covered preventative services and any limitations are outlined on each carrier's preventative care schedule.

Our Plan covers Telemedicine.

Telemedicine gives you and your family access to U.S. licensed, board-certified doctors – day or night, 7 days a week. Telemedicine providers can diagnose and treat most non-emergency illnesses and can even prescribe medications when appropriate. Based on the information you share with the doctor; the doctor will diagnose your condition and send a prescription directly to your pharmacy. Common conditions telemedicine is used for includes sore throats, sinus infections, earaches, allergies, and skin irritations.

Highmark offers telemedicine through **Well360 Virtual, powered by Amwell.**

Spring Health by Highmark.

For those enrolled in our medical plan, Highmark's Mental Well-Being powered by Spring Health will offer multiple levels of support including:

- Therapy and coaching
- One-on-one support
- Wellness exercises
- Personalized care
- Medical Management
- 24/7 Crisis Support

Why Spring Health?

Increased Access to Care	Better Outcomes	Reduced Cost
Spring Health provides precision-matched access to licensed clinicians in an average of 3 days or less.	Spring Health enables clinical outcomes that are both 50% better and 50% faster than standard care.	Spring is certified by the Validation Institute as the first and only comprehensive mental health solution to show net savings reducing total medical spend per participant in the first six months of engagement, especially those with costly chronic conditions.

Medical Plan Information (Continued)

2025 Per Pay Medical Coverage Rates

Rates are shown as a per pay rate, and coverage deductions occur on a per pay basis.

QHDHP $1,750 Plan - 2025 Per Pay Employee Medical Coverage Rates				
Salary Band	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$0 - $50,000	$6.53	$17.56	$15.66	$20.21
$50,000 - $75,000	$16.31	$43.91	$39.15	$50.53
Over $75,000	$52.18	$140.53	$125.27	$161.72

Prescription Drug Coverage

Highmark/ Express Scripts will administer the prescription drug benefit portion of your health plan with Allegheny College. Your prescription plan offers two ways to receive your medication(s):

✓ **Retail Network:** Use a Highmark participating retail pharmacy when filling short-term prescriptions for medications such as antibiotics. Highmark's National Plus pharmacy network includes more than 68,000 pharmacies nationwide, including pharmacy chains, leading mass merchants, supermarkets, and independents. To locate or verify that your pharmacy is part of the National Plus network, please follow these steps:

1. Access the Highmark website via https://www.highmark.com/member/bcbs/find-a-pharmacy
2. Click the "National Plus Network Pharmacy" link under Locate your pharmacy.
3. Clicking this link will lead you to the Express Scripts website. Click "Ok" to proceed.
4. Enter the zip code for the pharmacy within your area.

**For a list of retail pharmacy chains in the National Plus network, please see page 33.*

✓ **Mail Service Pharmacy:** Highmark, partnered with Express Scripts, offers Mail Order Pharmacy to fill your long-term prescriptions. Mail service is a cost-effective choice for long-term medications because you can get up to a 90-day supply for less than what you would pay for the same supply at retail. Highmark/Express Scripts will have access to your mail service refill information from your previous vendor. If your prescription does not have any remaining refills, is a controlled substance or a compound medication, you will need to obtain a new prescription. Ask your doctor or prescriber to write a new prescription for up to a 90-day supply, plus refills when appropriate.

- Bring your prescription to a Highmark participating pharmacy location or send your prescription to Express Scripts using the Mail Service Order Form. The Mail Service Order Form will be included in the member welcome packet.
- If your prescription does not have any remaining refills, is a controlled substance, or a compound medication, you will need to obtain a new prescription.
- You may need your provider to submit a prior authorization for certain compound medications.

With Highmark/Express Script's drug formulary, members have access to drugs in all major therapeutic categories. Your drug plan offering is under the Comprehensive formulary. This formulary contains the most extensive list of drugs. Please note that some medications may be considered "non-preferred", "non-formulary" or "not covered" under your new plan and copayments could increase. Members should contact their doctors and ask whether changing to a preferred option is right for you when available. It is up to your doctor to choose the best medicine for you. For more preferred options, look for the Highmark/Express Scripts Comprehensive Formulary Drug List found on the Highmark website at https://client.formularynavigator.com/clients/highmark/commercial.html.

Sempre Health

The Sempre Health program offers manufacturer discounts on your prescriptions. Perks include:

- Discounts on your prescription copays by refilling consistently and on time.
- Monthly refill reminders to help you stay adherent.
- Paying only your standard cost share when you refill your prescriptions on time.

Contact Highmark today for details and to enroll.

Health Savings Account

As a participant in our $1,750 Qualified High Deductible Health Plan (QHDHP), you may enroll in a Health Savings Account (HSA).

What is a Health Savings Account or HSA?
A Health Savings Account (HSA) is a bank account that is established to help pay for current and future medical expenses. The account is funded with pre-tax dollars and can be used to help pay for qualified medical expenses incurred by you, your spouse and your dependent children, even if your dependents are not covered under your medical plan. The money deposited in your HSA is yours to keep, regardless of whether you continue to be enrolled under our medical plan, you change jobs, or you retire. If you do not spend all the money placed in your HSA, the funds will roll over from one year to the next.

For 2025, the IRS HSA contribution limit is $4,300 for single coverage and $8,550 for family coverage. This limit is met using both the employer and employee contributions. All employee contributions will be managed through Paycom and can be changed at any time throughout the year.

Health Savings Account (HSA):

Employees with an annual salary of $40,000 or less are eligible for the below contribution.

Coverage Level	Employer Contribution Per Year
Employee Only	$500
Employee + Dependent(s) / Family	$1,000

How do I enroll in an HSA?

