# Plan Highlights for 2024-2025

✓ **Medical – We will be remaining with Health New England as our health insurance provider.**
Employees have a choice of four HMO plans. Employees who reside outside of the HNE service area will have the option to choose between two PPO plans. Highlights of the plans are:

- **HMO Essential 1000**
  Office visit copays $20; Specialists office visit copays $40
  Inpatient Hospital and Same Day / Outpatient Surgery subject to $1000 / $2000 deductible
  Prescriptions filled in a retail store (30-day supply) the copays for medications will remain $15/Tier 1 (generic) $50/Tier 2 & $100/Tier 3. Copays for the 90-day mail-order will be $30 / $100 / $300

- **HMO Essential 2000**
  Office visit copays $20; Specialists office visit copays $40
  Inpatient Hospital and Same Day / Outpatient Surgery subject to $2000 / $4000 deductible
  Prescriptions filled in a retail store (30-day supply) the copays for medications will remain $15/Tier 1 (generic) $50/Tier 2 & $100/Tier 3. Copays for the 90-day mail-order will be $30 / $100 / $300.

- **HMO Essential 3000**
  Office visit copays $25; Specialists office visit copays $40
  Inpatient Hospital and Same Day / Outpatient Surgery subject to $3000 / $6000 deductible
  Prescriptions filled in a retail store (30-day supply) the copays for medications will remain $20/Tier 1 (generic) $50/Tier 2 & $100/Tier 3. Copays for the 90-day mail-order will be $40 / $100 / $300.

- **HMO Wise Max - HDHP**
  $2,000 Individual / $4,000 Family Deductible
  Preventive office visits covered at 100%
  Prescription Drugs: Deductible, then $10 / $30 / $60 filled in a retail store (30-day supply); Deductible, then $20 / $60 / $180 for mail order (90-day supply).
  All services go toward the deductible before plan pays. Once any individual on a family plan has paid $3,200 towards the family deductible, the plan will begin to pay benefits for that individual.

- **PPO Essential 1000– (only available to employees outside the HNE service area)**
  Office visit copays $20; Specialists office visit copays $40
  Inpatient Hospital and Same Day / Outpatient Surgery subject to $1000 / $2000 deductible
  Prescriptions filled in a retail store (30-day supply) the copays for medications will remain $15/Tier 1 (generic) $50/Tier 2 & $100/Tier 3. Copays for the 90-day mail-order will be $30 / $100 / $300

- **PPO Essential 2000 – (only available to employees outside the HNE service area)**
  Office visit copays $20; Specialists office visit copays $40
  Inpatient Hospital and Same Day / Outpatient Surgery subject to $2000 / $4000 deductible
  Prescriptions filled in a retail store (30-day supply) the copays for medications will remain $15/Tier 1 (generic) $50/Tier 2 & $100/Tier 3. Copays for the 90-day mail-order will be $30 / $100 / $300.

- ✓ **Health Savings Account (HSA)** – Employees who enroll in the HNE HMO Wise Max HDHP medical plan are eligible to open a health savings account through Health Equity. This is a unique tax-advantage account that can be used to pay for current or future healthcare expenses. When combined with a high-deductible health plan, it offers saving and tax advantages that a traditional health plan can't duplicate.

    - Square One will contribute to your Health Savings Account to help pay for the annual deductible. Square One will contribute $1,000/Single and $2,000/Family per plan year. Please see pages 12-13 for contribution schedule.

| | 2024 IRS Limits | |
|---|---|---|
| | Single | Family |
| Maximum Contribution: | $4,150 | $8,300 |
| Catch Up Contribution (55+): | $1,000 | $1,000 |

- ✓ **Flexible Spending Accounts (FSA)** – Square One will continue to offer FSA plans through Flores (formerly Group Dynamic). This is a pre-tax employee-paid program, for reimbursement of out-of-pocket healthcare costs not covered by health, dental or vision insurance. The limits for 2024 will be $3,200 for qualified medical expenses and $5,000 for dependent care.

