2025
BENEFITS
GUIDE
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YOU ARE OUR MOST VALUABLE ASSET.

YOUR BENEFITS OVERVIEW

At Pace University, we are committed to offering a comprehensive employee benefit program that helps our employees stay healthy and maintain a work/life balance. We understand that our success depends greatly upon your success and your wellbeing. Pace University offers an industry-leading benefit program to meet the needs of you and your family.

The following is a brief overview of employee benefit programs provided by Pace University. For more detailed information on these programs, visit our website at **pace.edu/human-resources/benefits-and-wellness** or contact the contact the University Benefits Office by calling (914) 923-2828 or by emailing **benefits@pace.edu**.

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This Benefits Guide is intended only to provide information for the guidance of Pace University employees. The writers of the content have exercised their best efforts to ensure accuracy of the information, but accuracy is not guaranteed. If there are any discrepancies between the information on the website, verbal representations and the Plan documents, the Plan documents will always govern. The information is subject to change from time to time, and the University reserves the right to change or terminate these Plans at any time. The information contained on the website is not intended to replace the plan documents, nor is the information in any way intended to imply a contract.

LET'S GET STARTED

Annual Enrollment: November 13th – 26th

Log onto the Pace Portal (**portal.pace.edu**) and select "UKG Ready Employee Dashboard." Under My Benefits, click "Enrollment" to complete your Open Enrollment elections. You will need to click "Decline/Waive" if you do not want to enroll in a particular benefit, but do not skip a step in the process. Skipping any step will prevent enrollment submission.

If you are newly eligible or enrolling due to a Qualifying Life Event, you can either attach the documentation within UKG Ready or email it to **benefits@pace.edu**. You will have 31 days, from the date of the event, to complete the process in UKG Ready.

Eligibility

Health and welfare benefits are offered to full-time employees working 28+ hours per week. For newly eligible employees, benefits begin on the first of the month following or coinciding with your date of hire. You have 31 days to enroll. Benefit coverage and premium charges will be applied retroactive to the effective date of your coverage.

If you are newly eligible and do not take action within 31 days, you will default to no coverage for all voluntary coverage (including medical, dental, and vision). If you do not enroll during your initial enrollment window, your next opportunity to enroll will be during the next annual Open Enrollment period with a January 1st effective date, or following a Qualified Life Event.

Eligible Dependents

You can choose to enroll your eligible dependents under the plans in which you are enrolled. Your eligible dependents are:

- Your legal spouse
- Your registered domestic partner
  - You may be required to submit a notarized Affidavit and supporting documentation to the University Benefits office to affirm that your registered domestic partner and their children qualify as your dependents under Section 152 of the Internal Revenue Code
- Dependent children up to the allowable age, or disabled dependents of any age
  - Dependents must be children for whom you are the legal guardian and who are claimed as dependents on your federal tax return
  - Dependents are covered through the end of the calendar year in which they turn age 26 under the medical, dental, and vision plans

Mid-Year Qualifying Life Event

You can make certain changes to your benefit elections mid-year following a Qualified Life Event. Examples include:

- Marriage
- Legal Separation
- Divorce (must remove ex-spouse from coverage)
- Having a baby or adopting a child
- Loss of dependent eligibility on the University plan
- Your spouse loses eligibility or gains eligibility through another employer's benefit plan

If you experience a Qualified Life Event, you must elect for the change within 31 days of the event.

Benefits You Can Change at Any Time

- 403(b) contribution amounts
- Health Savings Account (HSA) contribution amounts
- Commuter Reimbursement Account benefits contribution amounts
- Beneficiary designation for Life Insurance, HSA and 403(b)

When Coverage Ends

Coverage ends on the last day of the month in which you and/or your dependents lose eligibility. COBRA benefit continuation for medical, dental, and vision may be elected within 60 days of the date coverage ends.

Loss of Dependent Eligibility: It is your responsibility to notify University Benefits of any dependents who are no longer eligible for the University plan benefits. This includes ex-spouses or dependent children who have aged off the plan, are married or lose their dependent tax status. If you fail to remove a dependent when he or she becomes ineligible, you will be required to pay the insurance premium and risk the insurance company denying the claim.

CARING FOR YOUR HEALTH

Medical Benefits

Insured by Aetna

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the risks of unexpected illness and injury. Routine exams and regular preventive care can help detect and prevent illnesses or health issues before they occur, rather than treating them after they have developed.

Pace University offers the option to choose one of three medical plans through Aetna. With Aetna's plan options, you have access to a national network of participating providers.