- The HSA set-up process will begin automatically with your plan enrollment through WealthCare Saver. Highmark has partnered with WealthCare Saver to act as the HSA administrator utilizing their innovative healthcare payment platform.
- A welcome kit and debit card will be issued within 2 weeks of enrollment.
- In accordance with the Patriot Act, your name, DOB, SSN, and address are verified to ensure the information supplied from the insurer is accurate.
- You must log into your Highmark Member Portal (https://www.highmark.com/member/member-guide) and accept the terms and conditions of the account.
- ***IMPORTANT:*** **Your Health Savings Account (HSA) cannot be opened until you log into the Highmark portal and accept the account terms and conditions! You cannot receive contributions from our company or add your pre-tax contributions unless your account is opened.**

When filing my taxes, how do I access IRS Form 8889 (HSA contributions & deductions)?
To retrieve IRS Form 8889, you must access your account online via the Highmark member portal website at https://www.highmark.com/member/member-guide. The tax forms are delivered electronically and will not be mailed to your home address.

Flexible Spending Account

A voluntary Flexible Spending Account (FSA) Plan is available through P&A Group. Flexible spending is an excellent way, using pre-tax money, to pay for out-of-pocket medical, dental, and vision expenses, as well as dependent care expenses that you anticipate in the coming year.

The plan offers you a Grace Period. This provision gives you two and a half months after the end of the plan year to incur eligible expenses, as long as you are actively enrolled as of the last day of the plan year. Participants have until September 15, 2026, to incur expenses during the plan year. You have until September 30, 2026 to submit for expenses incurred during the plan year. Unused balances will not rollover. Remember, only contribute money you are confident you will use to pay for qualified expenses during the plan year and Grace Period.

Total annual contribution for health care expenses cannot exceed $3,300 and total annual contribution for dependent care expenses cannot exceed $5,000 if filing a joint income tax return or $2,500 if filing a separate return.

Contribution and rollover limits are subject to change per the IRS.

Members will receive a Benefits Debit Card to pay for eligible services and products. Online personalized claim forms and online claims entry and submission are available at www.padmin.com or by calling P&A Group at 800-688-2611.

If you elect to enroll in the HDHP, and choose to contribute to a health savings account (HSA), there are limitations on your participation in a Flexible Spending Account.

You cannot be enrolled in a Medical FSA and contribute to an HSA.

Please contact your Human Resources representative to discuss.

Dependent Care Flexible Spending Account

A Dependent Care FSA lets you use pretax dollars to pay for eligible expenses related to care for your child, disabled spouse, elderly parent, or other dependent who is physically or mentally incapable of self-care, so you can work; or if you're married, for your spouse to work, or look for work or attend school full time. You can contribute to your Dependent Care FSA via payroll deductions, and funds are reimbursed to you by the FSA Administrator. Paying for your care is simple using your debit card.

Please note: *this is an IRS regulated account and the annual maximum contribution is $5,000.*

How does a dependent care FSA work?

- Money is deducted from your paycheck pretax
- Funds are deposited into your FSA, administered by P&A Group
- Includes care for kids under the age of 13, or adults that you care for and are unable to care for themselves
- You use your debit card to pay for qualified services
- You may also submit receipts to P&A Group, either online or via fax
- Money is reimbursed to you!

Dental Plan

Lincoln Financial Group Dental

Studies have shown that dental health is closely tied to physical health, but many of us don't take care of our teeth like we should. What you may not know is that preventative dental care – those twice-a-year cleanings – is covered at 100%, when an in-network provider is use!

LFG offers an extensive provider network. Remember if you use an in-network dentist you will get the most out of your dental plan.

Summary of Benefits

This is a summary of the dental benefits offered by Allegheny College. Please note, limitation and exclusions apply. Please reference your Lincoln Financial benefit grid for more detailed information.

	Lincoln Financial Advantage Plus Base	Lincoln Financial Advantage Plus Buy Up
Deductible (waived for Preventive Services) ***Employee/Family***	$50/$150	$50/$150
Benefit Period Max (per member)	$1,000	$1,000
Preventive Services	Plan pays 100%	Plan pays 100%
Basic Services	Plan pays 80% after deductible	Plan Pays 80% after deductible
Major Services	Plan Pays 50% after deductible	Plan Pays 50% after deductible
Orthodontics	Not Covered	Plan Pays 50% after deductible Adults & Children
Lifetime Orthodontic Maximum (per person)	Not Applicable	$1,500

NO ID CARDS WILL BE ISSUED FOR DENTAL COVERAGE - SIMPLY INDICATE THAT YOU HAVE COVERAGE THROUGH LINCOLN FINANCIAL AND PROVIDE YOUR SOCIAL SECURITY NUMBER.

Employee Contributions

Allegheny College requires employees to contribute to their cost of their dental coverage. The following chart outlines the cost for dental coverage on a per pay basis.

2025 Per Pay Dental Coverage Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Base Option	$9.10	$18.18	$19.11	$27.28
Buy Up Option	$10.50	$20.99	$25.69	$35.15

Vision Plan

Vision Benefits of America Vision Plan

Through this coverage you're eligible for a free vision preventative exam once a year – take advantage of this and get your eyes checked!

Remember to always use in network eye care providers to get the most out of your coverage!

