Benefits Enrollment Guide

July 1, 2025 - June 30, 2026

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	Claims: 877-835-1361 Option 1 Ben Admin: 877-835-1361 Option 1	Claims: CSclaims@nfp.com Benefits : DBbenadmin@nfp.com
ABACUS Good Health Solutions	800-643-8028	GoodHealthGateway.com
Boston Mutual Life & AD&D	1-877-624-2249	Home | Boston Mutual Life Insurance Company
AFLAC/Boston Mutual	978-870-5826	sean@kandabenefits.com
457 SMART Plan	877-457-1900	www.mass-smart.com

CLAIMS ADVOCACY

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 questioned 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

BENEFITS ADVOCACY

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 RESOURCES

RetireeFirst

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

- As a Medicare-enrolled retiree or soon to be, you will receive a dedicated phone line to a team of Retiree Advocates that understand the unique healthcare needs of retirees. Retiree Advocates take full responsibility for follow-up calls and
- end-to-end resolution of your issues. Whatever your healthcare concern may be, Retiree First will help make your benefits experience stress free.
- Personal information changes and card replacements
- Formulary, tier, quantity limit, and exceptions
- Copay assistance programs
- Physician and pharmacy outreach
- Inbound/Outbound three-way calls to Medicare, vendors, providers,
- pharmacies, and Social Security
- Financial assistance, including low-income and Premium Subsidy (LIPS) filing support
- Assistance with pharmacy-related questions such as generic availability, prior authorizations, and mail-order services
- Status calls throughout the process, ensuring your issue is of highest concern
- and we are working on a resolution
- In-person or virtual appointment scheduling assistance and wellness program
- enrollment support and engagement
- Claims, billing, and payment support

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

ENROLLMENT

OVERVIEW: OPEN ENROLLMENT FY 2026

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, 2025, through May 27th, 2025. Any changes made during this time will be effective as of July 1, 2025.

Now is your chance to explore Open Enrollment Plan Choices and adjust your existing health plans if you wish**. If you do not take any action during this enrollment period, you will automatically be transitioned to the HPHC plan, which closely resembles the benefits of your current HPI plan**. However, if you want to tailor your coverage to suit your needs better or to add or remove dependents from your plan, now is the time to make those changes.

When Can You Change Your Benefits:

you can review and change your benefits for the upcoming open enrollment for FY 2026. **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" 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 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.
- Your 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**

Harvard Pilgrim Health Care

a Point32Health company

MASSACHUSETTS Strategic Health Group

SmartStart Program

Make your switch to Harvard Pilgrim easier than ever.

New plan. New benefits. Questions answered.

- How soon do I get my ID card?
- How can I confirm coverage for an upcoming appointment or procedure?

SmartStart will guide you through enrollment even before your plan is active.

Pre-enrollment phone line

Our pre-enrollment call center dedicated team will help answer your questions about your new benefits and connect you with a nurse care manager when you or your dependents have complex medical conditions —providing needed support even before your new plan is active.

Contact us at SmartStart@harvardpilgrim.org or call 866-874-0817 for answers to your questions.

Member online secure account

Visit harvardpilgrim.org/create to activate your secure account and quickly access your plan benefits and information.

- View your ID card
- Find a doctor or a hospital
- Select a Primary Care Provider (PCP)
- Estimate your out of pocket costs and more

INSURANCE RATES

MEDICAL INSURANCE MASSACHUSETTS STRATEGIC HEALTH GROUP (M S H G) ADMINISTERED BY HARVARD PILGRIM HEATH CARE (HPHC) July 1st, 2025 - June 30th, 2026			
Plans		**Town Share**	**Employee Share Bi-Weekly Deductions**
HPHC ChoiceNet Open Access	**Family**	**$3,105.84**	**$645.06**
	Individual	**$1,394.87**	**$289.70**
HPHC Access America Value -EPO	**Family**	**$2,889.11**	**$600.05**
	Individual	**$1,297.22**	**$269.42**
HPHC ChoiceNet BB PPO	**Family**	**$3,817.64**	**$792.89**
	Individual	**$1,715.59**	**$356.31**

ALTUS DENTAL INSURANCE July 1st 2025 – June 30th, 2026		
Coverage Type	**Altus Low Plan**	**High Plan**
Employee	**$40.58**	**$51.86**
Family	**$111.58**	**$145.54**