- **Choice PPO –** This plan allows you to seek care from any in or out-of-network doctor at the time of service
- **Network Core –** This plan provides in-network only benefits in which you must seek care from participating providers.
- **Consumer Core HDHP/HSA –** This plan delivers in-network only benefits and is also eligible for the addition of a Health Savings Account (HSA).

With all three medical plans:

- In-network preventive services are covered at 100%
- You have Pharmacy coverage administered through Aetna/ CVS
- No requirement to select a Primary Care Physician (although it is recommended for coordination of care)
- There are no referrals needed to see in-network specialists
- Emergency care is covered at the in-network coverage rate, no matter where you receive service

Your out-of-pocket costs will usually be lower when visiting a provider in the Aetna network, so seeing an in-network provider is encouraged whenever possible. To find in-network providers near you, visit **aetna.com** and click **Find Care & Pricing**.

Tips for Saving on Your Health Care Expenses

Use network providers. You will receive a higher level of benefits if you use providers who participate in the network.

Request generic rather than brand name prescription drugs. Generic medications, while just as effective as name brand, are considerably less expensive.

Consider seeing your family physician rather than a specialist. Family physicians can often provide the same level of care for a variety of illnesses and conditions.

Call 833-691-1359 or visit aetna.com

Medical Plan Overview

	Consumer Core HDHP Open Access Aetna Select (formerly Elect Choice)	Network Core Plan Open Access Aetna Select (formerly Elect Choice)	Choice PPO Open Access Choice POS II (formerly Managed Choice)	
	In Network	**In Network**	**In Network**	**Out of Network**
Deductible (Individual/Family)	$1,650/$3,300	$250 / $500	$850/$1,700	$2,500/$5,000
Coinsurance (Plan Pays)	90%	100%	85%	60%
Out of Pocket Maximum	$2,500/$5,000	$2,000/$4,000	$2,000/$4,000	$6,000/$12,000
PCP Office Visits	Deductible & Coinsurance	$30 copay	$30 copay	Deductible & 70% Coinsurance
Specialist Visits	Deductible & Coinsurance	$50 copay	$50 copay	Deductible & 70% Coinsurance
Telehealth Services	Deductible & Coinsurance	$30 copay	$30 / $50 copay	Deductible and 70% Coinsurance
Preventive Care	100%	100%	100%	Deductible & 70% Coinsurance
Lab, X-ray and Advanced Radiology	Deductible & Coinsurance	Participating lab: 100%; Office Visit: $30/$50 copay*; Outpatient - 100%	Participating lab: 100%, no deductible; Office Visit: $30/$50 copay*; Outpatient - 100%	Deductible & 70% Coinsurance
Ambulance Service (Emergency Use only)	Deductible & Coinsurance	100%	Deductible & Coinsurance	Deductible & 85% Coinsurance
Emergency Room	Deductible & Coinsurance	$100 per visit; Waived if admitted	$100 per visit; Waived if admitted	$100 per visit; Waived if admitted
Urgent Care	Deductible & Coinsurance	$30 per visit	$30 per visit	$30 per visit
Hospitalization	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & 60% Coinsurance	100% after deductible	Deductible & 60% Coinsurance	Deductible & 60% Coinsurance

**If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.*

Download the Aetna App

App Store

Google Play

Prescription Drug Benefits

Our medical plan utilizes the Aetna Standard 3-Tier Open Formulary, which is updated every quarter. For information on quantity limits, step therapy and/ or pre-certification requirements for certain prescription drugs, please contact Aetna by calling the member services number on the back of your Member ID card or visit the Aetna website at **aetna.com** once your coverage is effective for a more customized experience.

	Consumer Core HDHP	Network Core Plan	Choice PPO	
	In Network	In Network	In Network	Out of Network
Presciption Drug Deductible (Annual)	Combined with medical	$125/$375 waived for generic	$125/$375 waived for generic	$125/$375 waived for generic
Pharmacy Maximum Out of Pocket	Combined with medical	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
Generic Preventive Medication	$0 copay & not subject to deductible	$0 copay & not subject to deductible	$0 copay & not subject to deductible	30% of submitted cost after applicable copay
Retail and Mail Order Drugs				
Tier 1 (typically generic drug)	80% Coinsurance	$20 copay	$20 copay	30% of submitted cost after applicable copay
Tier 2 (typically preferred brand name drugs)	70% Coinsurance	$45 copay	$45 copay	
Tier 3 (typically non-preferred brand name drugs)	50% Coinsurance	$70 copay	$70 copay	

Some covered prescription drugs need prior approval before the drug is covered. Some covered prescription drugs require step therapy before they are covered. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy. To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents.

