



Town of Wilbraham, 240 Springfield Street, Wilbraham, Massachusetts 01095

FY 2016 Benefits Handbook

For Employees and Non-Medicare Retirees



To obtain a printed copy of this Benefits Handbook, please contact:

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Town of Wilbraham, Selectmen's Office
240 Springfield Street, Wilbraham, MA 01095

Telephone: (413)596-2800 extension 100
FAX: (413)596-9256

An electronic version is available online at:
www.wilbraham-ma.gov

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Disclaimer: The Town retains the right to adopt rules and regulations as provided for under MGL Chapter 32B, Section 14. In accordance with Chapter 150E Massachusetts General Laws, health insurance and other benefit costs are subject to appropriation by the Town of Wilbraham. State or federal law or regulatory action may result in an increase in plan deductibles or co-payments.

What's new in FY 2016?

The good news is: there are **no premium rate increases** in either the health insurance or dental insurance premiums for the second year in a row. This is due to the excellent financial management of the Scantic Valley Regional Health Trust, combined with a manageable claims experience. Additionally, the Scantic Valley Regional Health Trust offers a comprehensive Wellness Program designed to assist employees and their families in working towards healthier habits, and managing chronic diseases. These efforts are designed to manage the claims experiences of the Trust over the long run.

What do I need to do during Open Enrollment?

Employee's who want to keep the same health, life, dental, and disability insurance plan(s) in which they are currently enrolled and add no additional coverage need to do nothing; **enrollment will be automatically continued unless a change form is completed.**

Employee's who want to cancel a plan must complete a termination form, employees who wish to enroll in a new or different plan, or add a dependent, must complete an enrollment form and submit supporting documents.

IMPORTANT:

Insurance premiums are paid one month in advance!
If you make any changes, your deductions for the new premium rates effective on July 1, 2015 will begin with the payroll of Friday, June 5, 2015.

Changes permitted during Open Enrollment:

- Enroll yourself and/or dependents for the first time (if you meet eligibility requirements) in any plan of your choice (employee must work a minimum of 20 hours per week to be eligible).
- Add eligible dependents to existing plans.
- Cancel any coverage(s) or delete any dependents for whom coverage is no longer required.
- Switch from your current plan to any of the other offered plans or plan options.

Key Criteria to Help Guide your Purchase Decision:

1. Health benefits: Which plans provide the benefits you have identified as important to you?
2. Costs: Please consult the new Summary Plan Descriptions which the Affordable Care Act requires for each health plan, as well as the Plan Comparison Charts (developed by Group Benefits Strategies) for ease of comparing different plan options.
3. Physician network and Hospital provider: Do you have a doctor you want to keep? Is there a certain hospital you want to be able to go to? (Eliminate plans which are not accepted by your doctor or hospital).

A Word about Retirement

If you are an employee who is considering retirement during the upcoming fiscal year, please note that the Town pays 60% of the premiums and the retiree pays 40%. Once you become eligible for Medicare, you **MUST** enroll in Medicare and elect a Medicare Supplement or Advantage Plan. For more information and to plan ahead, please contact Gloria Congram at 413-596-2800 ext 102.

Where to go for help

Your primary contact person for all insurance plan enrollment questions is:

WHO: Gloria Congram, Executive Assistant of the Millennium Insurance Agency
WHEN: Gloria is available Wednesdays from 9:00 a.m. to 1:00 p.m.
WHERE: Meeting Room 1 at the Town Office Building
PHONE: 413-596-2800 ext 102 (leave message if no answer she will call you back)
EMAIL: gcongram@tmcg-consult.com.

Hard copy literature is available for all plans (including Summaries of Benefits and Coverage) in the Selectmen's Office during normal office hours. Call or e-mail Herta (596-2800 ext 100 or hdane@wilbraham-ma.gov) if you would like to stop by to pick something up or have something sent to you.

On the Town of Wilbraham website at www.wilbraham-ma.gov you will also find this handbook, Summaries of Benefits and Coverage and other benefit information.

The Scantic Valley Regional Health Trust's website address is www.scantichealth.org

The Scantic Valley Regional Health Trust-Saving you Money

The Scantic Valley Regional Health Trust (SVRHT), the joint purchase group through which the Town of Wilbraham purchases health coverage, will offer FY16 health plan rates that are the same as Fiscal Year 2015 and FY 2014 rates. The Trust meets regularly in open session at the Wilbraham Town Office Building and meeting minutes are posted on the SVRHT website at www.scantichealth.org/.

High Technology Imaging Services The SVRHT voted to waive the co-pays for high technology imaging services when employees select from a list of non-hospital based imaging centers for scheduled services. The list of BCBS or HNE non-hospital based imaging centers is posted on the town's website at www.wilbraham-ma.gov. You can get a hard copy in the Selectmen's Office, or by calling your health plan member services department by calling the number of your insurance membership card. Please note: Tufts Health Plan has not issued a list, you need to call them directly to find out if the imaging center you have been referred to will require a co-payment or where you may be able to go instead and not pay a co-payment.

