WINCHENDON
MASSACHUSETTS

Benefits Enrollment Guide
July 1, 2025 – June 30, 2026

Town of Winchendon

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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 are 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

Enrollment:

How to Enroll or Change Your Benefits

During the annual Open Enrollment period, you can review and modify your benefits for the upcoming fiscal year. This is the only time to make changes unless you experience a Qualified Life Event, as detailed below.

If you experience a qualifying event, you have 30 days from the event date to change your benefit elections. Human Resources will require supporting documentation of your life event.

- Death
- Loss of Previous Coverage
- Gained new coverage
- Marriage
- Divorce
- Birth

INFORMATION FOR NEW HIRES

Before Enrollment

- 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.
- All new hires eligible for benefits will have 30 days from their hire date to enroll in benefits offered through the Town of Winchendon. If elections are not received by Human Resources during this period, you will not be enrolled and will have to wait till the next Open Enrollment to make elections.

After Enrollment

- Medical Insurance**:** If you elect coverage, you will receive an ID card in the mail that you should use 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 Insurance: You will receive a physical ID card for your dental insurance.

General

- Town of Winchendon's fiscal year is **July 1st through June 30th.**
- Medical Denta and Vision insurance aligns with the fiscal year, **July 1st through June 30th.**
- Plans are pre-tax and regulated by the IRS. Because of this, you can only make future changes to your elections during Open Enrollment or if you experience a qualifying life event.

If you do not receive an ID at the time of enrollment, please reach out to your HR department.

Insurance Rates

MEDICAL INSURANCE
ADMINISTERED BY HARVARD PILGRIM HEALTH CARE (HPHC)
July 1st, 2026 - June 30th, 2026

	Total Monthly Premium	Employer Total Monthly Contribution	Employee Total Monthly Contribution	Employee Bi-weekly*Rate (24 Pay Periods)	10 Month Employee Bi-weekly* Rate (20 Pay Periods)
HPHC- MA HMO Focus Network Best Buy *(Town pays 65% of the plan cost, Employees pays the remaining 35%)*					
Individual	$793.49	$515.77	$277.72	$138.86	$166.63
Family	$1,958.13	$1,272.78	$685.35	$342.67	$411.21
HPHC- MA HMO Best Buy Tiered Copay Choice Net *(Town pays 60% of the plan cost, Employees pays the remaining 40%)*					
Individual	$947.44	$568.46	$378.98	$189.49	$227.39
Family	$2,338.07	$1,402.84	$935.23	$467.61	$561.14
HPHC-MA PPO Plan Best Buy Tired Choice Net *(Town pays 60% of the plan cost, Employees pays the remaining 40%)*					
Individual	$1,117.99	$670.79	$447.20	$223.60	$268.32
Family	$2,758.91	$1,655.35	$1,103.56	$551.78	$662.14

DENTAL INSURANCE
ADMINISTERED BY HARVARD PILGRIM HEALTH CARE (HPHC)/ POINT 23
July 1st 2025 – June 30th 2026

Coverage Type	Monthly Employee Contribution	Employee Bi-Weekly* Rate (24 pay periods)	10 MONTH Employee Bi-Weekly* Rate (20 pay periods)
High Plan			
Employee	$38.58	$19.29	$23.15
Family	$112.15	$56.08	$67.29
Low Plan			
Employee	$28.11	$14.06	$16.87
Family	$67.72	$33.86	$40.63

VISION
ADMINISTERED BY AMERITAS/EYEMED NETWORK

Coverage type	Monthly contributions	Bi-Weekly Rate (24 pay periods)	10 MONTH Employee Bi-Weekly Rate (20 pay periods)
Individual	$6.20	$3.10	$3.72
Employee + Spouse	$11.56	$5.78	$6.94
Employee + Child(ren)	$11.20	$5.60	$6.72
Family	$17.60	$8.80	$10.56

MEDICAL INSURANCE

The Town of Winchendon Town is pleased to offer Medical insurance through Harvard Pilgrim Health Care (HPHC). The table below highlights the (3) three plans offered to employees and what each plan encompasses. More detailed information can be found in the Summary of Benefits, available upon request.

