mission
SOCIETY OF NEW YORK CITY

EMPLOYEE BENEFITS GUIDE

December 1, 2023 - November 30, 2024

Your Benefits. **Your** Choices. **Your** Health.

WELCOME

Mission Society Employees

Mission is dedicated to providing you with a comprehensive benefits program offering the flexibility to customize benefits to meet your needs, both now and in the future. Enclosed is a brief overview of your medical, dental and ancillary benefits. All benefits are effective **December 1, 2023** through **November 30, 2024**.

The **Mission Society** will continue to provide the Oxford EPO Liberty Network Plan (Liberty plan) and Oxford EPO Gated Metro Network (Metro plan).

Medical premiums have increased by 6.9% for the 2023-2024 plan year. **Great News!.** the Mission Society will absorb the cost of the premium increase, allowing employees' medical contributions to remain the same.

Your Health Reimbursement Account administered by SENECA GROUP and provided to you by the **Mission Society** will continue to cover many of your out-of-pocket expenses.

Seneca Harvesting will eliminate the stress of receiving and submitting your Explanation of Benefits. Enroll in this EasyEnrollment. Learn more about this benefit and its EasyEnrollment in one of the open enrollment meetings!

Dental premiums have increased by 2% for the 2023-2024 plan year, and the Mission Society will absorb the cost of the premium increase, allowing employees' dental contributions to remain the same.

The Voluntary Vision through VSP will renew with no plan changes.

You will not be able to change your benefits during the plan year unless you experience a qualified change in status.

What Is A Qualified Event?

Based on the IRS rules, you can change certain benefits during the plan year with a qualified status change that is consistent with your plan change. A qualified life event/change in family or employment status includes but is not limited to:

- Marriage, divorce, legal separation or annulment.
- Birth, adoption, or placement for adoption of an eligible child.
- Death of your spouse or child.
- Change in your spouse's employment status that affects benefits eligibility (starting a new job, leaving a job, changing from part-time to full-time, starting or returning from an unpaid leave of absence).
- Change in your child's eligibility for benefits (reaching age limit).
- FMLA leave, COBRA event, court judgement or decree.
- Becoming enrolled in Medicare or Medicaid.
- Receiving a Qualified Medical Child Support Order (QMCSO).

To make a change to your enrollment due to a qualified life event, you **must notify Human Resources within 30 days of the date of the qualified life event/change** in family or employment status. Otherwise, you will be required to keep current elections until the next open enrollment period.

Any employee who wishes to enroll in our plans, add or change dependent status, or waive current plan elections during our current Open Enrollment period **must** complete an Enrollment/Change Form.

All employees waiving medical coverage **must** complete a new coverage waiver form. **Employees need to complete these enrollment/change/waiver forms and return them to Human Resources by Monday, November 20, 2023 if you are making any changes to your current status.**

Questions? Please contact your BenefitsVIP Team at 866.284.2053 or email MyTeam@benefitsVIP.com.

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SENECA HRA INFORMATION & HARVESTING

HEALTH REIMBURSEMENT ARRANGEMENT

Mission sponsors a Health Reimbursement Arrangement (HRA) which reimburses a large portion of your annual out-of-pocket expenses as a supplement to your health coverage.

The HRA is administered by The Seneca Group and runs **December 1, 2023** to **November 30, 2024** with the medical plan.

Please remember to save all your receipts, as The Seneca Group may request them for substantiation of claims. All claims must be submitted within three months of the end of the plan year.

See page 4 for an outline of the adjusted out-of-pocket expense you will be responsible for with the medical insurance plan.

SENECA HARVESTING

Tired of ALL of the paperwork involved in manually submitting Explanation of Benefits (EOB) for healthcare expenses?

Those days are gone! We'll eliminate extra paperwork for verification of debit card payments and reimbursements.