Wellness Program. SVRHT has hired a Wellness Coordinator, Lyn Hollinger, to manage an incentive driven Wellness Program. The SVRHT Wellness Program offers employees and retirees and their families health promotion programs, disease screenings, and general behavior risk reduction programs, some with cash rewards. This is a long-term cost reduction strategy, rather than a cost shifting strategy. Participation in the Wellness programs is a Win-Win for employees and employers - improving quality of life while putting the SVRHT on track for reducing health costs for preventable conditions. Please consider participating in the SVRHT Wellness programs. For more information, please visit the SVRHT website at www.scantichealth.org or contact Lynn Hollinger at (413) 847-0249 or slynk@hotmail.com.

Fitness Benefits (i.e. Gym membership or Weight Loss program)

All three insurance providers (BC/BS, HNE and Tufts) offer **cash reimbursement** benefits on fitness programs (club membership or fitness classes) with their active employee health plans. Please contact your insurance provider directly, or our benefits administrator Gloria Congram, at 596-2800 Ext. 102 for information for these benefits or to obtain a reimbursement form.

Abacus: Two Special Health Benefits Savings Programs

The following two programs, a free prescription drug program and a program for disease management including free diabetes medications and supplies, are offered through a contract between the SVRHT and Abacus Health Solutions, a firm specializing in the design and administration of incentive based health management programs. Your participation is voluntary and completely confidential. It is important to note that no medical or health information about you or your family will ever be shared with the Town of Wilbraham. Employees and Retirees on Active plans (not retirees on Medicare Supplement and Medicare Advantage Plans!) are eligible to participate in these programs.

1. Free Prescription Program

myMedicationAdvisor is a voluntary prescription medication safety and savings program provided free of charge as part of the benefits package for employees who are enrolled in self insured health plans. **myMedicationAdvisor** is primarily a web-based program but does have a paper-based ordering process and a customer-friendly telephonic component for those without computers. The program offers education in the area of medication management, and provides answers to confidential medication questions. In addition, the program offers selected maintenance **medications free of charge** which are purchased more cost efficiently from international vendors, and which are offered to employees. Medication lists are updated every three months and are posted on the SVRHT website at www.scantichealth.com. **myMedicationAdvisor's** website is www.myMedicationAdvisor.com. Log on and start saving on prescription medications. If you would rather speak to somebody, please call toll free 1-877-467-3133.

2. Diabetes Care Rewards Program

The Good Health Gateway Diabetes Care Rewards Program offers **free of charge diabetes medications and supplies** for subscribers of self insured health plans who complete program requirements. If you have ever been told you have diabetes, pre-diabetes, elevated or high blood sugar, hyperglycemia, or low insulin levels, and you are encouraged to find out about participating in the Diabetes Care Rewards Program and receive its benefits. The purpose of this program is to encourage good diabetes care by having important screenings and exams. In addition to better health, the reward for meeting the program requirements is **FREE diabetes medications and supplies (\$0 co-pays)** To learn more, call their helpline at (800)-643-8028 or register online at www.GoodHealthGateway.com.

Enrollment Rules for Covering Spouses and Dependents

Eligible Spouses - The subscriber may enroll an eligible spouse for coverage under his or her health plan membership. An 'eligible spouse' includes the subscriber's legal spouse of either sex.

In the event of a divorce or legal separation, or if the subscriber re-marries after a divorce, please contact the benefits administrator, Gloria Congram, to discuss your options for your particular situation.

Eligible Dependents - The subscriber may enroll eligible dependents for coverage under his or her health plan membership. The subscriber's 'eligible dependents' include: a dependent child until the age of 26. These include the subscriber's or legal spouse's dependent children who qualify as dependents as subject of a court order which requires the subscriber to provide health insurance for the children. These may include:

1. A newborn child – the effective date of coverage for a newborn child will be the child's date of birth provided that the subscriber formally notified the plan sponsor within 30 days of the date of birth.
2. An adopted child – the effective date of coverage for an adopted child will be the date of placement with the subscriber for the purpose of adoption. The effective date of coverage for an adoptive child who has been living with the subscriber and for whom the subscriber has been getting foster care payments will be the date the petition to adopt is filed. If the subscriber is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody.
3. A child who is recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
4. A dependent child until they turn 26; (Note: The child is not required to reside with the subscriber!)
5. An unmarried disabled dependent child may maintain coverage under the subscriber's health plan membership. The child must be either mentally or physically handicapped so as not to be able to earn his or her own living, as determined by the health plan carrier. The subscriber must make arrangements for the disabled child to continue coverage under the family contract no more than 30 days after the date the child would normally lose eligibility.
6. A newborn infant of an enrolled dependent immediately from the moment of birth and continuing after, until the enrolled dependent is no longer eligible as a dependent.

