Benefits Guide

FY26

July 1, 2025 –June 30, 2026

Active Employees

Plainville

- MASSACHUSETTS -

CONTACTS

Carrier or Vendor	Website or Contact Information	Phone Number
BCBSMA	MyBlue Healthcare Insurance Plan | Blue Cross Blue Shield of Massachusetts (bluecrossma.org)	1-800-262-2583
Boston Mutual Life Insurance	Home | Boston Mutual Life Insurance Company	1-877-624-2249
Altus Dental	Welcome to Altus Dental	1-877-223-0588
Eye Med	EyeMed Vision Benefits	1-866-939-3633
Health Equity	HealthEquity - Industry's #1 HSA Administrator	1-877-924-3967
Aflac	Michael_Tortolani@US.Aflac.com	1-508-259-1701
Empower 457(B)	Aiman.janineh@empower.com	1-774-265-4090
Omni & TASCG 403	TSA Consulting Group - Plainville Public Schools (tsacg.com)	1-888-796-3786
Plainville's Treasurer/Collector	Janet Jannell	1-508-576-8444
Payroll & Benefits Co-ordinator	Robin Verdone	1-508-576-8441
Town of Plainville	benefits@plainville.ma.us	1-508-576-8444

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WELCOME

The Town of Plainville is proud to offer a comprehensive program of benefits designed to serve the diverse needs of our unique workforce, and we are committed to continually enhancing and expanding our offerings. The information in this document is meant to familiarize you with the benefits and programs currently in place.

Eligibility and required contributions for these benefits and programs depend on both your employee classification and whether you elect to extend coverage to your dependents.

The Town of Plainville offers all permanent full-time and part-time employees who work an average of 20 hours per week or more the opportunity to join the employee group health insurance plan. Employees who work seasonally or for a minimum of two months and who average at least 20 hours per week or more may also join the plan. Dependent spouses and children can also be covered by the plan.

Associate deductions for Flexible Spending Accounts, Medical, Dental, and Vision insurance are generally pre-tax; all other deductions are after-tax.

- Full-time employees are eligible for coverage on the day of hire.

Dependent spouses are eligible for coverage under the medical, dental, and vision plans. Dependent children can be covered for medical up to age 26 regardless of a dependent student or marital status. For dental and vision, dependent children can be covered up to age 26, regardless of student status. For the Voluntary Life insurance plan, you can add coverage for your unmarried dependent children under age 19 (or under age 26 only for unmarried full-time students).

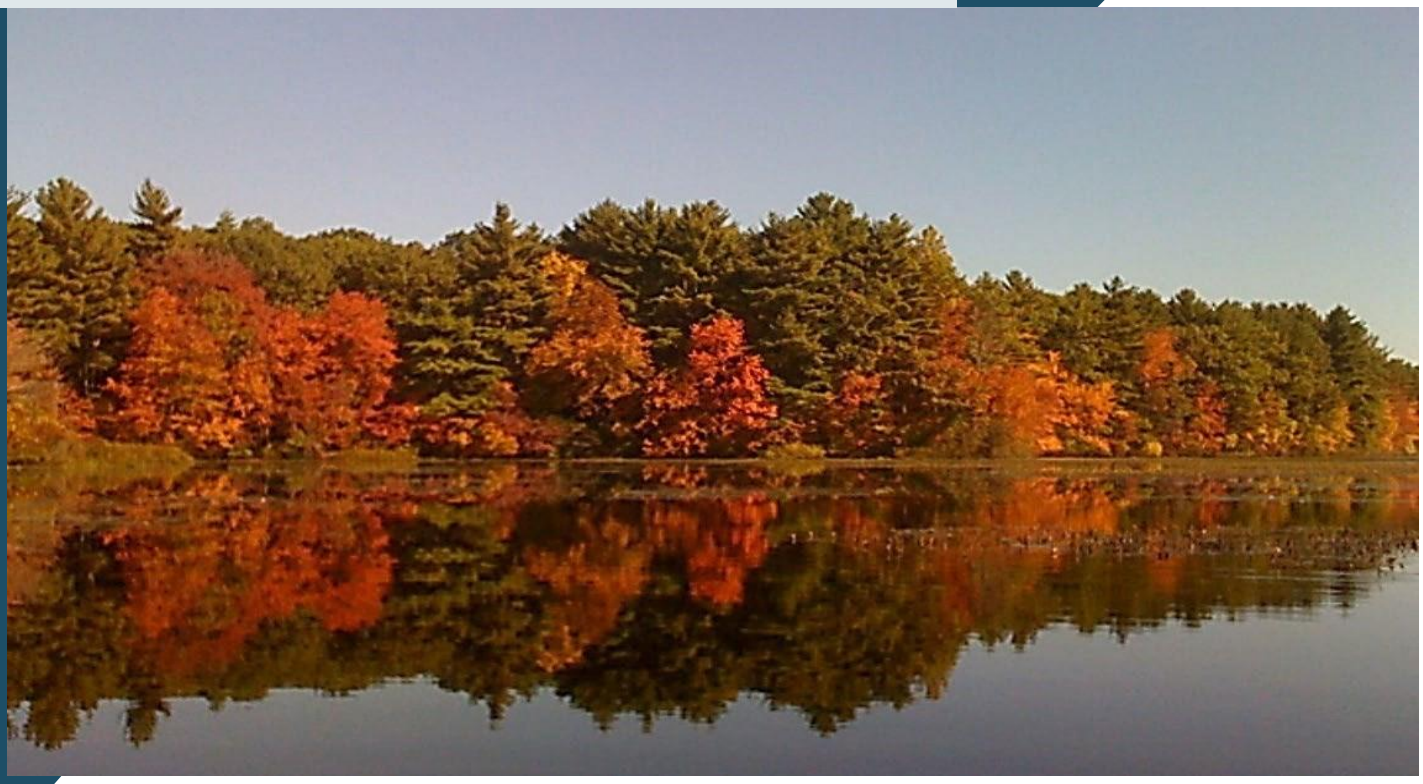
The Town of Plainville offers all eligible Town Retirees the opportunity to join the Retiree's group health insurance plan. Employees who retire from The Town of Plainville and receive a pension from the Norfolk County Retirement System are eligible.