HPHC Focus Network MA - HMO 500	
	In-Network Only
Plan Year Deductible	$500/ $1,000
PY-Max Out-of-Pocket (Includes Member cost share)	$2,500 / $5,000
Preventive Care	
Routine & Preventive Servicing & Testing	No Charge
Other Services	
Office Visit - Primary Care	$20 Copay
Specialist Office Visit	$60 Copay
Chiropractic Visits (20 visits per plan year)	$20 Coapy
Diagnostic Lab & X-ray	Ded., then 100%
CT, MRI, & PET Scan	Ded., then 100%
Outpatient Surgery	Ded., then 100%
Inpatient Hospital	Ded., then $275 Copay
Behavior Health Inpatient	$275 Copay per admission
Occupational & Physical Therapy (30 visits per plan year)	$20 Copay
Ambulance	Ded., then 100%
Emergency Room (copay waived if admitted)	Ded., then $100 Copay
Urgent Care	$60 Copay
Pharmacy Benefits- Express Scripts	
Retail Pharmacy up to 30-day supply)	Ded., then: $10 / $30 / $65
Mail 90-day supply)	Ded., then: $25 / $75 / $162.50
Plan Year Rx Deductible	$100 / $200

MEDICAL INSURANCE

Harvard Pilgrim Health Care

The Town of Winchendon Town is pleased to offer Medical insurance through Harvard Pilgrim Health Care (HPHC). The table below highlights the (3) three plans offered to employees and what each plan encompasses. More detailed information can be found in the Summary of Benefits, available upon request.

HPHC Choice Net Best Buy HMO			
	Tier-1	**Tier 2**	**Tier-3**
Plan Year Deductible	$500 / $1,000	$500 / $1,000	$500 / $1,000
PY-Max Out-of-Pocket (Includes Member cost share)	$2,500 / $5,000	$2,500 / $5,000	$2,500 / $5,000
Preventive Care			
Routine & Preventive Servicing & Testing	No Charge	No Charge	No Charge
Other Services			
Office Visit - Primary Care	$20 copay	$20 copay	$20 copay
Specialist Office Visit	$60 copay	$60 copay	$60 copay
Chiropractic, Occupational & Physical Therapy (20 visits Chiro , 30 visits per year OT, PT)	$20 copay	$20 copay	$20 copay
Diagnostic Lab & X-ray	Ded., then no cost	Ded., then no cost	Ded., then no cost
CT, MRI, & PET Scan	Ded., then $100 copay	Ded., then $100 copay	Ded., then $100 copay
Outpatient Surgery	Ded., then $250	Ded., then $250	Ded., then $250
Inpatient Hospital	Ded., then $275 copay	Ded., then $275 copay	Ded., then $1,500 copay
Behavior Health Inpatient	$275 copay	$275 copay	$275 copay
Behavior Health Treatment	$10 copay	$10 copay	$10 copay
Ambulance	No Charge	No Charge	No Charge
Emergency Room (copay waived if admitted)	Ded., then $100 copay	Ded., then $100 copay	Ded., then $100 copay
Urgent Care	$60 copay	$60 copay	$60 copay
Pharmacy Benefits- Express Scripts			
Retail Pharmacy up to 30-day supply)	$10 / $30 / $65	$10 / $30 / $65	$10 / $30 / $65
Mail 90-day supply)	Ded., then: $25 / $75 / $162.50	Ded., then: $25 / $75 / $162.50	Ded., then: $25 / $75 / $162.50
Plan Year Rx Deductible	$100 / $200	$100 / $200	$100 / $200

MEDICAL INSURANCE

Harvard Pilgrim Health Care

The Town of Winchendon Town is pleased to offer Medical insurance through Harvard Pilgrim Health Care (HPHC). The table below highlights the (3) three plans offered to employees and what each plan encompasses. More detailed information can be found in the Summary of Benefits, available upon request.

