



Benefits Enrollment Guide
July 1, 2026 - June 30, 2027



Town of

Merrimac
Massachusetts

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CONTACTS

The Town of Merrimac
 2 School Street
 Merrimac, MA 01860
978-346-0524

CARRIER	PHONE NUMBER	WEBSITE/EMAIL
Town of Merrimac	Carol McLeod 978-346-0524	cmcleod@townofmerrimac.com
Harvard Pilgrim Health Care Medical Insurance	888-333-4742	www.harvardpilgrim.org
Express Scripts Pharmacy	800-282-2881	express-scripts.com
Altus Dental Insurance	1-877-223- 0588	Welcome to Altus Dental
NFP Claims Advocacy Benefit Concierge	Ben Admin: 877-835-1361 Option 1	Claims: CSclaims@nfp.com Benefits : DBbenadmin@nfp.com
ABACUS Diabetes Rebate Program	800-643-8028	GoodHealthGateway.com
Boston Mutual Life & AD&D	1-877-624-2249	Home Boston Mutual Life Insurance Company
AFLAC	978-870-5826	sean@kandabenefits.com
457 SMART Plan	877-457-1900	www.mass-smart.com

The Town of Merrimac is pleased to announce our partnership with NFP Advocacy.

We are your dedicated Claims Specialist Team!

If you need assistance submitting a **medical & dental claim** or have questions about your medical and dental plans, our team is here to help. We can guide you through the claim process, assist in completing the required forms, and help you gather the necessary documentation. We are committed to ensuring that you navigate the process smoothly and effectively.

NFP Claims Advocacy : We can assist with any claims inquiries and solve all your claims-related questions.

- **Medical & Dental**
- **Claim resolution / approvals**
- **Claim denials (appeals)**
- **Questions and concerns regarding health benefits**
- **Reimbursement requests**

Contact Information:

Monday through Friday 9 am EST – 6 pm EST

Toll Free Number: (877) 835-1361/Option 1

Email: CSclaims@nfp.com



The Town of Merrimac is pleased to announce our partnership with NFP Concierge.

We are your dedicated Benefits Specialists Team!

If you need assistance understanding your available plan options, completing the enrollment process, or finding specialized healthcare providers, we are here to help. We can guide you through medical and dental plan issues. Additionally, we provide support during injuries, illnesses, mental health care, or any challenges you may encounter with customer care and support.

NFP Concierge: We can assist with any inquiries and solve all your benefit-related questions.

- **Medical, Dental**
- **Benefit Questions**
- **ID Card Issue**
- **Prescription Issues**
- **Provider Network Questions**

Contact Information:

Monday through Friday 9 am EST – 6 pm EST

Toll Free Number: (877) 835-1361 / Option 1

Email: DBbenadmin@nfp.com



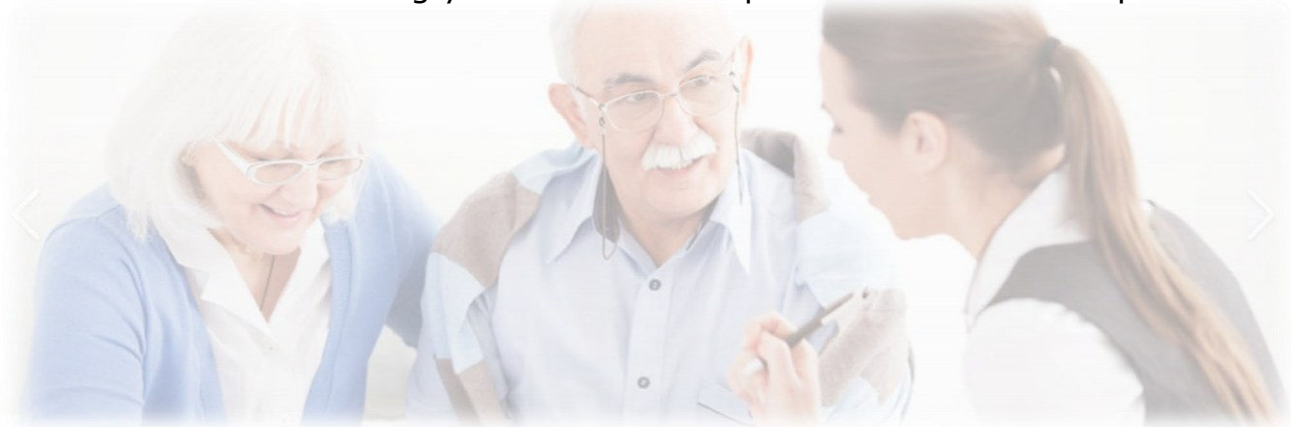
Retiree First provides you with personalized support from healthcare-benefits experts.

As a Medicare-enrolled retiree or soon-to-be retiree, you will have access to a dedicated phone line connecting you to a team of Retiree Advocates who understand the unique healthcare needs of retirees. Our Retiree Advocates take full responsibility for follow-up calls and provide comprehensive support to resolve your issues.

We offer an end-to-end resolution for your healthcare concerns to ensure your benefits experience is stress-free. Here are some of the services we provide:

- Assistance with personal information changes and card replacements
- Copay assistance programs
- Outreach to physicians and pharmacies
- Inbound and outbound three-way calls to Medicare, vendors, providers, pharmacies, and Social Security
- Financial assistance, including support for low-income premium subsidy (LIPS) filing
- Help with pharmacy-related questions such as generic availability, prior authorizations, and mail-order services
- authorizations, and mail-order services
- Support for in-person or virtual appointment scheduling and enrollment in wellness programs
- Assistance with claims, billing, and payment inquiries

We are committed to making your healthcare experience as smooth as possible.



For assistance, call Retiree First at **508-744-6804 (TTY 711)** to speak with your dedicated MSHG Retiree Advocate.

ENROLLMENT

OVERVIEW: OPEN ENROLLMENT FY 2027

The Town of Merrimac offers benefits to eligible employees, including various plan options. This guide helps you enroll. You can pay for medical and voluntary plans with pre-tax payroll deductions, saving money on taxes and lowering your salary deductions before federal income and Social Security taxes.

**Open enrollment will begin today, May 12th, 2026, through May 27th, 2026.
Any changes made during this time will be effective as of July 1, 2026.**

During the Open Enrollment period, you have the opportunity to review and adjust your health plan choices. If you wish to change your coverage or add or remove dependents, now is the appropriate time to implement those changes. **If you do not make any changes, your current plan selection will automatically carry over into the new year.** If you wish to change your coverage or add or remove dependents, now is the appropriate time to implement those changes.

When Can You Change Your Benefits:

you can review and change your benefits for the upcoming open enrollment for FY27.