ALTUS VISION	
Individual	**$5.05**
Employee + Spouse	**$10.10**
Employee + Child(ren)	**$12.96**
Family	**$19.81**

MEDICAL INSURANCE

Harvard Pilgrim Health Care
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	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 Teseting	100%	80% after deductible
Other Services		
Office Visit - Primary Care	$20 copay	80% after deductible
Office Visit – Specialist	$35 copay	80% after deductible
Diagnostic Lab & X-Ray	100% after deductible	80% after deductible
CT, MRI, & PET Scan	$100 Copay (after deductible)	80% after deductible
Out- Patient Surgery	$150 Copay (after deductible)	80% after deductible
Inpatient Hospital General Hospital Higher Cost Share Hospital	$300 Copay(after deductible) $700 Copay (after deductible)	80% after deductible
Behavior Health Hospital Service	$200 Copay(after deductible)	80% after deductible
Behavioral Health Office Visit	$15 copay	80% after deductible
Occupational & Physical Therapy 30 visits each per plan year	$20 copay	80% after deductible
Ambulance	100% after deductible	
Emergency Room (copay waived if admitted)	$100 Copay(after deductible)	
Urgent Care	$35 copay	80% after deductible
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)	

MEDICAL INSURANCE

Harvard Pilgrim Health Care
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	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 Teseting	100%
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	100% after deductible
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	$15 copay
Occupational & Physical Therapy 30 visits each per plan year	$20 copay
Ambulance	100% after deductible
Emergency Room (copay waived if admitted)	$100 Copay Peer 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)

MEDICAL INSURANCE

Harvard Pilgrim Health Care
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	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	100%
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 Lab	100% after deductible
CT, MRI, & PET Scan	$100 copay after deductible
Out- Patient Surgery	$150 copay after deductible
Inpatient Hospital **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	$15 copay
Occupational & Physical Therapy (30 visits each per plan yr)	$20 copay
Speech Therapy	$20 copay
Ambulance	100% after deductible
Emergency Room (copay waived if admitted)	$100 copay 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)

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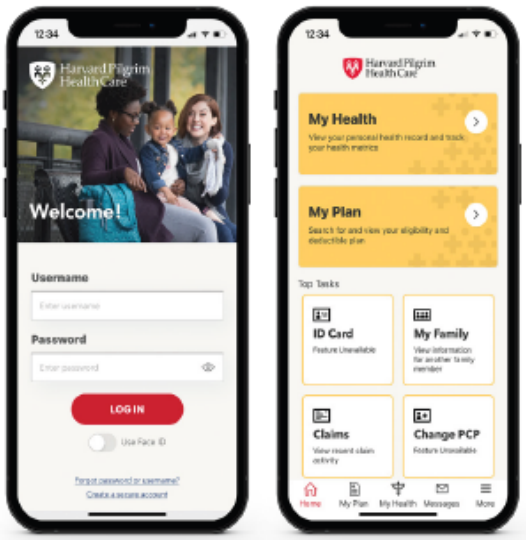
Member Secure Account and Mobile App

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 app[1], 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 costs[2]
- 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



Download on the App Store GET IT ON Google Play

Watch our member secure account video:

English

Spanish

Harvard Pilgrim Health Care

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MASSACHUSETTS Strategic Health Group

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.

To help avoid unanticipated costs, always choose providers within the Harvard Pilgrim network. If your plan requires you to use in-network healthcare providers, check with your PCP, who can assist in coordinating your care. Member cost sharing may apply. Members should refer to their plan documents for specific details regarding their coverage and benefits.

Harvard Pilgrim Health Care

a Point32Health company

MASSACHUSETTS Strategic Health Group

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.

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Harvard Pilgrim Health Care

a Point32Health company

MASSACHUSETTS Strategic Health Group

Weight Management Program

Get reimbursed for fees you pay toward qualified weight management programs[1]

Frequently Asked Questions

How do I qualify for a weight management reimbursement?

- Your employer must offer Harvard Pilgrim's weight management reimbursement benefit[2].
- 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 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

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**

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.

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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

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.