Signing up is as easy as 1-2-3

- Have your insurance company sign-in credentials at your fingertips (user ID, password) for you and any dependents with credentials.
- Open the email from Easy Enrollment and complete the registration.
- We'll take care of the rest - every time a carrier issues an EOB, we'll retrieve this information automatically.

Have questions?
Contact us at
877.224.8061

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

HEALTH REIMBURSEMENT ACCOUNT

THE SENECA GROUP
Specialized products for Employee Benefits Professionals

THE SENECA GROUP HRA

Below is an outline of the adjusted out-of-pocket expense you will be responsible for, based on the mandated insurance plan changes. Read the chart below to learn more.

LIBERTY NETWORK SILVER EPO HIGH PLAN
SUMMARY OF HRA BENEFITS

BENEFIT	MEMBER PAYS	SENECA GROUP PAYS	TOTAL OXFORD COST
Primary Care Office Visit Copay	$5	$35	$40
Specialist Office Visit Copay	$35	$35	$70
Urgent Care	$35	$40	$75
ER Visit Copay	$75	100% after $75 member copay	50% after deductible
In-Network Deductible	$0	$3,000	$3,000
In-Network Coinsurance	$0	$5,550	$5,550
Rx Deductible	$0	$200	$200
Rx Retail Copay	$0/$20/$50	$10/$30/$40	$10/$50/$90

METRO NETWORK SILVER EPO LOW PLAN
SUMMARY OF HRA BENEFITS

BENEFIT	MEMBER PAYS	SENECA GROUP PAYS	TOTAL OXFORD COST
Primary Care Office Visit Copay	$5	$25	$30
Specialist Office Visit Copay	$35	$45	$80
Urgent Care	$40	$40	$80
ER Visit Copay	$80	100% after $80 member copay	50% after deductible
In-Network Deductible	$0	$3,500	$3,500
In-Network Coinsurance	$0	$5,050	$5,050
Rx Deductible	$0	$150	$150
Rx Retail Copay	$0/$20/$40	$10/$45/$55	$10/$65/$95

For more information on this benefit contact
The Seneca Group
866.487.4157
Service@thesenecagroup.com

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

MEDICAL BENEFITS

UnitedHealthcare Oxford

BENEFIT	LIBERTY NETWORK SILVER EPO HIGH PLAN IN-NETWORK ONLY	METRO NETWORK SILVER EPO LOW PLAN IN-NETWORK ONLY
Annual Deductible Calendar Year Deductible	**Individual:** $3,250 **Family:** $6,500	**Individual:** $3,750 **Family:** $7,500
Out-of-Pocket Maximum Calendar Year Deductible	**Individual:** $9,100 **Family:** $18,200	**Individual:** $9,100 **Family:** $18,200
Coinsurance	Oxford 60% Employee 40%	Oxford 60% Employee 40%
Lifetime Maximum	Unlimited	Unlimited
Preventive Care Adult Preventive Care Adult Annual Physical Exam Well-Child Care	 Covered 100% Covered 100% Covered 100%	 Covered 100% Covered 100% Covered 100%
Outpatient Care Primary care physician office visits Specialist office visits Virtual Visits Outpatient facility surgery	 $40 copay $80 copay Covered 100% 40% after deductible	 $30 copay $80 copay Covered 100% 40% after deductible
Outpatient Lab & X-Ray Laboratory Services X-Ray Services MRIs, MRA, CT Scans and PET Scans	 $25 copay 40% after deductible 40% after deductible	 50% after deductible 40% after deductible 40% after deductible
Emergency Care Ambulance when medically necessary At hospital emergency room (waived if admitted) Urgent Care	 Covered 100% 40% after deductible $75 copay	 Covered 100% 50% after deductible $80 copay
Hospital Care Physician's and Surgeon's Services Semi-Private Room and Board	 40% after deductible 40% after deductible	 40% after deductible 40% after deductible
Maternity Care Prenatal and Postnatal care Hospital services for mother and child	 Covered 100% 40% after deductible	 Covered 100% 40% after deductible
Mental Health Inpatient Outpatient	 40% after deductible $40 copay	 40% after deductible $80 copay
Prescription Drug Deductible Retail Pharmacy (30 day supply) Tier 1/Tier 2/Tier 3 Mail Order (90 day supply) Tier 1/Tier 2/Tier 3	$200 Waived for Tier 1 $10/$50/$90 $25/$125/$225	$200 Waived for Tier 1 $10/$65/$95 $25/$162.50/$237.50