This is the only time to you can make changes to your plans, unless you experience a Qualified Life Event. If you have a qualifying event, you have 30 days from the date of the event to update your benefits. The Treasurer-Collector's office will require supporting documentation for the event.

How to Make Plan Changes During Open Enrollment:

Please log into the town website at www.townofmerrimac.com (1) Click on the "Finance Directors" tab. (2) Click on "Employee Resources." Choose the PDF enrollment form you wish to use to make plan changes.

Please complete a form for each benefit you want to enroll in or change. If plan change enrollment forms are not submitted to Carol McLeod at cmcleod@townofmerrimac.com by May 27th, you will not be enrolled and will have to wait until the next Open Enrollment period or qualifying life event to make plan change elections. If you choose to add or remove dependents on your medical and dental plans, you must provide proof of their eligibility. These documents must accompany your enrollment paperwork; otherwise, your dependents will not be enrolled or removed

QUALIFYING EVENTS	
Death	Marriage
Loss of Previous Coverage	Divorce
Gained New Coverage	Birth

INFORMATION FOR NEW HIRES

Before Enrollment

All new hires are eligible for benefits starting on their hire date. Eligible employees **have 30 days** from their Start date or within 30 days of your special enrollment period due to a qualifying life event.

If you elect to cover your dependents on your medical and dental benefits, proof of dependent eligibility is required. These documents must accompany your paperwork, or your dependents will not be enrolled or removed.

New Employee Enrollment

Please log into the town website at www.townofmerrimac.com

(1). Click on the "Finance Directors Tab". (2) Click on "Employee Resources." Choose the Pdf enrollment form you desire to make plan changes..

Please complete a form for each benefit you want to enroll in or change. If plan change enrollment forms are not submitted to Carol McLeod cmcleod@townofmerrimac.com

After Enrollment

- **Medical Insurance:** If you elect coverage, you will receive an ID card in the mail that should be used for all medical and prescription services.
- **Rx Prescription Drug Coverage:** Your HPHC ID card has a **new Prescription Drug ID number under Express Scripts**. Be sure to provide this number to your pharmacist and mail-order service to prevent a disruption in your prescription drug coverage.
- Your New ID card contains important information about you, your employer group, and the benefits you are entitled to.
- Always remember to carry your ID card with you, present it when receiving health care services or supplies, and ensure your provider has an updated copy of your ID card.
- **Dental & Vision Insurance:** **Altus Dental & Vision** will provide one dental & vision insurance card for individual and family plans. Covered dependents must present a copy of the subscriber's card at the time of service for proper verification.

If you do not receive Medical or Dental ID at the time of enrollment, please reach out to the carrier directly or contact

NFP Benefit Concierge Benefits Assistance

at DBbenadmin@nfp.com or phone @ (877) 835-1361 / Option 1

ELIGIBILITY AND ENROLLMENT

Eligibility:

Generally, you are eligible for health coverage if you are a regular, **full-time employee working at least 20 hours per week.**

- If you're eligible for health coverage, you may also cover your eligible dependents, which include but are not limited to:
- Your legal spouse or former spouse, unless either party has remarried or is not court-ordered.
- *You are not able to cover an ex-spouse and a current spouse.*
- Children up to age 26 (including birth children, stepchildren, legally adopted children, foster children, and children for whom you have legal guardianship)
- Your unmarried child over the age of 26, if physically or mentally handicapped and claimed as a dependent on your federal income tax return.

Required Documents for Dependents

To enroll a family member, you must submit a completed application and documentation verifying your dependent's eligibility. You must also provide the Social Security number for each dependent. To add your dependents to the health and dental plans, the following information is required:

- Spouse: Marriage Certificate
- Ex-Spouse: Divorce decree showing you are required to continue coverage
- Child(ren): Birth Certificate
- Step-Child(ren): Birth Certificate with your spouse listed as a parent.

GENERAL:

- **The Town of Merrimac** fiscal year is **July 1st through June 30th.**
- Medical insurance aligns with the fiscal year, **July 1st through June 30th.**
- Voluntary Dental & Vision insurance aligns with the fiscal year, **July 1st through**

INSURANCE RATES- Medical

**MEDICAL INSURANCE
 MASSACHUSETTS STRATEGIC HEALTH GROUP (M S H G)
 ADMINISTERED BY HARVARD PILGRIM HEALTH CARE (HPHC)
 July 1st, 2026 - June 30th, 2027**

**Cost Share Town & School
 55% Employer / 45% Employee**

Plans 55% Employer 45% Employee		Full Monthly Premium	Employee Share Bi-Weekly 26 Deductions
			Emp share 45%
HPHC ChoiceNet Open Access -HMO	Family	\$3,571.72	\$741.82
	Individual	\$1,604.10	\$333.16
HPHC Access America Value -EPO	Family	\$3,322.47	\$690.05
	Individual	\$1,491.80	\$309.84
HPHC ChoiceNet BB PPO	Family	\$4,390.29	\$911.83
	Individual	\$1,972.93	\$409.76

**Light Union Members Only
 70% Employer / 30% Employee**

		Full Monthly Premium	Employee Share Bi-Weekly 26 Deductions
			Emp share 30%
HPHC ChoiceNet Open Access -HMO	Family	\$3,571.72	\$494.55
	Individual	\$1,604.10	\$222.11
HPHC Access America Value -EPO	Family	\$3,322.47	\$460.03
	Individual	\$1,491.80	\$206.56

INSURANCE RATES- Dental & Vision

ALTUS DENTAL INSURANCE

July 1st 2026 – June 30th, 2027

Coverage Type	Altus Low Plan	Altus High Plan
Individual Employee	\$44.64	\$57.04
Family	\$122.74	\$160.10

ALTUS VISION

Individual Employee	\$5.05
Employee + Spouse	\$10.10
Employee + Child(ren)	\$12.96
Family	\$19.81

MEDICAL INSURANCE



Log in to the Harvard Pilgrim Health Care Portal [Home | Harvard Pilgrim Health Care](#) for detailed benefit summaries or contact customer service representative for specifics about your plan.