- ✓ **Limited Purpose Flexible Spending Account (LPFSA)** - Square One will offer a Limited Purpose FSA plan through Flores (formerly Group Dynamic). This LPFSA is only available to employees who are enrolled in the Health New England HMO Wise Max High Deductible Health Plan. The limit for 2024 will be $3,200 for qualified dental and vision expenses. This is a pre-tax employee-paid program for reimbursement of out-of-pocket healthcare costs not covered through your dental or vision plan.

- ✓ **Health Reimbursement Account (HRA)** - Square One will continue to offer a health reimbursement arrangement (HRA) with Health Equity for employees enrolled in the Health New England HMO Essential 1000 Plan, which helps to pay for your annual deductible. We will reimburse up to $500 per single and $1,000 per 2-person or family towards the annual deductible. Your enrollment is automatic upon enrolling in the Health New England HMO Essential 1000 Plan.

- ✓ **Health Reimbursement Account (HRA)** - Square One will continue offer the health reimbursement arrangement for employees who are enrolled in the Health New England HMO Essential 2000 Plan. We will reimburse up to $1,000 per single and $2,000 per 2-person or family towards the annual deductible. Your enrollment is automatic upon enrolling in the Health New England HMO Essential 2000 plan.

- ✓ **Health Reimbursement Account (HRA)** - Square One will also offer the health reimbursement arrangement for employees who are enrolled in the Health New England HMO Essential 3000 Plan. We will reimburse up to $1,500 per single and $3,000 per 2-person or family towards the annual deductible. Your enrollment is automatic upon enrolling in the Health New England HMO Essential 3000 plan.

- ✓ **Health Reimbursement Account (HRA)** - Square One will continue to offer a health reimbursement arrangement (HRA) with Health Equity for employees enrolled in the Health New England PPO Essential 1000 Plan, which helps to pay for your annual deductible. We will reimburse up to $500 per single and $1,000 per 2-person or family towards the annual deductible. Your enrollment is automatic upon enrolling in the Health New England PPO Essential 1000 Plan.

- ✓ **Health Reimbursement Account (HRA)** - Square One will continue offer the health reimbursement arrangement for employees who are enrolled in the Health New England PPO Essential 2000 Plan. We will reimburse up to $1,000 per single and $2,000 per 2-person or family towards the annual deductible. Your enrollment is automatic upon enrolling in the Health New England PPO Essential 2000 plan.

- ✓ **Dental** – Dental coverage is remaining with Delta Dental. Coverage and benefits will remain the same. See page 14 for details. Note that Delta's PPO Plus Premier plan network includes 96% of all dentists in Massachusetts.