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)

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	• $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	• Impact-resistant lenses for children • Standard Progressive Lenses	$0
CONTACT LENSES (instead of glasses)		
Contacts Every 12 months	• $150 allowance for contacts	$0
	• Contact lens fitting and evaluation	Up to $60
VALUE-ADDED PROGRAMS		
VSP Essential Medical Eye Care Program	• 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	• 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

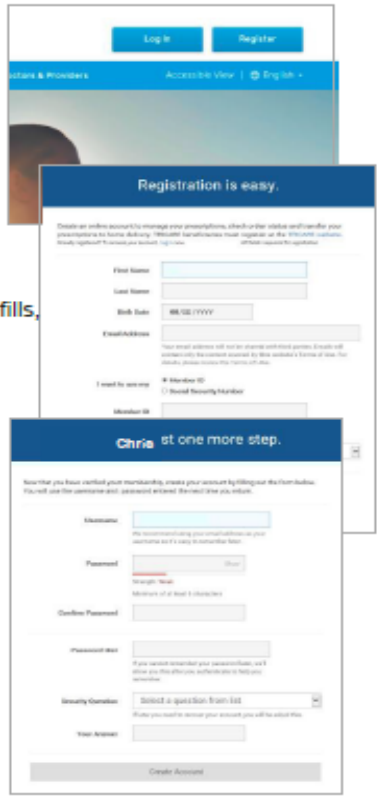
See reverse side for more information.

EXPRESS SCRIPTS® + RxBenefits

Registering with Express Scripts

Online access to savings and convenience

Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts® mobile app



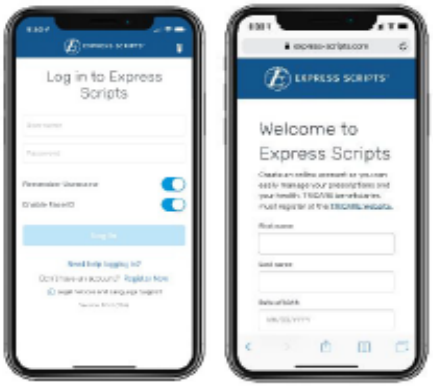
Register now so you can experience:

- **More savings.**
  Compare prices of medicines at multiple pharmacies. Get free standard shipping[1] from the Express Scripts Pharmacy℠.
- **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 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.

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RxBenefits

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.

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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.

ONETOUCH every touch is a step forward + RxBenefits

* Your prescription benefit is managed by Express Scripts. Some health plans may have more than one test strip covered at the lowest co-pay.

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Good Health GATEWAY
Diabetes Care Rewards Program

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 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

ABACUS –HEALTHY WEIGHT PROGRAM

Good Health GATEWAY®
Diabetes Care Rewards Program

The Good Health Gateway® Healthy Weight Program

offers participants education, support, and access to resources designed to help individuals lose weight and maintain their weight loss.
You are eligible to participate in this medication-assisted weight loss program if you are an employee, spouse, or dependent over the age of 18 who is enrolled in the MSHG active health plan. Enrollment in the program is voluntary, and participants must meet medically verified eligibility requirements.
As a participant in the Program, you are eligible to receive covered anti-obesity medication at $0 copay, if you are engaging in all program requirements described below.

- ✓ Take and share weight readings 3-4 times a week and a minimum of 12 days out of every 30 days on a cellular-connected weight scale provided by the Program.
- ✓ Accept Program text messages.
- ✓ Have completed within the past 12 months or will complete annual physical with your doctor.
- ✓ Participate in Program follow-up for at least 6 months (and up to 12 months) after you are no longer taking weight loss medication.
- ✓ Have brief, regular calls with a Program coach who will support you in your weight loss efforts.
- ✓ Complete Program activities and view Program videos sent to you via text or in-app messaging to help support you in the Program.

Please note:

- Failure to remain engaged with these Program requirements will result in the loss of $0 copayment until the Program activity is again completed.
- Program participants who meet all the Program requirements can obtain a 30-day supply of medication at any in-network retail pharmacy.
- Enrollment in the Program can only be done electronically by downloading the FREE Good Health Gateway Healthy Weight App and registering for the Program. As a health plan participant, you can enroll at any time.
- Download the FREE App on your Android in the Google Play store or on your Apple iPhone in the Apple Store by searching for the "Good Health Gateway Healthy Weight" App.

For program inquiries please contact the Good Health Gateway Member Services at 800-643-8028.

To enroll, download the FREE GHG Healthy Weight app from Google Play or the App Store. You will need to answer some questions in the app and talk to your doctor to determine if this benefit is right for you. Participation is voluntary and confidential.