HPHC Best Buy ChoiceNet PPO		
	In-Network	Out of Network
Plan Year Rx Deductible Single / Family	\$250 / \$750	\$400 / \$800
PY-Medical Max Out-of-Pocket (included deductible, coinsurance)	\$2,500 / \$5,000	
Plan Year Rx Out-of-Pocket Max	\$3,000 / \$6,000	
Preventive Care		
Preventive Care Routine Testing	No Charge	20% coinsurance
Other Services		
Office Visit - Primary Care	\$20 copay	20% coinsurance
Office Visit – Specialist	\$35 copay	20% coinsurance
Diagnostic Lab & X-Ray	No Charge (Non-Hosp Based)	20% coinsurance
CT, MRI, & PET Scan	\$100 Copay (after deductible)	20% coinsurance
Out- Patient Surgery	\$150 Copay (after deductible)	20% coinsurance
Inpatient Hospital General Hospital Higher Cost Share Hospital	(Tier 1&2) \$300 Copay per admission (Tier 3) \$700 Copay per admission	20% coinsurance
Behavior Health Hospital Service	\$200 Copay	20% coinsurance
Behavioral Health Office Visit	\$20 copay	20% coinsurance
Occupational & Physical Therapy (30 visits each per plan yr.)	\$20 copay	20% coinsurance
Ambulance	No Charge	
Emergency Room (copay waived if admitted)	\$100 Copay	
Urgent Care	\$35 copay	20% coinsurance
Pharmacy Benefits- Express Scripts		
Retail Pharmacy (30-day supply)	\$10 (Generic) / \$25 (Preferred Brand) / \$50 (Non-Preferred Brand)	
Mail Order (90-day supply)	\$20 (Generic) / \$50 (Preferred Brand) / \$110 (Non-Preferred Brand)	

Log in to the Harvard Pilgrim Health Care Portal [Home | Harvard Pilgrim Health Care](#) for detailed benefit summaries or contact customer service representative for specifics about your plan.

HPHC-Access America Value EPO	
In-Network Only	
Plan Year Rx Deductible Single / Family	\$250 / \$750
PY-Max Out-of-Pocket (included deductible, coinsurance and copays)	\$2,500 / \$5,000
Plan Year Rx Out-of-Pocket Max	\$1,000 / \$2,000
Preventive Care	
Preventive Care & Routine Testing When performed in-network	No Charge
Other Services	
Office Visit - Primary Care	\$20 copay
Office Visit – Specialist	\$35 copay
Chiropractic Visits (20 per plan year)	\$20 copay
Diagnostic Lab & X-ray	No Charge
CT, MRI, & PET Scan	\$100 Copay (after deductible)
Out- Patient Surgery	\$150 Copay (after deductible)
Inpatient Hospital	\$300 Copay(after deductible)
Behavior Health Hospital Service	\$200 Copay(after deductible)
Behavioral Health Office Visit	\$20 copay
Occupational & Physical Therapy 30 visits each per plan year	\$20 copay
Ambulance	No Charge
Emergency Room (copay waived if admitted)	\$100 Copay Per Visit (after deductible)
Urgent Care	\$35 copay
Pharmacy Benefits- Express Scripts	
Retail Pharmacy (30-day supply)	\$10 (Generic) / \$25 (Preferred Brand) / \$50 (Non-Preferred Brand)
Mail Order (90-day supply)	\$20 (Generic) / \$50 (Preferred Brand) / \$110 (Non-Preferred Brand)

Log in to the Harvard Pilgrim Health Care Portal [Home | Harvard Pilgrim Health Care](#) for detailed benefit summaries or contact customer service representative for specifics about your plan.

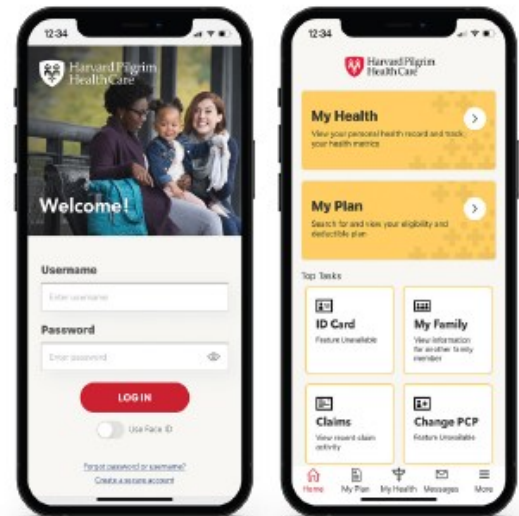
HPHC ChoiceNet Open Access HMO	
In-Network Only	
Plan Year Rx Deductible Single / Family	\$250 / \$750
PY-Max Out-of-Pocket (included deductible, coinsurance and copays)	\$2,500 / \$5,000
Plan Year Rx Out-of-Pocket Max	\$1,000 / \$2,000
Preventive Care	
Preventive Care & Routine Testing When preformed in-network	No Charge
Other Services	
Office Visit - Primary Care	\$20 copay
Office Visit – Specialist	\$35 copay
Chiropractic Visits (20 per plan year)	\$20 copay
Diagnostic Lab & X-Ray	No Charge
CT, MRI, & PET Scan	\$100 copay after deductible
Out- Patient Surgery	\$150 copay after deductible
<u>Inpatient Hospital</u> General Hospital Higher Cost Hospital	\$300 copay after deductible \$700 copay after deductible
Behavior Health Hospital Service	\$200 copay after deductible
Behavioral Health Office Visit	\$20 copay
Occupational & Physical Therapy (30 visits each per plan yr)	\$20 copay
Speech Therapy	\$20 copay
Ambulance	No Charge
Emergency Room (copay waived if admitted)	\$100 copay per visit
Urgent Care	\$35 copay
Pharmacy Benefits- Express Scripts	
Retail Pharmacy (30-day supply)	\$10 (Generic) / \$25 (Preferred Brand) / \$50 (Non-Preferred Brand)
Mail Order (90-day supply)	\$20 (Generic) / \$50 (Preferred Brand) / \$110 (Non-Preferred Brand)

Member Secure Account and Mobile App

Quickly access your benefits

Log in at harvardpilgrim.org/login or activate your secure online account at harvardpilgrim.org/create or via the Harvard Pilgrim mobile app¹, to quickly and securely access your health plan benefits information.

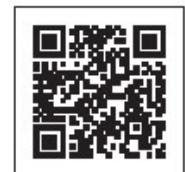
- Understand your coverage
- Check your claims, referrals, and authorizations
- View plan limits, including your out-of-pocket costs
- Find a doctor or a hospital
- Explore Behavioral Health resources
- Select or change your Primary Care Provider (PCP)
- Estimate your costs²
- Access health and wellness resources
- View your ID card and add it to your Apple Wallet or Google Pay
- Email Member Services through the secure messaging tool



Watch our member secure account video:



English



Spanish

Log in to the Harvard Pilgrim Health Care Portal [Home | Harvard Pilgrim Health Care](#) for detailed benefit summaries or contact customer service representative for specifics about your plan.

How to Find a Doctor

Our Online Provider Directory Helps Make it Easier

Looking for a Primary Care Provider (PCP), Specialist or Hospital? You can use our “Find a provider” online tool to look up your plan’s participating providers. The tool is updated five days per week to reflect the most recent providers in our network.

Get Started in 3 Simple Steps:

- 1. Log in to your secure member account** at harvardpilgrim.org for personalized search results. If you don’t have an account, visit harvardpilgrim.org/create to activate your secure online account and access your plan’s directory.
- 2. Click on “Find a provider”** on the top right of the webpage and refine your search by specialty, location, name or distance.
- 3. Narrow your options** by checking details such as in-office and virtual availability, and whether providers are accepting new patients.