To enroll a spouse or dependent, please submit the following documentation:

<u>Relationship</u>	<u>Documentation</u>
Spouse	Photocopy of town- or city-issued marriage certificate (church or Justice of the Peace certificates are NOT accepted), <u>and</u> Page 1 of your last filed Federal Tax Return (1040 or 1040A.) Social Security numbers and income may be blacked out. Federal Tax Return requirement does not apply to same-sex marriages (an affidavit will be provided).
Divorced or Separated Spouse	Photocopy of the health insurance provision language from divorce/ separation agreement, <u>and</u> first page listing names of both parties or signature page.
Child until the age of 26	Photocopy of town- or city-issued birth certificate (long form listing parents' names) (<u>hospital records are not accepted</u>), or Court Order documenting guardianship, or adoption papers.

The Affordable Care Act (ACA)

Health Plan Design

There are no benefit plan changes on the Active Employee and Non-Medicare Retiree Health Plans for FY 2016, and premium rates remain the same as in FY 2015 and 2014.

The Affordable Care Act (ACA), offers certain new coverage, payment limits and other provisions which the Scantic Valley Regional Health Trust (SVRHT) Board discussed and voted to include in their plans: These include:

- Coverage of routine patient costs for services and items furnished in connection with clinical trials (health plans may not discriminate against individuals who participate in qualified clinical trials!).
- Coverage of wigs in certain circumstances.
- Annual or lifetime dollar limits must be removed from all “essential health benefits” as defined by the ACA.
- Beginning with plan years renewing on or after January 1, 2014, all group health plans need to include out of pocket maximums of no more than \$6,350 for individuals and \$12,700 for families. In 2014, all medical cost sharing must be applied to the out of pocket maximum. (Note: In 2015, all medical and pharmacy benefits must be applied to the out of pocket maximum).
- Beginning with plan years renewing on or after January 1, 2014, group health plans cannot impose pre-existing condition exclusions, regardless of age.
- For plan years beginning on or after January 1, 2015, employers will be prohibited from establishing waiting periods of more than 90 days for new enrollees.
- Plans that require designation of a PCP, must permit each participant, beneficiary, and enrollee to designate any available participating PCP.

Exchange Notification

Effective October 1, 2013, employers must notify their employees:

- About the Health Insurance Marketplace;
- That, depending on their income and what coverage may be offered by the employer, they may be able to get lower cost private insurance in the Marketplace; and
- That if they buy insurance through the Marketplace, they may lose the employer contribution (if any) to their health benefits.

The notice in its entirety is included at the very end of this handbook. .

All health plans the Town offers are considered affordable and meet minimum coverage standards according to federal definitions.

Summary of Benefit and Coverage

Under the Affordable Care Act all Health Plans must provide a Summary of Benefits and Coverage for each health plan offered which follows a described format and contains information designed to assist consumers to evaluate and compare the plans. All Summaries of Benefits and Coverage for each BCBS, Health New England, and Tufts Health Plan are available in hard copy in the Selectmen’s Office or online at our website at www.wilbraham-ma.gov.

Dependent Coverage for Adult Children to Age 26

The Affordable Care Act requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans. Beginning in 2014, children up to age 26 can stay on their parent's employer plan, even if they have an offer of coverage through their own employer.

To add a child to your insurance plan, you need: photocopy of town- or city-issued birth certificate (long form listing parents' names, hospital records are not accepted), or Court Order documenting guardianship, or adoption papers.

For more information contact Gloria Congram, Benefits Administrator, at 413-596-2800 extension 102 (leave message).

IMPORTANT:

It is the responsibility of the employee to notify the employer of any changes in Adult Child status. 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.

Massachusetts Health Care Reform

All Massachusetts residents have been required to maintain health insurance since passing of the Massachusetts Health Care Reform Act in 2006. Those who cannot show that they have health insurance have to pay a penalty on their Massachusetts income tax return. On June 28, 2012, the Supreme Court upheld the constitutionality of the Affordable Care Act, the federal health reform law passed in 2010. When the Affordable Care Act (ACA) took effect in 2014, Massachusetts residents were subject to federal health insurance requirements as well as state requirements.