Benefit	VBA Vision Plan
Eye Examination	$0
Clear Standard Lenses ***Single Vision/Bifocal/Blended Bifocal/ Trifocal/Lenticular/Polycarbonate (persons up to age 19)/Basic Scratch Coating***	$0
Clear Standard Lenses ***Progressive Lenses***	Included/$20 copay/$40 copay
Eyeglass Benefit - Frame Allowance ***Lenses/Oversize Lenses/Scratch-Resistant Coating***	Up to $50
Elective Contact Lens Benefit (in lieu of eyeglasses)	Up to $60
Contact Lens Benefit (in lieu of eyeglasses) ***Contact Lenses Disposable*** ***Contact Lenses Planned Replacement*** ***Contact Lenses Evaluation, Fitting, & Follow-up Care***	Covered in Full Covered in Full 15% discount
Medically Necessary Contact Lenses (with prior approval)	Included

This is a summary of the vision benefits offered by Allegheny College. Limitation and exclusions apply. Please reference your benefit grid for more detailed information.

NO ID CARDS WILL BE ISSUED FOR VISION COVERAGE

PLEASE LOG INTO THE VBA WEBSITE TO PRINT OFF A VISION ID CARD.

Employee Contributions

Allegheny College requires employees to contribute to their cost of their vision coverage. The following chart outlines the cost for vision coverage on a per pay basis.

2025 Per Pay Vision Coverage Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Vision	$3.27	$5.88	$5.88	$7.98

AblePay

What is AblePay Health?

AblePay is a program that can save you money on your out-of-pocket medical expenses (up to 13%) along with helping you if you ever have questions/concerns on a medical bill. AblePay is offered at **NO-COST (no monthly/ annual fees)** to you and it also provides flexible payment terms for your out-of-pocket medical expenses. **One of our employees has already saved over $440 on medical bills through AblePay!**

How do I get started

1. Scan the QR code or click https://enroll.ablepayhealth.com/apply/allegheny25 to enroll.
2. Enter your demographic Information
3. Add your family members that you'll be responsible for (they can have a different insurance plan)
4. Add your default payment term and payment method(s)
5. Receive your AblePay card in the mail and keep with insurance card

Where do I use AblePay?
Sample providers currently accepting AblePay are at the bottom of the page (includes all hospitals and employed doctors in the physician groups). AblePay is also having success in getting discounts for their members at other providers throughout the country – try and use the card everywhere!

How do I use AblePay?
Show your AblePay card along with your insurance card to medical providers. They will process your AblePay card like secondary insurance. After your service is complete and your insurance company processes your claim, your provider will bill AblePay. You will get an email from AblePay notifying you that we received your bill and the amount you owe (after your insurance has paid their portion). You will have 5 days to decide if you would like to change your payment method and terms to one of the options below. If you do nothing, after 5 days the first payment will be pulled from your default payment method based on the term you originally chose.

Savings example:
You have a $1000 medical bill from Meadville Medical Center (sample provider accepting AblePay). You pay AblePay $870, save $130, while the full $1000 goes toward your deductible and is satisfied at the provider! You can tie an FSA or HSA card as a payment method to further stretch those funds! Have an unpaid medical bill? Contact AblePay to see if they can help!

1 Payment	Save 13% with Bank ACH, 10% with credit/debit card
3 Payments	Save 10% with Bank ACH, 7% with credit/debit card
6 Payments	Save 8% with Bank ACH, 5% with credit/debit card
12-24 Payments	Save 0% with Bank ACH and with credit/debit card (no interest)

Any questions? Visit the website (ablepayhealth.com) or call them at (484) 292-4000!

Life & Disability Coverage

Allegheny College provides Basic Group Life, Accidental Death and Dismemberment, Short-Term Disability, and Long-Term Disability to all full-time employees. **This benefit is 100% paid by Allegheny College!**

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.

When choosing a beneficiary, you may enter your own information and list "Self" as a beneficiary. If choosing an international beneficiary, you may enter an international phone number as well as other information as custom fields. **Please note for international beneficiaries:** you would need to have an attorney or someone handing the estate to make sure the insurance was delivered to the correct party.

These benefits are administered by Lincoln Financial Group for Allegheny College. The following table summarizes these benefit for you. Further detail can be found in LFG's certificate of coverage.

Life & Disability Insurance Informational Table		
Basic Group Life Insurance	Employer-paid	1.5 x salary up to $250,000
Accidental Death & Dismemberment (AD&D)	Employer-paid	1.5 x salary up to $250,000
Long-Term Disability	Employer-paid	60% of your pre-disability monthly earnings up to a maximum monthly benefit of $5,000
Short-Term Disability	Employer-paid	100% of your weekly base pay up to a maximum benefit of $1,500 per week

Short-Term Disability Benefits

In the event you are unable to work due to a covered injury or sickness, Allegheny College's short-term disability (STD) plan will provide you with paycheck protection. Short-term disability benefits begin on the 5th consecutive day of the disability. Our short-term disability plan pays 100% of your weekly base pay.

The maximum duration for one period of disability will be paid up to a maximum of 26 weeks. This benefit is provided through Lincoln Financial Group.

Long-Term Disability Benefits

In the event you are unable to continue to work for a period of time longer than 180 days due to your disability, Allegheny College's long-term disability (LTD) plan will provide you with a source of income. Our long-term disability plan pays 60% of your base pay up to a maximum benefit of $5,000 per month.

The maximum duration of long-term disability benefits is determined by your age when the disability begins. There are limitations to mental health, substance abuse, and self-reported conditions under the plan. This benefit is provided through Lincoln Financial Group.

Life & Disability Coverage (Continued)

Voluntary Life

This coverage is voluntary, and 100% employee paid. This benefit is available to you through Lincoln Financial Group.

Eligibility:

- **Class 1:** All active faculty members with at least 1 year benefit eligible contract; excludes faculty members participating in the early retirement incentive program working at least 30 hours per week.
- **Class 2:** All active full-time non-faculty members working at least 9 months per year and working at least 33.75 hours per week.
- **Class 3:** All active faculty members participating in the early retirement incentive program working at least 30 hours per week.