You can also search for providers without logging into your secure account. To search for participating providers, visit harvardpilgrim.org/providerdirectory. You will need to select your plan name, mentioned on the top right of your member ID card.

How to Select or Change Your PCP

- **Log in to your member account** and click “Change PCP” under the “Your Plan Snapshot” section.
- **Search for your PCP** by location, provider name or provider ID. Click “Select PCP.”
- **Save your choice** to help ensure your care is coordinated, especially for plans that require in-network providers. Your PCP can also assist in coordinating any specialty care you might need.

> Need Assistance?

Call Members Services at the number on the back of your member ID card.

Fitness Reimbursement Form Instructions

Please read the instructions below, then fill out the Fitness Reimbursement Form.

Want your reimbursement faster? Submit your request online at harvardpilgrim.org/fitnessreimbursement

Getting reimbursed is easy

Please enclose copies of the following:

- Copy of your health/fitness membership agreement
- Completed Fitness Reimbursement Form
- Receipts showing that you paid for at least four months in a calendar year for membership or subscription fees (must show your name and the facility or program name). Fees must equal or exceed amounts being claimed.



Mail to:

Harvard Pilgrim Health Care
P. O. Box 9185
Quincy, MA 02269

Frequently Asked Questions

How do I qualify for a fitness reimbursement?

- You must be eligible for fitness reimbursement through your Harvard Pilgrim plan.
- Fitness facility or other qualified fitness membership must be for at least four months in a current calendar year.
- Current Harvard Pilgrim membership must be at least four months in a calendar year and must coincide with four months of fitness membership or subscription.

When can I submit my Fitness Reimbursement Form?

- Starting on May 1 of the current calendar year and when you have met the above-stated criteria.

Weight Management Program

Get reimbursed for fees you pay toward qualified weight management programs¹

Frequently Asked Questions

How do I qualify for a weight management reimbursement?

- Your employer must offer Harvard Pilgrim's weight management reimbursement benefit².
- You must be active with coverage that includes the weight management program benefit.

When can I submit my Reimbursement Form?

- Starting with January 1 of the current calendar year and when you have met the above stated criteria.
- Submission must be received by March 31 of the following year.
- Subscribers may submit for weight management reimbursement for themselves and/or dependents only once per calendar year.

What qualifies for reimbursement?

- Eligible programs include Weight Watchers® digital, traditional or At-Work programs, as well as hospital-based weight loss programs.
- Not eligible for reimbursement: Fees for individual counseling sessions; food, books, videos, scales or other items not included as part of the fee for the course or class.

How much can I claim for reimbursement?

- You'll be reimbursed up to the maximum amount offered through your employer. Reimbursement varies, so please check with your employer for your specific reimbursement amount.

What happens after I submit the Reimbursement Form?

- Once you submit your request, reimbursement takes up to eight weeks. We'll send a check to the subscriber's address of record, made payable to the subscriber.

> Questions? Call Member Services at **888-333-4742**

How to submit your reimbursement request

Log in to your secure member account at harvardpilgrim.org/reimbursement, or submit the form on page 2 by mail. Include paid receipts verifying enrollment in a qualifying weight management program (receipts must show name of the member, name of the program, amount paid per session(s), and date(s) paid).

Mail to:

Harvard Pilgrim Health Care
P. O. Box 9185
Quincy, MA 02269

¹ Reimbursement may be considered taxable income. For tax information, consult your employer or tax advisor.

² Ask your employer or review your plan documents in your member account to see if your coverage includes this benefit.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Benefits Summary

MSHG-TOWN OF MERRIMAC LOW PLAN

Group Number 3333

Altus Dental Plus –Included Connection Dental DentMax Networks

Annual Maximum

\$500

Maximum Lifetime Cap

Unlimited

Deductible

Individual \$0

Family \$0

Dependent Coverage

Dependent children are covered under these benefits up until the end of the month that they turn 26.

Plan pays 100%; Member Coinsurance 0%

- Oral exam twice per calendar year
- Cleaning two per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- Bitewing x-rays one set per calendar year
- Complete x-ray series or panoramic film once every 36 months.
- Single x-rays as required
- Sealants for children under age 16, once every 36 months on unrestored permanent molars

Monthly Premium effective 7/1/25 -6/30/28

Individual: \$22.00 Two Person:\$44.00 Family: \$68.20

P Pre-treatment Estimate Recommended

A Prior Authorization Required

See back page for additional information >

MSHG TOWN OF MERRIMAC HIGH-PLAN

Benefits Summary

Group Number 3333-0001

Altus Dental Plus –Included Connection Dental DentMax Networks

Exams, cleanings, bitewing x-rays, single x-rays, fluorides, sealants and full mouth/Panorex x-rays do not count against your annual maximum.

Annual Maximum

\$1,750

Elective Orthodontic Lifetime Maximum

\$1,000

Maximum Lifetime Cap

Unlimited

In-Network Deductible

Individual \$0

Family \$0

Out-of-Network Deductible

Individual \$50

Family \$150

Dependent Coverage

Dependent children are covered under these benefits up until the end of the month that they turn 26.

P Pre-treatment Estimate Recommended

A Prior Authorization Required

See back page for additional information >

In Network: Plan pays 100%; Member Coinsurance 0%

Out of Network: Plan pays 100%; Member Coinsurance 0%

- Oral exam twice per calendar year
- Cleaning three per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- Bitewing x-rays one set per calendar year
- Complete x-ray series or panoramic film once every 36 months.
- Single x-rays as required
- Sealants for children under age 16, once every 36 months on unrestored permanent molars
- Space maintainers unilateral space maintainers once per lifetime for lost deciduous (baby) teeth. Bilateral space maintainers once every 60 months for lost deciduous (baby) teeth

In Network: Plan pays 100%; Member Coinsurance 0%

Out of Network: Plan pays 80%; Member Coinsurance 20% - (Deductible Applies)

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings and composite (white) fillings
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth one procedure per tooth per lifetime.
- P • Root planing and scaling once per quadrant every 24 months
- P • Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered)
- P • Gingivectomies once per site every 24 months
- P • Soft tissue grafts once per site every 60 months
- P • Crown lengthening once per site every 60 months
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Periodontal maintenance following active therapy two per year

In Network: Plan pays 60%; Member Coinsurance 40%

Out of Network: Plan pays 50%; Member Coinsurance 50% - (Deductible Applies)

- P • Crowns over natural teeth, build ups, posts and cores replacement limited to once every 60 months
- P • Bridges and crowns over implants replacement limited to once every 60 months
- P • Partial and complete dentures replacement limited to once every 60 months
- P • Surgical placement of endosteal implant and abutment replacement limited to once every 60 months

In Network: Plan pays 50%; Member Coinsurance 50%

Out of Network: Plan pays 50%; Member Coinsurance 50%

- P • Elective braces and related services for dependent children under the age of 19. Subject to a lifetime maximum. No pre-approval required.