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

MEDICAL ENHANCEMENTS

UnitedHealthcare Oxford

How To Locate A Network Provider

Follow these easy steps to locate a doctor, hospital or health facility participating with Oxford.

- **Step 1:** Go to **www.myuhc.com**.
- **Step 2:** Click on "Find medical and mental health providers and facilities".
- **Step 3:** Select "Freedom" (Select "Choice Plus" if you are outside the NY, NJ CT area.)
- **Step 4:** Select by Doctor Name, Specialty, Facility location and other options.

Oxford Claims Address:
Attn: Claims Department
P.O. Box 29130
Hot Springs, AR 71903

For members residing outside of the Oxford service area (NJ, NY), please keep in mind the following:

Claims submitted on behalf of Oxford plan members should be sent directly to the **Oxford Claims Department for payment**. Claims sent directly to United Healthcare for Oxford plan members **will not** be processed for reimbursement.

Virtual Visits - See a doctor whenever, wherever.

With **Oxford's Virtual Visits**, you can see and talk to a doctor via mobile device of computer - 24/7, no appointment needed. The doctor can give you a diagnosis and even have a prescription delivered to your pharmacy, all in about 20 minutes. And with an Oxford plan, each Virtual Visit costs you $50 or less.

Get care in 20 minutes or less for these minor needs: Allergies, Bladder/urinary tract infection, Bronchitis, Cold/flu, Fever, Pinkeye, Rash, Sinus problems, Sore throat, Stomachache.

To get started with a Virtual Visit, go to **uhc.com/virtualvisits**. Please have these items ready to register and complete your Virtual Visit: health plan ID card, credit card, pharmacy location.

Quit for Life - Show your heart some love.

Most people need help to quit smoking. As part of your UHC place, you have a program available - at no additional cost to you. **Quit for Life** is just like having a coach right at your fingertips. Enroll in the Quit for Life program at **myuhc.com**.

To learn more, Visit the **Health Resources** tab and choose the **Quit for Life** tile.

UnitedHealthcare will Provide Members with Year-Long Access to the Peloton App

Stronger with Peloton

Eligible UnitedHealthcare members will be able to access thousands of live and on-demand classes via the Peloton App for up to 12 months, or receive a four-month waiver toward their All-Access Membership, including thousands of live and on-demand fitness classes — from cardio and HIIT to strength training and yoga at no additional cost. Register at **myuhc.com** .

The Peloton App gives you:

- **Access to thousands of fitness classes -** There's something for nearly every fitness interest, ability and schedule — from 5-minute meditation to 60-minute outdoor running classes.
- **The flexibility to get active anytime, anywhere.** The app is available on mobile devices, Apple T V, Android T V, Amazon Fire TV and Roku devices and no fitness equipment is required.
- **Ways to help you have fun and stay motivated** Enjoy the app's many features, training programs and challenges, all designed to help you track your progress and stay motivated.

MEDICAL ENHANCEMENTS

UnitedHealthcare Oxford

Gym Reimbursement

Get started. Choose a gym or sign up for fitness classes

Decide on a cardio (aerobic) workout that you'll enjoy and find a facility with the equipment or classes that promote cardiovascular wellness. To get reimbursed, the facility and classes you choose must be open to the general public. Remember to check with your doctor before you start exercising or increasing your activity level.