As a result of the Affordable Care Act:

- a MassHealth expansion allowed new categories of residents to qualify for MassHealth Standard benefits or new MassHealth CarePlus coverage
- legally present low-income non-citizens who do not qualify for MassHealth coverage will be eligible for federally funded health insurance subsidies
- the federal government will give health insurance tax credits and subsidies to low and moderate-income residents (up to 400% FPG) to help lower their health insurance costs
- seniors with Medicare Part D prescription drug plans will pay less for prescription drugs during the coverage gap known as the "donut hole", and the coverage gap will eventually be eliminated by 2020. (See HealthCare.gov for details.)
- residents without health insurance may face federal penalties and state penalties

 To learn about how the Affordable Care Act changes might affect you, see MassResources.org

All group health plans the Town of Wilbraham offers meet Minimum Creditable Coverage Standards which satisfies the individual mandate requirement of the Massachusetts Health Care Reform Act (Chapter 58 of the Acts of 2006)

Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States, including Massachusetts, have premium assistance programs that can help pay for coverage. If you or your dependents are already enrolled in Medicaid (Medicaid in Massachusetts is called MassHealth) or CHIP and you live in Massachusetts (or any of the other states that offer premium assistance), contact your State Medicaid or CHIP office to find out if premium assistance is available at <http://www.mass.gov/MassHealth> or by calling 1-800-462-1120.

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, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or <http://www.insurekidsnow.gov/state/mass/> to find out how to apply. If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan within 60 days of being determined eligible for premium assistance (not only during Open Enrollment!).

For more information and to find out which states offer this program (if you do not live in Massachusetts), go to the Department of Labor U.S. Department of Health & Human Services Employee Benefits Security Administration Centers for Medicare and Medicaid Services website at www.dol.gov/ebsa www.cms.hhs.gov or call 1-866-444-EBSA (3272) 1-877-267-2323 ext 61565.

Women's Health and Cancer Rights Act- WHCRA-Notice

The Women's Health and Cancer Rights Act (WHCRA) helps protect many women with breast cancer who choose to have their breasts rebuilt (reconstructed) after a mastectomy. Mastectomy is surgery to remove all or part of the breast. This federal law requires most group insurance plans that cover mastectomies to also cover breast reconstruction. It was signed into law on October 21, 1998. The United States Departments of Labor and Health and Human Services oversee this law. The law applies to group health plans for plan years starting on or after October 1, 1998, and to group health plans, health insurance companies, and HMOs, as long as the plan covers medical and surgical costs for mastectomy.

Under the WHCRA, mastectomy benefits must cover:

- Reconstruction of the breast that was removed by mastectomy Surgery and reconstruction of the other breast to make the breasts look symmetrical or balanced after mastectomy
- Any external breast prostheses (breast forms that fit into your bra) that are needed before or during the reconstruction
- Any physical complications at all stages of mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery)
- Mastectomy benefits may have a yearly deductible and may require that you pay *co-insurance*. Co-insurance is when less than the full amount of the bill is paid by the insurance company and the patient must pay the difference.

Consolidated Omnibus Budget Reconciliation Act (COBRA)-Notice

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and qualified beneficiaries the right to continue health insurance coverage for up to 18 months (up to 36 months in certain circumstances) under the Town's group health plan when a "qualifying event" would normally result in loss of eligibility. Included are such events as resignation, termination of employment, a reduction in an employee's work hours, an unpaid leave of absence, divorce or legal separation, a dependent child no longer meeting eligibility requirements or the death of an employee. Under COBRA the employee or beneficiary pays the full cost of the premium at the Town of Wilbraham's group rate. Coverage is subject to timely premium payments to the Town of Wilbraham. For more information please contact the benefits administrator or visit the website of the U.S. Department of Labor at: <http://www.dol.gov/dol/topic/health-plans/cobra.htm>

HIPAA Health Insurance Portability & Accountability Act of 1996

Special Enrollment Rights (HIPAA)

Employees have the right to decline health insurance coverage if they have other coverage and may in the future be able to enroll themselves and their dependents on a town sponsored plan if they request coverage within **30 days** after their other coverage ends. In addition, if you have a new dependent as a result of marriage, birth or adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption and provide proof (e.g., marriage certificate, birth certificate, adoption record) of this "qualifying event". HIPAA limits the circumstances under which coverage may be excluded for pre-existing medical conditions. Under the law, a pre-existing conditions exclusion generally may not be imposed for more than 12 months. It also provides for the right to receive a certificate of health coverage from your employer. For more information please contact the benefits administrator or visit the website of the US Department of Labor at http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html.

HIPAA Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please be advised that the Town of Wilbraham is a member of the Scantic Valley Regional Health Trust (SVRHT), a joint purchasing group. SVRHT contracts with Group Benefits Strategies (GBS) to administer the health insurance program for the member communities. Even for self-insured plans, the Town of Wilbraham does not directly pay for services and does not receive Private Health Information (PHI). The Town of Wilbraham may ask the employee's permission to receive such information in certain circumstances; for instance, when reimbursing an employee for expenses from a Medical Flexible Spending Account. For a full copy of the notice, please contact Herta Dane, Human Resources Coordinator, at (413) 596-2800, Ext. 100 or visit this link on the Town's website under Employee Benefits at <http://www.wilbraham-ma.gov/DocumentCenter/View/776>.