Mail Order Program

The mail order program benefits employees who are on maintenance medications for chronic conditions such as diabetes, asthma and high blood pressure (or any medication you take on a regular basis). Under the Network Core and Choice PPO plans, mail order prescriptions are available at 1X copay for a 90-day supply.

KNOW BEFORE YOU GO

Your Guide For Where to Go When You Need Medical Care

Lower ← Cost and Time → Greater

	Virtual Care / Teladoc	CVS Minute Clinic	Doctor's Office	Urgent Care Center	Emergency Room
	Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when where and how it works best for you. Visit the website or call to register.	Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care, to keep track of medications.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room.
Conditions Treated	• Colds and flu • Rashes • Sore throats • Headaches • Stomachaches • Fever • Allergies • Acne • UTIs and more	• Colds and flu • Rashes or skin conditions • Sore throats, earaches, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccine	• General health issues • Preventive care • Routine checkups • Immunizations and screenings	• Fever and flu symptoms • Minor cuts, sprains, burns, rashes • Headaches • Lower back pain • Joint pain • Minor respiratory symptoms • Urinary tract infections	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose
Your Cost and Time	• Costs the same or less than a visit with your PCP • Appointments in an hour or less • No need to leave home or work	• Same or lower than doctor's office • No appointment needed	• May charge coinsurance and/or deductible • Usually need appointment • Short wait times	• Costs lower than ER • No appointment needed • Wait times vary	• Highest cost • No appointment needed • Wait times may be long

24-Hour Nurse Line

When you need information and support for questions about your health, Aetna's 24-Hour Nurse Line is there to help. While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line nurses can provide information on more than 5,000 health topics, at any time and at no cost to you. Call 1-800-556-1555 or login to Aetna.com to get connected to one of Aetna's on-call nurses.

RESOURCES TO STRETCH YOUR DOLLARS

Pace University provides a variety of ways to help you budget and pay for daily expenses, which means less stress from big financial events during the year.

Health Savings Account (HSA)

Insured by Inspira Financial

Pace employees who are enrolled in the Consumer Core HDHP medical plan are eligible to enroll in a Health Savings Account (HSA). An HSA is a tax-exempt account in which participants can deposit funds from their paycheck to be used to pay for certain out-of-pocket healthcare expenses. The funds from your HSA can also be invested and grow tax-free, and those funds can also be used for eligible expenses.

You may withdraw funds, tax free, to pay for your qualified healthcare expenses, as well as your spouse and tax dependent children. Qualified medical expenses include those listed in IRC section 213(d) on the IRS website, similar to Healthcare FSA eligible expenses,including deductibles, copays, coinsurance amounts, over-the-counter drugs, and dental and vision expenses. Funds can be used to pay for COBRA, Long Term Care and certain Medicare premiums or withdrawn at age 65 without penalty (subject to ordinary income tax). Non-qualified withdrawals are subject to ordinary income tax and a 20% penalty

You're eligible to open an HSA if:

- You enroll in the Consumer Core HDHP
- Your only coverage is a high-deductible health plan, and you have not enrolled in Medicare coverage

If you're covered under your spouse's plan and that plan is not a high-deductible health plan or your spouse contributes to a Health Care Flexible Spending Account (FSA), then you are not eligible to contribute to an HSA.

How Does it Work?

- Once you enroll in the Consumer Core HDHP Medical Plan, you will have the ability to establish an HSA account.
- After opening your HSA, you will have the ability to contribute money pre-tax (via payroll deduction) up to the IRS maximum.
- You own the account and will continue to have access to it if you should leave the health plan, change jobs or retire.
- Use your HSA debit card to pay for qualified health care expenses for yourself, your spouse and your tax dependents.
- Once the HSA balance reaches $1,000, you may elect to invest the additional amount (in excess of $1,000) in an HSA Investment account (fees and charges may apply).

IRS Maximums 2025

- Single: $4,300
- Family: $8,550
- Catch-Up Contributions (55+): $1,000

Full details of the expenses you can claim can be found in IRS Publication 502.

Flexible Spending Accounts (FSAs)

Administered by BRI, an Inspira Financial Solution

A Flexible Spending Account is an employer-sponsored account in which employees can deposit funds from their paycheck pre-tax to be used to pay for eligible expenses. There are two Flexible Spending Accounts being offered through Inspira Financial.

If you elect to contribute funds to an FSA, you will reduce your taxable income while paying for services you would pay for anyway. If you choose to make an election, you will receive a debit card.