Reimbursement requirements

After you've completed a total of 50 workouts - gym visits, classes, group events - in a six-month period, send us:

1. Your completed Sweat Equity Program Reimbursement Form
2. Proof of your payment (e.g., receipt, automatic bank withdrawal statement) for the gym fee, as well as any money you paid for fitness classes and organized group fitness events (e.g., marathon), during the six-month period
3. Copy of the brochure or flier or printout of the website page that describes the cardio (aerobic) machines at the gym you used or the cardio benefits of the class you took or organized group fitness event in which you participated
4. Mail these documents to:
   Oxford Sweat Equity Program
   P.O. Box 29130
   Hot Springs, AR 71903

   These documents must be mailed to us (postmarked) no later than 180 days from the last date of the six-month period for which you are asking for reimbursement. Requests postmarked after this date will not be reimbursed.
   We cannot accept requests for reimbursement before your six-month program end date, even if you have completed the required number of qualifying workouts before this date.

Real Appeal

Your program includes:

- Step-by-step guidance and customization for a program that fits your needs, preferences and goals
- Support and motivation for a full year to help you lose weight or maintain results
- A personalized dashboard to help you keep track of your calories, fitness and goals

24/7 Convenience

Staying accountable to your goals may be easier than ever with:

- Food, activity, weight and goal trackers
- Unlimited access to digital content
- An online group class designed to help you build camaraderie and accountability with others in the program
- Weekly health tips from celebrities, athletes and health experts

Success Kit

Resources to help you kick-start your weight loss and keep yourself on the road to results. Your kit will be delivered after your first class. It includes:

- Step-by-step success guides
- Workout DVDs
- Quick and simple recipes
- Nutrition guide
- And much more

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

DENTAL BENEFITS

MetLife

Good dental health is important to your overall well-being. That's why the **Mission Society** offers a Dental PPO Plan through MetLife Dental**.**

The Dental PPO plan allows you to receive care from both In-Network and Out-of-Network providers, however, you will always get the best value when you use a MetLife provider.

Freedom of Choice

MetLife's Freedom of Choice Dental plan allows employees to receive dental services both In-Network and Out-of-Network.

The MetLife Freedom of Choice Dental PPO gives you the choice of obtaining benefits through two different dental plans.

Choose the DMO plan and pay lower out-of-pocket costs or choose the PPO plan and choose from a broader choice of dentists.

How To Locate a Dental Provider

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.

Step 1
Go to **MetLife.com**

Step 2
Select **"I want to find a MetLife:"** Click **"Dentist"** and enter your zip code and select your network—**PDP Plus**

Step 3
Advanced Search - go to the Advanced Search option to locate a dentist by name, language spoken, specialty or gender

Members can also contact
800.GETMET8 (800.438.6388)
for assistance

Once you're enrolled you may take advantage of online self-service capabilities with MyBenefits

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

To register, just go to
www.metlife.com/mybenefits
And follow the easy registration instructions.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

DENTAL BENEFITS

MetLife

	PASSIVE PPO PLAN		DMO PLAN
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Annual Deductible	**Individual:** $50 **Family:** $150	**Individual:** $50 **Family:** $150	**Individual:** None **Family:** None
Benefit Maximum Annual	$2,000		Unlimited
Diagnostic & Preventive Services Prophylaxis (Cleanings) Oral Examinations Topical Fluoride X-rays; Bitewing Sealants	100% deductible waived	100% deductible waived	100%
Basic Services Fillings Extractions Oral Surgery Endodontics Periodontics Periodontal surgery Denture Repairs	80% after deductible	80% after deductible	Per Fee Schedule
Major Services Bridge and Dentures Crowns Inlays Onlays	50% after deductible	50% after deductible	Per Fee Schedule
Orthodontic Services (children only to age 19)	Not Covered	Not Covered	$2,400 copay

Please note: If you choose to switch between plans, you must notify MetLife no later than the 15th of the month prior to the month in which you would like to change to take place.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