Medicare

MGL Chapter 32B Section 18A

In accordance with M. G. L. Chapter 32B, Section 18A, retirees, their spouses and dependents shall enroll in Medicare health benefits as soon as they are eligible. Failure to fully enroll in Medicare may jeopardize future participation in the Town's contributory group health insurance plan. Upon enrollment in Medicare eligible retirees and their spouses and dependents will be eligible to enroll in supplemental coverage to Medicare.

Retirees need to apply for Medicare to discover whether they are eligible or not. Retirees may be eligible through a current or former spouse. The only certain way to determine your eligibility is to apply for Medicare Benefits.

Medicare Modernization Act of 2003 - Medicare D

The Medicare Modernization Act of 2003 requires all employers that offer prescription drug coverage to notify covered employees and retirees who are Medicare eligible, or who may be Medicare eligible, as to the value of the current prescription drug benefit compared to that of the optional Medicare Part D drug benefit that went into effect on January 1, 2006.

NOTICE: All of the health plans that the Town of Wilbraham offers have prescription drug benefits that are at least as good as the standard Medicare Part D prescription drug benefit, and these plans are considered to be "creditable coverage". This statement is based on reviews performed by qualified actuaries of the prescription drug benefits and spending by the employer on each health plan compared to what Medicare would pay. Therefore, if you plan to continue to be covered under the Town of Wilbraham's health benefits plans, you do not need to purchase Medicare Part D*. If in the future you should want to purchase Part D for whatever reason, because you have been covered by a plan that has benefits as good as or better than Part D benefits, you would not be charged the Part D late enrollment premium penalty.

Flexible Spending Plan (Section 125 or “Cafeteria Plan”)

Pre-tax Insurance Options

The Town of Wilbraham offers employees who are eligible to participate in the town’s group health insurance plan a “Section 125 Cafeteria Plan” pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. It also allows employees to purchase basic group term life and group dental insurance on a pre-tax basis, and offers the opportunity to open two separate “flexible spending accounts” where employees put money into an account on a pre-tax basis to be used for certain purposes. The Summary Plan Description (SPD) is available on our website and in the Selectmen’s Office.

Flexible Spending Accounts: FSA

The Town offers two flexible spending account options under the Section 125 Cafeteria or Flexible Benefits Plan. Participation in the Flexible Spending Plan is available for all employees who are eligible to participate in the group health insurance program (minimum work hours is 20 per week). It is necessary for payroll to support the amount of the deductions to allow for the pre-tax benefit. The employee determines an annual amount up to an allowable maximum and then makes weekly payroll deductions into these accounts. The employee gets reimbursed from these accounts by filing claim forms and substantiating documents with the Plan Administrator, Lynne Frederick, Assistant Town Treasurer. Two different accounts are offered:

Medical Expense Reimbursement Account

The medical expenses reimbursed through this account are expenses normally deductible on your federal income tax return. The IRS currently limits the amount employees can defer into this account to \$2,550 per year. Expenses which may be reimbursed include, for example, your health insurance co-payments, prescription medications, prescription eye glasses, chiropractor fees, dental expenses, and certain surgical procedures. **Only those expenses which are approved by the Internal Revenue Service (IRS) may be paid from this account.** (Over the counter drugs are NOT covered!)

Before you enroll, you must first decide how much you want to contribute to your account. You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the 2016 fiscal year. If you have not spent all the amounts in your Medical or Dependent Care accounts by the end of the plan year, you may continue to incur claims for expenses during the “Grace Period”. The “Grace Period” extends 2 ½ months after the end of the plan year (June 30, 2016).

If you enroll, you will be asked to sign a HIPAA Authorization form allowing certain town employees to receive your private health information in connection with your requests for reimbursement.

Dependent Care Reimbursement Account

The expenses reimbursed through this account are Child Day Care and Dependent Adult Care up to a maximum of \$5,000 per year. (This would be in place of taking the deduction in your federal tax return.)

This Plan is administered in the Town Treasurer’s Office. For more information please contact Lynne Frederick, Asst. Treasurer, at 413-596-2800 x 207 or via email at lfrederick@wilbraham-ma.gov.

