2024-2025 BENEFITS

Enrollment & Reference Guide

Town of Suffield CT

YOUR BENEFITS EFFECTIVE

JULY 1, 2024

Full-time Eligible Employees

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This enrollment and reference guide has been designed for all eligible Dispatch employees of The Town of Suffield.

This guide contains brief descriptions of the options provided in each benefit category. These summaries are intended to help you choose among the available options under the benefits program. This guide does not take the place of the legal plan documents. If there is a conflict between this enrollment guide and the plan documents, the plan documents will govern. If you require more detailed information, contact the The Town of Suffield's Human Resources Department.

The Town of Suffield reserves the right to modify, amend, or terminate any or all of the provision of these plans at any time for any reason.

The Health Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Benefit, or is subject to limitation or exclusion, a Covered Person still has the right and privilege to receive such medical services or supply at the Covered Person's own personal expense.

Each year, The Town of Suffield offers a benefits Open Enrollment period so that employees have an opportunity to re-evaluate and make changes to their enrollment in some benefit plans.

For the 2024-2025 Plan Year Open Enrollment is May 15 - May 25, 2024 and applies to the following benefits plans:

Medical: Cigna - HSA6

Vision: Cigna

Dental: Cigna - DPPO4

Supplemental Plans: Accident, Hospital, Critical Illness

All changes made during Open Enrollment are effective July 1, 2024.

This Booklet and the accompanying materials will help you understand what plans are offered. Review it carefully and determine which plans you wish to participate in during the upcoming plan year.

ABOUT YOUR BENEFITS

It is important to ensure that you and your family have the coverage you need when you need it most. Because different people have different needs, The Town of Suffield offers you a choice of benefits. They help you obtain these benefits and covers a significant portion of their costs. You pay for the balance through payroll deductions.

CONTACT INFORMATION

Provider Name	Phone	Website	Group #
Cigna (medical, dental, vision)	800-244-6224	www.mycigna.com	3341783
Cigna (accident, hospital, illness)	800-754-3207	SuppHealthClaims.com	3341783
Reliance Standard (life and disability)	800-351-7500	Life Policy: GL167657	
		Short Term Disability: STD170543	
		Long Term Disability: LTD430636	

WHO IS ELIGIBLE?

All full-time regular employees regularly scheduled to work at least 20 hours per week, and eligible dependents, may participate in the The Town of Suffield medical, vision and dental coverage.

Your eligible dependents include:

- Your spouse or Domestic Partner
- Your children up until the end of the month in which they turn age 26 in the medical and vision plans
- Your children up until the end of the month in which they turn 23 in the dental plan

HOW YOUR BENEFITS WORK

The Town of Suffield benefits program offers you a selection of benefit plans that you can tailor to meet your needs.

You can elect only the benefits plans you and your family needs.

You can decline some coverage that you do not need.

You can evaluate your benefit coverage and change every year during the annual Open Enrollment period.

After Open Enrollment ends, due to plan rules and IRS regulations, you cannot change your elections unless you have a “Qualified Change of Status”.

A “Qualified Change of Status” is generally defined as:

- Marriage or divorce
- Birth, adoption, or placement for adoption
- Death of dependent
- Change in dependent’s employment status (new employment, change in hours or status which affect eligibility for coverage)
- Termination of dependent’s employment and subsequent loss of coverage
- Losing or gaining eligibility for Medicaid, Medicare, or Children’s Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP
- Over-age child (A child can be covered until age 26 in the medical, DPPO6 and vision plans or until age 23 in the DPPO4 plan.)

A Qualified Change in Status must be reported to HR within 30 days of the event.

WHEN COVERAGE BEGINS AND ENDS

Coverage as a new hire will begin the first day of the month following 30 days. Changes made during the annual Open Enrollment period for medical, dental and vision benefits are effective July 1st.

PAYING FOR YOUR BENEFITS

Benefits are an important part of you total compensation. The Town of Suffield provides coverage for some benefits at no cost to you as outlined below. Your contributions – the amount you pay for your benefits – are automatically deducted from your paycheck.