HPHC Choice Net Best Buy PPO			
	Tier-1 & 2	**Tier 3**	**Out of Network**
Plan Year Deductible	$500 / $1,000	$500 / $1,000	$500 / $1,000
PY-Max Out-of-Pocket (Includes Member cost share)	$2,500 / $5,000	$2,500 / $5,000	$2,500 / $5,000
Preventive Care			
Routine & Preventive Servicing & Testing	No Charge	No Charge	No Charge
Other Services			
Office Visit - Primary Care	$20 copay	$20 copay	Ded., then 20% coinsurance
Specialist Office Visit	$60 copay	$60 copay	Ded., then 20% coinsurance
Chiropractic, Occupational & Physical Therapy (20 visits Chiro , 30 visits per year OT, PT)	$20 copay	$20 copay	Ded., then 20% coinsurance
Diagnostic Lab & X-ray	Ded., then no cost	Ded., then no cost	Ded., then 20% coinsurance
CT, MRI, & PET Scan	Ded., then $100 copay	Ded., then $100 copay	Ded., then 20% coinsurance
Outpatient Surgery	Ded., then $250	Ded., then $250	Ded., then 20% coinsurance
Inpatient Hospital	Ded., then $275 copay	Ded., then $1,500 copay	Ded., then 20% coinsurance
Behavior Health Inpatient	$275 copay	$275 copay	Ded., then 20% coinsurance
Behavior Health Treatment	$10 copay	$10 copay	Ded., then 20% coinsurance
Ambulance	No Charge	No Charge	No Charge
Emergency Room (copay waived if admitted)	Ded., then $275 copay	Ded., then $275 copay	Ded., then $275 copay
Urgent Care	$60 copay	$60 copay	Ded., then 20% coinsurance
Pharmacy Benefits- Express Scripts			
Retail Pharmacy up to 30-day supply)	$10 / $30 / $65	$10 / $30 / $65	NA
Mail 90-day supply)	Ded., then: $25 / $75 / $162.50	Ded., then: $25 / $75 / $162.50	NA
Plan Year Rx Deductible	$100 / $200	$100 / $200	NA

Prescription Drug Coverage

Tier 1 $	Generic drugs, certain over-the-counter medications, and selected brand-name drugs	**Tier 2** $$	Brand-name drugs without generic equivalents and some high-cost generic drugs	**Tier 3** $$$	Drugs not in Tier 1 or Tier 2 (non-preferred brands, and highest cost generics)

Your Drug Coverage

What is covered?

- Most generic drugs
- Select brand-name drugs without generic equivalents
- Certain over-the-counter medications

What is not covered?

- Most brand-name drugs with generic equivalents
- Cosmetic drugs
- Some brand-name and higher-cost generic drugs

Are there limitations on certain drugs?

Yes, we may limit the quantity of some drugs we cover. For example, you may be able to receive only a certain number of pills or doses.

Do some drugs require prior authorization?

Yes, certain drugs do require prior authorization. This process helps us ensure that you are using the most effective and safe medications for your health conditions. Your prescriber must request prior authorization on your behalf.

Can I request an exception?

Yes. If you need a drug that we either don't cover or limit, you or your provider can ask us for an exception. For details, visit **harvardpilgrim.org/rx**. Choose the year and then **Premium 3-Tier** for information on exceptions.

What is step therapy?

Step therapy is a process that requires you to first try one drug for a medical condition before we cover another drug for that condition. For example, if Drug A and Drug B both treat the same medical condition, we may require you to try Drug A first. If Drug A does not work, then we will cover Drug B.*

How can I learn more?

Use our online Prescription Drug List to find out which drugs we cover. It will show you which ones have quantity limits or require prior authorization or step therapy. Visit **harvardpilgrim.org/rx**, choose the year and then **Premium 3-Tier** to find out how your drugs are covered.