Monthly Premium effective 7/1/25 -6/30/28

Individual: \$57.04 Two Person: \$89.29 Family: \$160.10

VOLUNTARY – VISION INSURANCE



You and your family have the option to enroll in Altus Vision. The best benefits are available when you choose a doctor from the **In-Network Coverage with VSP Choice Network**. Vision is a voluntary benefit and is fully funded by employees. To find an eye doctor in the Insight Network, please visit <https://vision.altusdental.com>



Benefit	Frequency	In-Network	Out-of-Network
Exam	One visit per plan year (12 months)	\$10 Copay	Up to \$55
Lenses	One visit per plan year (12 months)	\$25 Copay	Up to \$100 (amount varies)
Frames	One visit per plan year (24 months)	\$150 allowance	Up to \$70
Contact Lenses	One visit per plan year (12 months)	\$150 allowance	Up to \$120 (Elective) Up to \$210 (Necessary)

VOLUNTARY – VISION INSURANCE

Altus Vision™ in partnership with VSP® Vision Care

Benefits Summary: Altus Vision™ - 150

Benefit	Description	Copay	
In-Network Coverage with VSP Choice Network: 45,000 Preferred Providers 117,000 Access Points			
WELLVISION® EXAM			
Exams 1 exam every 12 months	• Comprehensive eye exam to ensure overall visual wellness	\$10	
PRESCRIPTION GLASSES			
Frames 1 pair every 24 months	<ul style="list-style-type: none"> • \$150 allowance for wide selection of frames • 20% savings on amount over allowance. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied • Frame allowance backed by a wholesale guarantee, meaning VSP fully covers more frames than retail allowance plans • Allowance may differ at Costco® Optical, however it is of equivalent value. Costco® Optical allowance of \$80 is equivalent to \$150 frame allowance at VSP doctor locations and participating retail chains 	\$25	
Lenses 1 pair every 12 months	• Single vision, lined bifocal, lined trifocal, and lenticular lenses		
Covered Lens Enhancements	<ul style="list-style-type: none"> • Impact-resistant lenses for children • Standard Progressive Lenses 	\$0	
CONTACT LENSES (instead of glasses)			
Contacts Every 12 months	<ul style="list-style-type: none"> • \$150 allowance for contacts • Contact lens fitting and evaluation 	\$0 Up to \$60	
VALUE-ADDED PROGRAMS			
VSP Essential Medical Eye Care Program	<ul style="list-style-type: none"> • Exams and services to treat immediate issues like pink eye and sudden changes in vision • Treatment options to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more • Members with diabetes who do not have diabetic eye disease receive full retinal screening at no cost. Members with diabetic eye disease, glaucoma, and age-related macular degeneration (AMD) receive additional exams and services with \$20 copay. Limitations and coordination with medical coverage may apply. Ask your VSP network doctor for details 		
Extra Savings			
Additional Lens Enhancements	<ul style="list-style-type: none"> • Average savings of 30% on enhancements including tints, UV protection, scratch-resistant coating, anti-glare coating and more • Discount rate for Premium Progressive Lenses: \$95-\$105; Custom Progressive Lenses: \$150-\$175 		
Featured Frames	• Extra \$20 allowance on featured brands like bebe®, Calvin Klein, Flexon®, Lacoste, Nike, and more. Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Not applicable at Costco® Optical. Ask your VSP network doctor for more details		
Additional Glasses and Sunglasses	• 20% savings on additional prescription or non-prescription glasses and/or sunglasses from any VSP provider within 12 months of last WellVision Exam		
Laser Vision Correction	• Average 15%-20% savings. See VSP.com for more information		
TruHearing®¹	• Save up to 60% on the latest brand-name hearing aids. Visit TruHearing.com/VSP or call 877.396.7194 for more information		
Monthly Rates			
Employee Only	Employee & Spouse	Employee & Child(ren)	Family
\$5.05	\$10.10	\$12.96	\$19.81

See reverse side for more information.



Registering with Express Scripts

Online access to savings and convenience

Manage your medicines anywhere, any time with [express-scripts.com](https://www.express-scripts.com) and the Express Scripts® mobile app

Register now so you can experience:

- More savings.**
 Compare prices of medicines at multiple pharmacies. Get free standard shipping¹ from the Express Scripts PharmacySM.
- More convenience.**
 Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.
- More confidence.**
 Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.
- More flexibility.**
 Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.

Get Started Today!

Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

- Go to [express-scripts.com](https://www.express-scripts.com) and select **Register**, or download the Express Scripts mobile app for free from your mobile device's app store and select **Register**.
- Complete the information requested, including personal information and member ID number or Social Security number (SSN). Create your username and password, along with security information in case you ever forget your password.
- Click **Register now** and you're registered.
- To set preferences,² select **Communication Preferences** from the menu under **Account**, then scroll to **Communication and Viewing Preferences**. Click **Edit preferences**. Preferences can only be selected via the member website.

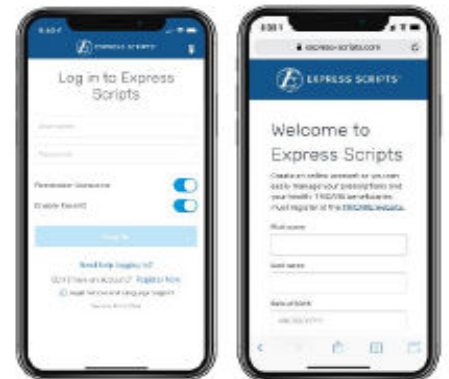
Members who have touch or facial ID authentication on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

¹ Standard shipping costs are included as part of your prescription plan benefit.

² Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, iPad®, and Android™ mobile devices.





Member Services Quick Reference Card

Member Services for Member Support

RxBenefits' experienced, high-performing call center team delivers a superior level of service.

Availability

Member Services assists you with questions or concerns regarding your pharmacy benefits such as:

- Benefit Details
- Claims Status
- Pharmacy Network
- Coverage Determination/Inquiries
- Mail and Specialty Scripts
- Pharmacy Information

**800.334.8134 or
CustomerCare@rxbenefits.com**
7:00 AM to 8:00 PM CT
Monday – Friday

Key Details on Common Issues

Pharmacy Benefits & Coverage Inquiries

As plan members, you and your dependents can call for questions related to:

- Coverage Questions
- Clinical Programs
- Copay
- Deductible Issues

Paper Claims

Submit prescription receipts along with your specific PBM's claim form to be processed for direct reimbursement. Claims should be mailed to the address listed on your ID card or fax them to RxBenefits at 205.449.5225.