Pre-Tax Options

Your benefit contribution are deducted from your paycheck on a before-tax basis. (except domestic partner coverage)

- Medical coverage for you and your dependents
- Dental Coverage for you and your dependents
- Vision coverage for you and your dependents
- Supplemental Health Plans (critical illness, accident, and hospital)

PRE-TAX DEDUCTION AUTHORIZATION SALARY REDUCTION AGREEMENT

By enrolling in the medical, dental, vision, or supplemental coverage, you are authorizing The Town of Suffield to make a pre-tax deduction from your paycheck each pay period. It equals your share of the insurance premium.

The authorization revokes any previous salary reduction agreement you may have. The deduction authorization remains in effect for all future Plan Years unless revoked or modified

MEDICAL PLAN HIGHLIGHTS

CIGNA HSA 6 - MEDICAL PLAN

Type of Care	In Network	Out of Network
Primary Care Doctor Visit	0% after deductible	20% after deductible
Specialist Doctor Visit	0% after deductible	20% after deductible
Preventive Visit	0% after deductible	20% after deductible
Pharmacy	$5/30/45 after deductible MO 1x/2x/2x	Not Covered
Emergency Room	0% after deductible	0% after deductible
Urgent Care	0% after deductible	20% after deductible
Hospital Stay	0% after deductible	20% after deductible
Basic Diagnostic (Lab)	0% after deductible	20% after deductible
Basic Diagnostic (X-Ray)	0% after deductible	20% after deductible
Advanced Diagnostic (MRI/CT Scan)	0% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	20% after deductible
Deductible (Individual/Family)	$2,000/$4,000	$2,000/$4,000
Deductible (Plan/Calendar Year)	Calendar Year	Calendar Year
Coinsurance	0%	20%
Out of Pocket Maximum (Individual/ Family)	$4,000/$8,000	$4,000/$8,000

Enrollment Tier	Monthly Cost to You
Employee Only	$159.87
Employee + One	$287.76
Employee + Family	$447.63

Refer to certificate of insurance for complete plan details.

HEALTH SAVINGS ACCOUNT (HSA)

HSAs are tax-advantaged savings accounts that are available to employees who are enrolled in a High Deductible Health Plan. The account is employee-owned, and money may be contributed by both the employer and employee to the account. Suffield will make a $800 contribution into the HSA for Employee Only enrollees and $1,600 for Employee + 1 or Family enrollees. The employee owns the account and remains in control of the funds in the account. The account is portable, and you may continue to make deposits into the account as long as you are enrolled in a compliant HDHP.

The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for using HSA funds to pay for non-qualified expenses. Funds roll over year after year if you don't spend them, and can accumulate a significant balance. There is a limit to how much money can be put into an HSA every year, but no limit on how much money can be in the account.

Why would I open an HSA?
You can use your HSA to pay deductible expenses, any applicable coinsurance, and other qualified health care expenses. In addition, because contributions are made on a pre-tax basis, you are lowering your taxable income. Lastly, any unused funds that you deposit into the HSA are available for you to use year after year, since the money rolls over and can continue to be utilized if you choose to leave Suffield.

Can I add my own pre-tax dollars to the HSA?
Yes, you can make contributions of up to $4,150 in Calendar Year 2024 if you have employee only coverage, or $8,300 for all other levels of coverage. If you are over age 55, you can contribute an additional $1,000 in 2024 as a "catch-up" contribution.

Does Suffield open an HSA for me?
When you enroll in a HIgh Deductible Health Plan, an HSA will be opened for you. You will receive a welcome kit and debit card in the mail. You must complete the enrollment process by providing confirmation of your identity. If you do not complete the enrolment process you cannot access the funds deposited. You can use your HSA to pay deductible expenses, any applicable coinsurance, and other qualified health care expenses.

What happens to any money I don't use in 2024?
Your HSA funds will roll over, year after year. They belong to you.

If I leave employment, what happens to my HSA?
Your HSA is portable, so if you leave employment for any reason, your HSA goes with you.