What kinds of over-the-counter medications are available in Tier 1?

Tier 1 includes certain cough, cold and allergy medicines; skin treatments (dermatology); stomach medicines (gastrointestinal); pain relievers; and eye preparations (ophthalmic).

How can I get an over-the-counter medication covered under my prescription drug benefit?

Visit **harvardpilgrim.org/rx** and choose the year and then **Premium 3-Tier**. Use the Prescription Drug Lookup to find out which over-the-counter medications are included in Tier 1. Ask your provider to write a prescription for the generic version and have it filled at a participating pharmacy.

*If you have already tried Drug A or are unable to try Drug A, an exception may be granted.

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PHARMACY BENEFITS

Filling Your Prescriptions

Where can I get my prescriptions filled?

You can get your prescriptions filled at any of the more than 68,000 retail pharmacies that belong to our national participating pharmacy network. To confirm whether your pharmacy is in the network, visit **harvardpilgrim.org/rx,** choose the year and then **Premium 3-Tier** to find participating pharmacies.

Can I get a 90-day supply?

If you take maintenance medications (i.e., ones you take continually for conditions such as heart disease, diabetes or depression), you can get a 90-day supply from many retail pharmacies or through our mail order program. Although most maintenance medications are appropriate for mail order, we may exclude drugs from the program for clinical reasons or to prevent potential waste.

To learn more, visit **harvardpilgrim.org/rx**, choose the year and then **Premium 3-Tier** for details. Depending on your coverage, your cost sharing may be lower when you get these drugs through the mail order program.

What if I take specialty medications?

If you take medications for conditions such as hepatitis C, multiple sclerosis or rheumatoid arthritis, your provider must order your prescriptions through our designated specialty pharmacy. Visit **harvardpilgrim.org/rx** for information on our specialty pharmacy program, choose the year and then **Premium 3-Tier** for details.

What do I pay for my medications?

Depending on your plan, your payments — also called "cost sharing" — may include a combination of copayments, coinsurance and a deductible. Refer to the Prescription Drug Coverage insert or Schedule of Benefits to find out what you will pay when you pick up prescriptions at the pharmacy.

If you have questions about your prescription drugs, please speak with your doctor.

Learn more at harvardpilgrim.org/rx or call 888-333-4742 TTY: 711.

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Let us bring your medications to you

With Optum® Home Delivery, you can get a 3-month supply of your long-term medications. Plus, we mail them to you with free standard shipping.

Want more reasons?

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We deliver your medication to your door. You don't even have to leave home or wait in the pharmacy line.

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You may pay less than what you do at in-store pharmacies. And, standard shipping is free.

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With a 3-month supply, you may be less likely to miss a dose. You can even sign up for automatic refills.

Flexible Payment Options

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Use the website and app any time to track orders, request refills, price medications and more. Pharmacists and customer support team are available 24/7.

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Here are the ways to sign up.

- **optumrx.com** or with the Optum Rx app.
- Or ask your doctor to send an electronic prescription to Optum Rx.
- Or call the number on your member ID card.

Scan code. Log in. Sign up.

Optum

Harvard Pilgrim Health Care
a Point32Health company

DENTAL INSURANCE

The Town of Winchendon offers voluntary dental plans through Harvard Pilgrim (HPHC/Point 23). There are two dental options: The High Plan offers an annual allowance of $1250.

Manage Your Benefits:

Go to www.point32health.org/dental-logint to access secure information about your Dental benefits, including how to find a dentist within the network.

HIGH PLAN OPTION

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	100%	None
2	Basic Services	80%	None	80%	None
3	Major Services	50%	None	50%	None
4	Orthodontic Services	0%	None	0%	None

Annual Deductible	In-Network	Out-of-Network
Amount	$50	$50
Maximum Per Family	$150	$150
Applies To	Class 2, Class 3	Class 2, Class 3

- Each member must pay the deductible amount for dental services before the plan will begin to cover the member's dental procedures. The deductible is combined for all applicable services for each Benefit year per member.