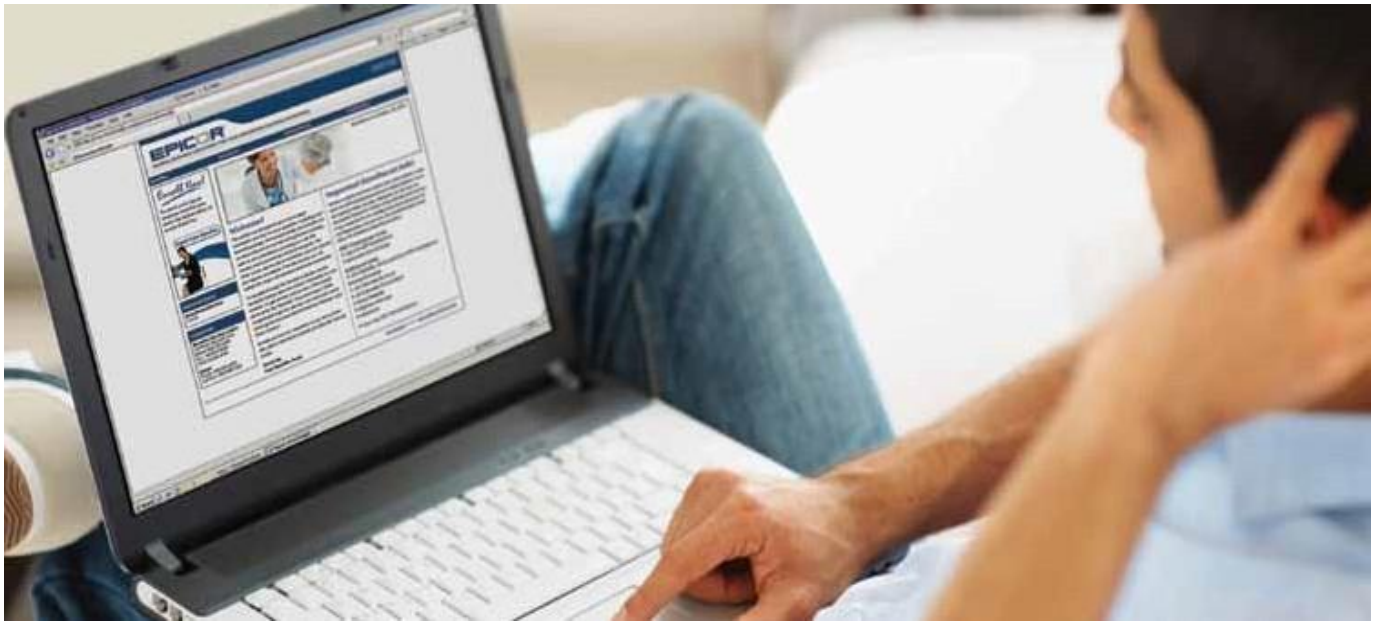
- ✓ **Vision –** Vision coverage is remaining with EyeMed, benefits and coverage will remain the same.

- ✓ **Basic Life, AD&D Insurance** – will be administered by Lincoln Financial. Coverage & benefits will remain the same and continue to be 50% paid for by Employees through payroll deductions.

- ✓ **Voluntary Short Term Disability** –will be administered by Lincoln Financial. Coverage & benefits will remain the same and continue to be 50% paid for by Employees through payroll deductions.

- ✓ **Long Term Disability** –will be administered by Lincoln Financial and Square One will continue to pay 100% of the cost of this program for the 2024-25 Plan Year.

- ✓ **Voluntary Accident, Critical Illness, Whole Life & Hospital Indemnity** –all benefit eligible employees have the opportunity to elect supplemental accident, critical illness, whole life, and hospital indemnity insurance administered by Colonial Life. These benefits are paid for by Employees through payroll deductions.



# Eligibility & Enrollment

## Eligibility Rules

Full-time employees working 30 or more hours and part-time employees working 21+ hours per week are eligible to participate in the Square One Employee Benefits Program. For most of our benefit plans your coverage will become effective thirty days from date of hire. You must be actively at work for your coverage to be effective on your eligibility date. You may also enroll your eligible dependents in the Square One Benefit Plans. Your eligible dependents include your spouse, as well as your dependent children, whether natural, adopted, stepchildren, foster, or those for whom you have legal custody by court decree. When enrolling in medical, dental or vision coverage, you may enroll any dependent child up to age 26.

## Enrollment Is Simple

For Health, Dental and Vision insurance, complete your enrollment online via ADP Self-Service. For Basic Life Insurance & Short-Term Disability, you will remain enrolled if you are currently enrolled. If you are not currently enrolled, complete an enrollment form along with Evidence of Insurability. For Long-Term Disability, all eligible employees are automatically enrolled and no action is required. For Flexible Spending Plans, you must complete an FSA election form.