Dependent spouses can also be covered by the plan.

Massachusetts General Law Ch. 32B governs municipal employee eligibility for health insurance and establishes eligibility rules for membership.

- All retiree health insurance plans are individual plans.
- If an employee retires before age 65, he/she may remain on the Town's active employee health plans.
- Once an active employee reaches age 65, they may enroll in Medicare Part A & B and then enroll in a Retiree plan. (but they don't have to).
- Once a retired employee enrolls in a retiree Plan, their spouse is no longer eligible for the Towns employee family plan. They may enroll in the Towns retiree plan if they are Medicare eligible and over the age of 65.
- The Town pays 50% of the Retiree plan premium.
- The Retiree pays the other 50% of the Retiree plan cost as well as their applicable Part B premium (Part B premiums are income-adjusted).
- Upon the death of the Town Retiree, the Spouse may remain on their individual Town Retiree Plan but must pay 50% of the premium cost.
- Retired Plainville school teachers are covered under the Group Insurance Commission Retired Municipal Teachers (RMT) health insurance plan.

OVERVIEW



The information in this guide provides an overview of your benefits choices and information on how to enroll. Medical, dental, and vision plans are paid pre-taxed payroll deductions, providing tax savings and reducing employee medical premiums from gross salary before calculating federal income and Social Security taxes. To enroll in the Towns plan offerings, please complete an enrollment form for each benefit you would like to enroll in and return the completed form(s) on or before May 15th directly to the Office of the Treasurer or by emailing to benefits@plainville.ma.us. If you require additional assistance or more information on how to enroll in The Town's benefits, please contact Janet Jannell or Robin Verdone at the Treasurer's office at benefits@plainville.ma.us or call 1-508-576-8444.

AVAILABLE BENEFITS

Medical	Flexible Spending Account
Dental	Dependent Care Flexible Spending Account
Vision	Short-Term Disability
Life Insurance	Group Accident Insurance
457(b) Deferred Compensation	Group Critical Illness Insurance
403(b) Retirement Savings Plan (school employees only)	Group Hospital Indemnity Insurance

ENROLLMENT CHECKLIST

Use this checklist to help you through the enrollment process. The Town of Plainville's annual enrollment period is April 15, 2025, through May 15, 2025. Changes are effective on July 1, 2025.

Before Enrollment:

Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. Benefit and enrollment guides are available at the Office of the Treasurer.
Please contact Janet Jannell or Robin Verdone at benefits@plainville.ma.us.

- ☐ Review this 2026 Benefits Guide carefully as you consider your plan choices.
- ☐ Attend a Benefits Enrollment Meeting to hear benefits staff explain the details of each plan and give you an overview of all benefit programs.
- ☐ Decide if you want to enroll in a Flexible Spending Account (Health Care and / or Dependent Day Care). Remember: You must actively enroll each year.

During Enrollment:

- ☐ Actively enroll between April 15, 2025, through May 15, 2025.
- ☐ Review your beneficiary(ies). Please review your beneficiary information and update it if necessary.
- ☐ Once you have completed your enrollment, please wait 24-48 hours for the Payroll Coordinator to approve elections before receiving confirmation.

After Enrollment:

- ☐ Verify your FY26 benefit elections after May 15, 2025. If you notice any errors, notify Janet Jannell or Robin Verdone at the Treasurer's Office at benefits@plainville.ma.us After May 15, 2025, elections cannot be changed except within 31 days of a qualifying life event.

IMPORTANT REMINDERS FOR NEW HIRES

Before Enrollment

If you elect to cover your dependents on your medical, dental, or vision benefits, proof of dependent eligibility may be required. These documents must accompany your paperwork, or your dependents will not be added.

All employees electing employee + spouse coverage or family coverage may be required to answer the question, "Is the spouse eligible for coverage at his or her workplace?" Be sure to make your elections within 31 days after your eligibility date or during the open enrollment period. If you do not make elections, then you may not be able to get coverage until the next open enrollment period.

As long as you enroll within 31 days of your eligibility date, new hires are not required to provide proof of good health to enroll in disability insurance or Voluntary Life (for less than the guaranteed issue maximum).

After Enrollment

Medical coverage: 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 make sure your provider always has an updated copy of your ID card.

Dental coverage: If you elect coverage, you will receive an ID card. For dental services, coverage will be tied to the employee's Social Security number. Be sure to give this to your provider at the time of service.

Vision coverage: If you elect coverage, you will receive an electronic ID card via email. Be sure to give this to your provider at the time of service.

General

The plan year is July 1st through June 30th.

Our plans are pre-tax, which means you save money, and you can only make future changes to your elections during Open Enrollment or if you have a qualifying life event. Choose your benefit elections carefully.

ELIGIBILITY AND ENROLLMENT

The Town of Plainville offers all full-time and part-time employees and their dependent spouses and children who work an average of 20 hours per week or more the opportunity to join the employee group health insurance plans. Seasonal Employees who work for a minimum of 90 days and who average at least 20 hours per week or more may also enroll themselves and their eligible dependents.

To continue eligibility throughout the plan year, you must maintain at least 20 or more eligible hours per week. Eligibility is reviewed quarterly.

Eligible Dependents May Include:

- Your legal spouse or domestic partner
- Your child who is less than age 26
- Court-ordered eligible dependents with legal guardianship

Changing Benefit Elections

You have a variety of benefits being offered to you. Be sure to consider your choices before you make your benefit decisions. Once you make your elections, most benefit choices will remain in effect until the next open enrollment period unless you have incurred a life event. Examples of life events include:

Life Events
Change in marital status (marriage, death of spouse, divorce, legal separation)
Change in number of dependents (birth, death, adoption, eligibility status, child support order)
Change in employment status for you or your spouse (new employment, termination, leave of absence, full-time to part-time or vice-versa)
Special enrollment rights under HIPAA
Medicare coverage

Access Blue Saver – High Deductible Plan (HDHP)

If you enroll in the Towns High deductible health plan (HDHP), you must meet your deductible before BCBSMA starts paying for your insurance-covered medical expenses. With the Town of Plainville's HDHP plan, once you meet your deductible, expenses are fully covered by BCBSMA. There is no out-of-network coverage, except for emergency room care. You will be responsible for the entire cost of care if you choose an out-of-network provider.