PHARMACY BENEFITS

The test strips you currently use may no longer be covered on your drug list.*

Please see the enclosed letter for more information. Talk to your doctor about OneTouch® products to avoid paying full cost for your diabetes supplies.

Latest Innovation



OneTouch Verio Flex®



OneTouch Verio®

OneTouch Verio Flex® meter

Takes the guesswork out of your numbers

- ColorSure® technology shows if results are in or out of range
- Optional Bluetooth® capability for connectivity to the OneTouch Reveal® mobile app

OneTouch Verio® meter

Provides helpful information, without any extra work

- ColorSure® technology shows if results are in or out of range
- Automatic messages with every result

To order a OneTouch Verio® system at no charge visit www.OneTouch.orderpoints.com and input order code 573EXP333 or call 1-800-668-7148 and provide order code 573EXP333.



* Your prescription benefit is managed by Express Scripts. Some health plans may have more than one test strip covered at the lowest co-pay. The Bluetooth® word mark and logos are registered trademarks owned by Bluetooth SIG, Inc. and any use of such marks by LifeScan Scotland Ltd. and its affiliates is under license. Other trademarks and trade names are those of their respective owners.
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DIABETES CARE REWARDS PROGRAM

The Good Health Gateway® Diabetes Care Rewards Program is offered to MSHG active health plan members living with diabetes including type 1, type 2, juvenile, pre-diabetes, or gestational diabetes. As an active health plan participant, you can enroll at any time.

When you join the program, you receive confidential, expert support and guidance to help you manage your diabetes while earning \$0 copays on covered diabetes medications and supplies for meeting the program requirements.

**How to get your Good Health Gateway
RX Rewards Card for \$0 copays**



How to earn your zero copay Good Health Gateway RX Rewards Card:

1. Register at GoodHealthGateway.com or by calling the **Member Services Line at 800-643-8028**.
2. Complete a telehealth call with our Diabetes Educator to develop your personal Diabetes Health Action Plan® Care Guide.
3. Submit confirmation of your completion of the program requirements:
 - ✓ Annual foot exam
 - ✓ Annual eye exam
 - ✓ Annual laboratory work-up of your fasting blood lipid levels
 - ✓ Annual laboratory work-up of your urine/protein levels
 - ✓ Laboratory work-up of your Hemoglobin A1c levels every 6 months
4. Receive your Good Health Gateway Rx Rewards Card for \$0 copays on covered diabetes medications and supplies at your local, in-network pharmacy or through OPTUMRx® Home Delivery.

The Good Health Gateway Diabetes Care Rewards Program is a HIPAA compliant Business Associate of Massachusetts Strategic Health Group. The Program is administered by Abacus Health Solutions, LLC.

800.643.8028
GOODHEALTHGATEWAY.COM

DID YOU KNOW....

These Voluntary Benefits are available to employees in the Town of Merrimac??



AND



Boston Mutual: Group Accident Coverage

- Coverage is 24 hrs/day, 7 days per week and you can cover spouses and dependents under the age of 26
- Plan pays set amounts of cash benefits for specific treatment due to injuries, whether those injuries occurred on the job or off the job
- Includes a \$100 health screening benefit once per year for things like bloodwork, pap smears, colonoscopies, PSA's, mammograms, and 15 others.

Boston Mutual: Critical Illness Coverage

- Pays a lump sum cash benefit directly to you upon diagnosis of a covered condition on the plan
- Covered conditions include:
 - Cancer
 - Heart Attack, Stroke, Heart Surgery
 - Coma and Paralysis
 - End Stage Renal Failure and Major Organ Transplants
 - Alzheimer's Disease and ALS... and many others
- Lump sum benefits range from 5K to 50K
- Includes a \$50 health screening benefit once per year for things like bloodwork, pap smears, colonoscopies, PSA's, mammograms, and 15 others.

Boston Mutual: Whole Life Insurance

- Guarantee approval from \$2/wk up to \$15/wk
- Available up to \$30/wk with simple underwriting (medical questions only)
- Family coverage available
- Guaranteed cash value, premium, portability, and guaranteed additional purchase.

Aflac: Short Term Disability

- Income Protection with a short term disability plan that you can design and customize
- 60% of pay

Contact: Sean Klingman phone: 978-870-5826 or email at sean@kandabenefits.com



FAMILY MATTERS. NO MATTER WHAT.®

Basic Life and Accidental Death & Dismemberment (AD&D) Benefit Summary

Designed for the Employees of

Town of Merrimac, MA

ELIGIBILITY & BENEFIT FEATURES

Class 1: All Active Employees.

Basic Life and AD&D: \$10,000

COST OF COVERAGE

The premium for your coverage is paid by you and your employer.

GUARANTEED ISSUE

No medical questions are required for amounts up to \$10,000 for first time applicants in their initial eligibility period.

REDUCTIONS IN BENEFITS

Your Life benefit amount will reduce upon retirement to \$1,000 .

Your AD&D benefit will terminate upon retirement.

* All insurance benefits shall terminate upon the employee's termination of employment.

ADDITIONAL FEATURES

Accidental Death & Dismemberment: Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. An additional death benefit is paid if death is the result of a covered accident.

Conversion: Employees have 31 days from the date of termination to convert their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or AD&D.

Waiver of Premium: If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface (does not apply to commercial flights); or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY – 120 Royall Street • Canton, MA 02021 • www.bostonmutual.com

Policy Series G0141-000980

335-5079 5/23

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Nonprofit
Locally based
Member driven

Serving Massachusetts communities since 1982



Life comes with challenges.
**Your Employee
Assistance Program
(EAP) is here to help.**

Your Employee Assistance Program can help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources, and referrals.

All services are at no cost to the employee, confidential, and available to you and your family members. This includes access to short-term counseling and the wide range of services listed below:

Mental Health Sessions

Manage stress, anxiety, and depression, resolve conflict, improve relationships, overcome substance abuse, and address any personal issues.

Life Coaching

Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and achieve greater balance.

Financial Consultation

Build financial wellness related to budgeting, buying a home, paying off debt, resolving general tax questions, preventing identity theft, and saving for retirement or tuition.