## When Can You Enroll?

You can sign up for Benefits at any of the following times:

- After completing initial eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified family-status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

**In order to enroll or make any changes for the 2024 open enrollment, all necessary paperwork MUST be completed by June 21, 2024.**

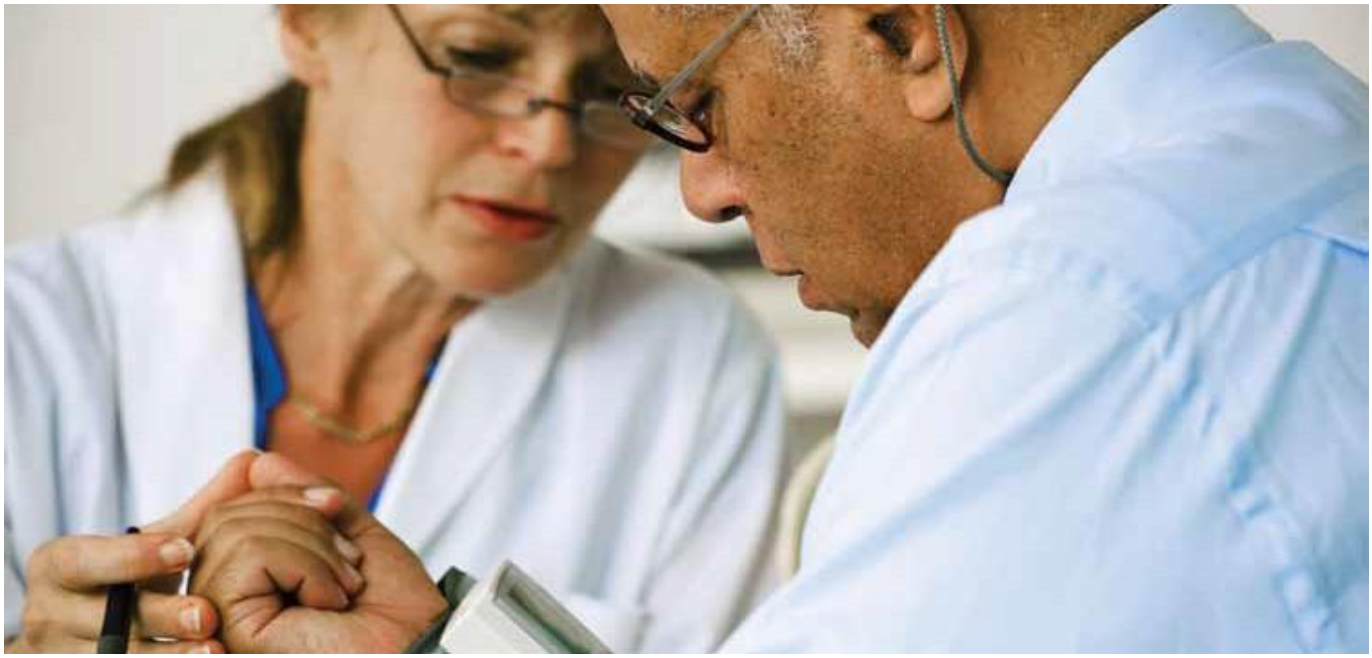
## Making Changes

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your Employer and another change is permitted under the plan terms.

Examples of these change in status events may include:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you have a family status change, you must timely notify your Personnel Manager and complete the necessary forms. For more information refer to your benefits booklet.



# Cost of Coverage: *How You Pay for Health Care Costs*

You share the cost of health care services with Square One and the medical plan you select. As you review the medical plan options you should consider the following types of costs:

**Premium:** A premium is the total cost for your medical insurance. You and Square One share this cost. You pay your portion through pre-tax payroll deductions.

**Deductible:** A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits.

**Copay:** A copay is a set payment you make for a specific service. For example, in the Health New England Essential 1000 plan you will make a $20 copay for visits to your primary care physician.

**Coinsurance:** When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, in the Health New England Wise Max plan, after you satisfy your deductible, you will pay 0% for most medical care that you receive from preferred providers.