Carefully estimate the amount you wish to contribute and make sure your estimated expenses are IRS eligible expenses under the FSA. Visit **irs.gov** for more information on the "Use It or Lose It" rule and to find a listing of eligible expenses.

Health Care FSA

The funds from a Health Care can be used to pay for eligible out-of-pocket healthcare expenses. The Healthcare FSA is available to employees who are enrolled in either the Network Core plan or the Choice Plan. Eligible expenses include medical, dental and vision expenses for you and your qualified dependents that are not reimbursable by your insurance plan. Examples of qualified expenses include deductibles, coinsurance, copays, orthodontia, eyewear, saline solution, and amounts exceeding the allowable charge for a service that was performed by an out-of-network provider.

Dependent Care FSA

The funds from a Dependent Care FSA can be used for eligible dependent care services provided that allow you (and your spouse) to go to work, seek employment or attend school full-time. Eligible dependents include children under the age of 13, disabled children of any age, disabled spouse or elderly parent who spends at least 8 hours a day in your home and is your tax dependent.

Qualified expenses include child daycare, summer day camp, preschool and elder care expenses.

IRS Contribution Limits:

- Health Care FSA Spending Limit: $3,300/year
- Dependent Care FSA Spending Limit: $5,000/year (or $2,500 if married and filing taxes separately)

Be Sure to Spend your Money
FSA money is "use it or lose it." If you don't spend your money before 12/31/2025, any balance remaining in your account will be forfeited. Claims for reimbursement must be submitted to Inspira Financial no later than March 30 of the following calendar year.

See plan document for applicable Grace Period.

Commuter Reimbursement Accounts (CRAs)

Administered by BRI, an Inspira Financial Solution

The commuter benefit program, administered by BRI, allows you to set aside money, on a pre-tax basis via payroll deductions, to pay for eligible transit and parking expenses. This reduces your taxable income and increases your take home pay. You may elect to contribute up to $325 per month for transit expenses and/or $325 per month for parking expenses (or up to the IRS monthly maximums if they differ from what is noted above).

How it Works

Qualified transportation expenses include the cost that you might incur in your regular commute to and from work (using mass transit, parking, vanpooling). You will receive a debit card if you make a commuter benefit election.

Which Costs are Covered

Qualified transportation benefits cover specific forms of transportation expenses, including the cost for transit passes and qualified transportation expenses.

Transit Passes: Including tokens, fare cards, vouchers, or similar items that entitle you to use mass transit facilities or van pooling services offered by an outside vendor other than Pace University. You must use your debit card for eligible transit expenses.

Qualified Parking: Including parking close to your work location or at a location from which you commute to work.

You are not permitted to use a paper claim form to obtain reimbursement applicable to your qualified mass transit expenses. Paper forms are permitted for reimbursement of qualified parking expenses.

You can enroll or change your elections at any time throughout the year.

IRS Contribution Limits:

- Commuter FSA Spending Limit: $325/month
- Parking FSA Spending Limit: $325/month

You can obtain information on the status of your account by calling BRI at 1 (800) 473-9595 or logging in at **benefitresource.com**.

Note: The Company Code is **paceuniv**. The Member ID is your U#.

Dental Benefits

Insured by Aetna

To find in-network providers, go to aetna.com > Find a Doctor

Good oral care enhances overall physical health, appearance, and mental well-being.
Problems with teeth and gums are common and easily treated. Pace University offers two dental plans through Aetna.

DPPO Plan

The dental PPO plan gives members the option of seeing any dental provider in the Aetna network or you can use a non-network dentist. No referrals are needed for specialty care. Orthodontia is covered only for children (appliance must be placed prior to age 20). If you choose a non-network provider, Aetna will reimburse you a percentage of the allowable charge (claim form must be completed by you).

All services, except for preventive, are subject to the plan's annual deductible before Aetna pays their percentage of coverage. All benefits paid by Aetna including claims for preventive care accrue towards the plan's calendar year maximum. Each family member has their own annual maximum.

DHMO Plan:

Members enrolled in the DHMO plan choose a dental provider in the Aetna DHMO network to be their primary care provider, and referrals may be required for specialty care. Service costs on the DHMO plan are based on a set fee schedule, and there is no annual maximum for the plan. Preventive care is covered at 100%, and orthodontic services are available to members of any age. The DHMO plan is an in-network only plan, so you will not be reimbursed if you see an out-of-network provider.

Note: Employees/Dependents must elect a Primary Care Dentist under the DMO dental plan.

