



TOWN OF SHREWSBURY

Richard D. Carney Municipal Office Building
100 Maple Avenue
Shrewsbury, Massachusetts 01545-5338

2020 - 2021

Welcome New Employee.

Congratulations on your employment with The Town of Shrewsbury. The following are some of the benefits available to you.

Health Insurance, Flexible Spending Accounts, Health Savings Accounts, Life Insurance and Altus Dental benefits are offered to employees hired for a permanent position that work 20 or more regular hours a week. Coverage is effective as of date of hire.

Health Insurance - You must enroll within 30 days of your hire date or you will be required to wait until Open Enrollment or when you experience a qualifying event. To enroll, you must complete an insurance application, a Payroll Authorization Agreement, and provide a copy of your Social Security card. For a Family plan, please also provide a copy of the city/town issued Marriage Certificate/Divorce Decree to enroll a current or ex-spouse and copy of the Birth/Adoption Certificate or Court Order to enroll each child. Copies of Social Security cards are required to enroll any and all dependents.

Plan details and applications are available on the Town's website, <https://shrewsburyma.gov>. Click on Government and under Town Departments click on Treasurer.

The following plans are available:

- Harvard Pilgrim PPO
- Harvard Pilgrim Benchmark HMO
- Harvard Pilgrim High Deductible
- Tufts Benchmark HMO
- Tufts High Deductible
- BCBS Benchmark HMO
- BCBS High Deductible
- Fallon Select Care Benchmark HMO
- Fallon Select Care High Deductible
- Fallon Direct Care Benchmark HMO
- Fallon Direct Care High Deductible

Documents attached

- Health Insurance Rate Sheet
- Plan Comparison Chart
- Payroll Authorization Agreement
- Health Insurance Enrollment Forms
- *Information about Qualifying Events
- Notice- Enrollment of Adult Children
- Initial COBRA Rights Notice
- Health Insurance Marketplace Notice
- HIPAA Notice of Privacy Practices
- Medicaid/CHIP Notice
- Miscellaneous Legal Notices
- Medicare Eligibility Information
- Medicare Part D Creditable Coverage Notice

1. **Flexible Spending Accounts for Medical/Dental Care (up to \$2,750) and Dependent Care (up to \$5,000)** allow you to set aside a portion of your paycheck on a pre-tax basis. They are offered during an Open Enrollment period in April with a July 1st effective date. A change in status during the year allows you to enroll outside of the Open Enrollment window. The following are qualifying events for enrollment in these plans: New Hire, Marriage, Divorce, Birth, Adoption, and a Return from LOA. The effective date is the date of the event. You must enroll within 30 days of the qualifying event or you will be required to wait until Open Enrollment. To enroll, please contact Cafeteria Plan Advisors at 781-848-9848.
2. **Health Savings Accounts** - are available to those enrolled in a High Deductible Health Plan. This plan allows you to make tax-free contributions to an FDIC-insured savings account. Attached is a brochure and enrollment form. Please contact Health Equity directly with any questions at 1-866-346-5800.

3. **Life Insurance** – Three plans offered through Boston Mutual Life Insurance. You must enroll within 30 days of your hire date. To enroll at a later date you will be subject to medical underwriting.
- **Basic Term Life Insurance** - a \$7,000 term life policy with a \$7,000 AD&D benefit.
 - **Optional Term Life Insurance** for the employee, spouse and dependent children. There are no dividends or cash value.
 - Employee:** increments of \$10,000 to \$500,000, not to exceed 7 times base pay. Guaranteed issue is \$150,000.
 - Spouse:** increments of \$10,000 to \$150,000, not to exceed employee's amount. Guaranteed issue is \$30,000.
 - Dependent:** \$10,000 for unmarried children to age 19, or up to 25 if full-time students.
 - **Voluntary Supplemental Insurance** – A Whole Life policy with guaranteed issue, without medical at initial eligibility. Face value is based on the subscriber's age and amount of weekly contribution (with a maximum contribution of \$12.00 per week). Please call Life Plus Insurance Agency at 781-837-9222 for more information and to enroll.

Documents attached:

- FAQ for Basic and Optional Life Insurance
- Rate Sheet Optional Life Insurance
- Application for Basic and Optional Life Insurance

4. **Altus Dental** – Town Employees - Contact Benefits Administrator, Donna Bouchard for enrollment
School Employees – Contact School Payroll department for enrollment
5. **Insurance Declination Form** - must be completed by newly benefit eligible employees **who are not** enrolling in Health, Life or Town Dental insurance.
6. **Deferred Compensation- Life Annuity Plans-ROTH** If interested, contact:
- **Commonwealth of Massachusetts 457 Deferred Compensation SMART Plan**
Eileen Neubert, SMART Plan Representative, Tel: (877) 457-1900, say representative, 4 times, then enter (extension) 20083 - Email: Eileen.Neubert@empower-retirement.com
 - **Pacific Life Insurance Company - 457 Deferred Compensation Plan**
Michael Farmer, Financial Planner, Tel: (508) 926-1452 - Email: mike.farmer@ifpadvisor.com
 - **ICMA-RC – 457 Deferred Compensation Plan / ROTH**
Michael Savage, Certified Retirement Counselor, Tel: (888) 803-2721 msavage@icmarc.org
7. **The Town of Shrewsbury Wellness Program** funds initiatives that focus on improving our health in ways that aren't covered through insurance. These programs include yoga classes, coordinated by the Parks and Recreation department, and other programs through the West Suburban Health Group including but not limited to the following:
- My Medication Advisor** - a web-based program that includes the opportunity for filling 3 months of maintenance medications at a time through vendors from Canada, England, New Zealand and Australia with a \$0 co-pay.
- Good Health Gateway** - a diabetes care rewards program for those insured through a Town health plan as a subscriber or dependent. You can be eligible for free diabetic medications and supplies by following five care guidelines.
- Fitness Reimbursements** for members our Health Plans. The benefit varies by carrier.
- For more information go to <http://westsuburbanhealth.com/wellness/>.
8. **MetLife Auto & Home** offers Town of Shrewsbury employees special group discounts on auto insurance. Contact Lisa Souza at 781-749-2007, or Lsouza@metlife.com for more information.

Your payroll clerk will inform you of other available benefits based on your department and position.

Best Wishes,

Donna Bouchard

Benefits Administrator

Office of the
TREASURER



TELEPHONE: (508) 841-8359
FAX: (508) 841-8316
benefits@shrewsburyma.gov

TOWN OF SHREWSBURY

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Availability of Summaries of Benefits and Coverage

The health insurance benefits available to you as an employee represents a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

You have the choice of several different plans. Selecting a health insurance plan is an important decision. To help you make an informed choice the plans offered by the Town provide a Summary of Benefits and Coverage (SBC). These SBCs summarize key plan features in a standard format to help you compare your options.

The SBCs are available on the Town of Shrewsbury's website. From the home page select the Treasurer's Department, then Health Insurance, then Summaries of Benefits and Coverage.

New Hire Benefits Paperwork Checklist

If enrolling in:

Health Insurance

- Employee Payroll Agreement
- Health Insurance Application (Fallon, BCBS, Harvard Pilgrim or Tufts)*
 - Social Security Cards – of employee, spouse and child(ren) you are enrolling
 - City/Town Issued Marriage License or Divorce Decree (if enrolling a spouse or ex-spouse)**
 - Children 's Birth Certificates, Adoption Forms or Guardianship Papers (if enrolling child(ren))
 - HSA deduction form (if enrolling in a High Deductible Plan)

Life Insurance

- Boston Mutual Enrollment Application (beneficiary info)

Dental Insurance (TOWN employees only)

- Insurance Application

Flexible Spending Account(s)

Contact Cafeteria Plan Advisors directly for enrollment: 781-848-9848

If declining Health, Dental and/or Life Insurance:

- Declination of Insurance Form

**TOWN OF SHREWSBURY
DECLINATION OF INSURANCE**

EMPLOYEE NAME _____

SOCIAL SEC. # _____

DEPARTMENT _____

I have been offered the opportunity to participate in the insurance benefit plans made available through the Town of Shrewsbury. These plans have been explained to me and I wish not to enroll in the following plans at this time:

Health Insurance

I understand that I have the opportunity to enroll in Health Insurance at Open Enrollment each year (effective July 1st) or with a Qualifying Event off anniversary

Altus Dental Insurance (Town employees only)

Basic Life Insurance \$7,000 & \$7,000 AD&D

Optional Life Insurance Face value premium based on age bracket

Whole Life Insurance Face value based on age & weekly premium

I understand that I must prove my insurability for Life Insurance if I want to be covered at a later date by completing an Evidence of Insurability application and possibly a physical exam at my expense.

Employee's Signature

Date

**TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2020-2021**

JUNE PAYROLL CHANGES FOR JULY 1, 2020 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY	TOWN		TOWN 21 P/R		EMPLOYEE MONTHLY	EMP. 26 P/R		EMP. 21P/R BI-WEEKLY*	COBRA
			MONTHLY	BI-WEEKLY	BI-WEEKLY*	BI-WEEKLY		BI-WEEKLY			
INDEMNITY PLAN											
<i>Harvard Pilgrim PPO</i>											
50/50	FAMILY	\$5,902.00	\$2,951.00	\$1,362.00	\$1,686.29	\$2,951.00	\$2,951.00	\$1,362.00	\$1,686.29	\$1,686.29	\$6,020.04
50/50	FAMILY (SS)	\$5,902.00	\$2,951.00	\$1,362.00	\$1,686.29	\$2,951.00	\$2,951.00	\$1,362.00	\$1,686.29	\$1,686.29	\$6,020.04
50/50	INDIVIDUAL	\$2,658.00	\$1,329.00	\$613.38	\$759.43	\$1,329.00	\$1,329.00	\$613.38	\$759.43	\$759.43	\$2,711.16
50/50	INDIVIDUAL (SS)	\$2,658.00	\$1,329.00	\$613.38	\$759.43	\$1,329.00	\$1,329.00	\$613.38	\$759.43	\$759.43	\$2,711.16
HIGH DEDUCTIBLE HEALTH PLANS WITH HEALTH SAVINGS ACCOUNTS (HSA)											
BLUE CROSS HSA QUALIFIED PLAN											
60/40	FAMILY	\$2,315.00	\$1,157.50	\$641.08	\$793.71	\$1,157.50	\$926.00	\$427.38	\$529.14	\$529.14	\$2,361.30
50/50	FAMILY (SS)	\$2,315.00	\$1,157.50	\$641.08	\$793.71	\$1,157.50	\$926.00	\$427.38	\$529.14	\$529.14	\$2,361.30
60/40	INDIVIDUAL	\$862.00	\$517.20	\$238.71	\$295.54	\$517.20	\$344.80	\$159.14	\$197.03	\$197.03	\$879.24
50/50	INDIVIDUAL (SS)	\$862.00	\$517.20	\$238.71	\$295.54	\$517.20	\$344.80	\$159.14	\$197.03	\$197.03	\$879.24
TUFTS HSA QUALIFIED PLAN											
60/40	FAMILY	\$2,198.00	\$1,099.00	\$608.68	\$753.60	\$1,099.00	\$879.20	\$405.78	\$502.40	\$502.40	\$2,241.96
50/50	FAMILY (SS)	\$2,198.00	\$1,099.00	\$608.68	\$753.60	\$1,099.00	\$879.20	\$405.78	\$502.40	\$502.40	\$2,241.96
60/40	INDIVIDUAL	\$839.00	\$503.40	\$232.34	\$287.66	\$503.40	\$335.60	\$154.89	\$191.77	\$191.77	\$855.78
50/50	INDIVIDUAL (SS)	\$839.00	\$503.40	\$232.34	\$287.66	\$503.40	\$335.60	\$154.89	\$191.77	\$191.77	\$855.78
HPHC HSA QUALIFIED PLAN											
60/40	FAMILY	\$2,080.00	\$1,248.00	\$576.00	\$713.14	\$1,248.00	\$832.00	\$384.00	\$475.43	\$475.43	\$2,121.60
50/50	FAMILY (SS)	\$2,080.00	\$1,248.00	\$576.00	\$713.14	\$1,248.00	\$832.00	\$384.00	\$475.43	\$475.43	\$2,121.60
60/40	INDIVIDUAL	\$797.00	\$478.20	\$220.71	\$273.26	\$478.20	\$318.80	\$147.14	\$182.17	\$182.17	\$812.94
50/50	INDIVIDUAL (SS)	\$797.00	\$478.20	\$220.71	\$273.26	\$478.20	\$318.80	\$147.14	\$182.17	\$182.17	\$812.94
FALLON SELECT HSA QUALIFIED PLAN											
73/27	FAMILY	\$1,795.00	\$1,310.35	\$604.78	\$748.77	\$1,310.35	\$484.65	\$223.68	\$276.94	\$276.94	\$1,830.90
50/50	FAMILY (SS)	\$1,795.00	\$1,310.35	\$604.78	\$748.77	\$1,310.35	\$484.65	\$223.68	\$276.94	\$276.94	\$1,830.90
73/27	INDIVIDUAL	\$665.00	\$485.45	\$224.05	\$277.40	\$485.45	\$179.55	\$82.87	\$102.60	\$102.60	\$678.30
50/50	INDIVIDUAL (SS)	\$665.00	\$485.45	\$224.05	\$277.40	\$485.45	\$179.55	\$82.87	\$102.60	\$102.60	\$678.30
FALLON DIRECT HSA QUALIFIED PLAN											
78/22	FAMILY	\$1,671.00	\$1,303.38	\$601.56	\$744.79	\$1,303.38	\$367.62	\$169.67	\$210.07	\$210.07	\$1,704.42
50/50	FAMILY (SS)	\$1,671.00	\$1,303.38	\$601.56	\$744.79	\$1,303.38	\$367.62	\$169.67	\$210.07	\$210.07	\$1,704.42
78/22	INDIVIDUAL	\$620.00	\$483.60	\$223.20	\$276.34	\$483.60	\$136.40	\$62.95	\$77.94	\$77.94	\$632.40
50/50	INDIVIDUAL (SS)	\$620.00	\$483.60	\$223.20	\$276.34	\$483.60	\$136.40	\$62.95	\$77.94	\$77.94	\$632.40