**Out-of-Pocket Maximum:** The annual out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible, copays and coinsurance, for eligible expenses during a plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of the usual, customary and reasonable charges for the balance of the calendar year.

## Your Total Costs

**Remember, the total cost you pay for health care services in a plan year is the combination of your out-of-pocket costs when you access medical care and the premium payments you are required to make for coverage.**

# Selecting Your Medical Insurance Plan

Everyone spends some money on medical care each year. If you're like most people, you can expect to visit your doctor at least once during cold and flu season. In addition, you might obtain an annual physical exam and take a few prescription drugs over the course of the year. Some people will spend a night or two in the hospital, and others will need some health care services each year, and some will need more care than others.

How do you select the right medical insurance plan? We suggest that you consider the different plan features, the level of managed care you are willing to accept and your own state of health before making a plan decision. And you should consider the premium contribution requirement before you enroll for a particular plan.

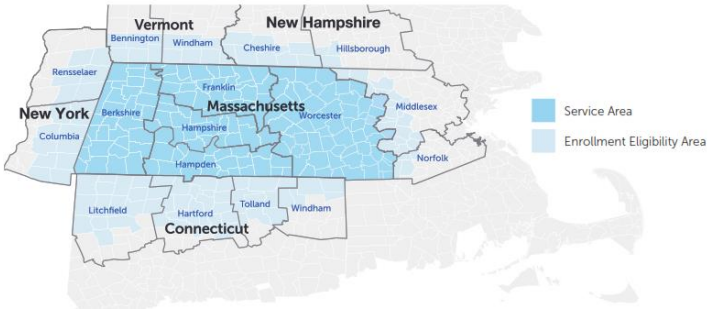
The plan grid below compares a number of the major features of each of our medical plans. Use this grid, in conjunction with the benefit descriptions on the following page, to make an informed plan decision.

| Benefit Description | Health New England HMO Essential 1000 | Health New England HMO Essential 2000 | Health New England HMO Essential 3000 | Health New England HMO HDHP Wise Max |
|---|---|---|---|---|
| Calendar Year deductible | $1,000 / $2,000 per member / family | $2,000 / $4,000 per member / family | $3,000 / $6,000 per member / family | $2,000 / $4,000 per member / family<br><br>Once any family member has paid $3,200 towards family deductible, the plan will pay benefits for that individual |
| Calendar year out-of-pocket maximum | $6,000 / $12,000 per member / family | $6,000 / $12,000 per member / family | $6,350 / $12,700 per member / family | $5,000 / $10,000 per member / family |
| Physician office visit | $20 copay | $20 copay | $25 copay | 100% after deductible |
| Specialist office visit | $40 copay | $40 copay | $40 copay | 100% after deductible |
| Preventive and wellness | 100% | 100% | 100% | 100% |
| Complex Radiology | $75 copay after deductible | $100 copay after deductible | $100 copay after deductible | 100% after deductible |
| Inpatient hospital care | 100% after deductible per admit | 100% after deductible per admit | 100% after deductible per admit | 100% after deductible per admit |
| Emergency room services | $250 copay waived if admitted | $250 copay waived if admitted | $250 copay waived if admitted | 100% after deductible |
| Retail Prescription Drugs 30 days | Generic: $15<br>Formulary: $50<br>Non Formulary: $100 | Generic: $15<br>Formulary: $50<br>Non Formulary: $100 | Generic: $20<br>Formulary: $50<br>Non Formulary: $100 | After Deductible:<br>Generic: $10<br>Formulary: $30<br>Non Formulary: $60 |
| Mail Order Prescriptions 90 days | Generic: $30<br>Formulary: $100<br>Non Formulary: $300 | Generic: $30<br>Formulary: $100<br>Non Formulary: $300 | Generic: $40<br>Formulary: $100<br>Non Formulary: $300 | After Deductible:<br>Generic: $20<br>Formulary: $60<br>Non Formulary: $180 |

Coinsurance percentages shown in the above plan descriptions represent the percentages paid by the health plan.