**FLEXIBLE SPENDING ACCOUNTS MUST BE RENEWED EVERY YEAR IN JUNE.
THERE IS NO AUTOMATIC RENEWAL.**

FY 2016 Premium Rates

ACTIVE EMPLOYEE PREMIUM RATES												
	Employee Weekly 32%			Employee Monthly 32%			Town Monthly 68%			Total Monthly 100%		
BC/BS	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family
Blue Care Elect PPO	\$127.68		\$279.52	\$510.72		\$1,118.08	\$1,085.28		\$2,375.92	\$1,596.00		\$3,494.00
Network Blue HMO	\$48.88		\$121.12	\$195.52		\$484.48	\$415.48		\$1,029.52	\$611.00		\$1,514.00
HNE	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family
Three tier Plan HMO	\$43.20	\$87.76	\$118.32	\$172.80	\$351.04	\$473.28	\$367.20	\$745.96	\$1,005.72	\$540.00	\$1,097.00	\$1,479.00
Tufts	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family
Tufts EPO	\$52.56		\$131.36	\$210.24		\$525.44	\$446.76		\$1,116.56	\$657.00		\$1,642.00

DENTAL INSURANCE (100% employee paid)			
	Employee Weekly:		
BC/BS Dental 2	Individual	Double	Family
	\$11.49		\$33.55

BASIC GROUP LIFE INSURANCE (50% employee paid)		
Policy Amount:	Employee Monthly:	Town Monthly:
\$5,000 Life*	\$1.55	\$1.55
\$5,000 AD&D**		

*reduces to \$1,000 at retirement

**cancels at retirement

NON-MEDICARE RETIREE PREMIUM RATES									
	Retiree monthly 40%			Town monthly 60%			Total Monthly 100%		
BC/BS	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family
Blue Care Elect PPO	\$638.40		\$1,397.60	\$957.60		\$2,096.40	\$1,596.00		\$3,494.00
Network Blue HMO	\$244.40		\$605.60	\$366.60		\$908.40	\$611.00		\$1,514.00
HNE	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family
Three tier Plan HMO	\$216.00	\$438.80	\$591.60	\$324.00	\$658.20	\$887.40	\$540.00	\$1,097.00	\$1,479.00
Tufts	Individual	Double	Family	Individual	Double	Family	Individual	Double	Family
Tufts EPO	\$262.80		\$656.80	\$394.20		\$985.20	\$657.00		\$1,642.00

DENTAL INSURANCE	
No Coverage for Retirees*	
*Retirees who are enrolled at the time of retirement may continue coverage under COBRA for up to 18 months.	

BASIC GROUP LIFE INSURANCE (50% retiree paid)		
Policy Amount:	Retiree Monthly:	Town Monthly:
\$1,000 Life	\$0.30	\$0.60

*life reduces to \$1,000 at retirement

**AD&D cancels at retirement

Voluntary Term Life and AD&D Insurance

Employees who are enrolled in the Group Term Life Insurance policy have the option to join the voluntary plan which provides additional Life and Accidental Death and Dismemberment (AD&D) coverage in increments of \$10,000 to a maximum of \$150,000 (the maximum coverage may not exceed five times your annual salary). This is offered at guaranteed issue for up to certain amounts depending on age during the first 31 days of employment.. Proof of good health and satisfactory to Boston Mutual is required for amounts above the Guaranteed Issue Amounts or beyond the 31 day eligibility period. Premiums are 100% employee paid, monthly premium rate costs for Life and AD&D are as follows:

Per Volume of Insurance						
Age	Monthly	10,000	20,000	30,000	50,000	100,000
	Premium					
	Rate per					
34 & under	0.11	1.10	2.20	3.30	5.50	11.00
35-39	0.16	1.60	3.20	4.80	8.00	16.00
40-44	0.23	2.30	4.60	6.90	11.50	23.00
45-49	0.35	3.50	7.00	10.50	17.50	35.00
50-54	0.57	5.70	11.40	17.10	28.50	57.00
55-59	0.78	7.80	15.60	23.40	39.00	78.00
60-64	1.24	12.4	24.80	37.20	62.00	124
65-69	2.12	21.2	42.40	63.60	106	212
70-74	3.62	36.2	72.40	108.6	181	362
75-79	5.94	59.4	118.8	178.2	297	594

Family Coverage:

You may insure your spouse in units of \$5,000 to a max of \$50,000, not to exceed 50% of your coverage amount.

Dependent children age 1-19 years (up to 25 if full time student) are eligible for \$10,000.

Dependent children age 14 days to 1 year are eligible for \$1,000.

The total monthly premium cost to insure all eligible dependent children for Life Insurance is only \$1.90 per Family Unit. All life coverage for dependent children is guaranteed issue.

Medical Questions:

If you and your dependents enroll within 31 days of becoming eligible, you and your spouse may purchase a specific amount of insurance on a guaranteed basis.

No medical questions asked for coverage at or under a Guaranteed Issue Amount.