*(SS) REPRESENTS SURVIVING SPOUSE

*SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)

**TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2020-2021**

JUNE PAYROLL CHANGES FOR JULY 1, 2020 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY	TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY	TOWN 21 P/R BI-WEEKLY*	EMPLOYEE MONTHLY	EMP. 26 P/R BI-WEEKLY	EMP. 21/P/R BI-WEEKLY*	COBRA
BENCHMARK HMO PLANS									
BLUE CROSS NETWORK BLUE BENCHMARK									
60/40	FAMILY	\$2,863.00	\$1,717.80	\$792.83	\$981.60	\$1,145.20	\$528.55	\$654.40	
50/50	FAMILY (SS)	\$2,863.00	\$1,431.50	\$660.69	\$818.00	\$1,431.50	\$660.69	\$818.00	\$2,920.26
60/40	INDIVIDUAL	\$1,068.00	\$640.80	\$295.75	\$366.17	\$427.20	\$197.17	\$244.11	
50/50	INDIVIDUAL (SS)	\$1,068.00	\$534.00	\$246.46	\$305.14	\$534.00	\$246.46	\$305.14	\$1,089.36
TUFTS BENCHMARK									
60/40	FAMILY	\$2,838.00	\$1,702.80	\$785.91	\$973.03	\$1,135.20	\$523.94	\$648.69	
50/50	FAMILY (SS)	\$2,838.00	\$1,419.00	\$654.92	\$810.86	\$1,419.00	\$654.92	\$810.86	\$2,894.76
60/40	INDIVIDUAL	\$1,084.00	\$650.40	\$300.18	\$371.66	\$433.60	\$200.12	\$247.77	
50/50	INDIVIDUAL (SS)	\$1,084.00	\$542.00	\$250.15	\$309.71	\$542.00	\$250.15	\$309.71	\$1,105.68
HPHC BENCHMARK									
60/40	FAMILY	\$2,683.00	\$1,609.80	\$742.98	\$919.89	\$1,073.20	\$495.32	\$613.26	
50/50	FAMILY (SS)	\$2,683.00	\$1,341.50	\$619.15	\$766.57	\$1,341.50	\$619.15	\$766.57	\$2,736.66
60/40	INDIVIDUAL	\$1,030.00	\$618.00	\$285.23	\$353.14	\$412.00	\$190.15	\$235.43	
50/50	INDIVIDUAL (SS)	\$1,030.00	\$515.00	\$237.69	\$294.29	\$515.00	\$237.69	\$294.29	\$1,050.60
FALLON SELECT BENCHMARK									
73/27	FAMILY	\$2,129.00	\$1,554.17	\$717.31	\$888.10	\$574.83	\$265.31	\$328.47	
50/50	FAMILY (SS)	\$2,129.00	\$1,064.50	\$491.31	\$608.29	\$1,064.50	\$491.31	\$608.29	\$2,171.58
73/27	INDIVIDUAL	\$790.00	\$576.70	\$266.17	\$329.54	\$213.30	\$98.45	\$121.89	
50/50	INDIVIDUAL (SS)	\$790.00	\$395.00	\$182.31	\$225.71	\$395.00	\$182.31	\$225.71	\$805.80
FALLON DIRECT BENCHMARK									
78/22	FAMILY	\$1,980.00	\$1,544.40	\$712.80	\$882.51	\$435.60	\$201.05	\$248.91	
50/50	FAMILY (SS)	\$1,980.00	\$990.00	\$456.92	\$565.71	\$990.00	\$456.92	\$565.71	\$2,019.60
78/22	INDIVIDUAL	\$736.00	\$574.08	\$264.96	\$328.05	\$161.92	\$74.73	\$92.53	
50/50	INDIVIDUAL (SS)	\$736.00	\$368.00	\$169.85	\$210.29	\$368.00	\$169.85	\$210.29	\$750.72

(SS) REPRESENTS SURVIVING SPOUSE

*SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)

WEST SUBURBAN HEALTH GROUP

IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by WSHG.

The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details.

The carrier documents are the only documents that coverage is based on.

Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.

WEST SUBURBAN HEALTH GROUP

Effective 07-01-2020

BENCHMARK HEALTH PLAN COMPARISON CHART July 1, 2020

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None
Deductible - applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - See plan document for full details	IND \$300 FAM \$900	IND \$300 FAM \$900	IND \$300 FAM \$900	IND \$300 FAM \$900
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year. Effective July 1, 2015, out-of-pocket maximums for prescription copays have been added as required by ACA (in-network only).	Medical - \$2,000 per member \$4,000 per family per plan year Prescription- \$2,000 per member \$4,000 per family per plan year see plan for details	Medical - \$2,000 per member \$4,000 per family per plan year Prescription- \$2,000 per member \$4,000 per family per plan year see plan for details	Medical - \$2,000 per member \$4,000 per family per plan year Prescription- \$2,000 per member \$4,000 per family per plan year see plan for details	Medical & Prescription Combined - \$2,000 Individual per plan year \$4,000 Family per plan year
Family Covered	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Member must select	Member must select	No selection required	Member must select
Specialist Referrals	PCP must refer	PCP must refer	No referral required	PCP must refer
Providers of Service	<u>HARVARD PILGRIM</u> providers except in emergencies	<u>HMO BLUE</u> providers in all 6 New England states except in emergencies	<u>TUFTS HEALTH PLAN</u> providers except in emergencies	**SELECT CARE - An expansive network that includes physician practices, community-based hospitals and medical facilities throughout Massachusetts, southern New Hampshire and southwestern Vermont. *DIRECTCARE - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT				
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Deductible applies then: Tier 1 : \$250 Tier 2 : \$500 Tier 3 : \$1500 per/Admit NOTE-Mental Health/Substance Abuse copay \$250	Deductible , then Tier 1: \$500 copay Tier 2: 1500 copay	Semi-private room & board & ancillary services Tier 1: \$500 copay, then deductible applies Tier 2: \$1500 copay, then deductible applies NOTE-Mental Health/Substance Abuse	\$500 copay per admission, then deductible No co-pay or deductible for Mental Hospital/Substance Abuse Facility

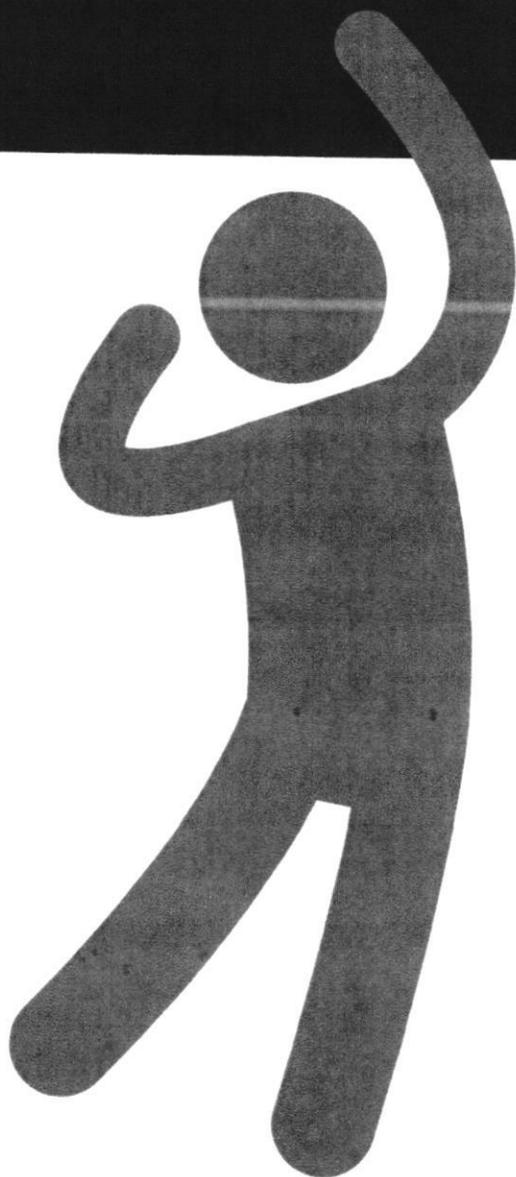
	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Physician Services	Nothing	Nothing	Nothing	Nothing, after deductible
Skilled Nursing Facility	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then covered in full	Covered in Full after Deductible, up to 100 days per plan year	\$500 copay per admission, then deductible Max of 100 days per year.
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	Nothing	Nothing
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	Deductible applies, then \$100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible applies, then \$100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	\$100 copay, then deductible applies (Inpatient copay applies if admitted)	\$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible applies, then \$250 copay per visit	Deductible applies, then \$250 copay per visit	\$250 copay per outpatient surgery, then deductible	\$250 copay per outpatient surgery, then deductible
CT, MRI and Pet Scans	Deductible applies, then \$100 Copay per procedure	Deductible, then \$100 copay (scheduled outpatient)	\$100 copay, then Deductible	\$100 copay, then deductible
Hemodialysis	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Physical Therapy	Copay: \$20 per visit - Limited to 30 visits per plan year	\$20 copay; up to 60 visits per calendar year (Unlimited for autism)	Speech and short-term PT/OT \$20 copay per visit; 30 visits per plan year	\$20 copay. PT / OT Max limit up to 60 visits per plan year
Office Visits Primary Care Physician	\$20 copay per visit	\$20 copay	\$20 copay per visit	\$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care (Mental Health copays excluded from OOP max)	\$20 copay per visit	\$20 per visit	\$20 copay per visit	\$20 copay per visit
Office Visits Specialist	Tier 1 : \$30 copay per visit Tier 2: \$60 copay per visit Tier 3: \$90 copay per visit	\$60 copay per visit	\$60 copay per visit	\$60 copay per visit
OB/GYN	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	\$0 copay - 1 every 2 years	\$0 copay; one visit every 12 months	\$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	\$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers
Pre-Admission Testing -	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	Nothing	Nothing for prenatal and postnatal outpatient care	Prenatal: \$20 copay first visit only; Postnatal: \$20 copay per visit