Maximums	In-Network	Out-of-Network
Annual	$1,250	$1,250
Lifetime Orthodontic	N/A	N/A

- The maximum listed is the dollar amount that the plan will pay towards the cost of dental care within the specified period per member.
- The annual maximum is combined for in-network and out-of-network services.
- The annual maximum applies to: Class 2, Class 3

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	90th

- Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Point32Health Dental or Point32Health Dental leased dental networks. As such, OON providers set their own fees and Point32Health reimburses the member based upon the established OON allowance.
- Point32Health Dental plans with a maximum allowable charge allowance (MAC) only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Point32Health's Dental INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

Rollover Services	Service Maximum (Paid by Plan)	Rollover Maximum
Maximum Amounts	$750	$1,563

- A member may be eligible for a rollover of unused annual maximum for Class 1, Class 2 and Class 3 Services. The following requirements must be adhered to:
  - At least one claim must be submitted for Class 1 covered services during the Benefit year.
  - The member must have received services in excess of any deductible.
  - The member must not have received services that exceed the service maximum, which is the amount paid by the plan.
  - If eligible, the amount of rollover services may not be greater than the rollover maximum.
  - A member's rollover services may be eliminated, and the accrued service lost, if there is a break in coverage of any length of time, for any reason, or if the service maximum is exceeded in any given Benefit year.

***Out-of-network benefits are based on the 90th percentile of the prevailing fee data for the dentist's zip code.**

DENTAL INSURANCE

The Town of Winchendon offers voluntary dental plans through Harvard Pilgrim (HPHC/Point 23). There are two dental options: A High Plan and a Low Plan. The Low Plan offers an annual allowance of $1,000.

Manage Your Benefits:

Go to www.point32health.org/dental-logint to access secure information about your Dental benefits, including how to find a dentist within the network.

LOW PLAN OPTION

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	100%	None
2	Basic Services	80%	None	80%	None
3	Major Services	50%	None	50%	None
4	Orthodontic Services	0%	None	0%	None

Annual Deductible	In-Network	Out-of-Network
Amount	$50	$50
Maximum Per Family	$150	$150
Applies To	Class 2, Class 3	Class 2, Class 3

- Each member must pay the deductible amount for dental services before the plan will begin to cover the member's dental procedures. The deductible is combined for all applicable services for each Benefit year per member.

Maximums	In-Network	Out-of-Network
Annual	$1,000	$1,000
Lifetime Orthodontic	Not Covered	Not Covered

- The maximum listed is the dollar amount that the plan will pay towards the cost of dental care within the specified period per member.
- The annual maximum is combined for in-network and out-of-network services.
- The annual maximum applies to: Class 2, Class 3

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	80th

- Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Point32Health Dental or Point32Health Dental leased dental networks. As such, OON providers set their own fees and Point32Health reimburses the member based upon the established OON allowance.
- Point32Health Dental plans with a maximum allowable charge allowance (MAC) only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Point32Health's Dental INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

Rollover Services	Service Maximum (Paid by Plan)	Rollover Maximum
Maximum Amounts	$750	$1,250

- A member may be eligible for a rollover of unused annual maximum for Class 1, Class 2 and Class 3 Services. The following requirements must be adhered to:
  - At least one claim must be submitted for Class 1 covered services during the Benefit year.
  - The member must have received services in excess of any deductible.
  - The member must not have received services that exceed the service maximum, which is the amount paid by the plan.
  - If eligible, the amount of rollover services may not be greater than the rollover maximum.
  - A member's rollover services may be eliminated, and the accrued service lost, if there is a break in coverage of any length of time, for any reason, or if the service maximum is exceeded in any given Benefit year.

* **Out-of-network benefits are based on the 90th percentile of the prevailing fee data for the dentist's zip code.**

VOLUNTARY – VISION INSURANCE

You and your family have the option to enroll in a vision plan through Ameritas using the Eyemed network. The most liberal benefits are paid when you use a doctor in network. The vision plan is a voluntary benefit. It is 100% employee paid. To find an eye doctor visit EyeMed.com or download the app.