VOLUNTARY VISION BENEFITS

VISION
SIGNATURE PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$10	Up to $50
Frequency Exam Lenses Frames	 12 months 12 months 12 months	 12 months 12 months 12 months
Frames	$130 plus 20% savings on amount over $130	Up to $70
Lenses Single Vision Lenses Bifocal Vision Lenses Trifocal Vision Lenses	 $25 copay $25 copay $25 copay	 Up to $50 Up to $75 Up to $100
Elective Contact Lenses	$130 allowance	Up to $105

Using Your VSP Benefit Is Easy

- Create an account at **vsp.com**. Once your plan is effective, review your benefit information.
- Find an eye doctor who's right for you. Visit **vsp.com** **or call** **800.877.7195.**
- At your appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com.**
- That's it! VSP handles the rest - there are no claim forms to complete when you see a VSP provider.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

VOLUNTARY VISION BENEFITS

VSP VISION

As a VSP member, you will receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

- Value and Savings.
- High Quality Vision Care.
- Choice of Providers.
- Great Eyewear.

Extra Discounts & Savings!

Glasses and Sunglasses

- Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details.
- 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam.

Contacts

- 15% off cost of contact lens exam (fitting and evaluation).

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.

Did you know that comprehensive eye exams can spot symptoms of many health problems such as diabetes, hypertension, high cholesterol, glaucoma and cataracts? Don't take chances with one of your most precious possessions. ..the gift of sight.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

CONTRIBUTIONS

MEDICAL LIBERTY EPO PLAN

TIER	TOTAL MONTHLY COST	EMPLOYEE BI-WEEKLY
Employee Only	$1,001.01	$64.93
Employee + Spouse	$2,002.01	$129.87
Employee + Child(ren)	$1,701.71	$110.39
Family	$2,852.87	$185.06

MEDICAL METRO EPO PLAN

TIER	TOTAL MONTHLY COST	EMPLOYEE BI-WEEKLY
Employee Only	$877.50	$54.29
Employee + Spouse	$1,755.00	$108.58
Employee + Child(ren)	$1,491.76	$92.30
Family	$2,500.00	$154.73

DENTAL PASSIVE PPO/DMO PLAN

TIER	TOTAL MONTHLY COST	EMPLOYEE BI-WEEKLY
Employee Only	$38.48	$3.78
Employee + Spouse	$79.95	$7.84
Employee + Child(ren)	$86.02	$8.44
Family	$124.63	$12.22

BI-WEEKLY VISION CONTRIBUTIONS
(Employee pays 100% of Premium)

TIER	EMPLOYEE BI-WEEKLY
Employee Only	$7.12
Employee + Spouse	$11.40
Employee + Child(ren)	$11.63
Family	$18.75

FLEXIBLE SPENDING ACCOUNT

THE SENECA GROUP
Specialized products for Employee Benefits Professionals

Flexible Spending Account (FSA)

The FSA plan benefit runs calendar year and additional information will be forthcoming in December. The FSA is a special savings account that enables you to lower the after-tax cost of your out-of-pocket expenditures by setting aside money from your paycheck in one or both of these accounts, before taxes are calculated. The money can then be used to reimburse yourself, or your dependent for Dependent Care FSA, for certain eligible expenses. Read the chart below carefully to see what is covered.

ACCOUNT TYPE	EXAMPLES OF ELIGIBLE EXPENSES	BI-WEEKLY CONTRIBUTION LIMITS	ACCESS TO FUNDS	PRE-TAX BENEFIT
HealthCare FSA	• Medical Plan Deductibles • Most Insurance Co-pays • Prescription Drugs • Some OTC medicines* • Vision Exams/Eyeglasses/ Contacts • Laser Eye Surgery • Acupuncture • Weight Loss Programs • Dental and Orthodontia • Birth Control Pills / Devices • Chiropractic	Maximum contribution is **$3,050** per year	Allows immediate access to the entire contribution amount from the first day of the benefit year, before all scheduled contributions have been made	Save 20% - 40% on your health care expenses Save on purchases not covered by insurance Reduce your taxable income
Dependent Care FSA	• Daycare • Day Camp • Eldercare • Before and After School Care	Maximum contribution is **$5,000** per year	You will be able to Submit claims up to your current account balance You will only be reimbursed based on your accumulated contribution amounts	Save 20% - 40% on your dependent care expenses Reduce your taxable income