You may use your Health Savings Account (HSA) dollars and Town of Plainville contributions to help pay for qualified medical expenses incurred with your high-deductible health plan (HDHP) Access Blue Saver.

Maximum Tax-deductible Contribution to an HSA for Calendar 2025:

- IRS allow 4,300 for an individual medical insurance plan.
  - The Town of Plainville will contribute $1500; the pre-tax limit you can contribute after the Town contribution is $2,800.
- IRS allows $8,300 for employee plus one and family medical insurance plan.
  - The Town of Plainville will contribute $3,000; the pre-tax limit you can contribute after the Town contribution is $5,300 Catch-up provision for anyone over the age of 55 is $1000.

Cost of Coverage

Access Blue Saver – HDHP	Bi-weekly Deduction	Annual Deduction
Employee Only:	$87.62	$2,278.08
Employee + Family:	$252.99	$6,577.74

Plan Rules	Out-of-Network	In-Network
Can I go to any doctor and receive plan benefits?	No, you must choose in-network physicians	In-Network Benefit Only
Do I pay less if I see certain doctors?	Yes, you will pay less out-of-pocket when you use preferred network doctors	In-Network Benefit Only
Do I need a referral to see a specialist?	No, you can see the specialist you choose without a referral	In-Network Benefit Only
Can I use mail-order for prescription drugs I use regularly	Yes, for Certain Drugs*	In-Network Benefit Only
Will I be balance billed by my provider?	Only if you see a doctor outside the network. If the charge is above the plan allowance, you may receive a balance-due bill. Participating doctors charge a negotiated fee and do not balance bill	In-Network Benefit Only

**Must meet criteria for therapeutic classes.*

This is not a complete list of covered services. For more details, please visit [MyBlue Healthcare Insurance Plan | Blue Cross Blue Shield of Massachusetts (bluecrossma.org)]

Access Blue Saver - HDHP		
	In Network	**Out of Network**
Annual Deductible* Individual / Family	$2,000 / $4,000	N/A
Annual Out-of-Pocket Maximum* Individual / Family	$5,000 / $10,000	N/A
Coinsurance	N/A	N/A
Maximum Policy Benefit	No Max Benefits limits	N/A
Office Visit PCP	Deductible, then CIF	Not Covered
Specialist	Deductible, then CIF	Not Covered
Chiropractor / Acupuncture	Deductible, then CIF	Not Covered
Preventive Care	$0 – Covered in Full	Not Covered
Emergency Room	$50 copay Waived if admitted	$50 copay Waived if admitted
Urgent Care	Deductible, then CIF	Deductible, then CIF
Inpatient Hospital Services	Deductible, then CIF	Not Covered
Outpatient Surgery	Deductible, then CIF	Not Covered
Labs & X-Rays	Deductible, then CIF	Not Covered
CAT Scans, MRI, PET Scans	Deductible, then CIF	Not Covered
Prescription Drugs Retail (30-day Supply)		
Generic	$10 copay	Not covered
Preferred-Brand	$25 copay	Not covered
Brand	$50 copay	Not covered
Mail-Order (90-day Supply)		
Generic	$20 copay	Not covered
Preferred-Brand	$50 copay	Not covered
Brand	$110 copay	Not covered

**Annual Deductible and Out-of-Pocket Maximums reset every July 1st.*

Network Blue NE Value – HMO

If you enroll in the Town's HMO plan, you must use in-network providers for your care. When you see an in-network provider, your out-of-pocket costs are limited to a $25 copay for primary care or a $25 copay for a specialist office visit. There is no out-of-network coverage; you will be responsible for the entire cost of care if you choose an out-of-network provider.

Cost of Coverage

Network Blue NE - HMO	Bi-weekly Deduction	Annual Deduction
Employee Only:	$119.50	$3,107.04
Employee + Family:	$327.83	$8,523.48

Plan Rules	Out-of-Network	In-Network
Can I go to any doctor and receive plan benefits?	No, you must choose in-network physicians	In-Network Benefit Only
Do I pay less if I see certain doctors?	Yes, you will pay less out-of-pocket when you use preferred network doctors	In-Network Benefit Only
Do I need a referral to see a specialist?	Yes, this plan will pay some or all the costs to see a specialist for covered services but only if you have a referral before you see the specialist	In-Network Benefit Only
Can I use mail-order for prescription drugs I use regularly	Yes, for Certain Drugs*	In-Network Benefit Only
Will I be balance billed by my provider?	Only if you see a doctor outside the network. If the charge is above the plan allowance, you may receive a balance-due bill. Participating doctors charge a negotiated fee and do not balance bill	In-Network Benefit Only

**Must meet criteria for therapeutic classes.*

This is not a complete list of covered services. For more details, please visit [MyBlue Healthcare Insurance Plan | Blue Cross Blue Shield of Massachusetts (bluecrossma.org)](bluecrossma.org)

Network Blue NE Value - HMO		
	In Network	Out of Network
Annual Deductible* Individual / Family	N/A	N/A
Annual Out-of-Pocket Maximum* Individual / Family	$5,000 / $10,000	N/A
Coinsurance	N/A	N/A
Maximum Policy Benefit	No Max Benefits limits	N/A
Office Visit PCP	$25	Not Covered
Specialist	$25	Not Covered
Chiropractor / Acupuncture	$25 / $25	Not Covered
Preventive Care	$0 – Covered in Full	Not Covered
Emergency Room	$100 copay Waived if admitted	$100 copay Waived if admitted
Urgent Care	$25 copay	$25 copay
Inpatient Hospital Services	$500 / admission	Not Covered
Outpatient Hospital Services	$250 / admission	Not Covered
Labs & X-Rays	$0 – Covered in Full	Not Covered
CAT Scans, MRI, PET Scans	$75 Copay in hospital, $0 no cost for other providers	Not Covered
Prescription Drugs Retail (30-day Supply)		
Generic	$15copay	Not Covered
Preferred-Brand	$30 copay	Not Covered
Brand	$50 copay	Not Covered
Mail-Order (90-day Supply)		
Generic	$30 copay	Not Covered
Preferred-Brand	$60 copay	Not Covered
Brand	$150 copay	Not Covered

**Annual Deductible and Out-of-Pocket Maximums reset every July 1st.*

Blue Care Elect Value – PPO

If you enroll in the Towns PPO- Blue Care Elect Plan, you may use any provider for your care. However, when you see a provider in-network, your out-of-pocket costs are limited to a $25 copay for primary care or a $25 Copay. for specialist office visits. Out-of-network care is also covered, but you will pay more for your care.