Benefit Amount:

- **Employee:** Choose from a minimum of $10,000 to a maximum of 5X annual salary (up to $500,000) in increments of $10,000. Guarantee Issue Amount is 5X annual salary, up to $100,000.
- **Spouse:** Choose from a minimum of $5,000 to a maximum of $100,000, in $5,000 increments. Guarantee Issue Amount is 100% of Employee's benefit, up to $25,000.
- **Dependent Child(ren):** Benefit of $10,000, with a Guarantee Issue Amount of $10,000.
- **Additional Benefits:** Bereavement Counseling Services, Travel Assistance Services, ID Theft Recovery Services, Legal Assistance, and Employee Assistance Program.

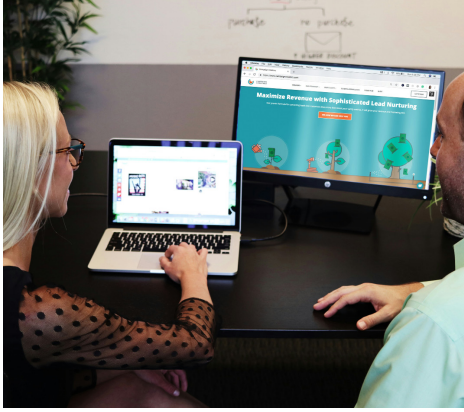
For more information, please contact **Lincoln Financial Group** at 1-877-275-5462 or visit lincolnfinancial.com.

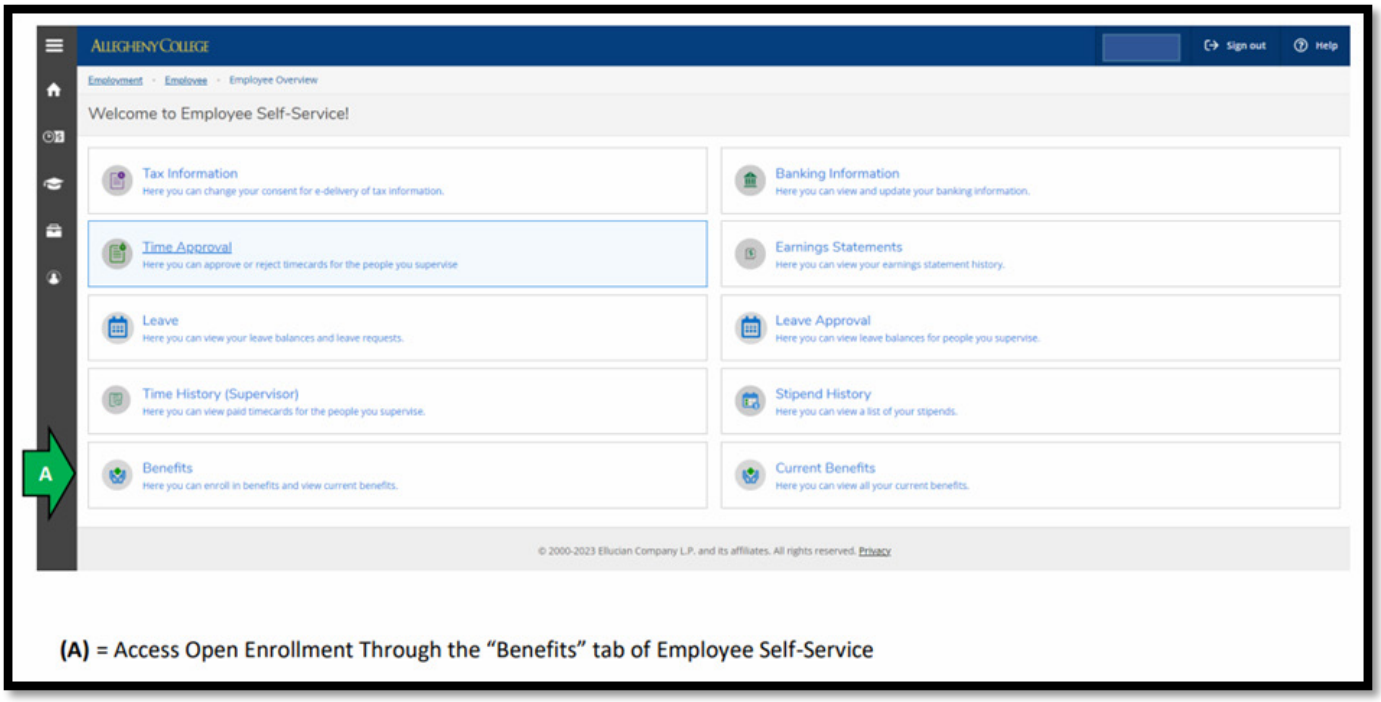
Carrier Contact Information

If you have any questions, please use the following sources:

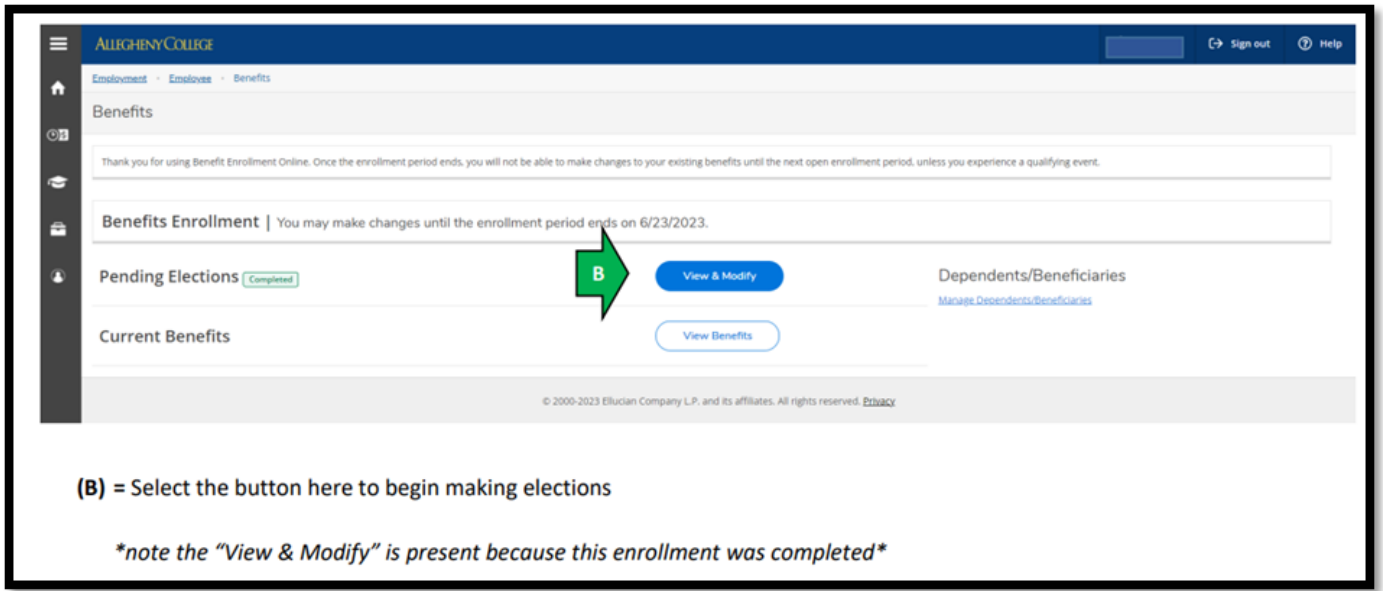
Medical & Prescription Plan	Highmark Blue Cross Blue Shield	Member Services: 1-800-241-5704 Website: www.myhighmark.com
Mental Health Services	Highmark powered by Spring Health	Member Services: 1-855-629-0554 Website: www.springhealth.com
Health Savings Account (HSA)	Highmark Blue Cross Blue Shield	Member Services: 1-800-241-5704 Website: www.myhighmark.com
Flexible Spending Account (FSA) and Dependent Care Flexible Spending Account	P&A Group	Member Services: 716-852-2611 Website: https://padmin.com/
Dental Plan	Lincoln Financial Group	Member Services: 1-877-275-5462 Website: www.lincolnfinancial.com
Vision Plan	Vision Benefits of America	Member Services: 1-800-432-4966 Website: www.vbaplans.com
AblePay	AblePay Health	Member Services: 484-292-4000 Website: ablepayhealth.com
Basic Life / AD&D Insurance	Lincoln Financial Group	Member Services: 1-877-275-5462 Website: www.lincolnfinancial.com
Supplemental Term Life	Lincoln Financial Group	Member Services: 1-877-275-5462 Website: www.lincolnfinancial.com
Short-Term Disability	Lincoln Financial Group	Member Services: 1-877-275-5462 Website: www.lincolnfinancial.com
Long Term Disability	Lincoln Financial Group	Member Services: 1-877-275-5462 Website: www.lincolnfinancial.com