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Dental Services	Children up to age 13 - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	Children under age 12: Preventive dental one exam every six months., incl. Cleaning, fluoride treatment and x-rays. All members: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed.	Children under age 12; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	Family dental coverage: \$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
OTHER FEATURES				
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
Home Health Care	Member cost sharing depends on types of services provided and tier placement of provider rendering services, as listed in the Schedule of Benefits. For example, for services provided by a physician, see "physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Hospice Care	Same as Home Health Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	Deductible, then CIF^	Deductible, then 20% coinsurance	Covered in Full	Deductible, then CIF^ 20% coinsurance after the deductible for prosthetic limbs which replace, in whole or in part, an arm or leg.
Ambulance	Nothing when medically necessary	Deductible then covered in full	Covered in full when medically necessary	Covered in full when medically necessary
Radiation Therapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	\$20 copay, 20 visits per plan year	\$20 copay per visit. 12 visits maximum per calendar year	\$20 copay per visit; up to 12 visits per plan year	\$20 copay per visit; up to 12 visits per plan year.
Prescription Drugs (Inpatient drugs paid in full)	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail Pharmacy: Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Fitness Benefit	Reimbursement	Reimbursement	Reimbursement	Reimbursement
	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.</p> <p>Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®</p>	<p>Up to \$300 reimbursement toward health club membership or exercise classes. See plan materials for details.</p> <p>Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to \$150 per calendar year toward your program fees.</p>	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club, including exercise classes per calendar year. See plan materials for details.</p> <p>JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM</p>	<p>It Fits! Program reimburses families on Select Care up to \$400 per family contract (\$200 for individual contracts) and Direct Care members up to \$500 per family contract (\$250 for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.</p> <p>The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.</p>
<p>* Fallon DirectCare - Members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group, Fallon Clinic, Highland Healthcare Associates IPA, Lahey Clinic, Lawrence General IPA, Lowell General PHO, Mount Auburn Cambridge IPA, and Northeast PHO.</p> <p>**FCHP SelectCare - Members have access to FCHP Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern, Massachusetts.</p>				

WINNING WITH AN HSA

Health savings accounts (HSAs)



HSAs: *the new*
RETIREMENT **STRATEGY**

SAVE NOW AND FOR THE FUTURE



HealthEquity®

HSAs ARE AN EASY WIN

in today's complex healthcare system



How an HSA works

An HSA paired with an HSA-qualified health plan allows you to make tax-free¹ contributions to an federally-insured² savings account. Balances earn tax-free interest and can be used to pay for qualified medical expenses. HSA-qualified health plans typically cost less than traditional plans and the money saved can be put into your HSA.

HSAs empower savings:

- Lower monthly health insurance premiums
- Money put into your HSA is not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed
- You can invest your HSA funds for increased tax-free earning potential³

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave your employer.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future. Contrary to what many may think, healthy individuals aren't the only users who benefit from an HSA.

HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.
Your HSA cash balance is held at an FDIC-insured or NCUA-insured institution and is eligible for federal deposit insurance, subject to applicable requirements and limitations.
Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, not guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

GET STARTED WITH AN HSA TODAY

1 Select an HSA-qualified health plan

Enroll in an HSA-qualified plan. These plans typically cost less than traditional plans and provide tax saving opportunities. HealthEquity will work with your employer or health plan to automatically set up your account and supply a HealthEquity® Visa® Health Account Card¹ to conveniently pay for eligible expenses.

2 Add money to your HSA

Fund your HSA through pre-tax payroll deductions or transfer money into your account through the HealthEquity member portal. To take full advantage of tax savings and to build a reserve for the future, consider maximizing your contributions as set by the IRS:

HSA eligibility

To make tax-free² contributions to an HSA, the IRS requires that:

- you are covered by an HSA-qualified health plan.
- you have no other health coverage (such as other health plan, Medicare, military health benefits, medical FSAs).
- you cannot be claimed as a dependent on another person's tax return.

HSA CONTRIBUTION LIMITS

2019 INDIVIDUAL
\$3,500

2020 INDIVIDUAL
\$3,550

2019 FAMILY
\$7,000

2020 FAMILY
\$7,100

At age 55, an additional
\$1,000 is allowed annually.

This card is issued on The Bancorp Bank member FDIC pursuant to a license from Visa U.S.A. Inc. Your card can be used wherever Visa debit cards are accepted for qualified expenses. This card cannot be used at ATMs and you cannot get cash back. Card cannot be used at gas stations, restaurants or other establishments not health related. See Cardholder Agreement for complete usage restrictions. HSAs are covered taxed at a federal income tax level when used appropriately, for qualified medical expenses. Also, all states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

3 Watch your HSA grow

Your federally-insured HSA earns tax-free¹ interest. Maximize your tax-free earning potential by investing HSA funds using the convenient online investment tool.²

4 Use your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses, including:

- Acupuncture
- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Fertility enhancement
- Hearing aids
- Lab work
- Medical supplies
- Physical exams
- Prescriptions
- Orthodontia
- Radiology
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- and more...



You will receive a HealthEquity debit card for easy access to your funds.



For an expanded list of qualified medical expenses, visit:
HealthEquity.com/qme

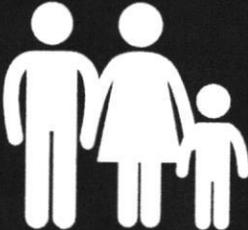
HSA earnings level and individual income tax level. Use only appropriate for qualified medical expenses. All United States recognize HSA funds as tax-free with zero tax options. Please consult a tax advisor regarding your HSA options and rules.
 1. Investment earnings are subject to the rules including the pro-rata loss of the principal investment and are not FDIC insured, are guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. Investing may not be suitable for everyone. 2. HSA funds making any investments should be held in prospectus.
 HealthEquity, Inc. Health Account Card Issued by: The Bancorp Bank member FDIC provided to all members. Deposit A fee. Your card can be used as multiple Visa debit cards. Accepted for qualified expenses. This card cannot be used at ATM and you cannot get a check and you do not need a PIN. Subject to applicable law, certain restrictions apply. HealthEquity, Inc. Cardholder Agreement for complete usage rules. See

YOU CAN WIN WITH AN HSA

An HSA can benefit Americans from all walks of life and empower savings now and for the future. Contrary to popular belief, you do not have to be healthy or wealthy to benefit from an HSA – just wise! To see how different types of healthcare consumers win, see the link below.

See how *you* can personally benefit from an HSA:
HealthEquity.com/Me

Who are you?

SAVER			SHOPPER
SURVIVOR			MINIMALIST



Account mentors

**We are available to help,
every hour of every day**

We understand the significance of your benefits selection. Our team of specialists based in Salt Lake City is available 24 hours a day, providing you with insight to help you optimize your health savings account. Call today.

866.346.5800

HealthEquity.com/HSAlearn

EASY ACCESS to your ACCOUNT WHEREVER you are.



HealthEquity mobile app¹
available for FREE at:

- Apple® App Store®
- Google Play™



1. App download and use subject to the HealthEquity Terms of Use and Privacy Policy. © 2019 HealthEquity. All rights reserved.



HealthEquity®

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Draper, UT 84020
info@healthequity.com | www.HealthEquity.com

Working... m_HSAs_ER_June_2019

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WEST SUBURBAN HEALTH GROUP

Effective 07-01-2020

HSA Qualified - HDHP HEALTH PLAN COMPARISON CHART July 1, 2020

red font indicates change or clarification
PLAN TYPE

^ CIF = Covered in Full

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None
Deductible - Once deductible is satisfied, all services CIF [^] as noted, with the exception of Prescription Copays	IND \$2,000 FAM \$4,000 (Non-embedded, plan year deductible, family plan deductible needs to be satisfied before insurance plan kicks in)	IND \$2,000 FAM \$4,000	IND \$2,000 FAM \$4,000	IND \$2,000 FAM \$4,000
Out-of-Pocket (OOP) Maximum-	Medical & RX COMBINED - \$5,000 per member \$10,000 per family per plan year see plan for details	Medical & RX COMBINED - \$5,000 per member \$10,000 per family per plan year see plan for details	Medical & RX COMBINED - \$5,000 per member \$10,000 per family per plan year see plan for details	Medical & RX COMBINED - \$5,000 per member \$10,000 per family per plan year see plan for details
Family Covered	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Member must select	Member must select	Member must select	Member must select
Specialist Referrals	PCP must refer	No referral required	PCP must refer	PCP must refer
Providers of Service	HARVARD PILGRIM providers except in emergencies	HMO BLUE providers in all 6 New England states except in emergencies	TUFTS HEALTH PLAN providers except in emergencies	**SELECT CARE - An expansive network that includes physician practices, community-based hospitals and medical facilities throughout Massachusetts, southern New Hampshire and southwestern Vermont. *DIRECTCARE - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT				
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
Physician Services	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
Skilled Nursing Facility	Deductible, then CIF [^] up to 100 days per plan year	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
Newborn Well Baby Care (Inpatient)	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
CT, MRI and Pet Scans	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
Hemodialysis	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]	Deductible, then CIF [^]
Physical Therapy	Deductible, then CIF [^] Limited to 30 visits per plan year	Deductible, then CIF [^] Limited to 60 visits per member per calendar year for physical and occupational therapy (unlimited for autism)	Deductible, then CIF [^]	Deductible, then CIF [^] Limited to 60 visits per plan year

red font indicates change or clarification

PLAN TYPE

^ CIF = Covered in Full

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Office Visits Primary Care Physician	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Preventive QV - PCP	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Office Visits Specialist	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
OB/GYN	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Routine Vision Exam	Deductible, then CIF ^A	Nothing. Covered once every 12 months.	Covered in full	Deductible, then CIF ^A Covered in full - one visit every 12 month period Eyewear discounts available at participating EYEMed providers
Pre-Admission Testing -	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Maternity Care visits	Routine OPD, Pre and Post Natal CIF ^A	Nothing for prenatal; all other services Deductible, then CIF ^A	Nothing for prenatal and postnatal outpatient care	Prenatal: Nothing Postnatal: Deductible then CIF ^A
Dental Services	Deductible, then up to age 13 - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	Children under age 12: Preventive dental one visit every 6 months., incl. Cleaning, fluoride treatment and x-rays. All members: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed. See Outpatient Surgery for benefit information.	Children under age 12: Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	Family dental coverage: All services subject to the deductible and then the following cost share: \$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
OTHER FEATURES				
Private Duty Nursing	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
(only when medically necessary)				
Home Health Care	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Hospice Care	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Durable Medical Equipment	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Ambulance	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Radiation Therapy	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Chemotherapy	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A	Deductible, then CIF ^A
Chiropractor Visits	Deductible, then CIF ^A 12 visits per plan year	Deductible, then CIF ^A 12 visits per calendar year	Deductible, then CIF ^A 12 visits per plan year	Deductible, then CIF ^A 12 visits per plan year
Prescription Drugs	Retail Pharmacy: Copays AFTER DEDUCTIBLE	Retail Pharmacy: Copays AFTER DEDUCTIBLE	Retail Pharmacy: Copays AFTER DEDUCTIBLE	Retail Pharmacy: Copays AFTER DEDUCTIBLE
(Inpatient drugs paid in full)	Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE Tier 1: \$25.00 copay Tier 2: \$75.00 copay	Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE Tier 1: \$25.00 copay Tier 2: \$75.00 copay	Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE Tier 1: \$25.00 copay Tier 2: \$75.00 copay	Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay (up to a 30-day supply) Mail Order: (up to 90 day supply) Copays AFTER DEDUCTIBLE Tier 1: \$25.00 copay Tier 2: \$75.00 copay

red font indicates change or clarification

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE				
^ CIF = Covered in Full	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
	Tier 3: \$165.00 copay	Tier 3: \$165.00 copay	Tier 3: \$165.00 copay	Tier 3: \$165.00 copay

red font indicates change or clarification

PLAN TYPE

^ CIF = Covered in Full

BENEFIT

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Fitness Benefit	Reimbursement	Reimbursement	Reimbursement	Reimbursement
	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.</p> <p>Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®</p>	<p>Up to \$300 reimbursement toward health club membership or exercise classes. See plan materials for details.</p> <p>Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to \$150 per calendar year toward your program fees.</p>	<p>Fitness reimb up to \$150 per subscriber at a Health & Fitness club, including exercise classes per calendar year. See plan materials for details.</p> <p>JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM</p>	<p>It Fits! Program reimburses families on Select Care up to \$400 per family contract (\$200 for individual contracts) and Direct Care members up to \$500 per family contract (\$250 for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.</p> <p>The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.</p>

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**FCHP SelectCare - Members have access to FCHP Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern, Massachusetts.

Town of Shrewsbury 2020 - 2021 Employee Payroll Agreement

I _____ authorize the Town of Shrewsbury to deduct the premiums designated below from my payroll check.