# PPO Plans

We also offer two PPO plans for employees who reside outside of Massachusetts.




| Benefit Description | Health New England PPO Essential 1000 | | Health New England PPO Essential 2000 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Calendar Year deductible | $1,000 / $2,000 per member / family | | $2,000 / $4,000 per member / family | |
| Calendar year out-of-pocket maximum | $6,000 / $12,000 per member / family | $7,500 / $15,000 per member / family | $6,000 / $12,000 per member / family | $7,500 / $15,000 per member / family |
| Physician office visit | $20 copay | Paid at 80% after deductible | $20 copay | Paid at 80% after deductible |
| Specialist office visit | $40 copay | Paid at 80% after deductible | $40 copay | Paid at 80% after deductible |
| Preventive and wellness | 100% | Paid at 80% after deductible | 100% | Paid at 80% after deductible |
| Complex Radiology | $75 copay after deductible | Paid at 80% after deductible | $100 copay after deductible | Paid at 80% after deductible |
| Inpatient hospital care | 100% after deductible per admit | Paid at 80% after deductible | 100% after deductible per admit | Paid at 80% after deductible |
| Emergency room services | $250 copay waived if admitted | $250 copay waived if admitted | $250 copay waived if admitted | $250 copay waived if admitted |
| Retail Prescription Drugs 30 days | Generic: $15<br>Formulary: $50<br>Non Formulary: $100 | Generic: $15, then 20%<br>Formulary: $50, then 20%<br>Non Formulary: $100, then 20% | Generic: $15<br>Formulary: $50<br>Non Formulary: $100 | Generic: $15, then 20%<br>Formulary: $50, then 20%<br>Non Formulary: $100; then 20% |
| Mail Order Prescriptions 90 days | Generic: $30<br>Formulary: $100<br>Non Formulary: $300 | Not Covered | Generic: $30<br>Formulary: $100<br>Non Formulary: $300 | Not Covered |

Coinsurance percentages shown in the above plan descriptions represent the percentages paid by the health plan.

# Health Reimbursement Arrangement

A Health Reimbursement Arrangement (HRA) is an employer-funded program that reimburses employees for qualified deductible expenses. Your participation in the HRA is automatic when you enroll in the Health New England HMO and PPO Essential 1000 Plan, the Health New England HMO and PPO Essential 2000 Plan, and the Health New England HMO Essential 3000.

## HMO and PPO Essential 1000 HRA

| TOTAL HEALTH NEW ENGLAND DEDUCTIBLE | HRA PAYS FIRST: | PARTICIPANT PAYS SECOND: |
|---|---|---|
| Single Plan: $1,000 | $500 | $500 |
| 2-Person and Family Plan: $2,000 | $1,000<br>(but no greater than $500 for one member) | $1,000 |

## HMO and PPO Essential 2000 HRA

| TOTAL HEALTH NEW ENGLAND DEDUCTIBLE | HRA PAYS FIRST: | PARTICIPANT PAYS SECOND: |
|---|---|---|
| Single Plan: $2,000 | $1,000 | $1,000 |
| 2-Person and Family Plan: $4,000 | $2,000<br>(but no greater than $1,000 for one member) | $2,000 |

## Essential 3000 HRA

| TOTAL HEALTH NEW ENGLAND DEDUCTIBLE | HRA PAYS FIRST: | PARTICIPANT PAYS SECOND: |
|---|---|---|
| Single Plan: $3,000 | $1,500 | $1,500 |
| 2-Person and Family Plan: $6,000 | $3,000<br>(but no greater than $1,500 for one member) | $3,000 |

**What expenses are eligible for reimbursement?**

Deductible expenses as defined by the HNE HMO or PPO Essential 1000, HMO or PPO Essential 2000, and HMO Essential 3000 Health Plan such as:

- Inpatient Hospitalization and Same Day Surgeries
- Diagnostic testing (x-rays) and high-cost imaging (MRI's)
- Other medical care services that are applied toward the annual deductible.