*Over the counter drugs require a prescription in order to be an eligible expense.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

ANCILLARY BENEFITS

Guardian

Basic Life Insurance

Basic Life Insurance coverage provides important supplemental financial protection for your family in the event of your death. All full-time employees working a minimum of 35 hours per week are eligible for Basic Life Insurance. The Life Insurance benefit is equal to 2x basic annual earnings (annual base salary), up to a maximum benefit of **$400,000**. Benefits are reduced to 65% at age 65 then 50% at age 70.

Accidental Death & Dismemberment Insurance (AD&D)

AD&D Insurance coverage provides important financial protection in the event of death or dismemberment as the result of an accident. The dismemberment benefit will be provided when an employee experiences a loss within 365 days of a related accident. All employees working a minimum of 35 hours per week are eligible for the AD&D benefit which is equal to 2x basic annual earnings up to a maximum of **$400,000**. Benefits are reduced to 65% at age 65 then 50% at age 70.

BENEFIT	
Life Benefit Amount	2x your annual salary up to $400,000
AD&D Benefit Amount	2x your annual salary up to $400,000
Reduction of Benefits Schedule	Reduces to 65% of original amount at age 65 Reduces to 50% of original amount at age 70

Glossary

- **Life Benefit:** A policy that pays a beneficiary a specified death benefit amount when the insured dies.
- **AD&D Benefit:** This is paid, in addition to the life benefit, if you die in a covered accident. It also pays if you suffer a covered dismemberment.

Make sure your Life and Accident Death benefits will be paid as you intend.

Your beneficiary is the person or estate that will receive a benefit payment in the event of your death. Make sure you name a beneficiary when you are first eligible for life and AD&D benefits. Then, make sure to review your beneficiary designation and make any necessary changes as your personal situation changes.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

ANCILLARY BENEFITS

Guardian

Long Term Disability

Long Term Disability provides a reasonable replacement of monthly income to an insured that becomes disabled for more than 6 months due to an accident or illness. All employees working a minimum of 30 hours per week are eligible for Long Term Disability Insurance. An insured must be disabled for 180 days before benefits begin. The Long Term Disability benefit is equal to 60% of your earnings (based on salary) to a maximum benefit of **$10,000** per month.

BENEFITS	LONG TERM DISABILITY
Benefit Percentage	60% of pre-disability earning
Maximum Monthly Benefit	$10,000
Elimination Period	180 days
Maximum Duration of Benefit	SSNRA
Pre-existing Condition Limitations	3/12

Pre-Existing Condition

A **"Pre-Existing Condition"** means the insured employee received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines in the **3 months** just prior to his/her effective date of coverage; and the disability begins in the first **12 months** after the employee's effective date of coverage unless you have been treatment free for 12 consecutive months after your effective date of coverage.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

STATE-MANDATE BENEFITS

Guardian®

What is Disability Benefits Law (DBL)?

Disability Benefits Law (DBL) is a New York State-mandated disability insurance program designed to provide employees with temporary cash benefits when disabled by an off the job injury or illness.

What are the eligibility requirements?

Full-time employees are eligible after completion of four consecutive weeks of employment unless they have previously established their eligibility. Part-time employees are eligible on the 25th day of regular employment unless eligibility has been previously established.

What are the benefits payable to employees under DBL?

The benefit amount payable for Statutory DBL is 50% of an employee's average weekly wages to a maximum of $170 per week.

The maximum duration for DBL benefits is 26 weeks.

Benefits begin on the eighth consecutive day of disability.

What is Paid Family Leave (PFL)?