Vision Plan	Ameritas
Network	**EYEMED**
Frequency	
Frame Frequency	12 Months
Contact Frequency	12 Months
In-Network Coverage	
Frame Retail Allowance	$150 Max. Then 20% Off Remaining Balance
Material Copay:	$10
Single Vision Lenses	Covered in full
Bifocal Lenses	Covered in full
Trifocal Lenses	Covered in full
Lenticular Lenses	20% discount
Contact Lenses Elective Allowance	Covered Up to $150
Contact Lenses Therapeutic Allowance	Covered in full
Lasik Discount	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating
Out-of-Network Coverage	
Frame Retail Allowance Max.	$120
Single Vision Lenses Allowance Max.	$68
Bifocal Lenses Allowance Max.	$96
Trifocal Lenses Allowance Max.	$129
Lenticular Lenses Allowance Max.	N / A
Contact Lenses Elective Allowance Max.	$120
Contact Lenses Therapeutic Allowance Max.	$200

Disclaimer: This is a brief summary of the plans for comparison and does not include all provisions and exclusions.

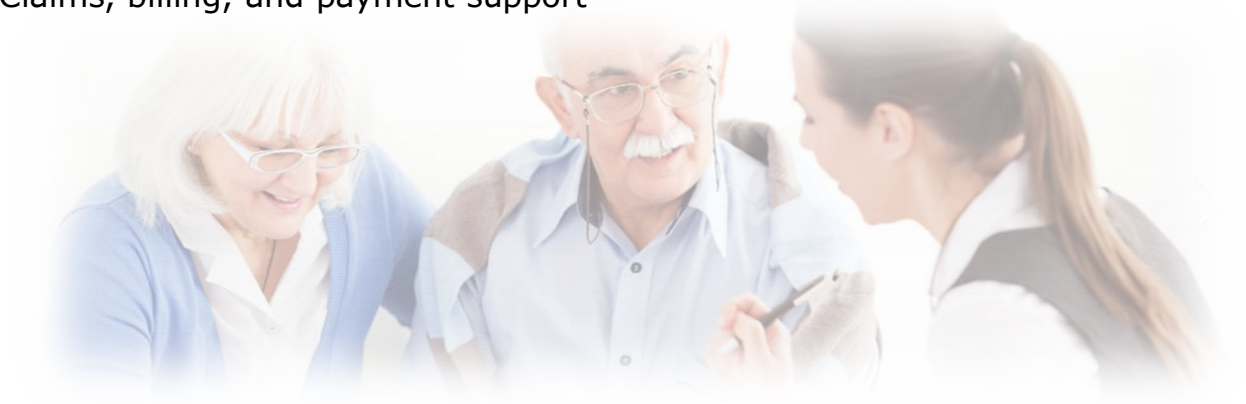
RetireeFirst

RetireeFirst 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, RetireeFirst 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 RetireeFirst at **508-744-6804 (TTY 711)** to speak with your dedicated Retiree Advocate.

CONTACTS

	CARRIER	PHONE NUMBER	WEBSITE
Medical	**Harvard Pilgrim Health Care**	**888-333-4742**	**www.harvardpilgrim.org**
Dental	**HPHC / Point 23**	**866-615-4963**	**www.point32health.org/dental-login**
Vision	**Ameritas: Eyemed Network**	**866-289-0614** **Claims & Network Quesitons** **800-487-5553** **Billing & ID Card Questions**	**www.Eyemed.com**

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 [Your Dental Plan] options also have an annual deductible, generally for basic and major [Your Dental Plan] 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.

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

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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

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

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov | 1-919-855-4100

NORTH DAKOTA– 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)

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

SOUTH DAKOTA - 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

WEST VIRGINIA – 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

WINCHENDON
MASSACHUSETTS

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