Can I withdraw money from a HSA for non-medical expenses?
Yes, but if you withdraw funds for non-medical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you don't have a penalty, but you must still pay ordinary income taxes on the money you withdraw for non-medical expenses.

Can I use the money in my HSA account to pay for my dependents' medical expenses?
You can use the money in the account to pay for the medical expenses of yourself, your spouse or your dependent children, whether they are covered by the plan or not. Please note that domestic partner expenses should not be paid using your HSA.

When can I start using my HSA dollars?
You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

VISION PLAN

CIGNA

The vision plan provides vision care through Cigna's network, which includes those in private practice as well as retail chains. When making an appointment with a network provider, please identify yourself as a participant in this vision plan. If purchased through the provider network, eye examinations and eyewear will result in less out of pocket cost to you and your enrolled dependents; however, the plan does provide out of network coverage as well. The high level benefits are as follows:

	In Network	Out of Network
VISION		
Exam	No cost	up to $75
LENSES		
Single	$20 copay	up to $40
Bifocal	$20 copay	up to $65
Trifocal	$20 copay	up to $75
Lenticular	$20 copay	up to $100
Progressive	$20 copay	up to $75
CONTACTS		
Elective	Amount over $130 (discounts apply)	Amount over $105
Medically Necessary	Covered in full	Amount over $210
FRAMES		
Benefit	80% amount over $130	up to $71

Enrollment Tier	Monthly Cost to You
Employee Only	$7.08
Employee + One	$12.38
Employee + Family	$19.81

See certificate of insurance for complete plan details

DENTAL PLAN

CIGNA - DPPO4

	IN NETWORK	OUT OF NETWORK
Annual Maximum	$1,000	$1,000
Orthodontia Maximum	$1,000	$1,000
Deductible • Individual • Family	 $50 $150	 $50 $150
Dedcutible (Plan/Calendar Year)	Calendar Year	Calendar Year
Preventive	100%	100%
General Anesthesia	Not Covered	Not Covered
Basic Services	80%	80%
Major Services	50%	50%
Orthodontia	50%	50%
Periodontal Surgery	50%	50%
Major and Minor Periodontoics	50%	50%

Enrollment Tier	Monthly Cost to You
Employee Only	$6.35
Employee + One	$15.99
Employee + Family	$19.86

See certificate of insurance for complete plan details

CIGNA SUPPLEMENTAL HEALTH PLANS

All eligible employees will have the opportunity to enroll in Cigna's Supplemental Health plans. An unexpected illness or injury can disrupt every facet of your life, including your physical, emotional and financial well-being. Regular expenses, big and small, can add up. These voluntary benefits are designed to help strengthen your overall benefits package and provide additional protection for you and your family through fixed benefits paid directly to YOU.

Key Features to Consider:
› Flexible. Use the money however you want. Pay for anything you need – medical deductibles, child care, groceries, etc.
› Supplement your medical plan. Benefits are paid in addition to other coverage you may have.
› Cost effective. Your premium is conveniently deducted from your paycheck at a low group rate.

ACCIDENTAL INJURY INSURANCE

Pays a fixed cash benefit directly to you when you have a covered accident- related injury, like an ankle sprain or arm fracture.

Accidental Injury Benefit Example Situation: Chloe broke her leg playing soccer.
Chloe's covered benefits:
› Doctor's officevisit
› Diagnostic exam (X-ray)
› Broken leg
› Physical therapy sessions
Accidental Injury benefit paid directly to Chloe: $1,200

CRITICAL ILLNESS INSURANCE

Pays a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition, such as a heart attack or stroke.

Critical Illness Benefit Example Situation: Marco had a heart attack while raking leaves.
Marco's covered benefits:
› Heart attack diagnosis
Critical Illness benefit paid directly to Marco: $10,000

HOSPITAL CARE INSURANCE

Pays a fixed cash benefit directly to you[1] when you experience a covered hospital[3] stay, for events like an in-patient procedure or childbirth.