	PPO Plan		DHMO Plan
	PPO Network	Out-of-Network	DHMO Network Only
Annual Deductible* (Individual/ Family)	$50 / $150	$50 / $150	None
Preventive Services (Oral exams, cleaning, images)	100%	100%	100%
Basic Services (Root canal therapy, fillings, denture repairs)	90%	80%	Set Fee Schedule
Major Services (Inlays, onlays, crowns, implants)	60%	50%	Set Fee Schedule
Annual Benefit Maximum	$2,000	$1,500	Unlimited
Orthodontic Services**	60%	50%	Set Fee Schedule (Adult and Children)
Orthodontia Lifetime Maximum	$1,000	$1,000	Unlimited

**The deductible applies to: Basic & Major services only*
***Orthodontia is covered only for children (appliance must be placed prior to age 20).*
****Full dental benefit details are in the plan summary document*

Find the full schedule of benefits with the DHMO **here**.

Vision Benefits

Insured by Aetna

If you enroll in a medical plan with Pace University, you will be automatically enrolled in the Vision Plan.

Regular eye examinations can not only determine your need for corrective eyewear, but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone, therefore regular eye exams are recommended. All benefits eligible employees may elect to enroll in the vision plan offered by Aetna. The vision plan offers high-level coverage when visiting an in-network provider, and a reimbursement amount is available when seeing an out-of-network provider.

Aetna Vision Plan		
	In Network	**Out of Network**
Exam (Use your Exam Coverage once every Calendar Year)		
Eye Exam with Dilation as Necessary	$10 Copay	$45 Reimbursement
Retinal Imaging	Member pays discounted fee of $39	Not Covered
Standard Contact Lens Fit /Follow Up	Member pays discounted fee of $40	Not Covered
Premium Contact Lens Fit /Follow Up	10% off Retail Price	Not Covered
Frames (Use your Frame Coverage once every two Calendar Years)		
Any Frame available, including frames for prescription sunglasses	$0 Copay; $130 Allowance, 20% off balance over allowance	$71 Reimbursement
Standard Plastic Lenses (Use your Lens/Lens Option Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses)		
Single / Bifocal / Trifocal / Lenticular Vision	$20 Copay	$32 / $55 / $65 / $80 Reimbursement
Standard / Premium Progressive Lens (copay includes bifocal cost)	$85 Copay / $85 Copay; 80% of Charge less $120 allowance	$55 Reimbursement
Lens Options		
UV Treatment	Member pays discounted fee of $15	Not Covered
Tint (Solid And Gradient)	Member pays discounted fee of $15	Not Covered
Standard Plastic Scratch Coating	Member pays discounted fee of $15	Not Covered
Polycarbonate Lenses - Adult / Children to age 19	Member pays discounted fee of $40 / $0 Copay	Not Covered / $35 Reimbursement
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Photochromic/Transitions Plastic	20% off Retail	Not Covered
Other Add-Ons	20% off Retail Price	Not Covered
Contact Lenses (Use your Contact Lens Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses)		
Conventional	$0 Copay; $130 Allowance, 15% off balance over allowance	$105 Reimbursement
Disposable	$0 Copay; $130 Allowance	$105 Reimbursement
Medically Necessary	Covered in Full	$210 Reimbursement

PLANNING AHEAD

Pace University 403B Defined Contribution Retirement Account

Pace University provides employees with the opportunity to accumulate a source of retirement income on a tax-deferred basis in a 403(b) account. Full-time employees who meet the age and full-time service criteria are eligible to receive the University contribution. The University contributes 9% of your base salary to the plan, each pay period, if you contribute at least 3% of your base salary. You decide how to allocate the investment of both your required contributions and those made on your behalf by the University. You are 100% vested in all funds in the account.

To be eligible for the employer match, you must be:

- At least age 21 and completed two Years of Service,
- At least age 26 and completed one Year of Service ("Years of Service" is defined as 1,000 hours of service in a 12-month period).

Eligibility Criteria may be waived upon establishing service requirements stated above at another institution of higher education or 501(c)3 organization within three years of your full-time hire date at Pace.

The IRS determines the maximum allowable amount that can be contributed to a retirement account each year. In 2025, the maximum allowable contributions are:

- Deferral limit: $23,500
- Age 50 Catch-Up Deferrals: $7,500

Military service and certain predecessor employer service may be considered service with the Employer. Please see Summary Plan Description for details before you apply for service credit.

Life and Accidental Death and Dismemberment

Administered by Reliance Matrix

Basic Life and AD&D

Life and Accidental Death and Dismemberment (AD&D) Insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump-sum payment in the event of your death. Pace University provides active full-time employees with Basic Life and AD&D coverage equal to your annual salary up to $100,000 at no cost to you. You can designate your beneficiaries on the UKG site and make changes to your beneficiaries at any time.