Pay Frequency	26-Bi-Weekly <small>Town Departments</small>			26-Bi-Weekly <small>Teachers</small>			26-Bi-Weekly <small>School Administrators</small>			21-Bi-Weekly <small>Aides, ABAs, Ext. Day, and Food Svcs</small>		
	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
Benchmark Plans												
BC/BS												
Individual	___ \$197.17	\$295.75	8260	___ \$197.17	\$295.75	8261	___ \$197.17	\$295.75	8264	___ \$244.11	\$366.17	8263
Family	___ \$528.55	\$792.83	8250	___ \$528.55	\$792.83	8251	___ \$528.55	\$792.83	8254	___ \$654.40	\$981.60	8253
Tufts												
Individual	___ \$200.12	\$300.18	8280	___ \$200.12	\$300.18	8281	___ \$200.12	\$300.18	8284	___ \$247.77	\$371.66	8283
Family	___ \$523.94	\$785.91	8270	___ \$523.94	\$785.91	8271	___ \$523.94	\$785.91	8274	___ \$648.69	\$973.03	8273
HPHC												
Individual	___ \$190.15	\$285.23	8230	___ \$190.15	\$285.23	8231	___ \$190.15	\$285.23	8234	___ \$235.43	\$353.14	8233
Family	___ \$495.32	\$742.98	8210	___ \$495.32	\$742.98	8211	___ \$495.32	\$742.98	8214	___ \$613.26	\$919.89	8213
Fallon Select												
Individual	___ \$98.45	\$266.17	8330	___ \$98.45	\$266.17	8331	___ \$98.45	\$266.17	8334	___ \$121.89	\$329.54	8333
Family	___ \$265.31	\$717.31	8310	___ \$265.31	\$717.31	8311	___ \$265.31	\$717.31	8314	___ \$328.47	\$888.10	8313
Fallon Direct												
Individual	___ \$74.73	\$264.96	8430	___ \$74.73	\$264.96	8431	___ \$74.73	\$264.96	8434	___ \$92.53	\$328.05	8433
Family	___ \$201.05	\$712.80	8410	___ \$201.05	\$712.80	8411	___ \$201.05	\$712.80	8414	___ \$248.91	\$882.51	8413
HDHP (HSA) Plans												
BC/BS												
Individual	___ \$159.14	\$238.71	8051	___ \$159.14	\$238.71	8061	___ \$159.14	\$238.71	8071	___ \$197.03	\$295.54	8081
Family	___ \$427.38	\$641.08	8052	___ \$427.38	\$641.08	8062	___ \$427.38	\$641.08	8072	___ \$529.14	\$793.71	8082
Tufts												
Individual	___ \$154.89	\$232.34	8053	___ \$154.89	\$232.34	8063	___ \$154.89	\$232.34	8073	___ \$191.77	\$287.66	8083
Family	___ \$405.78	\$608.68	8054	___ \$405.78	\$608.68	8064	___ \$405.78	\$608.68	8074	___ \$502.40	\$753.60	8084
HPHC												
Individual	___ \$147.14	\$220.71	8055	___ \$147.14	\$220.71	8065	___ \$147.14	\$220.71	8075	___ \$182.17	\$273.26	8085
Family	___ \$384.00	\$576.00	8056	___ \$384.00	\$576.00	8066	___ \$384.00	\$576.00	8076	___ \$475.43	\$713.14	8086
Fallon Select												
Individual	___ \$82.87	\$224.05	8057	___ \$82.87	\$224.05	8067	___ \$82.87	\$224.05	8077	___ \$102.60	\$277.40	8087
Family	___ \$223.68	\$604.78	8058	___ \$223.68	\$604.78	8068	___ \$223.68	\$604.78	8078	___ \$276.94	\$748.77	8088
Fallon Direct												
Individual	___ \$62.95	\$223.20	8059	___ \$62.95	\$223.20	8069	___ \$62.95	\$223.20	8079	___ \$77.94	\$276.34	8089
Family	___ \$169.67	\$601.56	8060	___ \$169.67	\$601.56	8070	___ \$169.67	\$601.56	8080	___ \$210.07	\$744.79	8090
Indemnity Plans												
HPHC PPO												
Individual	___ \$613.38	\$613.38	8160	___ \$613.38	\$613.38	8161	___ \$613.38	\$613.38	8164	___ \$759.43	\$759.43	8163
Family	___ \$1,362.00	\$1,362.00	8150	___ \$1,362.00	\$1,362.00	8151	___ \$1,362.00	\$1,362.00	8154	___ \$1,686.29	\$1,686.29	8153
Life Insurance												
Basic Life	___ \$1.96	\$1.96	8904	___ \$1.96	\$1.96	8902	___ \$1.96	\$1.96	8905	___ \$2.42	\$2.42	8903
Optional Life	___ \$ _____	_____	8915	___ \$ _____	_____	8916	___ \$ _____	_____	8917	___ \$ _____	_____	8918
	Formula: Rate \$ _____ x Ins. Total per 1,000 \$ _____ x 12 / _____ (pay frequency)											
Voluntary Life	___ \$ _____	_____	8930	___ \$ _____	_____	8931	___ \$ _____	_____	8934	___ \$ _____	_____	8933
Town Dental Ins												
Altus Dental	(24 week)											
Individual	___ \$24.31	\$0.00	8970	___ NA			___ NA			___ NA		
Family	___ \$62.51	\$0.00	8971									

I understand that if my premiums are not deducted correctly from my payroll/retirement check it is my responsibility to notify the Town Benefits Administrator, and I will be responsible for all back premiums. I also understand that the Town deducts premium one month in advance of coverage and additional premium due upon initial enrollment will also be deducted from my first payroll/retirement check. I acknowledge that I have received a notice informing me of my right under COBRA (Consolidated Omnibus Budget Reconciliation Act). I also acknowledge that I have received the Town of Shrewsbury's HIPAA Privacy Policy.

EFFECTIVE DATE: _____

SIGNED: _____

DATED: _____

**Health Insurance Enrollment Forms
(Complete the plan of your choice)**

- Fallon
- Harvard Pilgrim
- Tufts
- Blue Cross

Fallon Community Health Plan Employer Group Membership Transaction Form



Please complete all fields on form. (Please print clearly.)

PLEASE CHOOSE YOUR PROVIDER NETWORK

FCHP DIRECT CARE FCHP SELECT CARE Plan name (if applicable): _____

EMPLOYEE INFORMATION IF WE MAY CONTACT YOU BY E-MAIL, PLEASE SUPPLY ADDRESS WHERE INDICATED.*

NAME (LAST, FIRST, MI)		MAIDEN NAME (IF APPLICABLE)		PRIMARY LANGUAGE	
STREET ADDRESS		CITY		STATE	ZIP CODE
HOME PHONE ()					
BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> OTHER			
WORK PHONE ()	*E-MAIL	SOCIAL SECURITY NO		STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA	
DATE HIRED	AVERAGE NO HOURS WORKED	DEPARTMENT #	EMPLOYEE #	IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIMARY CARE PHYSICIAN SELECTION
EVER TREATED BY THIS PHYSICIAN? (IF YES, UNDER WHAT NAME?) <input type="checkbox"/> NO <input type="checkbox"/> YES			IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: / /		

DEPENDENT INFORMATION

PRIMARY CARE PHYSICIAN (PCP)
SEE PROVIDER LIST

NAME OF DEPENDENT (LAST, FIRST, MI - MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE		EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL		RACE		
NAME OF DEPENDENT (LAST, FIRST, MI - MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE		EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL		RACE		
NAME OF DEPENDENT (LAST, FIRST, MI - MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE		EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL		RACE		
NAME OF DEPENDENT (LAST, FIRST, MI - MAIDEN NAME IF APPLICABLE)		<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE		EVER TREATED BY THIS DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
*E-MAIL		RACE		

GROUP INFORMATION

REASON FOR TRANSACTION

GROUP NUMBER	ADDING COVERAGE <input type="checkbox"/> New hire <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (explain in "Remarks" section below) ENDING COVERAGE <input type="checkbox"/> Termination of employment <input type="checkbox"/> Change to other insurance (give name of other insurance in "Remarks" section below) <input type="checkbox"/> Other (explain in "Remarks" section below)	CHANGES TO EXISTING COVERAGE Change to: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other <input type="checkbox"/> Addition of a dependent (complete "Dependent" section above) <input type="checkbox"/> Change in name, address, or other application information (give previous information in "Remarks" section below) <input type="checkbox"/> COBRA <input type="checkbox"/> Other (explain in "Remarks" section below)
GROUP NAME WSHG Town of Shrewsbury		
REQUESTED EFFECTIVE DATE		
TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER		

REMARKS

AGREEMENT (SUBSCRIBER'S SIGNATURE)

I agree to the terms and conditions located on the back of this form.

X _____

For FCHP Use Only	Territory	Receipt Date	Employer's Signature	Date
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Temporary Membership Card

WELCOME! Thank you for choosing Fallon Community Health Plan (FCHP) for your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information on your membership in FCHP and your membership card(s). In the meantime, this sheet is your **temporary membership card**. Also included in this kit will be information on how to obtain a *Member Handbook/Evidence of Coverage*, which defines your benefits and regulates benefit decisions. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the FCHP Group Agreement and the FCHP Direct Care or FCHP Select Care *Member Handbook/Evidence of Coverage*.

CHOOSING YOUR PHYSICIAN: At the time of enrollment, you also must select a primary care physician for every person covered under this contract: a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to fchp.org or your FCHP Direct Care or FCHP Select Care *Provider Network* directory for a complete list of providers and their locations. You must make these selections now and list your choices on this Membership Transaction Form. If you wish to notify us of a physician change or if you need help choosing a physician, please call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). To make an appointment, call your doctor's office or medical center directly.

EMERGENCY CARE: Emergency services do not require referral or authorization. When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). If you receive care outside of the plan service area, Fallon Community Health Plan requires you to notify the plan within 48 hours or as soon as is medically possible. For more information on emergency benefits and plan procedures for emergency services, consult your *Member Handbook/Evidence of Coverage*.

OUT-OF-AREA CARE: When you are out of the service area, you are covered for any unexpected illness or injury that needs prompt medical attention. Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) to report use of services, and call your doctor to arrange for follow-up care.

REMEMBER: FCHP will not pay for any services that are not provided or appropriately arranged by Fallon Community Health Plan, except in life-threatening emergencies in the area or any emergencies out of the service area.

CONSENT: Submission of this form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation, processing and payment of related claims.

AGREEMENT: I am employed by the company named on this form, working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage (or I am otherwise eligible for the named company's health insurance coverage, e.g., as a former employee covered under COBRA). I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the FCHP coverage I have selected. I understand that FCHP is a health maintenance organization and that membership becomes effective in accordance with the FCHP Group Agreement and the *Member Handbook/Evidence of Coverage*. I have read this Membership Transaction Form and understand how to obtain and use services under my FCHP coverage. I certify that all information is correct to the best of my knowledge.

QUESTIONS ABOUT COVERAGE? Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or visit our Web site at fchp.org.

New Members — Register at tuftshealthplan.com for fast access to your secure online account and personal benefit information.

Please fill in the “employee” sections of this membership application completely. Failure to do so could delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon. If you need a temporary ID, please use the yellow copy of this completed form.

Employer Section

Your employer must fill out this section.

Employee Section

- **Personal Information:** Complete all enrollment information. If your plan (HMO, POS, or EPO) requires the selection of a primary care provider (PCP), be sure to fill out this section for all members, including dependents.
- **Product Code:** Please be sure to fill in the correct product code for the plan you have selected.
- **Primary Care Provider:** If your plan requires you to choose a PCP, it is important that you select one right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are an established patient of the PCP you have listed. (You are an established patient if you have routinely received health care services from this provider in the past.) If you are selecting a new PCP, contact the provider’s office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam. You will then need to transfer your medical records to your new PCP.
- **Other Health Coverage:** If you have other or additional insurance (such as Medicare), please check the correct box and fill in the requested information. If you do not have any other insurance, be sure to check the “No” box.

When the Application is Complete

- Give the application to your employer.
- Employee keeps the yellow copy. This is also your temporary ID.
- Employer keeps the pink copy.
- Employer mails the original white copy to:
Tufts Health Plan
P.O. Box 9186
Watertown, MA 02471-9186

If You Need Emergency Care

If a health care emergency occurs, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP.

Notices

By enrolling, you understand and agree that if you or any of your enrolled dependents obtain a health care benefit or payment that you are not entitled to receive, or if you knowingly present a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney’s fees and costs, including the cost of the investigation.

Tufts Health Plan arranges for the provision of health care services through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan. Tufts Health Plan does not directly provide health care services.