Hospital Care Benefit Example Situation: Susan was hospitalized2 following a car accident.
Susan's covered benefits:
› Hospital admission
› Hospital stay
› Hospital ICU stay
Hospital Care benefit paid directly to Susan: $1,400

WELLNESS INCENTIVE BENEFITS

Your Cigna Supplemental Health plan(s) comes with a Wellness Incentive benefit. This benefit is paid to each covered person who completes at least one wellness treatment, health screening test or preventive care service.

If you are interested in enrolling, please indicate your elections during Open Enrollment.

Please note the above descriptions are only a brief summary and examples are provided for illustrative purposes only. Refer to the Benefit Summaries for more details on your coverage, election options, and rates.

SEARCHING FOR PARTICIPATING PROVIDERS

MEDICAL

Medical Provider Search:

1. Go to https://hcpdirectory.cigna.com/web/public/consumer/directory/search
2. Under “How are you Covered” select “Employer or School”
3. You must either enter an address, city, or zip code in the box on the next screen
4. Then choose a search category below the box, such as: “Doctor by Type”, “Doctor by Name” or “Health Facilities”
5. Enter the Type, Name, or Location you desire. You may be asked to filter your results for Primary Care Providers or Specialists
6. You will also be given the options to log in (requires you to resgister as a member) or select your plan
7. Select “Open Access Plus” as the plan name

VISION

Vision Provider Search:

1. Go to https://eyedoclocator.eyemedvisioncare.com/cigna/en
2. You can choose to search by location or by doctor or office name
3. Enter your zip code or allow the site to use your location

DENTAL

Dental Provider Search:

1. Go to https://hcpdirectory.cigna.com/web/public/consumer/directory/search
2. Under “How are you Covered” select “Employer or School”
3. You must either enter an address, city, or zip code in the box on the next screen
4. Then choose a search category below the box, such as: “Doctor by Type”, or “Doctor by Name”
5. Enter the Type, Name, or Location you desire.
6. You will also be given the options to log in (requires you to resgister as a member) or select your plan
7. Select “Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)” as the plan name

REGISTERING ONLINE TO ACCESS ID CARDS AND CLAIMS INFO

- Go to my.cigna.com/web/public/guest
- Log In or Register as a member

OR DOWNLOAD THE MYCIGNA MOBILE APP:

- Available for Android or I-Phone users
- Free to download
- Can store all your ID card information
- Search for providers, procedures, and cost estimates
- See recent claims and their status

COBRA

Continuation Coverage Rights Under COBRA

The Town of Suffield Health and Welfare Benefit Plans, including the Group Medical, Dental, Vision, and Flexible Spending Account plans are subject to COBRA regulations. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plans. The right to COBRA continuation coverage was created by a Federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plans when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to protect your right to receive it.** This notice gives you only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plans and under Federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document(s) from a Plan Administrator. Contact Information appears at the end of this notice.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event know as a "qualifying event". Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plans because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plans because either or of the qualifying events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the **Plans** because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct;

4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from your spouse.

Your dependent children will become beneficiaries if they will lose coverage under the Plans because any of the following qualifying events happen:

1. The parent-employee dies;

2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. 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 is filed with respect to The Town of Suffield, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plans, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plans.

When is COBRA Coverage Available?

The Plans will offer COBRA continuation 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 in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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. The Plans require you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to:

The Town of Suffield Human Resources Department

Appropriate documentation (such as a copy of the divorce decree) to prove you have experienced a qualified event much be attached.

How is COBRA 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 beneficiary. 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. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event, or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plans is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

The qualified beneficiary must notify the Plan Administrator of receiving the disability determination: and

1. The latest of 60 days following:

Receipt of the determination,

The date of the qualifying event,

The date of loss of coverage, or

Receipt of explanatory notice of qualified beneficiary notice obligations; and

2. Prior to the end of the18-month period. The Social Security Disability Administration notice should be sent to:

The Town of Suffield

Second Qualifying Event Extension of 18-Month Period of Continuation of Coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plans. The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plans as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plans had the first qualifying event not occurred. **In all cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.** This notice must be sent to the Benefit Labor Team (888) 828 7762

Keep Your Plans Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

If You Have Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPPA), 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 the EBSA website at **www.dol.gov/ebsa**

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage

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

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact Human Resources.