Guaranteed Issue Amounts			
Age	Employee	Spouse	
Under 60	\$80,000	\$20,000	
60-69	\$30,000	\$10,000	
*70 & Over	\$10,000	-Not Eligible-	

*Employee's insurance deduction schedule applies

Plan Benefit Comparison Charts

Changes and clarifications in red font	BLUE CROSS BLUE SHIELD			HEALTH NEW ENGLAND	TUFTS HEALTH PLAN
BENEFIT	NETWORK BLUE HMO	BLUE CARE ELECT PREFERRED PPO		HMO	Choice Copay EPO
		In-Network	Out-of-Network		
Deductible	None	None	\$400 Individual \$800 Family	None	None
Out-of-Pocket (OOP) Maximum - <i>Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year (July 1 to June 30).</i>	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family	Medical: \$3,000 per member	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family
Effective July 1, 2015, a Prescription OOP maximum has been added per the Affordable Care Act (ACA)					
Lifetime Benefit Maximum	None	None	None	None	None
INPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
General Hospital/Mental Hospital & Substance Abuse Facility (semi-private room & board & special services)	\$500 copay	\$500 copay	20% coinsurance* Nothing for emergency/accident admissions	\$500 copay	\$500 copay
Physician Services	Nothing	Nothing	20% coinsurance* Nothing for emergency/accident admissions	Nothing	Nothing
Skilled Nursing Facility	Nothing to 100 days per calendar year benefit maximum	Nothing to 100 days per calendar year benefit maximum combined with out of network days	20% coinsurance* to 100 days per calendar year benefit maximum, combined with in-network days	Up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing up to 100 days per calendar year
Rehabilitation Hospital	Nothing to 60 days per calendar year benefit maximum	Nothing to 60 days per calendar year benefit maximum	20% coinsurance* to 60 days per calendar year benefit maximum	Up to 100 days per calendar year, combined with inpatient rehabilitation	Nothing up to 100 days per calendar year

	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
OUTPATIENT HOSPITAL					
Emergency Room Visits for Emergency or Accident Care	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)
Emergency Room Visits for Medical Care	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay (waived if admitted or for observation stay)	\$100 copay, waived if admitted	\$100 copay, waived if admitted
Surgery	\$150 copay	\$150 copay	20% coinsurance*	\$150 copay	\$150 copay
Radiation and Chemotherapy	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Diagnostic X-ray and Lab	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Colonoscopy without surgery	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
High Cost Radiology (MRI, CT & PET)	\$100 copay* - copay waived if received at non-hospital facilities	\$100 copay* - copay waived if received at non-hospital facility	20% coinsurance*	\$100 copay*	\$100 copay* waived when there is an active cancer diagnosis
Hemodialysis	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Physical Therapy	\$20 copay to 60 visits per calendar year	\$20 copay to 100 visits per calendar year	20% coinsurance* to 100 visits per calendar year	\$20 copay (two months or 25 visits)	\$35 co-pay - 30 visits per year
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Surgery	\$20 PCP Office \$35 Specialists Office	\$20 PCP Office \$35 Specialists Office	20% coinsurance*	\$20 PCP Office \$35 Specialists Office	\$20 PCP Office \$35 Specialists Office
Adult Preventative Exam (includes preventative lab tests)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay

PCP Medical Care/ Mental Health Care/ Substance Abuse Care	\$20 copay	\$20 copay	20% coinsurance*	\$20 copay	\$20 copay
Well Child Care <i>(includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine GYN Exam <i>(one per calendar year, includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Mammogram	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay
Routine Vision Exam	\$0 copay (once every 12 months)	\$0 copay (once per calendar year)	All charges	\$0 copay (once per calendar year)	\$20 copay (once per calendar year)
Specialist Office Visit	\$35 copay	\$35 copay	20% coinsurance*	\$35 copay	\$35 copay
OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Visiting Nurse Home Health Care	Nothing (Includes Hospice Care)	Nothing	20% coinsurance*	Nothing	Nothing
Durable Medical Equipment	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit	Member pays 20%, plan pays 80% with no limit	Member pays 30%, plan pays 70% with no limit- breast, hand, arm & feet prosthetics member pays 20%, plan pays 80%
Ambulance	Nothing (for emergency or medically necessary transport)	Nothing (for emergency or medically necessary transport)	Nothing for accident or emergency; 20% coinsurance* other medically necessary ambulance transport	\$25 co-pay per member per day (included Chair Van services)	Nothing (for emergency or medically necessary transport)
Routine Pediatric Dental (through age 11)	Nothing (covered services each six months)	All charges	All charges	Preventative dental only; no charge after \$25 deductible per child per calendar year (for children under 12)	Not Covered