Product Codes

Write the corresponding letter in the product box in the member section of the enrollment application.

- | | |
|---|--------------------------------------|
| A - HMO Premium | Q - Carelink |
| B - HMO Value | R - HMO Select 15 |
| C - HMO Basic | S - HMO Select 20 |
| D - HMO Choice Copay | T - Advantage HMO Select 750 |
| E - Advantage HMO | U - Advantage HMO Select 2000 |
| G - Advantage HMO Saver | W - Rhode Island Healthpact |
| H - POS | X - Your Choice HMO |
| I - POS Choice Copay | Y - Your Choice PPO |
| J - EPO | Z - Steward Community Choice |
| K - EPO Choice Copay | RIC - Rhode Island Conversion |
| L - PPO | |
| M - Advantage PPO | |
| O - Advantage PPO Saver | |
| P - Navigator by Tufts Health Plan | |

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the Doctor Search feature. If you need help filling out this form, call a Member Services Specialist.

We speak 140 languages. Call Member Services.

- Nous parlons français
- Habliamos Español
- Nós falamos português
- Мы говорим по-русски
- Parliamo Italiano
- Wir sprechen Deutsch
- 我們會講普通話
- 我們會講廣東話
- Chúng tôi nói tiếng Việt
- Nou parle Kréol
- עברית

Member Services:
800-462-0224

MEMBER ENROLLMENT FORM

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186



FAILURE TO COMPLETE AREAS MARKED IN BLUE WILL CAUSE A DELAY IN ENROLLMENT.

EMPLOYER SECTION

Group/Company Name _____ Group Number _____
 Office Location _____ Date of Hire _____ Effective Date of Coverage _____

Type of Enrollment: New Hire Open Enrollment COBRA New Group Qualifying Event (MUST specify) _____ Qualifying Event Date _____

MEMBER SECTION

PRODUCT (Select corresponding letter from the list on the front page) _____ Other _____

Last Name _____ First Name _____ Middle Initial _____ Primary Language _____

Employee Social Security Number (required) _____ Date of Birth (MM/DD/YYYY) ____/____/____ Gender: Male Female

Mailing (Home) Address _____ City _____ State _____ ZIP _____ Home Telephone (____) _____

Marital Status: Single Married Divorced Domestic Partner Individual Family Other _____ Work Telephone (____) _____

Primary Care Provider (HMO, POS, EPO only) First Name _____ Last Name _____ PCP ID# _____ Are you an established patient of this PCP? Yes No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number	Choose a Primary Care Provider for each member (HMO, POS, EPO only, include first and last name.)	Check if currently used for primary care	PCP ID #
<input type="checkbox"/> Spouse			-		<input type="checkbox"/>	
<input type="checkbox"/> Domestic Partner			-		<input type="checkbox"/>	
Child/Dependent			-		<input type="checkbox"/>	
Child/Dependent			-		<input type="checkbox"/>	
Child/Dependent			-		<input type="checkbox"/>	
Child/Dependent			-		<input type="checkbox"/>	
Child/Dependent			-		<input type="checkbox"/>	

Please check if you are using additional membership applications for additional dependent children.

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? Yes No (Medicare) No

Name of Health Plan _____ Health Plan Number _____ Effective Date _____

Names of Family Members Covered _____ Is Spouse Employed? Yes No If Yes, Name and Address of Employer _____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature (required) _____ Date _____ Benefits Dept. Signature _____ Telephone _____ Date _____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY Please keep yellow copy as your temporary Tufts Health Plan ID



Harvard Pilgrim HealthCare

P.O. Box 9185 Quincy, MA 02269

REASONS FOR SUBMISSION (PLEASE CHECK ONE) <input type="checkbox"/> NEW ENROLLMENT/CONTRACT <input type="checkbox"/> CHANGE TO CONTRACT <input type="checkbox"/> TERMINATE CONTRACT	QUALIFYING EVENT DATE: <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> COBRA <input type="checkbox"/> LOSS OF INSURANCE <input type="checkbox"/> COURT ORDER <input type="checkbox"/> BIRTH/ADOPTION <input type="checkbox"/> P/T TO F/T <input type="checkbox"/> MARRIAGE/DIVORCE <input type="checkbox"/> MOVED IN/OUT OF SERVICE AREA <input type="checkbox"/> DEATH <input type="checkbox"/> VOLUNTARY CANCELLATION
--	--

REASON FOR CHANGES (CHECK ALL THAT APPLY)

CHANGE COVERAGE TYPE
 ADD DEPENDENT LISTED
 TERMINATE DEPENDENT LISTED
 TRANSFER/RE-ENROLL TO COBRA
 OTHER:

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	GROUP #DIVISION	DATE OF HIRE	EFFECTIVE DATE OF COVERAGE
---------------------	-----------------	--------------	----------------------------

SUBSCRIBER INFORMATION

HP ID	PRODUCT <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> ACCESS AMERICA	PLAN NAME			
SUBSCRIBER FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
SSN	HOME PHONE	WORK PHONE	CELL PHONE	EMAIL	
STREET ADDRESS (NO PO BOX for HMO allowed)		APT #	CITY	STATE	ZIP
PRIMARY LANGUAGE (OPTIONAL)	PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID #	

SPOUSE INFORMATION

SPOUSE FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
SSN	MAILING ADDRESS (IF DIFFERENT)			RELATION CODE
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID #	

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	RELATION CODE
MAILING ADDRESS (IF DIFFERENT)				SSN	
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID #		

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	RELATION CODE
MAILING ADDRESS (IF DIFFERENT)				SSN	
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID #		

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	RELATION CODE
MAILING ADDRESS (IF DIFFERENT)				SSN	
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID #		

PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS.

OTHER INSURANCE - IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? YES, PLEASE COMPLETE NO

NAME OF HEALTH PLAN	HEALTH PLAN ID NUMBER	EFFECTIVE DATE	NAMES OF SUBSCRIBER
---------------------	-----------------------	----------------	---------------------

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINISTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFAULDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

EMPLOYEE SIGNATURE DATE

EMPLOYER SIGNATURE

DATE

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	Contract change	Termination
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. **IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.**
- **Primary Care Provider:** If your plan is an HMO, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
 - 02 Spouse/Civil Union
 - 03 Child up to age 26
 - 06 Disabled (verification required)
 - 07 Ex-spouse
 - DP Domestic Partner
 - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.



Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please read the instructions below carefully.

For members of HMO Blue,[®] Network Blue,[®] Blue Choice,[®] HMO Blue New England,SM or Blue Choice New EnglandSM: You are required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting www.bluecrossma.com and selecting **Find a Doctor**.

For Access BlueSM Members: Although you are not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance. Please be sure to circle either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Section 2 and 3.

Print two copies, one for your records and one for your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you are seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298

Instructions

Section 1 To Be Filed Out By Your Employer

Your employer will fill out this section.

Type of Transaction - Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber will not be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Situation	Code #	Situation
041	<ul style="list-style-type: none"> Changing to other health plan Voluntary termination COBRA cancellation (under 18 months or nonpayment) 	061	<ul style="list-style-type: none"> Left employment COBRA ending
042	<ul style="list-style-type: none"> Over 65, changing to Group Medex® plan. (Requires Medicare A and B) Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) Over 65, changing to Medicare supplement other than Medex plans. 	063	Transfer
043	Medicare (age <= 65)	064	Cancellation as of original effective date
		070	Deceased
		071	Moved out of state (out of HMO service area)
		076	Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group ≠ transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events - Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment - Check this box for open enrollment.
- New Hire - Check this box for new hires to the company.
- COBRA - Check this box if person is continuing coverage under COBRA.
- Add Spouse - Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent - Check this box if adding any dependent.
- Loss of Coverage - Check this box if person lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions contact your account service representative.
- Other - Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., Court Order, Adoption, New Dependent Law under HCR, Legal Guardianship, etc.). Include supporting documentation. If you have questions contact your account service representative.

Section 2 Tell Us About Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID# - If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (*not* the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at 1-800-821-1388. A representative will be happy to help you select a doctor. PCP ID number can be found at www.bluecrossma.com, select Find a Doctor.

Other Insurance - Do you have other health insurance or Medicare? Please be sure to circle either Y (for yes) or N (for no) in the correct box. If you have other insurance, please write the name of the other insurance company and its location (city and state).

To Add or Delete a Member - Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Tell Us About Your Spouse (Member 2)

If you choose a Family membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an Individual membership.)

Other Insurance - Does your spouse have other health insurance or Medicare? Please be sure to circle either Y (for yes) or N (for no) in the correct box. If your spouse has other insurance, please write the name of the other insurance company and its location (city and state).

Section 4 Tell Us About Your Eligible Dependents (Members 3, 4, and 5)

If you choose a Family membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: Dependents cannot be covered under an Individual membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Select Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions please see your employer.

Note: If you are transferring from one medical/dental plan to another medical/dental plan, please provide notification that you will be continuing your personal savings account by completing Section 5 of the Enrollment and Change form.

Section 6 Signatures (Employer & Employee)

Employee: Please sign & date the application and return it to your employer. Employer: Please sign & date the application and return to Blue Cross Blue Shield of Massachusetts.

(REQUIRED)* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

Before Filling Out This Form.

Please PRINT CLEARLY using blue or black ink to avoid coverage delay or type in information



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Please mail to: P.O. Box 986001 Boston, MA 02298 or fax to 1-617-246-7531

1. To Be Filled Out by Your Employer

Company Name, Current Medical Group #, Medical Group #, Transferring To, Current BCBS ID #, Requested Effective Date, Date of Hire, Current Dental Group #, Dental Group #, Transferring To, Type of Transaction, Remarks, Open Enrollment, Change to Family, Loss of Coverage, etc.

2. Tell Us About Yourself (Member 1)

What products are you selecting?, HMO Blue, Dental Blue, HMO Blue New England, Kind of Membership (Medical), Kind of Membership (Dental), Your First Name, M.I., Last Name, Sex, Date of Birth, Street Address, Apt. #, City/Town, State, Zip Code, Social Security #, Telephone #, Other Insurance, PCP ID, Name of PCP, City/State, Is this your current PCP?, Are you covered by Medicare?, Part A Effective Date, Part B Effective Date, Part D Effective Date, Medicare #, Actively Working?, If Retired, Date.

3. Tell Us About (Member 2) Please Check One: Spouse, Domestic Partner, Divorced Spouse (court ordered)

Member 2's First Name, M.I., Last Name, Sex, Date of Birth, Street Address, Apt. #, City/Town, State, Zip Code, Social Security #, Telephone #, Other Insurance, PCP ID, Name of PCP, City/State, Is this your current PCP?, Is Member 2 covered by Medicare?, Part A Effective Date, Part B Effective Date, Part D Effective Date, Medicare #, Actively Working?, If Retired, Date.

1. If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

4. Tell Us About Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name, M.I., Last Name, Sex, Full-time student and aged 19 or older, Disabled and aged 26 or older, Social Security #, Date of Birth, PCP ID #, Name of PCP, Is this your current PCP?, etc.

Please check if you are using separate forms for additional dependent children Total # of Dependents:

5. Select Personal Savings Account

HSA: Health Savings Account, FSA - Health: Health Flexible Spending Account, FSA - Dep.: Dependent Care Reimbursement Account, Start Date, End Date, FSA GOAL AMOUNTS.

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan.

Employee's Signature Date Employer's Signature Date

Important Notice for Benefit Eligible Employees

There is a 30 day window from the qualifying event, to notify the Health Insurance Companies of any changes to your health insurance. If the insurance companies do not receive the appropriate documentation within the 30 day window the employee and/or dependent(s) cannot be enrolled until the next July 1st (through the annual Open Enrollment period) or until a subsequent qualifying event.

Please take the time to come in and submit the following changes as soon as they happen:

1. New Hires
2. Change of Employment Status - under/over 20 hours per week
3. Birth/Adoption - Birth Certificate or Adoption Certificate
4. Marriage - Marriage Certificate
5. Divorce, Legal Separation or Remarriage of an Employee or his/her Spouse
6. Involuntary Loss of Coverage - see HIPAA and CHIPRA Special Enrollment Notices
7. Change in Residence – this can affect your health plan, receiving your 1099 HC and mailings
8. Name Change
9. Phone Number Change
10. Adult Children turning Age 26 - see attached notice from West Suburban Health Group
 - Please Note: Disabled Children over 26 will need appropriate paperwork completed and approved by the insurance company each year to continue to be insured.
11. Turning age 65
12. Entitlement to Medicare for employee, spouse or child

Not updating your personal information could also result in costly consequences of claims being denied or not being paid in a timely manner.