Benefits reduce to 67% of original amount at age 70; to 50% of original amount at age 75. Conversion is available upon termination of employment, loss of any portion of your benefit, or employment status change if you become ineligible for benefits due to an employment status change.

Supplemental Employee Life and AD&D

Full-time employees have the option to purchase additional life insurance for themselves through Reliance Matrix. You may choose additional coverage equal to one, two or three times your annual salary, to a maximum of $750,000 (combined basic and supplemental coverage). The cost of supplemental coverage is based on your elected amount of coverage and your age.

Benefits reduce to 67% of original amount at age 70; to 50% of original amount at age 75.

- **Guaranteed Issue Amount:** $400,000
- **Coverage Available:** Choose 1x, 2x, 3x annual salary not to exceed $750,000 in combined basic and supplemental life.

Supplemental Spouse Life and AD&D

Full-time employees have the option to purchase life insurance for their spouse in the amount of $10,000. Spousal life insurance decreases to $6,700 at spouse's age 70 and $5,000 at spouse's age 75.

- **Guaranteed Issue Amount:** $10,000
- **Maximum Coverage Available:** $10,000

Supplemental Dependent Child Life and AD&D

Full-time employees have the option to purchase life insurance for their dependents ages 14-days to 19 years (23 if full-time student) in the amount of $5,000.

Guarantee Issue (GI) is the amount you can purchase as a newly eligible employee without having to provide evidence of good health.

Evidence of Insurability may be required if requested coverage amount is more than the Guaranteed Issue Amount.

Short-Term Disability (STD)

Administered by Reliance Matrix

Pace University provides eligible full-time employees with Short-Term Disability (STD) insurance at no cost. STD provides you with your weekly earnings in the event you become disabled and are unable to work due to an injury or illness for a period of time. The amount and duration of your salary continuation is based on your length of full-time service before the onset of the disability.

Employee Contribution	Pace Contribution
Less than 3 Months	No salary or benefits continuation. May be eligible for the NYS Disability benefit only.
3-12 Months	Eligible to a maximum of two (2) months at full base salary and up to four (4) additional months at one-half salary. This is the maximum benefit within a 52-week period.
12 Months and Over	Eligible to a maximum of 26 weeks at full base salary. This is the maximum benefit within a 52-week period.

Long-Term Disability (LTD)

Administered by Reliance Matrix

Pace University provides eligible full-time employees you with Long-Term Disability (LTD) Insurance at no cost after 1 year of continuous service. LTD provides a portion of your monthly earnings in the event that your disability due to an injury or illness continues past the 26 weeks of Short-Term-Disability. The LTD benefit is 60% of your monthly earning up to a maximum of $7,500 per month. LTD begins immediately following the 26th week of your disability and continues until age 65, or until you no longer meet the definition of disability, whichever occurs first. If 65+ at the time of disability, LTD continues for a maximum of 12 months.

Eligibility: All active full-time faculty and staff who have completed one year of continuous full-time service.

Enrollment: You will be automatically enrolled after completing 1 year of full time continuous service. You may be eligible to apply for service credit if you were covered for LTD by your previous employer. Please see plan certificate before you apply for service credit.

For more information or to file a disability claim
Call: (877) 202-0055
Visit: **matrixabsence.com**

Employee Assistance Program

Administered by Aetna

All employees are eligible to participate in the Employee Assistance Program (EAP) through Aetna. The EAP is a confidential, no-cost resource available 24/7/365 to help you and members of your household deal with a variety of life stages and/or concerns including:

- Depression, stress and anxiety
- Dealing with domestic violence
- Relationship difficulties
- Substance abuse and recovery
- Financial and legal advice
- Work-related issues
- Family issues and parenting
- Grief
- Child and elder care support
- Eating disorders

The program includes up to 3 phone or video consultations with licensed counselors, per household per calendar year.

Online Resources

The Resources for Living website offers a full range of tools and resources to help with your emotional wellbeing, work/life balance and more, including:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Live and recorded wellbeing webinars

Legal Services

You can get a free-30 minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions

If you opt for services beyond the initial consultation, you can get a 25% discount.

Financial Services

You can get a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issue
- Tax and IRS questions and preparation

You can also get a 25% discount on tax preparation services.