Paid Family Leave (PFL) is a New York mandated insurance program that provides paid, job-protected leave to employees so they can:

- Bond with a newly born, adopted, or fostered child.
- Care for a family member (spouse, domestic partner, child, parent/in-law, grandparent/grandchild) with a serious health condition.
- Assist loved ones when a family member (spouse, domestic partner, child or parent) is deployed abroad on active military duty.

What are the eligibility requirements?

Employees with a regular work schedule of 20 or more hours per week are eligible after 26 weeks of employment preceding the first full day of leave.

Employees with a regular work schedule of fewer than 20 hours per week are eligible after 175 days worked preceding the first full day of leave.

YEAR	MAXIMUM LENGTH OF PAID LEAVE	PAYABLE % OF EMPLOYEE'S AVERAGE WEEKLY WAGE	MAXIMUM WEEKLY BENEFIT % OF NEW YORK STATE AVERAGE WEEKLY WAGE
2021	12 weeks	67% of AWW	67% of NYSAWW
2022	12 weeks	67% of AWW	67% of NYSAWW

Paid Family Leave (PFL) Coordination with NY DBL and FMLA

Benefits for NY PFL will not run concurrent with benefits for NY Disability (DBL). Benefits for NY PFL can run concurrent or non-concurrent with federal Family and Medical Leave (FML). As NY PFL and federal FML do not always apply to the same types of leaves, any applicable coordination will be confirmed by the NY PFL carrier – any PFL request should be filed 30 days in advance, when practical – additional information will be shared by HR.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

WHOLE LIFE BENEFITS

MassMutual

Whole Life Insurance

Mission is offering employees supplemental Group Whole Life Insurance coverage through MassMutual that can provide permanent coverage and cash value accumulation. This benefit is in addition to the group coverage with Guardian.

Briefly, this is how the new MassMutual program works:

- Mission pays the cost for the first $50,000 of group whole life insurance; the cost will be imputed income on your W-2
- Employees can purchase up to an additional $200,000 group whole life insurance
- Up to $25,000 life insurance coverage is available for both spouse and children
- Coverage is portable at termination of employment
- Group Whole Life product provides cash value accumulation and opportunity for permanent coverage

WHOLE LIFE BENEFITS

MassMutual

You Can't Predict the Future - But you can prepare for it.
Starting right where you work

Planning for the life you want can be difficult while you're busy managing the life you have. MassMutual@WORK makes planning for financial wellness easy with guidance, educational online tools, and financial solutions all available through your workplace. How's that for a benefit? You've got this.

Let's face it, life happens

If you are looking for a smart way to help achieve multiple financial goals, consider MassMutual@WORK Group Whole Life Insurance. It can help you prepare for the unexpected by providing a generally income-tax-free death benefit, along with coverage that builds cash value.

Portable Coverage

You own the certificate along with the accumulated cash value and you can take it with you, even if you leave the company.

Built-in Guarantees

- Guaranteed death benefit
- Guaranteed cash value
- Guaranteed level premium

Accelerated Death Benefit Provisions

As the certificate owner, you can receive an advance, or acceleration, of a portion of the death benefit under your certificate, if the insured is diagnosed with a terminal illness or if the insured has a chronic illness.

- **Terminal Illness:** The Accelerated Death Benefit for Terminal Illness is payable when the insured meets the definition of Terminally Ill, generally diagnosed with an illness that will result in death within 12 months (24 months in some states).
- **Chronic Illness:** The Accelerated Death Benefit for Chronic Care is payable when the insured meets the definition of Chronically Ill, generally having a permanent loss of two activities of daily living, or requiring substantial supervision due to permanent severe cognitive impairment.
- These benefits are not long term care insurance and may be used for any purpose. In many cases, these benefits allow access to more funds than would be available through a certificate loan or certificate cash surrender value. There is a fee taken from the Chronic Care Benefit. Consult with your tax advisor regarding a request for accelerated benefits.

