TOWN OF MAYNARD FY2019

EMPLOYEE BENEFITS

July 1, 2018 to June 30, 2019

Health & Dental Open Enrollment

May 1, 2018 – May 25, 2018

Changes must be received in the Treasurer/Collector's office **NO LATER than Friday, May 25th**

Employee Benefits Fair

May 15, 2018

Fowler Auditorium, 1pm - 4pm

Representatives will be on hand to speak with you.
Come and find out more about your benefits.
Prizes and food will be available

Rates effective July 1, 2018

		Total	Town	Employee
HMO Blue New England Enhanced Value	Individual	$835.09	$626.33	$208.76
	Family	$2,182.61	$1,636.97	$545.64
Blue Care Elect Preferred Enhanced Value	Individual	$1,391.93	$1,043.95	$347.98
	Family	$3,468.03	$2,601.03	$867.00
Blue Cross Blue Shield Dental Blue	Individual	$45.84	$0	$45.84
	Individual +1	$91.48	$0	$91.48
	Family	$140.24	$0	$140.24
Boston Mutual Life Ins				
Active Employee ($5,000 AD&D)		$5.96	$2.98	$2.98
DPW and Dept Heads ($10,000 AD&D)		$11.92	$5.96	$5.96

NEW OFFERING effective 7/1/2018

		Total	Town	Employee
Blue 20/20 Vision Plan	Individual	$7.70	$0	$7.70
	Ind +1 child	$14.64	$0	$14.64
	Couple	$15.41	$0	$15.41
	Family	$22.65	$0	$22.65

BlueCross
BlueShield

New Vision Plan
Offered
Effective 7/1/2018

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Blue20/20

Exam-Plus Integrated Vision Plan: Insight Network

Blue 20/20 is administered by EyeMed Vision Care®, an independent company.

Vision care service	In-network member cost	Out-of-network reimbursement[1]
Comprehensive eye exam	$20 copay	up to $50
Contact lens fit and follow-up[2]		
• Standard	up to $55	n/a
• Premium	10% off retail price	n/a
Retinal imaging	up to $39	n/a
Frames	$130 allowance, then additional 20% off balance	up to $74
Standard plastic lenses		
• Single vision	$25 copay	up to $42
• Bifocal	$25 copay	up to $78
• Trifocal	$25 copay	up to $130
• Lenticular	$25 copay	up to $130
• Standard progressive lens	$90 copay	up to $140
• Premium progressive lens		
tier 1 - tier 3	$110-$135 copay	up to $196
tier 4	$90 copay, then 80% of charge less $120 allowance	up to $196
Lens options[2]		
• UV treatment	$15	n/a
• Tint (solid and gradient)	$15	n/a
• Standard plastic scratch coating	$15	n/a
• Standard polycarbonate	$40	n/a
• Standard polycarbonate for covered dependents under age 19	Paid in full	up to $26
• Standard anti-reflective coating	$45	n/a
• Premium anti-reflective coating	$57-$68	n/a
• Photochromic/Transitions® plastic	20% off retail price	n/a
• Polarized	20% off retail price	n/a
• Other add-ons	20% off retail price	n/a
Contact lenses[3]		
• Conventional	$130 allowance, then additional 15% off balance	up to $104
• Disposable	$130 allowance	up to $104
• Medically necessary	Paid in full	up to $210
Frequency		
• Exam	once every 24 months	
• Lenses for frames or one order of contact lenses	once every 12 months	
• Frames	once every 24 months	

Additional in-network savings and discounts

40% OFF	a complete second pair of glasses
20% OFF	non-prescription sunglasses
15% OFF	retail price or 5% off promotional price for laser vision correction through U.S. Laser Network

Blue 20/20 customer service: 1-855-875-6948

To locate an in-network provider near you, visit **blue2020ma.com**

For costs and further details of the coverage, including exclusions, please refer to your member booklet.

1. Your actual expenses for covered services may exceed the stated out-of-network amount.
2. Indicates a service that is a discounted arrangement as part of your vision plan.
3. Discount applies to materials only and not fittings for contact lenses.

Choose from thousands of independent and retail providers including:

LensCrafters® PEARLE VISION℠ sears OPTICAL OPTICAL jcp optical

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call the EyeMed Network/Patient Services number on your ID card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de EyeMed Network/Servicio al Paciente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se você não fala inglês, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para a EyeMed Network/Serviços ao Paciente usando o número no seu cartão de ID (TTY: **711**).

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Blue20/20

Application / Change Form

- ☐ **New Enrollee**
  (Please Complete A, C, D and E)
- ☐ **Change Request**
  (For changes, complete Sections A, B and all other applicable sections. Plan changes can only be made at Open Enrollment or due to a qualifying event.)
- ☐ **Termination Date:** ______________________

Please print clearly.
Please use a black or blue pen.

Blue 20/20 Group No.