How to Enroll



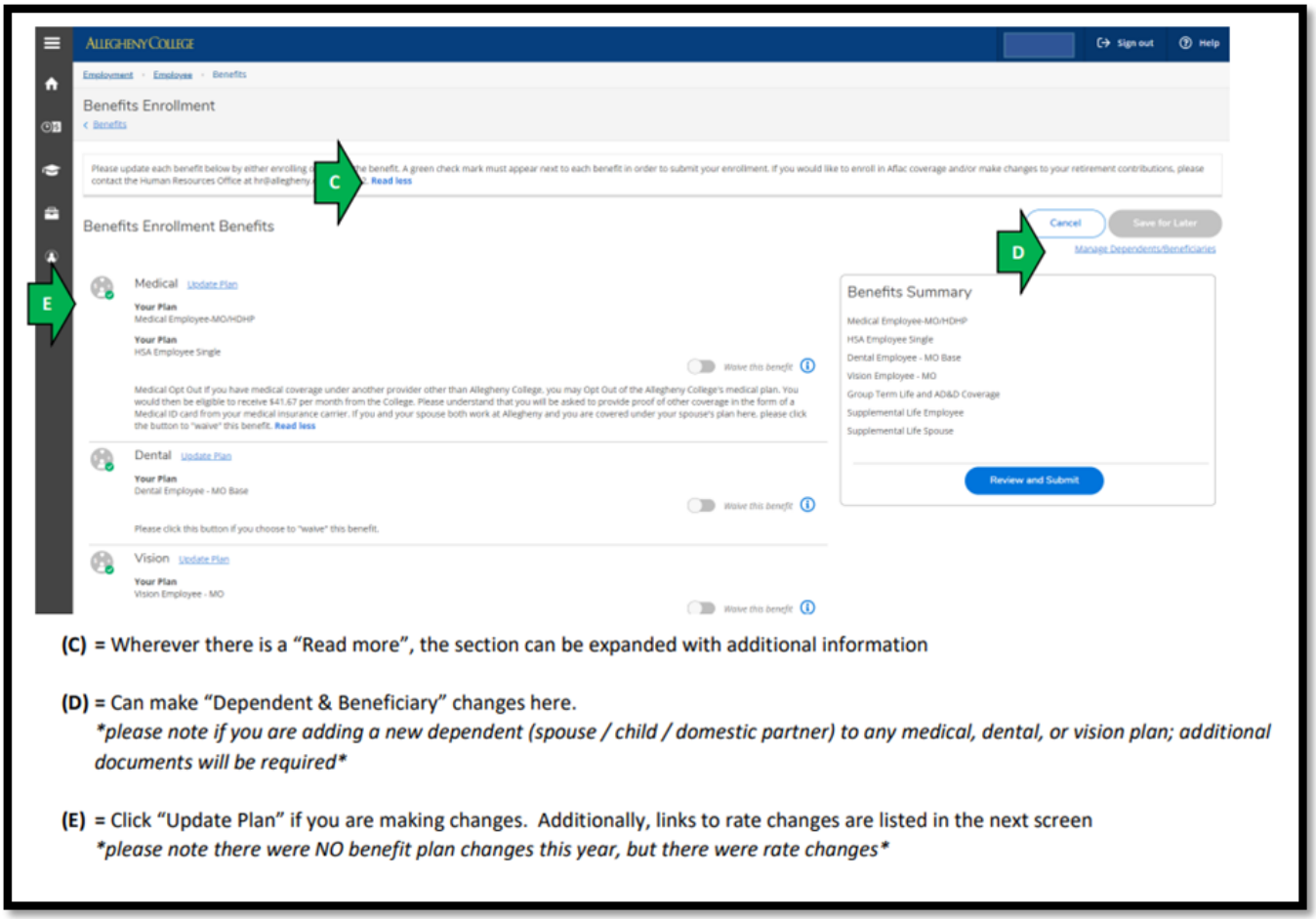


(A) = Access Open Enrollment Through the "Benefits" tab of Employee Self-Service



(B) = Select the button here to begin making elections

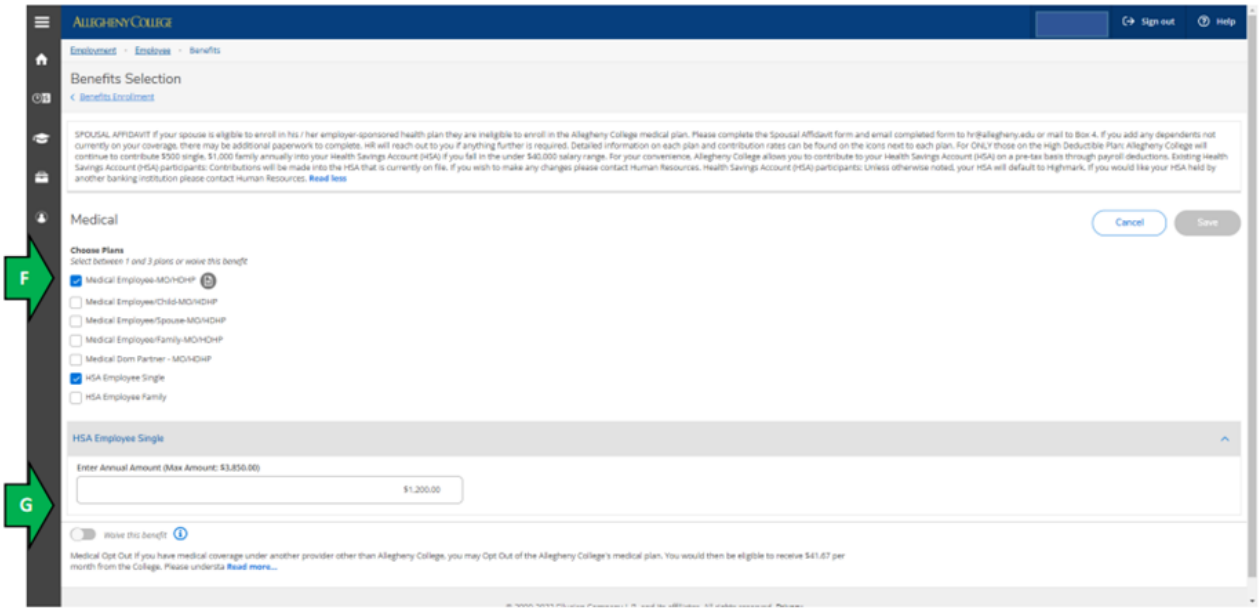
note the "View & Modify" is present because this enrollment was completed



(C) = Wherever there is a "Read more", the section can be expanded with additional information

(D) = Can make "Dependent & Beneficiary" changes here.
please note if you are adding a new dependent (spouse / child / domestic partner) to any medical, dental, or vision plan; additional documents will be required