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

VOLUNTARY BENEFITS

Aflac

Your Lifestyle. Your Coverage.
Aflac has policies to help protect any lifestyle—From helping protect your paycheck due to out-of-pocket medical expenses, to cash for groceries and getaways. And because Aflac pays you directly, it's up to you how to spend it. Some of the policies offered include:

Accident
Helps with costs associated with covered accidental injuries. 24 hour coverage to make sure you are protected always.

Hospital
Helps with expenses that may not be covered by major medical insurance, like deductibles and other expenses related to hospital stays.

Life Insurance
We're not just here to help protect your lifestyle, but the lifestyle of your family as well. Aflac offers both Term Life insurance up to 30 year term, and a Whole Life insurance. Meet with your Aflac representative to discuss your individual coverage. Coverage up to $250,000.

Cancer
We're here to help you and your family better cope financially and emotionally if a positive diagnosis of cancer ever occurs.

If you have questions,
contact your Aflac representative:
Giana Court
407.616.7702
Giana_Court@us.aflac.com

For additional information, please refer to your detailed plan summary. In the event of a discrepancy, the carrier Plan Document shall prevail.

ADVOCACY

BenefitsVIP®
Help starts here.

HELP STARTS HERE

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your benefits issues.

For service that's confidential and responsive, contact:

866.284.2053

Monday - Friday
8:30am - 8:00pm (ET)
Fax: **856.996.2735**
MyTeam@benefitsvip.com

QUESTIONS ANSWERED HERE

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

BenefitsVIP.com

BENEFITSVIP.COM
Request member assistance and order ID cards with a click.

HEALTHDISCOVERY.ORG
Get vital, useful and fun health insurance and wellness facts.

GLOSSARY

Annual Limit
Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for essential benefits for plan years beginning after Sept. 23, 2010.

Balance Billing
When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount.

COBRA Coverage
Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

Coinsurance
A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

Co-payment (Co-pay)
The flat fee you pay out of pocket each time you visit a provider.

Cost Sharing
Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance and copayments. Balance billed charges from Out-of-Network physicians are not considered cost-sharing. PPACA prohibits total cost sharing exceed $5,950 for an individual and $11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

Deductible
The amount you pay during the year for medical services, before your insurance starts to pay.

In-Network Provider
A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

Open Enrollment Period
A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

Out-Of-Network Provider
A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an Out-of-Network provider.

Out-Of-Pocket Limit
An annual limitation on all cost-sharing for which patients are responsible under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out of network health care providers or services that are not covered by the plan. PPACA requires out-of-pocket limits of $6,350 per individual and $12,700 per family, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance premiums.

Pre-existing Condition Exclusion
The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

Premium
The periodic payment required to keep a policy in force.

Preventive Benefits
Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. PPACA requires insurers to provide coverage for preventive benefits without deductibles, co-payments or coinsurance.

Usual, Customary and Reasonable Charge (UCR)
The cost associated with a health care service that is consistent with the going rate for identical or similar services within a particular geographic area. Reimbursement for Out-of-Network providers is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

Waiting Period
A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. Premiums are not collected during this period.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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, 2023.

Contact your State for more information on eligibility –

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

ALASKA – Medicaid
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
Website: http://myarhipp.com/

ANNUAL NOTICES

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
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

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – 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

IOWA – Medicaid and CHIP (Hawki)
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

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

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

LOUISIANA – 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)

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

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

MINNESOTA – Medicaid
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

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

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

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

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

NEW HAMPSHIRE – Medicaid
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
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

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

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

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

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

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

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022 Website: https://dhhr.wv.gov/bms/

WEST VIRGINIA – Medicaid and CHIP
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

WYOMING – Medicaid
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, 2023, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

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

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

MISSION
SOCIETY OF NEW YORK CITY

This benefit summary provides selected highlights of the employee benefits program available. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Our company reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

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A Foundation Risk Partners Company