A. Employee Information

Name of Employer:		Effective Date:	Dept. / Division:	
Social Security Number:	Date of Birth:	Sex: ☐ Male ☐ Female		
Last Name:	First Name:	MI:	Marital Status: ☐ Single ☐ Married	
Mailing Address:		City:	State:	Zip Code:
Date of Hire:	Home Phone Number:	Work Phone Number:	E-Mail Address:	

B. If Making a Change from Previous Enrollment

Check All That Apply:

- ☐ Name Change
- ☐ Employee SSN Correction
- ☐ Add/Remove Dependent
- ☐ Address/Telephone Number Change
- ☐ Date of Birth Correction
- ☐ Late Enrollee
- ☐ Other:

Add Dependent(s):

	Date of Occurrence
☐ Marriage	______________
☐ Domestic Partner	______________
☐ Newborn (up to age 1)	______________
☐ Adoption	______________
☐ Court Order	______________
☐ Loss of Coverage	______________
☐ Other	______________

	Date
☐ **Remove Dependent(s)**	______________

Reason: ______________________

Reinstate Coverage:

Date: ______________

Reason: ______________

Terminate Coverage:

Date: ______________

Reason: ______________

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Blue20/20

C. Coverage Selection

Options Selected: ☐ Employee ☐ Employee plus Spouse or Domestic Partner
☐ Employee plus Child ☐ Family

D. Family Information—Complete for anyone taking or dropping Blue 20/20 Coverage*

	Name (First, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M

* Application does not guarantee enrollment.

Eligibility Notes:

1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
2. Domestic Partners are eligible for coverage if they meet the definition of a Domestic Partner and if allowed by the employer.
3. Dependent Children are eligible for coverage up to age 26.

E. Statement of Understanding

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

Signature of Employee ______________________ Date ______________

Visit us at www.blue2020ma.com

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What do I need to do during the Enrollment Period?

Employees who want to keep the same health, life, dental, and life 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.

Employees who want to cancel a plan, enroll in a new plan, or add or delete a dependent must complete an enrollment/change form.

If you choose NOT to participate in the Town of Maynard's health, dental & life insurance program, you must complete the declination form found on the last page of this document and return to the Treasurer/Collector's Office.

Changes permitted during Open Enrollment:

- Enroll yourself and/or dependents for the first time (if you meet eligibility requirements) in the plan of your choice.
- Add previously non-covered 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.

Changes that happen during the plan year:

It is the employee's responsibility to inform the employer and health plan of any changes during the year. If you have a qualifying event that changes health care eligibility, such as (but not limited to) getting married, getting divorced, having or adopting a child, a child that reaches age 26, or losing health coverage through your spouse, please contact Gloria Congram **within 30 days** of the date of birth, marriage, divorce, loss of other health care coverage, or other qualifying event. After 30 days from the date of the event you may not be able to change coverage or enroll your new spouse or child until the next Annual Enrollment Period!

Where to go for help:

Your primary contact person for all insurance plan enrollment questions is

Gloria Congram – Benefits Administrator of The Millennium Insurance Agency.

Gloria is available Tuesdays from 12:30 p.m. to 6:00 p.m. in the Retirement Office at the Town Office Building. Her phone number is (978) 897-1307 and email at gcongram@townofmaynard.net

Hard copy literature including Summary of Benefits and Coverage is available for all plans in the Treasurer/Collector's Office during normal office hours.

Health Insurance
General Regulations 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.

In the event of a divorce or legal separation, the person who was the spouse of the subscriber prior to the divorce or legal separation will remain eligible for coverage under the subscriber's health plan membership, whether or not the judgment was entered prior to the effective date of this health plan. The former spouse will remain eligible for this coverage only until the subscriber is no longer required by the judgment to provide health insurance for the former spouse or the subscriber or former spouse remarries, whichever comes first.

If the subscriber remarries, the former spouse may continue coverage under a separate health plan membership with the subscriber's group, provided the divorce judgment requires that the subscriber provide health insurance for the former spouse. This is true even if the subscriber's new spouse is not enrolled under the subscriber's health plan membership. However, the former spouse must move from family coverage to individual coverage and additional premiums will be required; the former spouse only remains eligible under the group if the divorce decree provided for such coverage. If the former spouse remarries, the former spouse's eligibility ends.

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 who is under age 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 who is under age 26.

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 unmarried dependent who is under age 26 immediately from the moment of birth and continuing until the enrolled dependent turns 26 or upon termination of the dependents coverage whichever occurs first.

Health Insurance Summary of Benefits and Coverage (SBC)

The Patient Protection and Affordable Care Act (ACA) requires that health plans provide a "Summary of Benefits and Coverage (SBC) following a prescribed format for ease of comparison.