Most out-of-network costs are subject to an annual deductible and then are reimbursed at 80% of the plan allowance.

Cost of Coverage

Blue Care Elect - PPO Plan a	Bi-weekly Deduction	Annual Deduction
Employee Only:	$449.03	$11,676.34
Employee + Family:	$1116.31	$29,024.06

Plan Rules	Out-of-Network	In-Network
Can I go to any doctor and receive plan benefits?	Yes	Yes
Do I pay less if I see certain doctors?	Yes, you will pay less out-of-pocket when you use the preferred network doctors	
Do I need a referral to see a specialist?	No, you can always go directly to a specialist. However, you will receive out-of-network benefits if the specialist is not in the preferred network	
Can I use mail-order for prescription drugs I use regularly	Yes, for certain drugs*	In-Network Benefit Only
Will I be balance billed by my provider?	Only if you see a doctor outside the network. If the charge is above the plan allowance, you may receive a balance-due bill. Participating doctors charge a negotiated fee and do not balance bill	

**Must meet criteria for therapeutic classes.*

This is not a complete list of covered services. For more details, please visit MyBlue Healthcare Insurance Plan | Blue Cross Blue Shield of Massachusetts (bluecrossma.org)

Blue Care Elect Value - PPO		
	In Network	Out of Network
Annual Deductible* Individual / Family	N / A	$500 / $1,000
Annual Out-of-Pocket Maximum* Individual / Family	$5,000 / $10,000	$1,000 / $2,000
Coinsurance	N / A	20% coinsurance
Maximum Policy Benefit	No Maximum Benefit	
Office Visit PCP	$25 copay	20% coinsurance
Specialist	$25 copay	20% coinsurance
Chiropractor / Acupuncture	$25 copay / $25 copay	20% coinsurance
Preventive Care	No Cost	20% coinsurance
Emergency Room	$100 visit Waived if admitted	$100 copay; Waived if admitted Deductible does not apply
Urgent Care	$25 visit	20% coinsurance
Inpatient Hospital Services	$500 / admission	20% coinsurance
Outpatient Surgery	$250 / admission	20% coinsurance
Labs & X-Rays	$0 – Covered in Full	20% coinsurance
CAT Scans, MRI, PET Scans	$75 Copay in hospital, $0 no cost for other providers	20% coinsurance
Prescription Drugs Retail (30-day Supply)		
Generic	$15 copay	Not covered
Preferred-Brand	$30 copay	Not covered
Brand	$50 copay	Not covered
Mail-Order (90-day Supply)		
Generic	$30 copay	Not covered
Preferred-Brand	$60 copay	Not covered
Brand	$150 copay	Not covered

**Annual Deductible and Out-of-Pocket Maximums reset every July 1st.*

HEALTH SAVINGS ACCOUNT (HSA)

HealthEquity

A Health Savings Account (HSA) allows members to put money aside to pay for current and future qualified medical expenses using pre-tax dollars. An HSA allows dollars to "roll over" annually. Your HSA provides a triple tax advantage; contributions are tax-deductible, balances grow tax-free, and all withdrawals for qualified expenses are tax-free.

Eligibility Requirements

- Must be enrolled in a High Deductible Health Plan.
- Must not be enrolled in Medicare, TRICARE, or TRICARE for Life.
- Must not be covered by other major medical insurance(s) plans, including the plan of your spouse or parent.
- Must not be claimed as a dependent on someone else's tax returns.
- Must not have received VA medical benefits at any time in the past three months.
- Spouse not contributing to / participating in a general-purpose FSA through his / her employer.

Maximum Tax-deductible Contribution to an HSA for Calendar 2025:

- 4,300 for an individual medical insurance plan.

  The Town of Plainville will contribute $1,500; the pre-tax limit you can contribute after the Town contribution is $2,800.

- $8,300 for employee plus one and family medical insurance plan.

  The Town of Plainville will contribute $3,000; the pre-tax limit you can contribute after the Town contribution is $5,300.

Catch up provision for anyone over the age of 55 is $1,000.

Setting up your HSA for 2026

After you enroll in the Base Plan, your HSA will automatically be set up through Health Equity. You will receive instructions following enrollment on how to activate your account and establish a login and password. You may invest funds once your account balance reaches a certain amount or over $1,000.

- Expenses are not eligible for reimbursement until your HSA has been established. Once your HSA is opened, remember to designate a beneficiary for this account.

Debit Card

An HSA debit card will be provided to all new participants. Your HSA card can be used to pay for qualified medical expenses billed from an insurance company, a physician's office and a pharmacy.

Special Note for first-time HSA participants: If you have a Health Care Flexible Spending Account (FSA) balance on December 31, 2023, including pending claims that have not cleared your account, your HSA cannot be funded by the company until you have a zero balance in your FSA account.

IMPORTANT: If you use your HSA funds for non-qualified expenses, the purchase amount will be subject to tax, plus a 20% penalty if you are younger than age 65.

FLEXIBLE SPENDING ACCOUNT (FSA)

We continue to offer health care and dependent care flexible spending accounts (FSA), administered by Health Equity, which allow you to pay for eligible health and dependent care expenses with pretax dollars.

Please note that if you have currently elected an FSA, you must re-elect coverage for 2026 to continue participating, even if you do not change your election amount.

Health Care FSAs

You may elect to defer from $100 to $3,300 into a health care FSA.

- Run-out period - 90 days the amount of time to submit receipts at the end of the plan year.
- Run out days for terminated employees- 90 days.
- Carry over $660 to the following year. (IRS Max - 20% of IRs max amount 2025 = $660).
- Max amount allowed -$3050 Front-loaded.