Legal Referrals

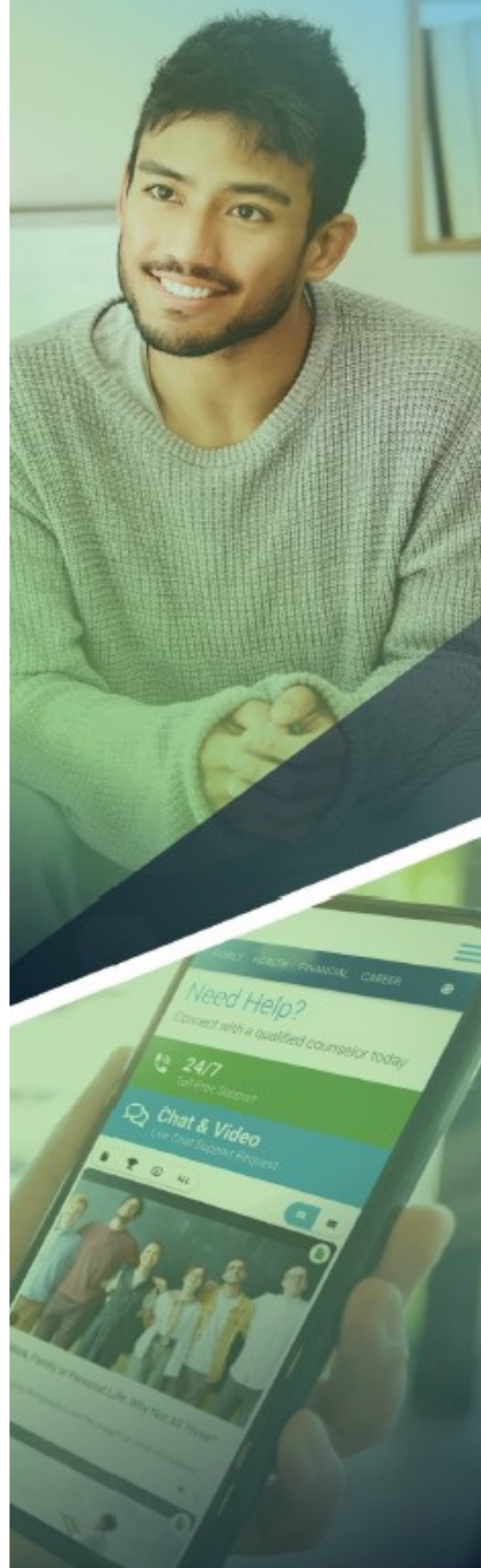
Receive referrals for personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Work-Life Resources and Referrals

Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Medical Advocacy

Get help navigating insurance, obtaining doctor referrals, securing medical equipment, and planning for transitional care and discharge.



Call: 800-451-1834
Visit: allonehealth.com/mia-eap



There are many features of the Massachusetts Deferred Compensation 457 SMART Plan with which you should become familiar. The SMART Plan is a voluntary retirement savings program authorized under section 457 of the Internal Revenue Code, commonly called a 457 deferred compensation program, that allows eligible employees to save and invest before-tax and after-tax dollars through salary deferrals (contributions). Below is a summary of some features of the retirement plan.

457 SMART PLAN

<p>When am I eligible?</p>	<p>You can contribute to the 457 SMART plan upon your hire date. Speak to a customer service representative by visiting SMART Plan website at www.mass-smart.com or by calling the SMART Plan Service Center at 877- 457-1900.</p>
<p>How much can I contribute before taxes?</p>	<p>Traditional 457 contributions are made with before-tax dollars, and earnings are taxed when distributed. You must contribute at least 1% of your gross income or \$10 per pay period.</p> <p>For 2026, you may contribute up to \$24,500, with an additional \$8,000 allowed if you're age 50 or older. If eligible, the Special Catch-Up provision lets you contribute up to \$49,000 per year for up to three years before retirement, based on your unused deferral limits.</p>
<p>How much can I contribute after taxes?</p>	<p>Roth 457 contributions are made with after-tax dollars, and both your contributions and any potential earnings grow tax-free, as long as IRS distribution requirements are met.</p> <p>The minimum contribution per pay period is 1% of your gross income or \$10, whichever is less.</p> <p>For 2026, you may contribute up to \$24,500, with an additional \$8,000 allowed if you are age 50 or older. If eligible, the Special Catch-Up provision allows you to contribute up to \$49,000 per year for up to three consecutive years before retirement, based on your previously unused elective deferral limits.</p>
<p>How do I know which contribution is the best choices for me?</p>	<p>You might want to consult with a financial planner, attorney, and/or tax advisor to help evaluate your situation. Take time to truly analyze your current financial circumstances, spending habits, and long-term retirement aspirations.</p> <ul style="list-style-type: none"> • If you are not yet participating in the SMART Plan, you can enroll on the website at by completing the Participant Enrollment form found on the website or by calling the SMART Plan Service Center at 877-457-1900. • If you're a current SMART Plan participant, you can change your contributions by logging in to your account at www.mass-smart.com Click on My Accounts, then My Contributions. You can also contact the SMART Plan Service Center at 877-457-1900.
<p>How do I modify my investments?</p>	<p>You may move money among the Plan's investment options or redirect your future contributions online. You can contribute to the 457 SMART plan upon your hire date. Speak to a customer service representative by visiting the SMART Plan website at www.mass-smart.com or by calling the SMART Plan Service Center at 877-457-1900</p>

Who is the Mass Strategic Health Group (MSHG) ?

Mass Strategic Health Group (MSHG) provides an inclusive environment where each community can choose solutions for their individual needs, while still being part of a larger group that ensures the best service and costs for you.

What do we offer ?

Your health and wellbeing is important, so MSHG is pleased to offer a comprehensive health benefits package to all eligible employees. Our benefits are designed to support you when you need it most. Some benefits are fully paid by MSHG, while others have a cost to the member, which allows you to create a benefits package that suits your individual needs.



DEFINITIONS



Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Maximum: Total dollar amount a plan pays during a plan year toward the covered expenses of each person enrolled.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Coinsurance: A percentage of the medical costs based on the allowed amount; you must pay for certain services after you meet your annual deductible.

Conversion: An Associate changes or “converts” her / his Group Life coverage to an Individual Life Insurance policy without having to answer any medical questions. Conversion is for an Associate who is leaving her / his job, reducing hours, or has reached the age when coverage may be reduced or eliminated, and still wants to maintain the protection that life insurance provides.

Copayment: A set dollar amount you pay for in-network doctor’s office visits, emergency room services, and prescription drugs.

Deductible: The total dollar amount you must pay out-of-pocket for covered medical expenses each plan year before the plan pays for services applicable to the deductible. The deductible does not apply to network preventive care and any services where you pay a copayment. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

DEFINITIONS

Generic Drugs: These drugs are usually the most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than purchasing formulary or non-formulary brand-name drugs.

In-Network: A group of health care providers, including dentists, physicians, hospitals, and other health care providers, that agrees to accept pre-determined rates when serving members.

Out-of-Network: A group of health care providers, including dentists, physicians, hospitals, and other health care providers, who do not participate in a health plan's provider network.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found in the formulary. You may purchase brand-name medications that are not on the recommended list but cost significantly more out-of-pocket.