Thank you in advance for your cooperation.

Donna Bouchard
Benefits Administrator
508-841-8359 or email Benefits@shrewsburyma.gov

Employee HSA payroll deduction form



Return completed forms to:

Company name: _____

Attn: _____

Fax: _____

Email address: _____

Annual employer contribution information

Self-only	Family	Other (optional)

For mid-year enrollees, contact your HR department for your pro-rated employer election amount.

Notes

HSA contribution limits and contribution calculator

2018 annual HSA contributions			2019 annual HSA contributions		
Coverage type	Total annual contribution*	Per month	Coverage type	Total annual contribution*	Per month
Self-only	\$3,450	\$287.50	Self-only	\$3,500	\$291.67
Family	\$6,900	\$575.00	Family	\$7,000	\$583.33

*Catch-up contribution (age 55+): additional \$1,000/year

*Catch-up contribution (age 55+): additional \$1,000/year

Total annual contribution	-	Total annual employer contribution	=	Total eligible amount
<input type="text"/>	(MINUS)	<input type="text"/>		0
Total eligible amount	/	Enter number of pay periods remaining in the year from form submittal date	=	Per-pay period max withholding
0	(DIVIDED)	1		0

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of December 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 866.346.5800.

Employee information and authorization

Employee name	Last 4 of SSN or employee ID
Please withhold \$ _____ from my (weekly/bi-weekly/monthly) payroll and apply the funds to my HealthEquity HSA.	
Signature	Date

Town of Shrewsbury Basic & Optional Life Insurance FAQ

How much life insurance does the Town offer?

The Town of Shrewsbury offers employees the opportunity to purchase \$7,000 of basic life insurance, and will pay 50% of the premium. Your cost for the basic coverage is \$4.24 per month.

How much more insurance can I buy?

If you enroll in basic life insurance you may also purchase optional life insurance in increments of \$10,000 to the maximum of \$500,000 (not to exceed 7 times your base pay), with a guaranteed issue amount of \$150,000. Over the age of 70 the guaranteed issue is \$10,000 without additional health questions.

What is the cost of optional life insurance?

See the back of this sheet for rates. This cost is based on your age at the time the policy is issued; therefore, your premium will **not** increase as you get older.

Can I purchase life insurance for my spouse or children?

Yes, however; you must have optional life coverage in order to insure your spouse and/or children. For your spouse you can purchase optional life insurance in increments of \$10,000 to the maximum of \$150,000 (not to exceed 100% of your optional life coverage), with a guaranteed issue amount of \$30,000. For your unmarried dependent children to age 19 (or up to 25 if a full-time student) you can purchase \$10,000 of optional life insurance.

Can I wait until I'm older to sign up for this coverage?

Each employee is offered one opportunity to sign up for this coverage without having to submit medical evidence of insurability. This means that in your first 30 days of employment you are guaranteed up to \$150,000 of insurance without having to answer any medical questions. When you get older you may not be medically capable of qualifying.

How can I get more info?

For more information please contact Donna Bouchard at (508) 841-8359.



PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Employer/Policyholder, Employee Name, Home Address, Gender, Occupation or Job Title, Date of Birth, Age, PAYROLL TYPE, Average Hours Worked, Date of Hire, Spouse, etc.

You Must Have Basic Coverage to Elect Voluntary Coverage

You Must Have Voluntary Coverage to Elect Dependent Coverage

LIFE

BASIC: Group #, Div., YES, NO, Insurance Amount. LIFE & AD&D

VOLUNTARY: Group #, Div., YES, NO, Insurance Amount. LIFE & AD&D, SPOUSE, DEPENDENT LIFE: CHILD(REN)

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: (Total Percentage of Benefit must equal 100%) List Additional Beneficiaries on separate sheet

BENEFICIARY

Table with columns: Primary Beneficiary(ies), Residential Address, Date of Birth, Social Security #, Tel. #, Relationship, % of Benefit. Includes Contingent Beneficiary(ies) section.

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary.

ACCEPTANCE OF INSURANCE - Employee Signature Required

SIGNATURE

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance.

Signature of Employee _____ Date _____

REFUSAL OF INSURANCE

Employee Name (Last, First, Middle) _____ Employee/Policyholder _____ Group No. _____

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

Basic Life & AD&D Voluntary Life & AD&D Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____ Signature of Witness _____ Date _____



Group Basic Life and Accidental Death & Dismemberment Benefit Summary for Eligible Employees of Town of Shrewsbury

The following information is a summary of benefits; this summary is not your Certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the group policy will be resolved by the language issued in the master policy. Please contact your benefits administrator for policy provisions.

Eligibility

All Eligible Active Employees working a minimum of 20 hours per week are eligible. *If you are not actively at work on the effective date then insurance will not become effective until you return to active employment.*

Employee Basic Life and AD&D Benefit

- Flat \$7,000.
- Upon retirement, Basic Life and AD&D coverage continues at \$7,000.

Cost of Coverage

You, the employee, currently contribute to the cost of the Basic Group Life and AD&D coverage. Please consult your Benefits Administrator for specific contribution percentage.

Portability

If you leave your employment prior to age 60, the coverage is "portable" for you. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium.

Conversion

Employees have 31 days from the date of termination to convert their Basic Life Insurance to an individual permanent life policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium.

Waiver of Premium

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

Accelerated Death Benefit

This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary.

Education Benefit

We will pay a percentage of an employee's life insurance benefit to a maximum of \$2,500 per year, for up to four years of education, to each qualifying dependent if the employee's death is the result of an accident while covered under Group AD&D.

Seat Belt Benefit

We will pay an additional 50% of the AD&D benefit, not to exceed \$10,000, in the event of an insured's death as a result of an automobile accident while wearing a properly secured seat belt.

Repatriation of Remains Benefit

If an employee dies as a result of an Accident while insured for AD&D and the death occurs outside a 100 mile radius from his or her primary residence, we will pay for Covered Expenses reasonably incurred to return his or her body to their primary residence up to \$5,000.

Exclusions

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

Also available to you...

Bereavement Counseling*

This service is provided to all beneficiaries who experience the loss of a loved one. Beneficiaries have access to a toll-free counseling service supported by professional counselors experienced with the human emotions associated with the death of a loved one.

**Services provided by Health Management Systems of America – a nationally recognized leader in the field of Mental and Behavioral Health Care Services. These services are currently available but are not part of your Boston Mutual policy/contract.*



Group Voluntary Life and Accidental Death & Dismemberment Benefit Summary for Eligible Employees of the Town of Shrewsbury

The following information is a summary of benefits; this summary is not your Certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the group policy will be resolved by the language issued in the master policy. Please contact your benefits administrator for policy provisions.

Eligibility

You as an **active full-time employee** working **20** or more hours per week, **your spouse under age 70**, **your unmarried children ages 14 days to 19 years (to age 25 if a full-time student)**, and **handicapped children over the age of 19** are **eligible for coverage**.

Dependents may not be insured if they are confined in a medical facility. Dependent coverage is available only if you, the employee, also elects coverage. If you are not actively at work on the effective date of coverage, then your insurance will not become effective until the date you return to active employment.

Guarantee Issue coverage will become effective for eligible employees on the later of the effective date as defined by the group policy or the date the application is approved by Boston Mutual. Proof of good health satisfactory to Boston Mutual is required for amounts above the Guarantee Issue Amounts or beyond the initial eligibility period.

Cost of Coverage

You pay for the cost of the Group Voluntary Term Life and AD&D coverage. Below, you will find samples of **Monthly** payroll deductions for you and your spouse:

Voluntary Life and AD&D Available Benefit Amounts

- You have the flexibility to choose coverage for yourself in units of **\$10,000** to a maximum of **\$500,000**. However, the maximum coverage amount you may elect cannot exceed seven times your base annual salary.
- You may insure your spouse in units of **\$10,000** to a maximum of **\$150,000**, not to exceed **100%** of your coverage amount.
- You may insure your dependent children for Life Insurance only. Coverage amounts are as follows:
 - 14 days to 1 year.....**\$1,000**
 - 1 year to 19 years*.....**\$10,000**

*(Age 25 for full-time students)

A spouse or child who is also an employee cannot be insured as a dependent. If both spouses are insured employees of the same group, their children can be insured as dependents of one spouse only.

Medical Questions

If you and your eligible dependents enroll within the initial eligibility period as defined by the policy, you and your spouse may purchase a specific amount of insurance on a guaranteed basis. No medical questions will be asked for coverage at or under the Guarantee Issue Amount. If you apply beyond your initial 31 day eligibility period or if you have been previously declined by Boston Mutual, Evidence of Insurability and Authorization to Release Medical Information forms will be required to be completed.

Guarantee Issue Amounts

<u>Age</u>	<u>Employee</u>	<u>Spouse</u>
Under Age 70	\$150,000	\$30,000
*Age 70 and over	\$10,000	-Not Eligible-

All life coverage for dependent children is Guarantee Issue

Sample Monthly Payroll Deductions

Age	Monthly Premium Rate per \$1,000	10,000	20,000	50,000	80,000	100,000
<35	\$0.11	\$1.10	\$2.20	\$5.50	\$8.80	\$11.00
35-39	\$0.15	\$1.50	\$3.00	\$7.50	\$12.00	\$15.00
40-44	\$0.22	\$2.20	\$4.40	\$11.00	\$17.60	\$22.00
45-49	\$0.32	\$3.20	\$6.40	\$16.00	\$25.60	\$32.00
50-54	\$0.51	\$5.10	\$10.20	\$25.50	\$40.80	\$51.00
55-59	\$0.80	\$8.00	\$16.00	\$40.00	\$64.00	\$80.00
60-64	\$1.17	\$11.70	\$23.40	\$58.50	\$93.60	\$117.00
65-69	\$1.98	\$19.80	\$39.60	\$99.00	\$158.40	\$198.00
70-74	\$3.48	\$34.80	\$69.60	\$174.00	\$278.40	\$348.00
75+	\$5.84	\$58.40	\$116.80	\$292.00	\$467.20	\$584.00

Premium rates for employees age 75 and above are available. Please contact your benefits administrator for details

This plan utilizes Boston Mutual's Issue Age billing option. Issue age billing means that Employees and Spouses enroll and are billed based on their age band as of the effective date of coverage. Once enrolled, Employees and Spouses remain in the age band they were originally issued at with Boston Mutual.

After the initial rate guarantee period, the group is subject to an annual review and possible rate changes.

- The cost to insure all eligible dependent children for Voluntary Life Insurance is only:

\$1.90 per Family Unit Monthly.

See reverse side for additional information

*** Employee's insurance reduction schedule applies. Please refer to the section: Benefit Reductions**

Benefit Reductions

- Your Group Voluntary Life insurance reduces upon the attainment of age **70** and periodically thereafter in accordance with the following schedule:

To **65%** of the original benefit at age **70**;
To **50%** of the original benefit at age **75**;
To **25%** of the original benefit at age **80**.

- Your spouse's insurance terminates upon the termination of Employee's insurance.
- Dependent Children coverage terminates upon notice to Boston Mutual that all dependent children are no longer eligible or when the Employee's insurance terminates, if sooner.

All insurance benefits shall terminate upon the employee's retirement.

Applying for coverage

Complete the provided enrollment form. When you sign it, you are giving your employer authorization to deduct the premiums from your pay. We will process your application quickly. Boston Mutual will notify you of the effective date of insurance for requests that are approved for coverage in excess of the Guaranteed Issue amount.

Additional Features

Group Voluntary Accidental Death & Dismemberment

The Group Voluntary Life Insurance benefit is doubled if death is due to an accident. Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. Group Voluntary AD&D is only available for employees and their spouses.

Portability

If you leave your employment prior to age **60**, the coverage is "portable" for you, your spouse under age **60** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or Group Voluntary AD&D.

Conversion

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

Waiver of Premium

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

Accelerated Death Benefit

This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary.

Education Benefit

We will pay a percentage of an employee's Group Voluntary Life insurance benefit to a maximum of \$2,500 per year, for up to four years of education, to each qualifying dependent if the employee's death is the result of an accident while covered under Group Voluntary AD&D.

Seat Belt Benefit

We will pay an additional 50% of the Group Voluntary AD&D benefit, not to exceed \$10,000, in the event of an insured's death as a result of an automobile accident while wearing a properly secured seat belt.