Some of the eligible expenses for Flexible Spending include:

- Medical – deductibles, copays, coinsurance, diagnostic tests, lab work, chiropractic care.
- Dental – orthodontia, x-rays, fillings, sealants, crowns, root canals, and dentures.
- Vision – contacts, glasses, Lasik eye surgery, prescription sunglasses, and contact lens solution.
- Prescriptions – all prescriptions are covered.
- Over the Counter – medications, first aid supplies, hearing aids, orthopedic inserts, thermometers, and sunscreen.

Dependent Care FSAs

You may elect to defer from $100 to $5000 of your salary into a dependent care FSA per household. If you are a highly compensated employee (HCE), defined by the IRS as an employee with annual compensation greater than $130,000, your election will be capped at $2,500 and may be reduced during the year, if necessary, to ensure that the plan passes required discrimination testing.

- Run-out period - 90 days.
- Run-out days for terminated employees- 90 days.
- Offer a grace period-90 days.
- Allow max IRS $5000. DCFSA is not front-loaded, and employees can only spend what they have contributed.
- Allow spend down till the end of the plan year for term employees.

Eligible Expenses Include:

Dependent care expenses cover qualified dependent children 12 or younger or a spouse/tax dependent who is mentally or physically incapable of caring for themselves.

- Dependent care expenses incurred must allow a single parent or both married parents to be gainfully employed or attend school full-time during the time the child is being taken care of.
- Your dependent must live in your home for at least 8 hours each day.
- Any daycare center or program must meet the state and local requirements to be eligible.
- A babysitter can watch the dependent inside or outside the home as long as the sitter is at least 19 years of age and is not your spouse or someone you claim on your tax return as a dependent.

Please note that for expenses to qualify for reimbursement, both you and your spouse (if applicable) must be working, looking for work or attending school full-time during the period for which you are requesting reimbursement.

VOLUNTARY - DENTAL INSURANCE

You and your family have the option to enroll in a dental plan through Altus Dental. Our dental plans encourage early detection of dental problems by paying fully for diagnostic and preventive services, such as routine check-ups and cleanings. Altus Dental is a voluntary benefit. It is 100% employee- paid. To find a participating dentist visit Welcome to Altus Dental or call 1-877-223-0588.

Altus Dental Plus Low and High Plan

If you elect dental coverage, you have the option of a $1,000 or $1,500 calendar year maximum. The Low Plan has no deductible, so coverage starts right away. However, there is no coverage for Major Restorative Services and Orthodontia Care. The High Plan has an annual deductible of $50 for an individual and $150 for a family. The High Plan Offers you a more comprehensive benefit with coverage for Major Restorative Care and Orthodontia Care.

OUT OF NETWORK- You have the Freedom to choose any dentist, but it is important to know that a non-participating dentist has not agreed to accept Altus Dental allowance. Your out-of-pocket cost may be higher, or you may have to pay in full at the time of service and file a claim. To find a participating dentist near you, use our Find A Dentist tool at Welcome to Altus Dental.

Altus Dental Low Plan		
Plan Details	When you usea participating dentist, you pay	When you do not use a participating dentist, you pay
Annual Deductible (Single / Family)	$0	
Plan Year Maximum	$1,000	
Class I Preventive & Diagnostic	No Charge	
Class II Basic Restorative Care	50% after deductible	
Class III Major Restorative Care	50% after deductible	
Class IV Orthodontia Available to children under age 19	N / A	
Orthodontia Lifetime Maximum	N / A	

Altus Dental High Plan		
Plan Details	When you usea participating dentist, you pay	When you do not use a participating dentist, you pay
Annual Deductible (Single / Family)	$50 / $150	
Plan Year Maximum	$1,500	
Class I Preventive & Diagnostic	No Charge	
Class II Basic Restorative Care	20% after deductible	20% after deductible
Class III Major Restorative Care	50% after deductible	50% after deductible
Class IV Orthodontia (Available to children under age 19)	50% of allowance	50% of allowance
Orthodontia Lifetime Maximum	$1,000	

VOLUNTARY – VISION INSURANCE

You and your family have the option to enroll in a vision plan through EyeMed. The most liberal benefits are paid when you use a doctor in the Insight network. EyeMed is a voluntary benefit. It is 100% employee paid. To find an eye doctor (Insight Network), visit EyeMed Vision Benefits For Lasik, call 1.800.988.4221.

Benefit	Frequency	Copay	In-Network EyeMed Doctor	Out-of-Network
Exam	One visit per plan year (12 months)	$10 Copay	Covered in full	Reimbursed up to $57
Lenses	One visit per plan year (12 months)	$25 Copay	Single vision, Bifocal, Trifocal, and Lenticular	Reimbursed: Single Vision up to $47 Bifocal Up to $79 Trifocal Up to $113 Lenticular Up to $113
Lenses	One visit per plan year (12 months)	$80 Copay $110- $200 Copay	Progressive Standard Progressive – Premium Tier 1-4	Progressive Standard Up to $73 Progressive – Premium Tier 1-4 Up to $77
Frames	One visit per plan year (24 months)	$0 Copay	20% off balance over $130 allowance	Reimbursed up to $104
Contact Lenses	One visit per plan year (12 months)	$0 Copay	Conventional-15% off balance over $130 allowance Disposable- 100% of balance over $130 allowance Medically Necessary- covered in full	Conventional & Disposable Reimbursed up to $104 ically Necessary Up to $210
Lasik			Discounted Services	Not covered