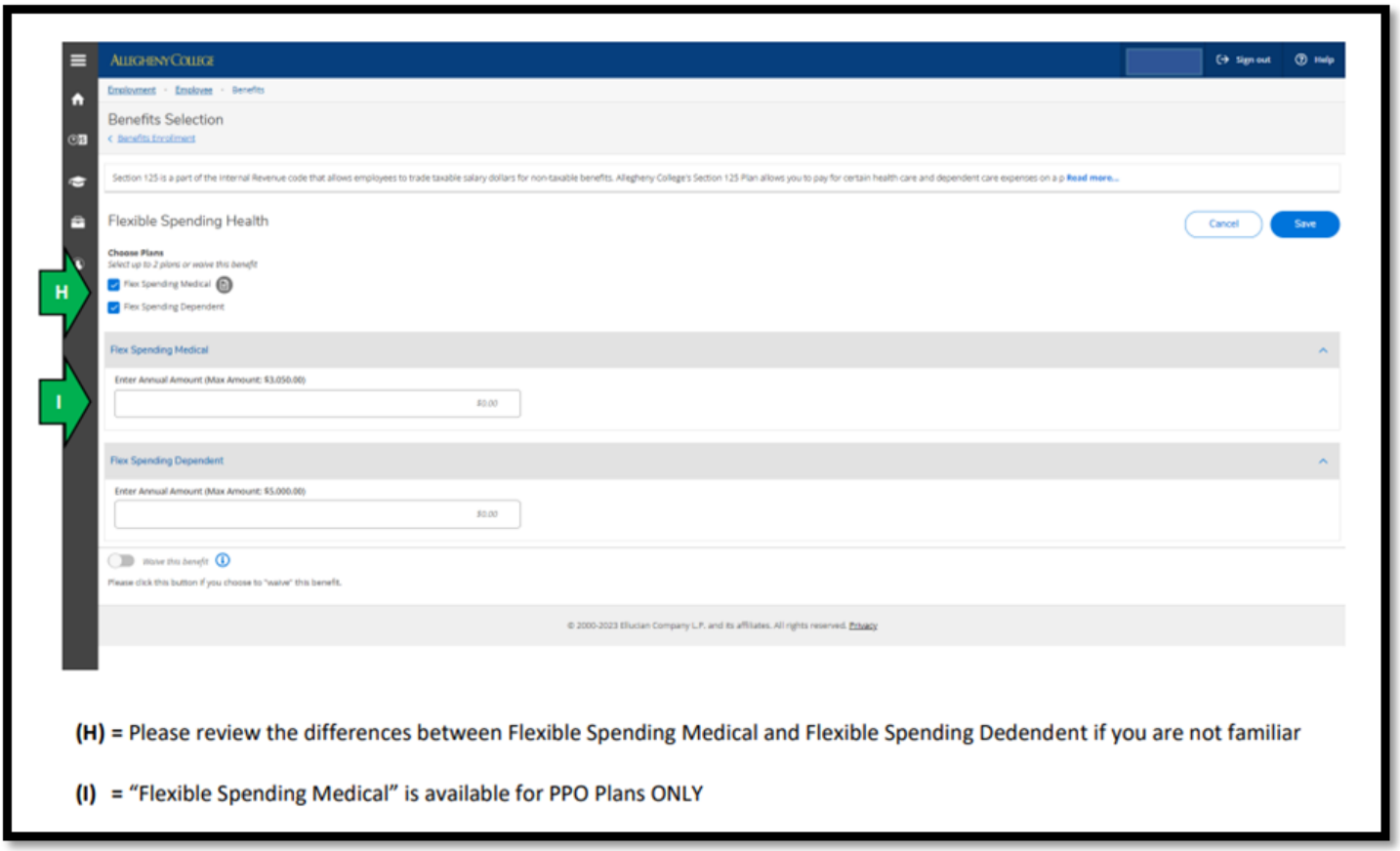
(E) = Click "Update Plan" if you are making changes. Additionally, links to rate changes are listed in the next screen
please note there were NO benefit plan changes this year, but there were rate changes



(F) = Available plans for selection are listed here *(similar but not pictured for Vision, Dental, etc.)*

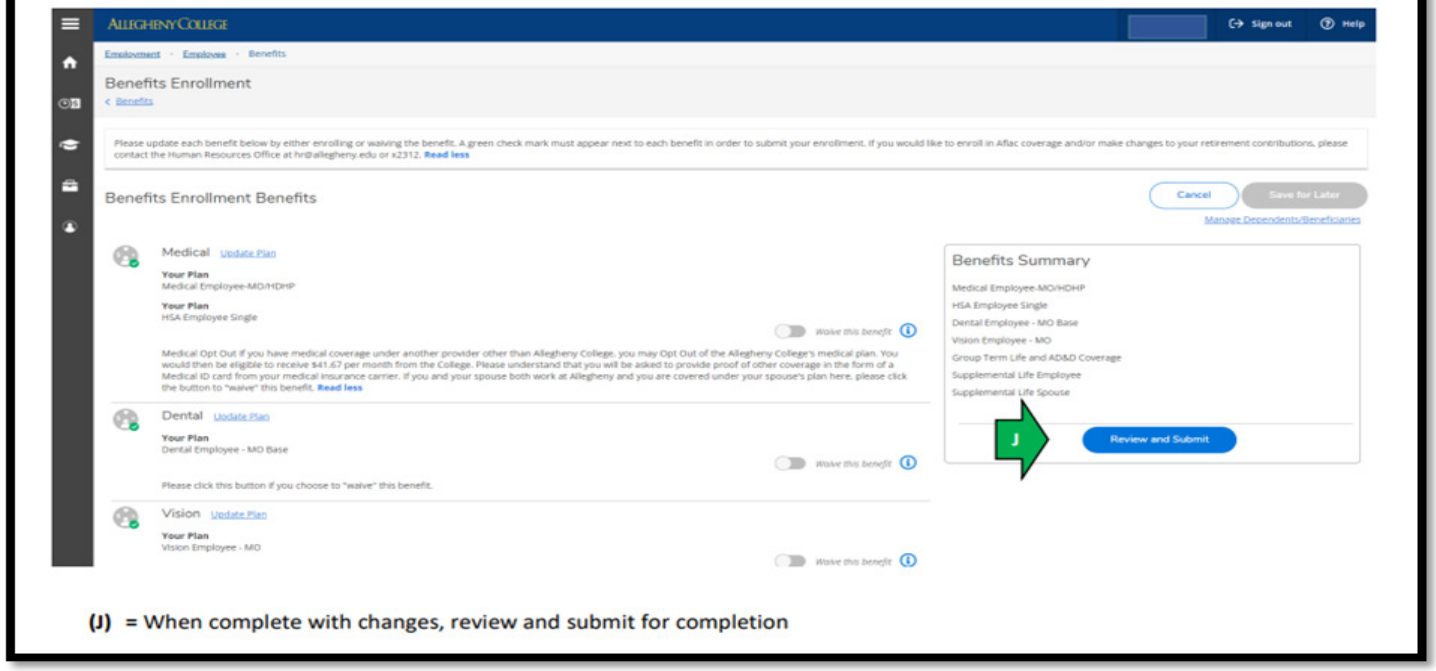
**this symbol links to additional plan and benefit rate information (i.e. medical, vision, dental, FSA, etc.)*