Repatriation of Remains Benefit

If an employee dies as a result of an Accident while insured for Group Voluntary AD&D and the death occurs outside a 100 mile radius from his or her primary residence, we will pay for Covered Expenses reasonably incurred to return his or her body to their primary residence up to \$5,000.

Exclusions

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: suicide or attempted suicide; intentionally self-inflicted injuries; insurrection, riot or war; diseases, or medical treatment for diseases; ptomaine or bacterial infection; accident while serving on active duty in the armed forces; travel or flight in any aircraft or device which can fly above the earth's surface (as detailed in the policy); commission of an assault or felony by an insured; the insured's intoxication or voluntary use of any drug, unless taken as prescribed by a physician; voluntary taking or inhalation of poison, gas, or fumes; or injury which occurred before the effective date of the insured's coverage under this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

Also available to you...

Bereavement Counseling*

This service is provided to all beneficiaries who experience the loss of a loved one. Beneficiaries have access to a toll-free counseling service supported by professional counselors experienced with the human emotions associated with the death of a loved one.

**Services provided by Health Management Systems of America – a nationally recognized leader in the field of Mental and Behavioral Health Care Services. These services are currently available but are not part of your Boston Mutual policy/contract.*

TOWN OF SHREWSBURY OPTIONAL TERM LIFE AND AD&D RATES

Must have Basic Life to sign up for Optional Life

ISSUE AGE OPTION

MONTHLY PREMIUM

Age	Monthly Premium Rate per 1,000										*GUARANTEED ISSUE AMOUNTS				
	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	\$110,000	\$120,000	\$130,000	\$140,000	\$150,000
<35	\$0.11	\$2.20	\$3.30	\$4.40	\$5.50	\$6.60	\$7.70	\$8.80	\$9.90	\$11.00	\$12.10	\$13.20	\$14.30	\$15.40	\$16.50
35-39	\$0.15	\$3.00	\$4.50	\$6.00	\$7.50	\$9.00	\$10.50	\$12.00	\$13.50	\$15.00	\$16.50	\$18.00	\$19.50	\$21.00	\$22.50
40-44	\$0.22	\$4.40	\$6.60	\$8.80	\$11.00	\$13.20	\$15.40	\$17.60	\$19.80	\$22.00	\$24.20	\$26.40	\$28.60	\$30.80	\$33.00
45-49	\$0.32	\$6.40	\$9.60	\$12.80	\$16.00	\$19.20	\$22.40	\$25.60	\$28.80	\$32.00	\$35.20	\$38.40	\$41.60	\$44.80	\$48.00
50-54	\$0.51	\$10.20	\$15.30	\$20.40	\$25.50	\$30.60	\$35.70	\$40.80	\$45.90	\$51.00	\$56.10	\$61.20	\$66.30	\$71.40	\$76.50
55-59	\$0.80	\$16.00	\$24.00	\$32.00	\$40.00	\$48.00	\$56.00	\$64.00	\$72.00	\$80.00	\$88.00	\$96.00	\$104.00	\$112.00	\$120.00
60-64	\$1.17	\$23.40	\$35.10	\$46.80	\$58.50	\$70.20	\$81.90	\$93.60	\$105.30	\$117.00	\$128.70	\$140.40	\$152.10	\$163.80	\$175.50
65-69	\$1.98	\$39.60	\$59.40	\$79.20	\$99.00	\$118.80	\$138.60	\$158.40	\$178.20	\$198.00	\$217.80	\$237.60	\$257.40	\$277.20	\$297.00
70-74	\$3.48	\$69.60	\$104.40	\$139.20	\$174.00	\$208.80	\$243.60	\$278.40	\$313.20	\$348.00	\$382.80	\$417.60	\$452.40	\$487.20	\$522.00
75-79	\$5.84	\$116.80	\$175.20	\$233.60	\$292.00	\$350.40	\$408.80	\$467.20	\$525.60	\$584.00	\$642.40	\$700.80	\$759.20	\$817.60	\$876.00

****EMPLOYEE MUST HAVE COVERAGE IN ORDER TO INSURE SPOUSE AND/OR CHILDREN****

- EMPLOYEE LIFE & AD&D = \$10,000 TO A MAXIMUM OF \$500,000 (NOT TO EXCEED 7 TIMES SALARY)
- SPOUSE LIFE & AD&D = \$10,000 TO A MAXIMUM OF \$150,000 (NOT TO EXCEED 100% OF EMPLOYEE BENEFIT)
- DEPENDENT (LIFE ONLY) = \$1,000 AGE 14 DAYS TO 1 YEAR; \$10,000 AGE 1 YEAR TO AGE 19 OR 25 IF FULL TIME STUDENT (\$1.90/MONTH)
- DEPENDENT CHILD(REN) - (LIFE ONLY) COVERAGE ALL GUARANTEE ISSUE

*Applicants requesting insurance over the Guaranteed Issue amount will require an Evidence of Insurability Form and Authorization to release medical information. These forms need to accompany the application.



Altus Dental is a member of the

Benefit Highlights

Plus Plan

Welcome to Altus Dental

This flyer highlights your dental benefits and explains how your Plus plan works. At Altus Dental, we pride ourselves on providing our members with excellent customer service. We look forward to providing you and covered family members with dental insurance. When your coverage begins, we will send you an ID card and a Certificate of Coverage.

How to Contact Us

INTERNET

You can access your account information online 24 hours a day, 7 days a week at www.altusdental.com.

INFOLINE

1.877.223.0588

InfoLine, our automated telephone information system, is also available 24 hours a day, 7 days a week.

CUSTOMER SERVICE

1.877.223.0588

Our customer service representatives are available Monday – Thursday 8 am to 7 pm and Friday 8 am to 5 pm, ET.

TOWN & SCHOOL OF SHREWSBURY

- The annual maximum is: \$1500 per member per calendar year
- The annual deductible is: \$50 per individual / \$150 per family
- The maximum lifetime cap is: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0% (exempt from calendar year maximum)

- Two oral exams per calendar year
- Two cleanings per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- One set of bitewing x-rays per calendar year
- One complete x-ray series or panoramic film every 36 months
- Single x-rays as required
- Sealants for children under age 16, once per unrestored permanent molar every 36 months

Plan pays 100%; Member Coinsurance 0%

- Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months
- Periodontal maintenance following active therapy – two per year

Plan pays 80%; Member Coinsurance 20% Deductible Applies

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

Plan pays 50%; Member Coinsurance 50% Deductible Applies

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

Dependent Coverage – Dependent children are covered up until the end of the month they turn age 26

How Your Plan Works

Dental insurance helps you pay for the most common dental procedures. And, it's important to understand how your Altus Dental Plus plan works so you can get the most from your dental benefits.

How does the plan work? It's easy when you use participating network dentists.

The Altus Dental network includes many of the dentists in your area, delivering easy access to care for you and your covered family members. We are the largest Preferred Provider Organization (PPO) in the state. We also offer access to dentists nationwide through the CONNECTION Dental network. All our dentists must pass our rigorous credentialing process, so you know it's care you can count on.

Finding a Dentist

You Already Have a Dentist

If you already have a dentist, simply ask if he or she participates with Altus Dental. If your dentist isn't in the network yet, please let us know. We actively recruit new dentists to the network.

Use Our Website

Log on to our website and use our online dentist directory to find a dentist in a location that's convenient for you, or to check if your dentist participates with Altus Dental. You may search by name, location or specialty. If your card displays the CONNECTION Dental logo, this means you have access to a national network and can search for a dentist or specialist in all 50 states. Our directory will provide you with the names and addresses of all the dentists that meet your search criteria, as well as maps and driving directions.

*Thanks for choosing
Altus Dental – we look forward
to providing you and any
covered family members
with quality dental benefits.*

Maximize your coverage with a participating dentist.

In-Network Care

When you receive care from a participating dentist, your out-of-pocket expenses will be less. That's because the dentist has agreed to accept the allowance as full payment, minus your coinsurance and any applicable deductibles – which means no "balance" billing. Just show your ID card and you're done – it's that simple! Participating dentists will handle all the paperwork and inquiries directly with us. We will also pay the dentist directly.

Out-of-Network Care

You also have the freedom to receive care from dentists who do not belong to the network. If you go to a non-participating dentist, you'll be reimbursed at a usual and customary level, which most dentists accept as payment in full, after any applicable deductibles or coinsurance.

Members Online

Once you're enrolled, **Members Online** helps you manage your dental benefits with ease. Simply log on to **www.altusdental.com** to verify your specific benefit and eligibility information or to research the status of a claim. You can also create a personal Claim Activity Statement and instantly print a copy of your ID card.

Our website is also a valuable resource for maintaining good oral health – from dental health articles and wellness commercials to our custom Children's Dental Health section. Or take the Dental Health Challenge and find out if you are at an increased risk for dental disease.

Claims and correspondence
should be sent to:

Altus Dental
P.O. Box 1557
Providence, RI 02901-1557

General & Legal Notices

- Enrollment of Adult Children
- Initial COBRA Rights Notice
- Health Insurance Marketplace Notice
- HIPAA Notice of Privacy Practices
- Medicaid/CHIP Notice
- Medicare Eligibility Information
- Medicare Part D Creditable Coverage Notice

West Suburban Health Group Town of Shrewsbury

IMPORTANT NOTICE

ENROLLMENT and COVERAGE for ADULT CHILDREN TO AGE 26

Effective July 1, 2012

The Patient Protection and Affordable Care Act (PPACA) of 2010 requires employers that offer health benefits to extend coverage to the Adult Children of their employees to the 26th birthday.

Frequently Asked Questions:

Note: The term "employee" refers to active employees and retirees who are eligible for the health insurance benefit.

1. Question: Who is included as an Adult Child under the federal reform law?

Answer: *Children* as defined by PPACA are the children, stepchildren, adopted children, and eligible foster children under age 26 of benefit-eligible employees. *Adult Children* are those age 19 through 25. Under the law, coverage must be granted to dependents up to age 26 regardless of their tax filing status, marital status, and financial dependency on their parent, or eligibility elsewhere. An Adult Child, like any child of a benefit-eligible employee, may enroll as a dependent on the parent's plan. An Adult Child may not enroll unless the parent is enrolled.

2. Question: When can I enroll my Adult Child (under age 26) on my policy?

Answer: You can enroll your Adult Child on your plan at Open Enrollment each year or if they have a qualifying event such as loss of coverage. If the enrollment is a qualifying event the appropriate documentation is required.

3. Question: What documentation is required?

Answer: The subscriber (employee) must fill out an enrollment application, adult child dependent affidavit form and provide the following:

- *For a child or stepchild:* photo-copy of the child's birth certificate showing the parent-child relationship of the subscriber and/or spouse. In the case of a stepchild, the marriage certificate for the parent and stepparent, one of whom must be the employee.
- *For an adopted child:* photocopy of proof of placement letter or adoption letter.
- *For a foster child:* photocopy of placement letter or court order.
- *For Guardianship:* a photocopy of the court order.

4. Question: My Adult Child age 19-26 is working and is eligible for coverage through his/her employer. Is my Adult Child eligible to enroll in my family health plan?

Answer: Yes. Your dependent may enroll in your plan. If your Adult Child is living outside the service area, he is not eligible for an EPO/HMO plan. To enroll your Adult Child who lives and works outside the service area and who is not a full-time student, the family would have to change to a PPO or POS plan.

5. Question: My Adult Child (under age 26) is a full-time student who lives outside the health plan's service area while at school and is enrolled on my Family EPO/HMO plan (Harvard Pilgrim EPO, Fallon Select and Direct Care, Network Blue NE, or Tufts EPO). May we retain the EPO/HMO coverage we currently have and continue to cover my Adult Child?

Answer: Your Adult Child may remain on your current EPO/HMO Family plan while your Adult Child is a full-time dependent student out-of-area and enrolled in your coverage. Your Adult Child (under age 26) who is a full-time student will only be covered for emergency/urgent care services while he/she is living outside the EPO/HMO service area. After graduating or otherwise leaving school, your Adult Child may remain on your EPO/HMO plan for as long as he/she is under age 26 and living within the health plans' service area.

6. Question: I am enrolled in an EPO/HMO plan, and my Adult Child (under age 26) has a permanent address outside the health plan's service area. May we retain the EPO/HMO coverage we have and add my Adult Child?