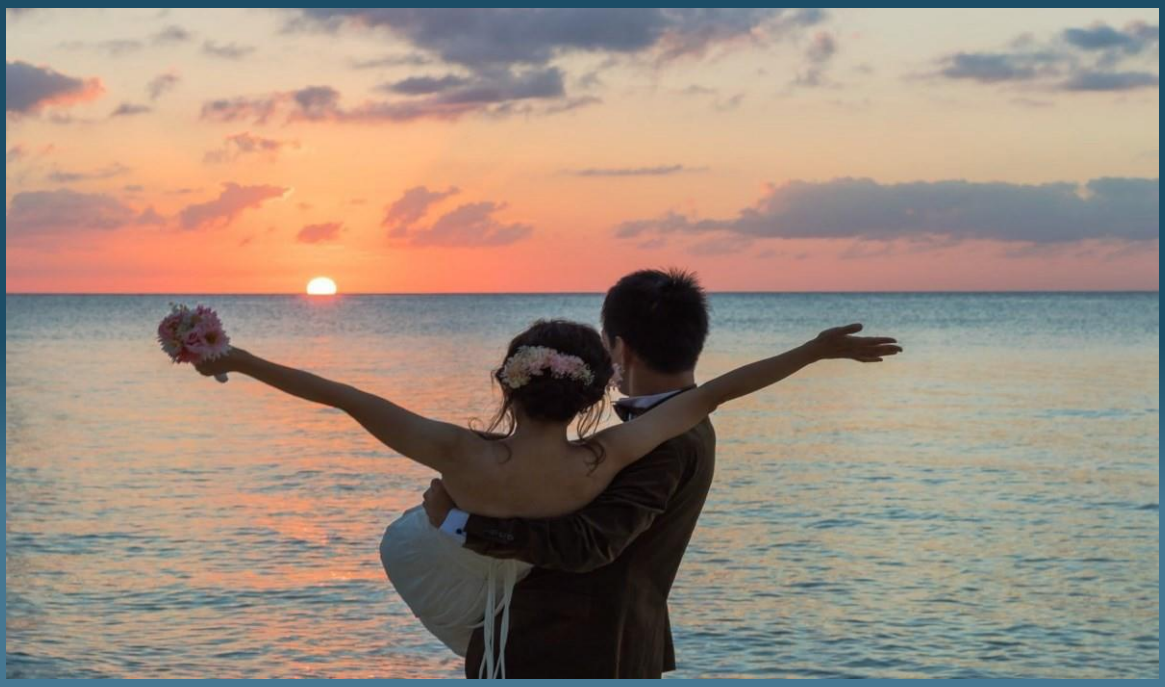
LIFE & AD&D INSURANCE

Your family depends on your income for a comfortable lifestyle and the resources necessary to realize their dreams – such as a college education. Like anyone, you don't like to think of the scenario where you're no longer there for your family. However, you do need to ensure their lives and dreams can continue if the worst should occur.

The Town offers life and AD&D coverage through Boston Mutual, providing half the cost of coverage.

Life/AD&D Benefits - 2x salary up to $5,000

Life & AD&D Insurance	
Basic Accidental Death and Dismemberment (AD&D)	**Matches Basic Life coverage**
AD&D Included Benefits	**Education Benefit** **Seat Belt Benefit** **Repartition Benefit**
Waiver of Premium	**Included**



VOLUNTARY LIFE

You have the freedom to select adequate levels of life insurance coverage to protect the well-being of your family. The Town of Plainville offers Voluntary Life through Boston Life Insurance Co. to all eligible active employees working 20 hours or more per week, their spouse under age 70, unmarried children ages 14 days to 19 years (25 if a full-time student), and disabled children over the age of 19 are eligible for coverage. These premiums are paid to employees paid 100% by you.

Supplemental Life Insurance Coverage	Coverage Amount
For Yourself	Maximum coverage of $500,000, sold in increments of $10,000, coverage cannot exceed 7 times employee salary.
For Spouse	Maximum coverage of $100,000, sold in increments of $5,000, coverage cannot exceed 50% of employee salary.
For Eligible Children	Maximum amount of coverage for children aged 14 days to one (1) year old is $1,000. Maximum amount of coverage for children ages 1 to 19 is $10,000.

Guaranteed Issued Amounts		
Age	19-69	70+
Employee	$100,000	$10,000
Spouse	$25,000	N/A

SHORT TERM DISABILITY

Aflac offers Group Short-Term Disability as one of its benefits. You have the choice to enroll in this benefit program, which can provide financial support in the event of an accident or illness that results in lost income. It's important to note that participation in this program is voluntary, and 100% of premiums are employee-paid through payroll deduction.

Group Short-Term Disability

Aflac's Group Short-Term Disability Insurance is designed to offer eligible employees monthly benefits in case they are unable to work due to an injury or illness. Once the elimination period is satisfied, benefit payments will start and continue for the duration of the disability benefit period. It's essential to keep in mind that Short-Term Disability is a taxable benefit.

Coverage Type	Benefits
Group Short-Term Disability	• Benefit Amount: $300-$6,000 with a max of 60% of the employee's base annual pay. • You must be totally disabled and unable to work due to sickness or injury. • Covers accidents and sicknesses for up to 90 days. • Benefit is dependent on your monthly income. • Benefits begin on the 7th day for accidents and on the 7th day for sickness. • Pre-existing conditions that were diagnosed within the 6-month period after the effective date of coverage will not be covered. • Claims will not be reduced or denied for pre-existing conditions that were diagnosed more than 6-months after the effective date of coverage.

Group Accident Insurance:

Aflac Group Accident Insurance provides cash benefits directly to you (unless otherwise assigned) that help with out-of-pocket medical and nonmedical expenses associated with treatment in the event of a covered accident.

Accident insurance is an extra layer of protection that gives you a lump-sum cash payment to cover deductibles, copayments, or out-of-pocket expenses like rent and groceries.

Eligible employees must be actively at work on the application date and the effective date. You must work at least 20 hours per week or more and have been continuously employed for the duration set by the employer. Seasonal and temporary employees are not eligible.

Some highlights of your Accident Insurance include:

- Coverage for all family members.
- There is no waiting/elimination period. When the accident occurs, you are eligible to get your benefit.
- There are no benefit reductions associated with an increase in your age.
- This benefit will be deducted from your payroll, which decreases the amount of taxation on your paycheck.

Group Critical Illness Insurance

Aflac Group Critical Illness Insurance provides cash benefits when an insured person is diagnosed with a covered critical illness – and these benefits are paid directly to you (unless otherwise assigned). The plan provides a lump-sum benefit to help with out-of-pocket medical expenses and the living expenses that can accompany a covered critical illness. It is also HSA-compatible.