(G) = If you are making annual amount changes

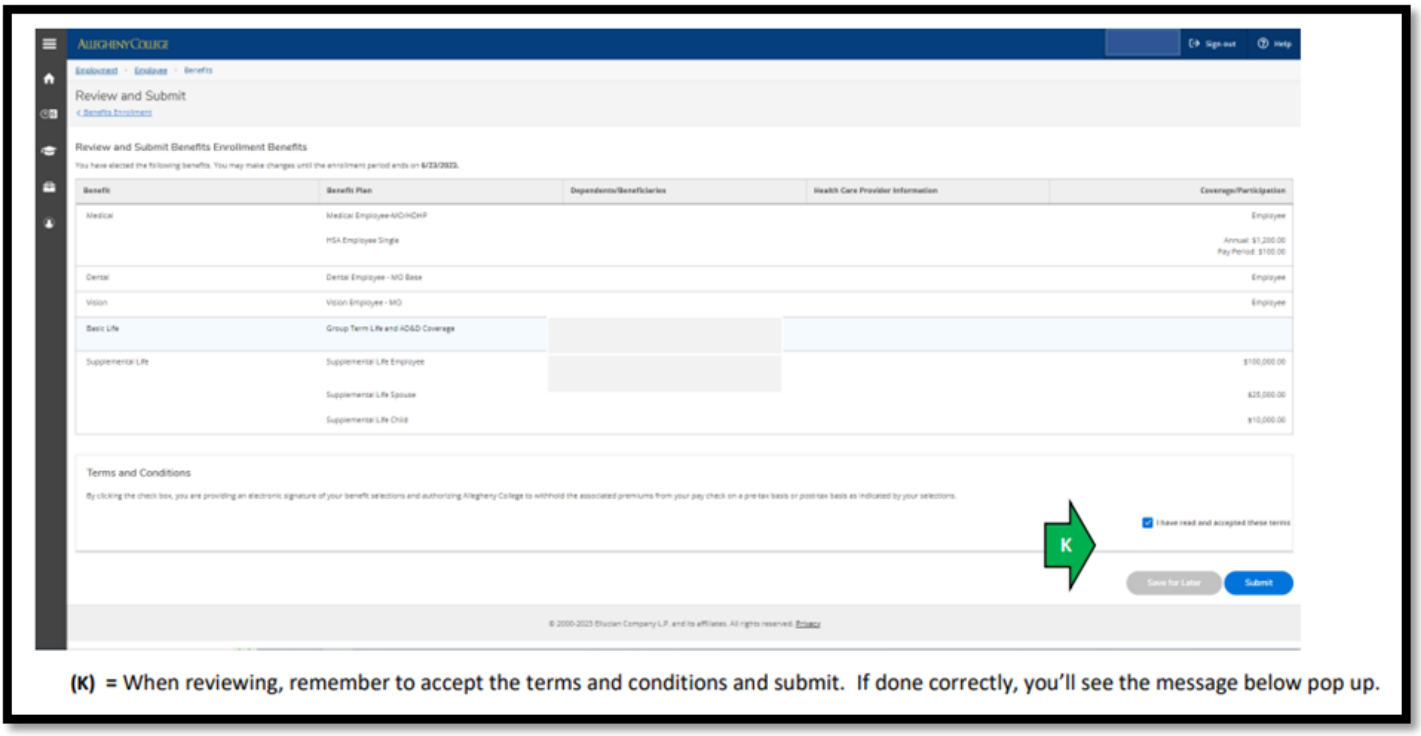


(H) = Please review the differences between Flexible Spending Medical and Flexible Spending Dedendent if you are not familiar

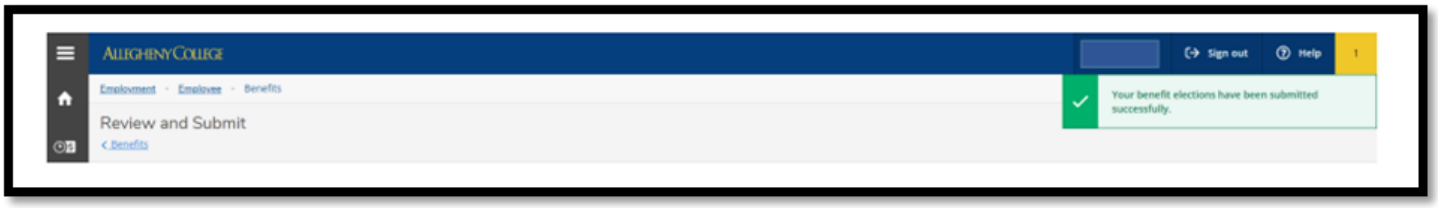
(I) = "Flexible Spending Medical" is available for PPO Plans ONLY



(J) = When complete with changes, review and submit for completion



(K) = When reviewing, remember to accept the terms and conditions and submit. If done correctly, you'll see the message below pop up.



NOTICES

IMPORTANT DISCLOSURES ABOUT OUR PLAN

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 because of a marriage, birth, adoption, or placement for adoption, you may be ableto 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 maybe 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 maybe 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 theirnewborn 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 asapplicable). 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 healthcare 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.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, you may contact the Centers for Medicare & Medicaid Services at 800-985-3059 or visit Submit a Complaint at Submit a complaint | CMS.

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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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