Answer: No. Your Adult Child who lives outside the health plan service area is not eligible to be on an EPO/HMO plan. You will need to decide if the entire family will switch to a PPO plan in order for you to cover your Adult Child who lives outside the service area, or remain on your EPO/HMO plan but not cover the Adult Child. Please review the benefits and costs carefully before making a decision. You will not be able to switch coverage until the next Open Enrollment, i.e. for July 1, 2013, unless you have a Qualifying Event.

7. Question: What if my Adult Child (under age 26) moves out of the EPO/HMO health plan service area after I have placed him/her on my plan?

Answer: If the Adult Child is establishing residency outside the service area for more than 3 months, it is the employee's responsibility to notify the employer of this change. If the employee wishes, the family may change to a PPO plan and thereby continue to cover the Adult Child. Otherwise, the Child will be dropped from the EPO plan's coverage and will be offered COBRA Continuation Coverage.

8. Question: When does coverage end for my Adult Child (under age 26) and what options are available for coverage then?

Answer: As long as you remain eligible for coverage as an employee, coverage ends for your Adult Child effective at 12:01 A.M. on the Adult Child's 26th birthday. The health plan will terminate the coverage at that time. You should notify your employer that your child has turned or will be turning 26, and then COBRA coverage will be offered to your Adult Child. Alternatively, your Adult Child can call the Massachusetts Health Connector at 1-877-623-6765 or go online at www.mahealthconnector.org to shop for health coverage. If your Adult Child is employed, he/she may be eligible for coverage through his/her employer. If your Adult Child age 26 or older is enrolled in a school of higher education, there may be a health benefits plan available to students.

11. Question: My child has a child. May the child of my child be enrolled in my Family plan?

Answer: No. The Patient Protection and Affordable Care Act does not require employers or health plans to cover the dependents of the employee's children.

12. Question: My Adult Child is handicapped and is mentally or physically incapable of earning his/her own living and is currently enrolled on my health plan. Do I need to do anything during the Open Enrollment to maintain my dependent's coverage?

Answer: No. The health plans periodically re-certify handicapped dependent coverage. Adult Children who are handicapped and incapable of earning a living are eligible to remain on the parent's coverage beyond age 26, subject to periodic re-certifications.

IMPORTANT: It is the responsibility of the employee to notify the employer of any changes in Adult Child status, such as moving out of the service area. If you do not notify the employer of changes and if it is found that your Adult Child is ineligible, you could be responsible for all medical charges that he/she incurs.

IMPORTANT NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under Town of Shrewsbury group health Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Town of Shrewsbury, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;

- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in a bankruptcy with respect to the employer, or enrollment of the employee to Medicare (part A or B or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), **you must notify the Plan Administrator within 60 days after the qualifying event occurs.**

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Notice must be sent to the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Notice must be sent to the Plan Administrator.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Donna Bouchard is the Benefits Administrator for the Town of Shrewsbury, and is located at 100 Maple Ave, Shrewsbury, MA 01545, (508) 841-8359. Group Benefits Strategies is responsible for administering COBRA continuation coverage and is located at 15 Midstate Drive, Suite 110, Auburn, MA 01501, (800) 229-8008.

THIS NOTICE IS REQUIRED BY THE NEW NATIONAL HEALTH REFORM LAW (ALSO KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

This notice is meant to help you understand health insurance Marketplaces, which were set up to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. Your employer is required by law (§ 1512 of the ACA, which creates 29 U.S.C. 218b) to provide you the information contained in this notice. You may or may not qualify for health insurance through the Health Connector.

If you are offered coverage by your employer that is considered “affordable” and meets a “minimum value” standard according to federal definitions (see below), you most likely will not qualify for the subsidized coverage offered through the Health Connector described in this notice. However, it may still be helpful for you to read and understand the information included here. Please ask your employer for more information if you have questions.

Overview:

When key parts of the national health reform law take effect in January 2014, there will be an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: **MAhealthconnector.org**.

What is the Massachusetts Health Connector?

The Health Connector is our state’s health insurance Marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers “one-stop shopping” to easily find and compare private health insurance options from the state’s leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) Code.

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector begins Oct. 1, 2013, for coverage starting as early as Jan. 1, 2014. (And in future years, open enrollment will begin every Oct. 15.) You can find out more by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Does access to employer-sponsored coverage affect my eligibility for subsidized insurance through the Health Connector?

An offer of health coverage from your employer could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- Your employer does not offer coverage to you, or
- Your employer does offer you coverage, but:
 - ▶ Your employer's offer of coverage for just you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or
 - ▶ The coverage your employer provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs).

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by your employer, please note that you will lose the employer contribution (*if any*) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes.

EMPLOYER SECTION

- 1. Employer-Sponsored Health Coverage: Does this employer offer employer-sponsored health insurance coverage that is affordable and meets a minimum value standard (according to federal standards) to at least some of its employees? Note: Whether a plan meets "Minimum Value" can be found on the plan's Summary of Benefits and Coverage (SBC).**

Check one:

- Yes **If yes, and if the employee receiving this notice qualifies for such benefits, they can find out more by contacting:** Benefits Administrator
508-841-8359
(may be an HR contact, a resource, or an appendix to this document)

- No **If no, or if employee receiving notice does not qualify for such benefits,** the Health Connector can help Employees evaluate coverage options, cost and eligibility. Please visit MAhealthconnector.org for more information, including an online application for health insurance coverage.

- 2. "Cafeteria Plan" Eligibility:** Many Massachusetts employers (*those with 11 or more full-time equivalent employees*) are required to offer a Section 125 plan, or "Cafeteria Plan." These plans allow employees to pay for their health insurance on a pre-tax basis. This Massachusetts law (956 CMR 4.00, authorized by M.G.L. c. 176Q, §16) requires employers to provide an option for their employees to buy health insurance with pre-tax income, even if those employees don't qualify for a health insurance plan offered by the employer. This is done by setting up a payroll deduction that lets workers make a health insurance premium payment with pre-tax dollars.

Does this employer offer a Section 125 plan in accordance with the state requirement, if it has 11 or more full-time equivalent workers? Or does it offer such a plan, even if it is not subject to the requirement?

Check one:

- Yes **If yes, employees can find out more by contacting or referring to:** Benefits Administrator
508-841-8359
(may be an HR contact, a resource, or an appendix to this document)

- No **If no, employees should contact their employer or visit MAhealthconnector.org for more information about health insurance options for which they might be eligible.**

Questions?

Visit MAhealthconnector.org or call **1-877 MA ENROLL** (1-877-623-6765) or TTY: 1-877-623-7773, Monday to Friday, 8:00 a.m. to 6:00 p.m.

HIPAA Special Enrollment Notice

If you are declining enrollment either for yourself or for 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 toward your coverage or your dependents' coverage). However, you must request enrollment within **30 days** after the date your coverage, or your dependents' coverage, ends (or after the employer stops contributing toward the other coverage).*

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

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within **60 days** after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within **60 days** after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Donna Bouchard, Benefit Administrator, at benefits@shrewsburyma.gov or 508-841-8539.

***Documentation is required for each life event within 30 days from the life event.**

Newborns Act Notice

Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Patient Protections

The Town of Shrewsbury's health plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in their networks and who is available to accept you or your family members. Until you make this designation, the health plan will designate one for you. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health plan or from any other person, including a primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional in their network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, for a list of the participating primary care providers, for a list of participating health care professionals who specialize in obstetrics or gynecology contact:

Insurance Company	Customer Service	Website
Blue Cross/Blue Shield	(800) 782-3675	www.bluecrossma.com
Harvard Pilgrim Health Care	(888) 333-4742	www.harvardpilgrim.org
Fallon	(800) 868-5200	www.fchp.org
Tufts	(800) 462-0224	www.tuftshealthplan.com

WHCRA Enrollment Notice

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility -

ALABAMA - Medicaid	FLORIDA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA - Medicaid	GEORGIA - Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS - Medicaid	INDIANA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA - Medicaid	KANSAS - Medicaid
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY - Medicaid	NEW HAMPSHIRE - Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA - Medicaid	NEW JERSEY - Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE - Medicaid	NEW YORK - Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS - Medicaid and CHIP	NORTH CAROLINA - Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA - Medicaid	NORTH DAKOTA - Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI - Medicaid	OKLAHOMA - Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA - Medicaid	OREGON - Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA - Medicaid	PENNSYLVANIA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA - Medicaid	RHODE ISLAND - Medicaid
Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA - Medicaid		VIRGINIA - Medicaid and CHIP	
Website: https://www.scdhhs.gov Phone: 1-888-549-0820		Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	
SOUTH DAKOTA - Medicaid		WASHINGTON - Medicaid	
Website: http://dss.sd.gov Phone: 1-888-828-0059		Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473	
TEXAS - Medicaid		WEST VIRGINIA - Medicaid	
Website: http://gethipptexas.com/ Phone: 1-800-440-0493		Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	
UTAH - Medicaid and CHIP		WISCONSIN - Medicaid and CHIP	
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669		Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002	
VERMONT - Medicaid		WYOMING - Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427		Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531	

To see if any other states have added a premium assistance program since January 31, 2019, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Important Notice from Town of Shrewsbury About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Town of Shrewsbury Group and about your options under Medicare's prescription drug coverage.

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

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can 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. Some plans may also offer more coverage for a higher monthly premium.**
 - 2. The Town of Shrewsbury Group Health Plan has determined that the prescription drug coverage for all plans offered by Town of Shrewsbury are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you do not need to join a Medicare drug plan. You can keep your prescription drug coverage with Town of Shrewsbury Group Health Plan and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**
-

When Can You Join A Medicare Drug Plan?

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per

month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Town of Shrewsbury Group Health Plan changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or *not* you are required to pay a higher premium (a penalty).

Date:	4/1/2020
Name of Entity/Sender:	Town of Shrewsbury
Contact--Position/Office:	Donna Bouchard, Benefits Administrator
Address:	100 Maple Ave. Shrewsbury, MA 01545
Phone Number:	508-841-8359

Medicare Eligibility

On May 17, 2006, the Town Meeting adopted Chapter 32 B Section 18A of the Mass Generals Laws. As a result, all **retirees** and their spouses and dependents who are eligible for premium-free Medicare Part A are required to enroll in Medicare Part A and B, and to enroll in a Senior Plan (which supplements Medicare) that the Town of Shrewsbury offers in order to remain covered under one of the Town's group health plans.

Eligibility for Medicare is based on the employee/retiree's, their spouse's or ex-spouse's (living or deceased) quarters of coverage, or if the employee/retiree, their spouse or ex-spouse (living or deceased) worked long enough in a government job where Medicare taxes were paid. The Social Security Administration determines eligibility, and will help you through the process. If the Social Security Administration concludes that you are not eligible for premium-free Medicare Part A you must furnish the Letter of Determination to the Town stating that you are not eligible so you may remain on a Town Active employee health insurance plan at or after retirement.

Active Employees and Dependents

If you are an **active employee** working beyond age 65 you must file an application with the Social Security Administration for premium-free Medicare Part A when you turn 65 even if you are not ready to retire or file for Social Security Retirement benefits, and also notify them that you plan to defer Medicare Part B enrollment. By deferring Medicare Part B you will be able to enroll at a later date with no penalties. Your spouse must follow the same procedure.

Three months prior to retirement, you and your spouse (if he/she is over age 65 or are enrolled in premium-free Medicare Part A due to disability) need to apply for Medicare Part B. Your retirement date is the date that you, your Medicare eligible spouse and/or disabled dependent child(ren) will use to when you apply. You will need to then provide the Town a copy of your Medicare A and B card(s), and enroll in a Senior plan. You do not need to sign up for the Part D (prescription drug) plan as our Senior plans include it as part of the monthly premiums. If your spouse is not Medicare eligible when you retire, he/she can remain on an Active plan until Medicare eligible. If you cover dependent children who are not Medicare eligible they can remain on an Active plan until they turn age 26.

Retirees, Retiree Spouses, and Surviving Spouses

If you are a **retiree**, a **spouse of a retiree**, or a **surviving spouse**, you must enroll in Medicare Part A and B when first eligible for premium-free Medicare Part A (due to disability or at your 65th birthday).

You will need to then provide the Town a copy of your Medicare A and B card(s), and enroll in a Senior (Medicare Supplemental) plan. You do not need to sign up for the Part D (prescription drug) plan as our Senior plans include it as part of the monthly premiums. If you cover dependent children who are not Medicare eligible they can remain on an Active plan until they turn age 26.