Critical Illness coverage includes strokes, heart attacks, and Parkinson's disease. Upon diagnosis, you can rest assured that a lump-sum cash benefit will be paid to you to be used for deductible costs, treatments, or living costs such as rent and groceries.

Eligible employees must work at least 20 hours per week or more.

Some highlights of your Critical Illness Insurance include:

- Spouse and child are covered at 50% of the face amount elected by the employee.
- Guaranteed issue on the first $20,000 of your elected amount and $10,000 guaranteed issue for spouse coverage.
- There is no waiting/elimination period. When you are diagnosed, you will receive a lump-sum benefit.
- Waiver of Premium is included: After 90 days of total disability due to a covered critical illness, we will fully waive all premiums for the duration specified in the certificate.
- There are no benefit reductions associated with an increase in your age.
- This benefit will be deducted from your payroll, which decreases the amount of taxation on your paycheck.

Group Hospital Indemnity Insurance:

Aflac Group Hospital Indemnity Insurance provides cash benefits directly to you (unless otherwise assigned) that help pay for some of the costs – medical and nonmedical – associated with a covered hospital stay due to a sickness or accidental injury.

Hospital Indemnity insurance is an extra layer of protection that will help you pay for deductibles, copayments, bills, groceries, or any other expenses that will make your life easier while you are in the hospital.

You must work at least 20 hours per week or more to be eligible for this benefit. Seasonal and temporary employees are not eligible.

Some highlights of your Accident Insurance include:

- Coverage available for all family members.
- The base accident product is always offered on a guaranteed-issued basis.
- There is no waiting/elimination period. When you enter the hospital for your stay, you are eligible to get your benefit.
- There are no benefit reductions associated with an increase in your age.
- This benefit will be deducted from your payroll, which decreases the amount of taxation on your paycheck.

VOLUNTARY BENEFITS – 403(b) PLAN

Retirement plans can vary drastically for everyone. To help eligible employees prepare for retirement goals, your employer has established a voluntary 403(b) plan that allows qualified teachers to participate through payroll deductions in before-tax and after-tax dollars through salary deferrals (contributions).

Below is a summary of some features of the retirement plan.

403(b) Plan – **Available for school employees only**

When am I eligible?	You can contribute to the 403(b) plan on your date of hire. Eligible employees may make voluntary elective contributions to the 403(b) plan.
What are the benefits of a 403(b) Plan?	Contributions are deposited into your personal individual account, and you control the amount of retirement savings contributions you would like to make. Additionally, participants are always fully vested in their contributions and earnings.
What is the annual contribution limit?	For 2024, employees can contribute up to $23,000 to their 403(b) account. Catch-up contribution limits for qualified employees aged 50 and over who participate in 403 (b), are $7,500 for 2024.
How are 403(b) contributions made?	Contributions made to the traditional 403(b) account are pre-tax deductions from your paycheck. Your income tax is reduced for every payroll contribution you make. Any earnings on your deposit are tax-deferred until withdrawn, usually upon retirement. All withdrawals from a traditional 403(b) account are taxed during the year of the withdrawal at your income tax rate appropriate for that year.
How do I modify my investments?	For a listing of authorized providers, visit www.tsacg.com/individual/plan-sponsor/massachusetts/plainville-public-schools/

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 2024 is $23,000. 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 2024 is $23,000. 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

COST OF COVERAGE

Medical

Access Blue Saver – HDHP	Bi-weekly Deduction	Annual Deduction
Employee Only:	$87.62	$2,278.08
Employee + Family:	$252.99	$6,577.68

Network Blue NE - HMO	Bi-weekly Deduction	Annual Deduction
Employee Only:	$119.5	$3,107.04
Employee + Family:	$327.83	$8,523.48

Blue Care Elect - PPO Plan	Bi-weekly Deduction	Annual Deduction
Employee Only:	$449.03	$11,674.78
Employee + Family:	$1,116.61	$29,031.86

Dental

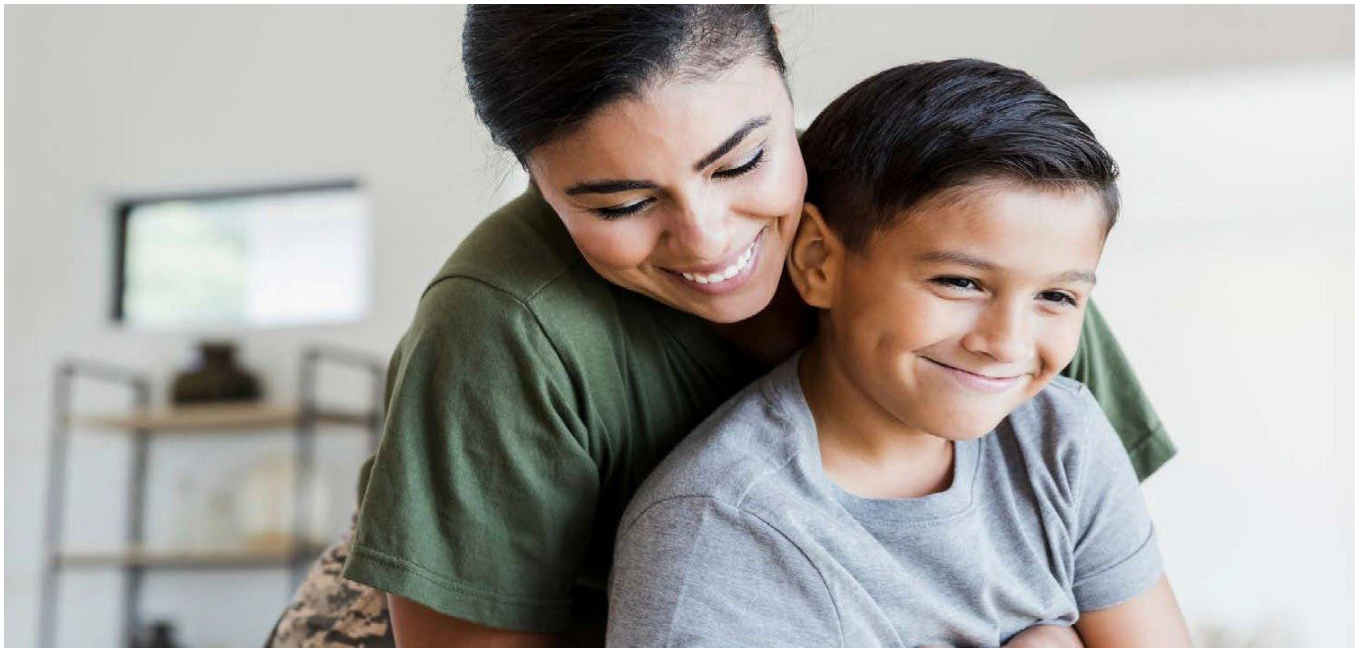
Altus Dental- High Plan	Bi-weekly Deduction	Annual Deduction
Employee Only:	$19.13	$497.38
Employee + One:	$40.54	$1,054.04
Employee + Family:	$59.67	$1,551.42