To access Resources for Living:
Call: (888) 238-6232
Visit: **www.resourcesforliving.com/login**
(Username: Pace University, Password: EAP)

Contributions

2025 Per Paycheck Rates

Medical & Vision Plans

	Employee Contribution	Pace Contribution	Pace Subsidy
Consumer Core HDHP/HSA Plan			
Employee	$33.62	$544.03	94%
Employee + 1	$281.07	$844.18	75%
Family	$421.63	$1,260.97	75%
Network Core Plan			
Employee	$129.04	$596.30	82%
Employee + 1	$422.46	$972.26	70%
Family	$631.85	$1,444.06	70%
Choice Plan			
Employee	$168.92	$656.40	80%
Employee + 1	$524.97	$1,064.35	67%
Family	$785.16	$1,581.50	67%

Medical Plan Waiver Reimbursement For Those Newly Waiving Coverage

For those who are currently covered under our Aetna medical plans and will be waiving coverage for the first time as of January 1, 2025, you will receive an annual (12-month) reimbursement of $960 ($40 per paycheck). Those who are currently waiving medical coverage, and will continue to do so as of January 1, 2025, will receive an annualized reimbursement of $960($40 per pay check).

Dental Plans

	Employee Contribution	Pace Contribution	Pace Subsidy
DPPO Plan			
Employee	$12.39	$16.19	57%
Employee + 1	$41.15	$20.59	33%
Family	$66.82	$24.51	27%
DMO Plan			
Employee	$2.91	$3.27	53%
Employee + 1	$7.48	$3.64	32%
Family	$15.00	$4.01	21%

Vision Plan

	Employee Contribution
Vision Plan	
Employee	$2.05
Employee + 1	$3.93
Family	$6.36

Helpful Insurance Terms

These terms will help you understand your benefits and coverage options.

Copay – a set fee you pay whenever you use certain medical services, like a doctor visit.

Deductible – the dollar amount you pay before your medical insurance begins paying deductible-eligible claims.

Coinsurance – the percentage of covered medical expenses you continue to pay after you've met your deductible and before you reach your out-of-pocket maximum.

Out-of-pocket maximum – the most you will pay annually / during the calendar year for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Balance billing – the amount you are billed by an out-of-network provider to make up the difference between what your provider charges and what insurance reimburses. This amount does not count toward your out-of-pocket maximum.

NEW! Ask Your Advocate

The Gallagher Benefit Advocate Center is ready to help you get the most from your benefits program by providing support to you and your family members at no cost to you. Your advocate can help you with questions related to:

- **Insurance cards:** Are you missing your insurance cards, need replacement cards or need to get in touch with an insurance carrier?
- **Benefits questions:** Do you need help with specific benefits questions relating to how plans work, coverage questions or in-network benefits?
- **Eligibility rules:** Who can be covered under the plan and when?
- **Provider search:** Do you need help finding an in-network or specialty provider?
- **Prescription/pharmacy issues:** Is the pharmacy telling you that your medication is not covered or charging you full price?

Call: (800) 370-4679
Email: **bac.pace@ajg.com**
Hours of Operation: Monday - Friday 8AM - 6PM

Contact Information

If you have questions about any of the benefit plan, contact the Gallagher Benefit Advocate Center or the University Benefits Office.

Benefit	Administrator	Phone #	Website
Medical/Pharmacy	Aetna	888-792-3862	**Aetna.com**
Health Savings Account	Inspira Financial	844-729-3539	**Inspirafinancial.com**
Dental	Aetna	888-792-3862	**Aetna.com**
Vision	Aetna	888-792-3862	**Aetna.com**
Employee Assistance Program	Aetna – Resources for Living	888-238-6232	**resourcesforliving.com**
Flexible Spending Accounts	Inspira Financial	844-729-3539	**Inspirafinancial.com**
Commuter Reimbursement Account	BRI, an Inspira Financial Solution	800-473-9595	**benefitresource.com**
Basic and Supplemental Life and AD&D	Reliance Matrix	877-202-0055	**Matrixabsence.com**
Short-Term and Long-Term Disability	Reliance Matrix	877-202-0055	**Matrixabsence.com**
403(b) Savings Plan	Pace University Benefits Office	800-842-2252	**tiaa.org**
Gallagher Benefit Advocate Center	Gallagher	800-370-4679	**bac.pace@ajg.com**

Legal Notices

This package contains the annual required ERISA notices for our employee benefit program for all employees joining the plan or current participants of the plan. Read carefully and keep in a secure place.