OTHER OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Chiropractor Visits	All charges	\$20 copay per visit (up to 12 visits per calendar year)	20% coinsurance* (up to 12 visits per calendar year)	All charges (% discount through Optum Health)	\$20 copay per visit (up to 12 visits per year)
Prescription Drugs	<u>Retail:</u> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay <u>Mail Order:</u> (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay Express Scripts, Inc. (ESI) is the PBM	<u>Retail:</u> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay <u>Mail Order:</u> (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay Express Scripts, Inc. (ESI) is the PBM	<u>Retail:</u> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay <u>Mail Order:</u> (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay Express Scripts, Inc. (ESI) is the PBM	<u>Retail:</u> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay <u>Mail Order:</u> (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay Catamaran is the PBM for retail and mail order.	<u>Retail:</u> (30 day supply) Tier 1: \$10.00 copay Tier 2: \$25.00 copay Tier 3: \$50.00 copay <u>Mail Order:</u> (90 day supply) Tier 1: \$20.00 copay Tier 2: \$50.00 copay Tier 3: \$110.00 copay CVS Caremark is the PBM
Fitness Benefit	Up to \$150 reimbursement toward membership or exercise classes at a health club. See plan details. \$150 reimbursement per calendar year, WeightWatchers®	Up to \$150 reimbursement toward membership or exercise classes at a health club. See plan details. \$150 reimbursement per calendar year, WeightWatchers®	Up to \$150 reimbursement toward membership or exercise classes at a health club. See plan details. \$150 reimbursement per calendar year, WeightWatchers®	Up to \$150 reimbursement per calendar year fitness club membership, Aerobic and Wellness classes, Personal Trainer fees and school and town sports registration fees. \$150 reimbursement per calendar year, WeightWatchers®	Up to \$150 fitness reimbursement per household, per calendar year \$150 reimbursement per calendar year when enrolled in a weight loss program.

***After Deductible**

Disclaimer:

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.

Dental Insurance

The town offers dental insurance through Blue Cross Blue Shield of Massachusetts. The following is a overview of coverage provided. For more information, visit the BCBS website at www.bluecrossma.com, or contact Gloria Congram at 596-2800 ext 102. Gloria is available to meet with you on Thursdays, in meeting room 1 from 9:30 a.m. to 1:30 p.m. The Plan document is also available on the town’s website, or in hard copy in the Selectmen’s Office.

Since Providers lists change frequently, please check with your preferred dentist to find out whether he/she is a BC/BS participating dentist.

BENEFITS	COVERAGE	BENEFITS	COVERAGE
Preventive and Diagnostic		Major Restorative	
Oral Exams- Cleanings 2/year	100%	Prosthodontics	50%
Periodic Oral Exams 2/year	100%	Crowns, Inlays, and On-lays	50%
Flouride Treatments 2/year	100%	Implants	50%
X-rays	100%		
Emergency Exams	100%	Annual Maximum Benefit	\$1,500.00 pp
Sealants	100%	Per calendar year (Jan 1– Dec 31)	
Space Maintainers	100%		
Minor Restorative		Deductibles	
Restorative Services	80%	Individual Plan	\$ 50.00/year
Oral Surgery	80%	Family Plan	\$150.00/year
Periodontics/ Endodontics	80%		
Prosthetic Maintenance	80%	Rates (EMPLOYEE PAYS 100%)	
General Anesthesia	80%	Individual weekly*	\$11.49
Emergency treatment	80%	Family weekly*	\$33.55

Deferred Compensation

Since March of 2013, the Town of Wilbraham has offered the Commonwealth of Massachusetts Deferred Compensation SMART Plan.

You can start contributing to a deferred contribution account in your name at any time. The sooner you begin the larger the potential return when you retire. Once enrolled you can change the amount of your contributions (within the allowable limits) or change your investment selections at any time. Please feel free to get an informational packet in the Selectmen’s Office or make an appointment to meet with our local representative, Heather Kane, (heather.kane@gwrs.com), or by calling the SMART Plan Service Center at (877) 4547-1900, say “Representative”, then request to be connected to your local office at 1350 Main Street, Suite 1005-D, Springfield, MA 01103. The website address is www.mass-smart.com.

Optional Life, Disability and Accident Insurance

The Town of Wilbraham offers the convenience of payroll deduction for optional whole life, disability and accident insurance from Boston Mutual Insurance Company. However, the Town makes no contribution to these policies, and does not endorse this program. Employees are encouraged to compare insurance plans offered from other companies to ensure they get the best coverage for their individual needs at the most competitive price. Separate Open Enrollment Periods for this program are offered through representatives from Boston Mutual.



Overview of Health Insurance Marketplaces

THIS NOTICE IS REQUIRED BY THE 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 subsidized 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:

As a result of the Affordable Care Act (ACA), there is 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 tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This tax credit is Enabled by §26B of the Internal Revenue Service (IRS) Code.

The next open enrollment for individuals and families to buy health insurance coverage through the Health Connector is scheduled to begin on November 15, 2014, and run through February 15, 2015. Individuals and families who experience a qualifying event can shop outside of open enrollment periods. You can find out more 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.

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: Gloria Congram, Executive Assistant, Millennium Insurance Agency 413-596-2802 or gcongram@tmcg-consult.com

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 Healthconnector.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: Gloria Congram, Executive Assistant, Millennium Insurance Agency 413-596-2802 or gcongram@tmcg-consult.com

No

If no, employees should contact their employer or 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. for more information about health insurance options for which they might be eligible.