App Store

Google Play

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

DID YOU KNOW....

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

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

AND

Aflac™

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

BOSTON MUTUAL LIFE INSURANCE COMPANY –1891–

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.

EMPLOYEE RESOURCES

MIIA | 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.

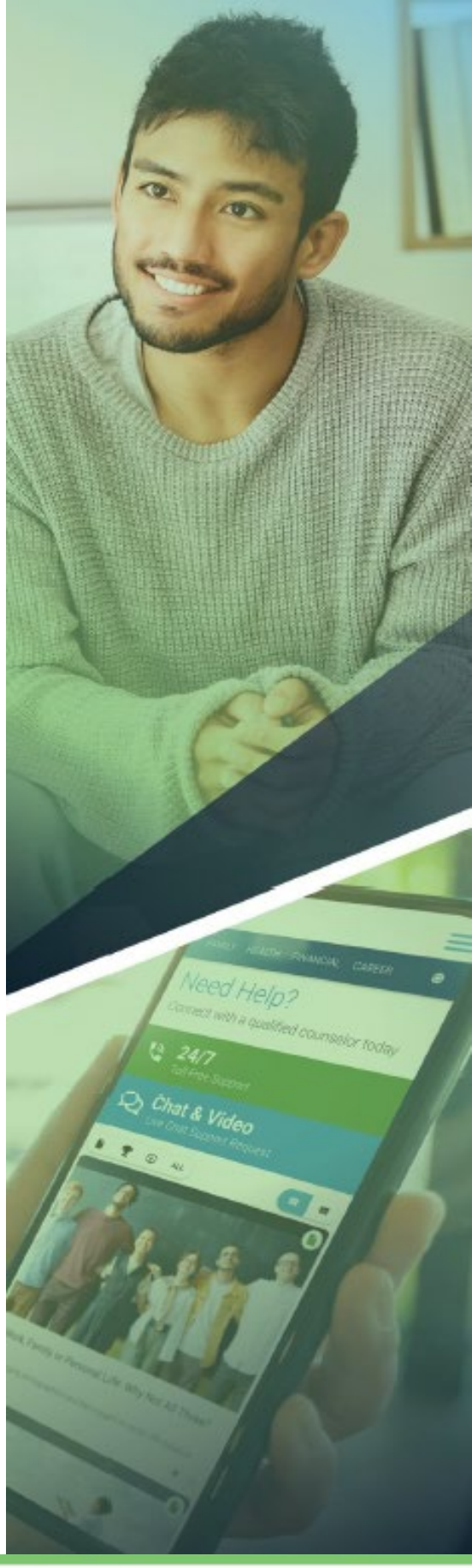
Life Coaching
Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and achieve greater balance.

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/miia-eap

ALLONE HEALTH

VOLUNTARY BENEFITS – 457 SMART Plan

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	
When am I eligible?	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.
How much can I contribute before taxes?	Traditional 457 Contributions are made with before-tax dollars. Any potential earnings on your contributions are taxed when distributed. The minimum contribution amount per pay period is 1% of your gross income or $10, whichever is less. The maximum contribution amount for 2025 is $23,500. Participants who are age 50 or older can contribute an extra $7,500 as a catch-up contribution in both years. You can also contribute what is called the 'special catch up', which allows you to contribute up to a maximum of $45,000/per year for three straight years, usually just before you retire.
How much can I contribute after taxes?	Roth 457 Contributions are made with after-tax dollars. Roth money, including contributions and potential earnings, will grow tax-free in your account. The minimum contribution amount per pay period is 1% of your gross income or $10, whichever is less. The maximum contribution amount for after taxes? 2025 is $23,500. Participants who are age 50 or older can contribute an extra $7,500 as a catch-up contribution in both years. You can also contribute what is called the 'special catch up', which allows you to contribute up to a maximum of $45,000/per year for three straight years, usually just before you retire.
How do I know which contribution is the best choices for me?	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. • If you are not yet participating in the SMART Plan, you can enroll on the website at www.mass-smart.com 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.
How do I modify my investments?	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

Mass Strategic Health Group (MSHG)

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

PremiumAssistance 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) | Georgia Medicaid
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
KIHIPP.PROGRAM@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 | HHSHIPPProgram@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 RIte 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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