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period of more than 12 months. Any pre-existing condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

PATIENT PROTECTION DISCLOSURE

Cigna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the member services department on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

WOMENS' HEALTH & CANCER RIGHTS ENROLLMENT ACT 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.

If you would like more information on WHCRA benefits, call your Plan Administrator.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

Form Approved OMB No. 1210-0149
(expires 5-31-2023)

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your DSO if you are a school-based employee, or Team Talent Operations if you are a Network Support employee.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)		12. Email address

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

•As your employer, we offer a health plan to:

X Some employees. Eligible employees:
(1) Work at least 30 hours per week
(2) Work 20 hours per week and have previously worked for at least 30 hours per week for at least one year
(3) or, are Temporary workers that work more than 90 days meeting the minimum hours

•With respect to dependents:

X We do offer coverage. Eligible dependents are:
An individual who is the son, daughter, stepson, or stepdaughter of the subscriber;
An individual who was legally adopted by the subscriber;
An individual who is placed with the subscriber for legal adoption by the subscriber;
A child for whom the subscriber is the court-appointed guardian; or
An eligible foster child (defined as an individual who is placed with the subscriber by an authorized placement agency or by judgment, decree, or other court order).
Domestic partner, same or opposite sex

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months? __ Yes (Continue) _ No (STOP and return this form to employee)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

14. Does the employer offer a health plan that meets the minimum value standard*?
__ Yes (Go to question 15) __No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? __ Weekly __Every 2 weeks __Twice a month
__ Monthly __Quarterly __ Yearly

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

16. What change will the employer make for the new plan year?
__ Employer won't offer health coverage
__ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? __ Weekly __Every 2 weeks __Twice a month
__ Monthly __Quarterly __ Yearly

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDRENS 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, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid AND CHIP
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
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: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA– Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid AND CHIP	SOUTH DAKOTA – Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid AND CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
OKLAHOMA – Medicaid AND CHIP	**VIRGINIA – Medicaid AND CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid AND CHIP	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
RHODE ISLAND – Medicaid AND CHIP	**WISCONSIN – Medicaid AND CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/angencies/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.

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

FAQS

PATIENT CARE ADVOCACY SERVICES

Sometimes dealing with an insurance company can be stressful. It may feel like they are speaking another language. Whether you have a question about your benefits or if you need help working with one of the insurance companies to ensure a claim is paid properly, our insurance broker MDG is here to help you.

This confidential service is available to you Monday-Friday, 8am to 5:30pm:

- Answer questions about your benefits
- Explain how to best use your plan
- Resolve claims and billing issues
- Clarify the total and out-of-pocket costs for services
- Assist with referrals and prior authorization
- Help with claim appeals
- Help you find a doctor or hospital

This service is completely free to you and your dependents and you are automatically enrolled when you participate in a Town of Suffield benefit plan. For assistance, contact MDG at 888-282-1591 or email Mybenefits@mdgbenefits.com

MDG
BENEFIT SOLUTIONS

Your benefit plan is supported by MDG Benefit Solutions
Mybenefits@mdgbenefits.com
888 282 1591 TOLL FREE
203 315 0510 FAX
www.mdgbenefits.com

GLOSSARY OF TERMS

• **Provider:** any doctor, clinic, hospital or lab that provides medical services.

• **Coverage**: what services are actually included in the medical plan.

• **Premiums:** the fixed amount of money that is withheld from every paycheck. This is the cost of being in

the plan and does not cover any services.

• **Co-pay:** the flat fee that is paid at every visit with a provider.

• **Deductible:** the amount of money you are responsible for first.

• **Co-insurance:** the split between insurance and you after you have met the deductible.

• **Out-of-Pocket Maximum:** the absolute maximum you will pay for services (co-pays OR deductible + coinsurance) in a plan year. This total does not include what you pay in premiums!

• **HRA:** Health Reimbursement Account – a plan that offers a way for your employer to “reimburse” some of your deductible