- Women's Health & Cancer Rights Act
- Newborns' and Mothers' Health Protection Act
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Paperwork Reduction Act Statement
- HIPAA Notice of Privacy Practices Reminder
- HIPAA Special Enrollment Rights
- Notice of Creditable Coverage
- Marketplace Notice
- Michelle's Law Notice

HIPAA Special Enrollment Rights

Pace University Group Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Pace University Group Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Pace University Benefits at 914-923-2828 or reach out via email at **benefits@pace.edu**.

Michelle's Law Notice

Eligibility for Continued Coverage for Dependent Students on Medically Necessary Leave of Absence

The Pace University Health Plan (Plan) provides dependent coverage for the children of its participants until a child has attained age 26, regardless of the child's status as a student. For children covered under the Plan after attaining age 26, Michelle's Law provides continued coverage for dependent children who are covered as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child has attained age 26 and is no longer a student, as defined in the Plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the Plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA Continuation Coverage

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Questions?

If you have any questions regarding the information in this notice or your child's right to Michelle's Law's continued coverage, or if you would like a copy of your Summary Plan Description (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact the Pace University Benefits Team.

Important Notice from Pace University Regarding Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice contains information about your current prescription drug coverage with Pace University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered and at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can receive assistance regarding prescription drug coverage is included at the end of this notice.

There are two important facts that you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can obtain this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Pace University has determined that the prescription drug coverage

offered by the Pace University Health Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can retain this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan and continue your current Pace University coverage, you have the option to do so.

- Your current medical and prescription drug coverage through Aetna remains unchanged for you and any enrolled dependents.
- Your employee contributions remain unchanged, even if you elect Medicare Part D prescription drug coverage – there is no reduction in your contribution.
- You are responsible for the entire cost of the Medicare Part D premium.
- Your current Pace University medical and prescription drug program will coordinate with your Medicare coverage in accordance with federal law.

If you do decide to join a Medicare drug plan and terminate your current Pace University coverage, you have the option to do so.

- When your coverage ends, coverage for your enrolled dependents will also end.
- You can re-enroll in the Pace University program in accordance with the Plan's procedures during an annual enrollment period, a special enrollment period, or if a qualified status change occurs that is consistent with the request for enrollment in accordance with Section 125.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Pace University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.

NOTE:You will receive this notice each year. You will also receive it prior to the next Medicare drug plan enrollment period and if this coverage through Pace University changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Note: Keep this Creditable Coverage Notice. If you decide to join one of the

Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	11/13/2024
Name of Entity/Sender:	Pace University
Contact—Position/Office:	Goldstein Academic Center
Office Address:	861 Bedford Road Pleasantville, New York 10570
Phone Number:	914-923-2828

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact Pace University Benefits, at 914-923-2828 or reach out via email at **benefits@pace.edu**.

Newborns' and Mothers' Health Protection 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 January 31, 2024. 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://myalhipp.com/**
Phone: 1-855-MyARHIPP 1-855-692-5447

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

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)

Medicaid Website:**Iowa Medicaid | Health & Human Services**
Medicaid Phone: 1-800-338-8366
Hawki Website:**Hawki - Healthy and Well Kids in Iowa | Health & Human Services** | Hawki Phone: 1-800-257-8563
HIPP Website: **Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)** | HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

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://kynect.ky.gov**
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/health-care-coverage/**
Phone: 1-800-657-3672

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. 15218
Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NEW JERSEY – MEDICAID AND CHIP

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)

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 AND CHIP

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

PENNSYLVANIA – 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)

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**
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

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

Website: **Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access**
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

WEST VIRGINIA – MEDICAID AND CHIP

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

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 January 31, 2024, 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

Marketplace notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.1, 2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Pace University Benefits at 914-923-2828 or reach out via email at **benefits@pace.edu**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Pace University		4. Employer Identification Number (EIN): 13-5562314
5. Employer address: Pace University, Goldstein Academic Center, 861 Bedford Road		6. Employer phone number: 914-923-2828
7. City: Pleasantville	8. State: NY	9. ZIP code: 10570
10. Who can we contact about employee health coverage at this job? Pace University Benefits		
11. Phone number (if different from above)	12. Email address: **benefits@pace.edu**	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

X Some employees. Eligible employees are: full time employees working at least 28 hrs per week

- With respect to dependents:

X We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

Disclaimer: This Benefits Guide is intended only to provide information for the guidance of Pace University employees. The writers of the content have exercised their best efforts to ensure accuracy of the information, but accuracy is not guaranteed. If there are any discrepancies between the information herein, on the benefits website, verbal representations, and the Plan documents, the Plan documents will always govern. The information is subject to change from time to time, and the University reserves the right to change or terminate these Plans at any time. The information contained in this guide is not intended to replace the plan documents, nor is the information in any way intended to imply a contract.