Out-of-Pocket Maximum: The maximum amount a Plan member must pay towards covered medical expenses in a plan year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire amount for covered services for the remainder of the plan year.

Deductibles and copays apply to the annual out-of-pocket maximum. You may be balance billed for services rendered out-of-network.

PDP Fee: PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing, and benefits maximums.

Portability: An Associate carries or "ports" her / his current Group Life coverage after employment ends without having to answer any medical questions. Portability is for an Associate who is leaving her / his job but still wants to maintain the protection that life insurance provides.

Pre-tax Plan: A plan for active employees that is paid for with pre-tax money. The IRS allows for certain expenses to be paid for with tax-free dollars. The state takes premiums out of your check before taxes are calculated, increasing your spendable income and reducing the amount you owe in income taxes. Consequently, the IRS has tax laws that require you to stay in the plans you select for a full plan year (January through December). You can only make changes during Open Enrollment or if you have a qualifying event.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Provider: Any type of health care professional or facility that provides services under your plan.

Qualifying Event: An occurrence that qualifies the Subscriber to change insurance coverage outside of the Open Enrollment.

Usual and Customary Charge (U&C): U&C fee refers to the Usual and Customary (U&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services.

Specialty Drugs: Prescription medications that require special handling, administration, or monitoring. These drugs may be used to treat complex, chronic, and often costly conditions.

FLSA EXCHANGE NOTICE



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2023)

PART A: General Information

When key parts of the healthcare law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover, you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage- is often 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 the coverage offered by your employer, please check your summary plan description or contact the Treasurer's Office.

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.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

MEDICAID / CHIP CONTACT INFORMATION

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 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.

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

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

ALABAMA– Medicaid

<http://myalhipp.com> | 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program:

<http://myakhipp.com> | 1-866-251-4861

CustomerService@MyAKHIPP.com

Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS– Medicaid

<http://myarhipp.com> | 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA– Medicaid

Health Insurance Premium Payment (HIPP) Program

<http://dhcs.ca.gov/hipp> | 1-916-445-8322

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://www.colorado.gov/pacific/hcpf/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991 / State Relay 711

Health Insurance Buy-In Program (HIBI):

<https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>

HIBI Customer Service: 1-855-692-6442

FLORIDA– Medicaid

<https://www.flmedicaidtplrecovery.com/>

flmedicaidtplrecovery.com/hipp/index.html

1-877-357-3268

GEORGIA– Medicaid

HIPP: [Health Insurance Premium Payment Program \(HIPP\)](http://www.georgia.gov/health-insurance-premium-payment-program) | [Georgia Medicaid](http://www.georgia.gov/health-insurance-premium-payment-program)

1-678-564-1162, Press 1

GACHIPRA: <https://medicaid.georgia.gov/programs/20third-party-liability/childrens-health-insurance-program-20reauthorization-act-2009-chipra>

1-678-564-1162, Press 2

INDIANA– Medicaid

Healthy Indiana Plan for low-income adults 19-64:

<http://www.in.gov/fssa/hip> | 1-877-438-4479

All other Medicaid:

<https://www.in.gov/medicaid> | 1-800-457-4584

IOWA– Medicaid and CHIP (Hawki) Medicaid:

<https://dhs.iowa.gov/ime/members> | 1-800-338-8366

Hawki: <http://dhs.iowa.gov/Hawki> | 1-800-257-8563

HIPP: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp> | 1-888-346-9562

KANSAS– Medicaid

<https://www.kancare.ks.gov> | 1-800-792-4884

MEDICAID / CHIP CONTACT INFORMATION

KENTUCKY– Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
1-855-459-6328

KIHIPPPROGRAM@ky.gov

KCHIP: <https://kidshealth.ky.gov/Pages/index.aspx>
1-877-524-4718

Medicaid: <https://chfs.ky.gov>

LOUISIANA– Medicaid

www.medicaid.la.gov or www.ldh.la.gov/lahipp

1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

<https://www.maine.gov/dhhs/ofi/applications-forms>
1-800-442-6003 TTY: Maine relay 711

Private Health Insurance Premium:

<https://www.maine.gov/dhhs/ofi/applications-forms>
1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS– Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>
1-800-862-4840 TTY: (617) 886-8102

MINNESOTA – Medicaid

<https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp> | 1-800-657-3739

MISSOURI – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
1-573-751-2005

MONTANA– Medicaid

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
1-800-694-3084 | HSHHIPPProgram@mt.gov

NEBRASKA – Medicaid

<http://www.ACCESSNebraska.ne.gov>
1-855-632-7633 | Lincoln: 1-402-473-7000 | Omaha: 1-402-595-1178

NEVADA– Medicaid

<http://dhcfp.nv.gov> | 1-800-992-0900

NEW HAMPSHIRE – Medicaid

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program> |
1-603-271-5218

HIPP program toll free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid>

1-609-631-2392

CHIP: <http://www.njfamilycare.org/Default.aspx>

1-800-701-0710

NEWYORK– Medicaid

https://www.health.ny.gov/health_care/medicaid
1-800-541-2831

NORTHCAROLINA– Medicaid

<https://medicaid.ncdhhs.gov> | 1-919-855-4100

NORTHDAKOTA– Medicaid

<http://www.nd.gov/dhs/services/medicalserv/medicaid>
1-844-854-4825

OKLAHOMA – Medicaid and CHIP

<http://www.insureoklahoma.org> | 1-888-365-3742

OREGON– Medicaid

<http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
1-800-699-9075

PENNSYLVANIA– Medicaid

<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx> | 1-800-692-7462

RHODE ISLAND– Medicaid and CHIP

<http://www.eohhs.ri.gov>
1-855-697-4347, or 1-401-462-0311 (Direct Rlte Share Line)

SOUTHCAROLINA– Medicaid

<https://www.scdhhs.gov> | 1-888-549-0820

SOUTHDAKOTA- Medicaid

<http://dss.sd.gov> | 1-888-828-0059

TEXAS– Medicaid

<http://gethipptexas.com> | 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid: <https://medicaid.utah.gov>

CHIP: <http://health.utah.gov/chip> | 1-877-543-7669

VERMONT – Medicaid

<http://www.greenmountaincare.org> | 1-800-250-8427

VIRGINIA – Medicaid and CHIP

<https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>

Medicaid: 1-800-432-5924 CHIP: 1-800-432-5924

WASHINGTON– Medicaid

<https://www.hca.wa.gov> | 1-800-562-3022

WESTVIRGINIA – Medicaid

<https://dhhr.wv.gov/bms>

<http://mywvhipp.com>

Medicaid: 1-304-558-1700

CHIP Toll-free: 1-855-MyWVHIPP (1-855-699- 8447)

WISCONSIN– Medicaid and CHIP

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
1-800-362-3002

WYOMING– Medicaid

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility>

1-800-251-1269



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