Altus Dental- Low Plan	Bi-weekly Deduction	Annual Deduction
Employee Only:	$17.10	$444.60
Employee + One:	$34.20	$889.20
Employee + Family:	$51.29	$1,333.54

Vision

Eye Med- Vision	Bi-weekly Deduction	Annual Deduction
Employee Only:	$2.58	$67.08
Employee + Spouse:	$4.62	$120.12
Employee + Child(ren):	$4.91	$127.66
Employee + Family:	$7.74	$201.24

VERIFICATION OF ELIGIBILITY



In order to cover your dependents under the medical, dental or vision plans you may be required to provide the following:

Biological child to age 26	Copy of marriage certificate. Copy of birth certificate or copy of prior year federal tax return showing dependent claimed on taxes.
Stepchild to age 26	Copy of birth certificate and copy of a marriage certificate showing your spouse as the biological parent.
Adopted child to age 26	Copy of papers showing placement of child in your home; or a copy of final adoption papers.
An employee's unmarried child (as described above) age 26 or older, primarily supported by the employee, and is incapable of self-sustaining employment because of mental or physical handicap	Copy of birth certificate or copy of prior year federal tax return showing dependent claimed on taxes and proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as reasonably necessary to verify continued eligibility for benefits.
Grandchildren to age 26	Copy of court order showing you have permanent legal guardianship of the child.

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.

FLSA / EXCHANGE NOTICE

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Town Of Plainville			4. Employer Identification Number (EIN) 046001270
5. Employer address 190SouthStreet			6. Employer phone number 1-508-576-8444
7. City Plainville	8. State MA	9. ZIP code 02762	
10. Who can we contact about employee health coverage at this job? Janet Jannell			
11. Phone number (if different from above)	12. Email address benefits@plainville.ma.us		

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

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

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

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

FLSA / EXCHANGE NOTICE

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

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

REQUIRED NOTICES

Newborns and Mothers' Health Protection Act

Under federal law, health care plans may not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother and with the mother's consent, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Continued Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may be able to continue your medical and dental coverage if you lose your health care coverage as the result of certain qualifying events. Contact the Office of the Treasurer for more information.

Women's Health and Cancer Rights Act of 1998

Under the Women's Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy was performed.
- Any necessary surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses
- Treatment of physical conditions related to the mastectomy, including lymphedema.

Our medical plans comply with these requirements. Benefits for these items are similar to those provided under the plan for similar types of medical services and supplies.

HIPAA Regulations Help to Protect Your Privacy

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) help to ensure that your health care-related information stays private. New employees will receive a Privacy Practice Notice which outlines the ways in which the medical plan may use and disclose protected health information (PHI). The notice also describes your rights. For more information, contact the Office of the Treasurer Department.

Your Rights under Michelle's Law

Effective January 1, 2010, full-time students covered under the group health plan, that would otherwise lose eligibility under the plan because of a reduction in their full-time class status due to a medically necessary leave of absence from school, may be eligible to extend their coverage under the plan for up to one year, or to age 26, whichever occurs first. The child must be a dependent child of a plan participant and be enrolled in the company group health plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the leave.

Mental Health Parity

Effective January 1, 2010, the Company sponsored medical plans were modified to cover mental health and substance abuse expenses subject to the same treatment limits, deductibles, copayments, co- insurance and out-of-pocket requirements that apply to other medical and surgical expenses. This change applies to both inpatient and outpatient services.

REQUIRED NOTICES

Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The Act also states that if an employee leaves their job to perform military service, they have the right to elect to continue existing employer-based health plan coverage for the employee and their eligible dependents for up to 24 months while in the military. Even if the employee doesn't elect to continue coverage during their military service, they have the right to be reinstated in their employer's health plan when they are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Office of the Treasurer.

Termination of Health Coverage for Cause, Including Fraud or Intentional Misrepresentation

P.A.C.E. reserves the right to terminate health care coverage for you and/or your dependent prospectively without notice for cause (as determined by the Plan Administrator), or if you and/or your dependent are otherwise determined to be ineligible for coverage under the plan. In addition, if you or your covered dependent commits fraud or intentional misrepresentation in an application for health coverage under the plan, in connection with a benefit claim or appeal, or in response to any request for information by P.A.C.E. or its delegees (including the Plan Administrator or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30-days' notice.

Failure to inform any of such persons that you or your dependents are covered under another group health plan or knowingly providing false information in order to obtain or continue coverage for an eligible dependent are examples of actions that constitute fraud under the plan.

ADDITIONAL INFORMATION

Creditable Coverage Disclosure Notice

If you are Medicare-eligible, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage. First, Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare.

Second, it was determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. If you are considering joining Medicare's prescription drug coverage, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. For more information about Medicare's prescription drug coverage please visit: www.medicare.gov.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility.

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

OM B 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

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

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.

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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.

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Plainville

- MASSACHUSETTS -

Information in this benefits guide and booklet is not guaranteed to be accurate or complete. If you have questions regarding benefits, consult with the Town's HR and Benefits team. Further, NFP and its subsidiaries and affiliates do not provide legal or tax advice, compliance, regulatory, and related contents for general informational purposes only. You should consult an attorney or tax professional regarding the application or potential implications of laws, regulations, or policies to your specific circumstances.