Summary of Benefits and Coverage (SBC) for both our **Blue Care Elect PPO Enhanced Value** and **HMO Blue New England Enhanced Value** plans are available either in electronic or hard copy format by contacting Gloria Congram at (978) 897-1307.

Children's Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Massachusetts, contact your State Medicaid or CHIP office to find out if premium assistance is available. Website: http://www.mass.gov/MassHealth Phone: 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, 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)**.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and qualified beneficiaries the right to continue health insurance coverage 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 Maynard's group rate with an additional 2% administrative fee and coverage is subject to timely premium payments to the Town of Maynard. 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

Health Insurance Portability and Accountability Act (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". 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 U.S. Department of Labor at http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html

Deferred Compensation

(Deferred Compensation is **not** subject to Open Enrollment restrictions; you can open an account at any time!)

457 Deferred Compensation Plans are offered to the employees of state and local governments, subdivisions of state governments or certain eligible key employees of tax-exempt organizations.
Deferred compensation plans allow participants to save for retirement now and pay taxes later by contributing a portion of their salaries to the plan. Your 457 plan may offer investment options through a group fixed and variable deferred annuity, or a selection of mutual funds, or a selection of bank products, or a combination of investment alternatives.

You can start contributing to a deferred contribution account in your name **at any time** and you can change the amount of your contributions – within the allowable limits- at any time. You can also change your investment selections at any time.

If you have any questions or would like to open a Deferred Compensation Account, please contact Ainsley Carbone at Smart Plan (877) 457-1900.

Flexible Spending Accounts

Flexible spending accounts let you set aside a portion of your paycheck **tax free** to pay for certain health and dependent care expenses. Contributions are deducted from your paycheck prior to federal, state and social security taxes. No tax on your contribution saves you money.

If you have any questions or would like to see when the next time you can enroll in the Flexible Spending Account, please contact Karen Smith at Cafeteria Plan Advisors, Inc. (781) 848-9848.

Aflac

All Town of Maynard employees are entitled to enroll in the following Aflac plans at GROUP prices: Accident, Life Insurance, Cancer, Hospital, Dental and Short Term Disability.

If you have any questions or would like to additional information, please contact Norm Robinson (508) 395-7429 or by email norman_robinson@us.aflac.com .

Life Insurance

The Town currently offers a Group Term Life Insurance Policy as well as a Voluntary Optional Life Insurance Policy through Boston Mutual. If you did not enroll in the life insurance plan when you originally became eligible you may enroll by completing an "Evidence of Insurability" form.

Massachusetts has adopted the Uniform Probate Code, which became effective March 31, 2012. Under the Probate Code, MGLA Chapter 190B Section 2-804, **if the named beneficiary of a life insurance policy is a divorced spouse, the designation is automatically considered to be revoked by operation of the Code.** If you are insured and divorced it is suggested that you review any beneficiary designation made on your life insurance policy for consideration of making a change.

ACKNOWLEDGEMENT

I hereby acknowledge receipt of the FY19 Town of Maynard "Open Enrollment" packet. I have been informed of my eligibility to enroll in the following Town programs:

HEALTH INSURANCE

The dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to employee for FY19 is $208.76.

( ) I wish to continue my current group health coverage.

( ) I do not wish to enroll in the group health coverage at this time because I have other coverage. **

( ) I wish to discontinue my group health insurance coverage. (Please complete a BCBSMA "Enrollment/Change" form and forward it to the Treasurer/Collector's Office NO LATER than Friday, May 25th) **

( ) I wish to enroll in the group health insurance coverage. (Please complete a BCBSMA "Enrollment/Change" form and forward it to the Treasurer/Collector's Office NO LATER than Friday, May 25th)

**** I understand that if I do not have health insurance I may be responsible for the full cost of all medical treatment and that I may incur tax penalties on the State and Federal levels.**

DENTAL INSURANCE

( ) I wish to continue my current group dental coverage.

( ) I do not wish to enroll in the group dental coverage at this time.

( ) I wish to discontinue my group dental coverage. (Please complete a BCBSMA "Enrollment/Change" form and forward it to the Treasurer/Collector's Office NO LATER than Friday, May 25th) *

( ) I wish to enroll in the group dental coverage. (Please complete a BCBSMA "Enrollment/Change" form and forward it to the Treasurer/Collector's Office NO LATER than Friday, May 25th)

LIFE INSURANCE

( ) I wish to continue my current group life coverage.

( ) I do not wish to enroll in the group life coverage.

( ) I wish to discontinue my group life coverage provided. (Please complete a Boston Mutual "Group Benefits" form and forward it to the Treasurer/Collector's Office NO LATER than Friday, May 25th.)

( ) I wish to enroll in the group life insurance coverage. (Please complete Boston Mutual's "Group Benefits, Evidence of Insurability & HIPAA" forms and forward it to the Treasurer/Collector's Office NO LATER than Friday, May 25th.)

______________________________ ______________________

Name of Employee Date