HRA eligible expenses are on deductible applied services only within the health plan, and must be incurred during the plan year.

**What amount of reimbursements can I receive through this HRA?**

The maximum amount to be reimbursed is as follows:

- $500 per single employee with no dependents who are enrolled in the Essential 1000 plan
- $1000 for employee with one or more dependents who are enrolled in the Essential 1000 plan
- $1000 per single employee with no dependents who are enrolled in the Essential 2000 plan
- $2000 per employee with one or more dependents who are enrolled in the Essential 2000 plan
- $1500 per single employee with no dependents who are enrolled in the Essential 3000 plan
- $3000 per employee with one or more dependents who are enrolled in the Essential 3000 plan

The HRA will not be responsible for costs associated with other in-network or out-of-network copays, coinsurance expenses or services.

**How are funds distributed?**

Members will not need to submit for reimbursement. The HRA vendor, Health Equity, will automatically pay providers directly for eligible deductible expenses.

**What is the tax treatment of an HRA?**

Employer reimbursements are excluded from employee's gross income.

**Can funds be carried over from one year to the next?**

No, the HRA benefit runs on a current plan year basis only.

# Dental

Square One offers a Dental PPO plan through Delta Dental of Massachusetts for all employees. With the Dental PPO plan, you also have the ability to obtain dental care services from the dentist of your choice (contracted or not). The dental plan provides a higher level of benefit if you choose to use an in-network provider.

Please Note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

| Benefit Description | Delta Dental of Massachusetts Dental PPO<br>MCHSP Delta Premier Plan 1 | |
|---|---|---|
| | *In-Network* | *Out-of-Network*[1] |
| Annual Deductible | $50 / $150<br>per member / family | $50 / $150<br>per member / family |
| Waived for Preventive Care? | Yes | Yes |
| Annual maximum dental benefit | $1,500 | $1,500 |
| Preventive Care Services | 100% | 100% |
| Basic Services | 80% | 80% |
| Major Services | 50% | 50% |
| Orthodontic Benefits | 100%<br>For children to age 19<br>$1,000 lifetime maximum | 100%<br>For children to age 19<br>$1,000 lifetime maximum |

Coinsurance percentages shown in the above plan descriptions represent the percentages paid by the dental plan.

[1] You can receive care from any licensed dentist, anywhere in the United States. If you choose a non-participating dentist, you will be responsible for the coinsurance amount listed above, as well as any charges above Delta Dental of Massachusetts's maximum allowable charge for covered services.

**Members can now schedule a virtual visit with a dentist 24/7 using their smartphone, tablet or computer!**

**IT'S EASY TO SCHEDULE A VIRTUAL VISIT**

Delta Dental has partnered with TeleDentistry.com to provide virtual visits.

Here's how it works:

**Step 1 –** Go online to teledentistry.com/ddma.

**Step 2 –** Complete a brief registration and health questionnaire.

**Step 3 –** You'll be connected with a TeleDentistry.com dentist to begin your visit.

TeleDentistry.com is backed by the power of Preventistry™, Delta Dental of Massachusetts' groundbreaking and unique approach to transforming the oral health care system. Preventistry combines clinical innovation, actionable data and digital engagement to provide a higher level of care and improve the health of our members.

DELTA DENTAL®

# Delta Dental PPO *Plus Premier*™

Visit **deltadentalma.com** for detailed benefit information

**Coverage Summary for**
Massachusetts Council of Human Service Providers
**Plan 1**

**Deductible: $50 per individual / $150 per family. Deductible does not apply for members under age 13. Deductible waived for Diagnostic and Preventive categories.**
**Calendar Year Maximum: $1,500 per person.**

| Category / Procedure | Qualifications | Members under age 13 | | Members age 13 and older | |
|---|---|---|---|---|---|
| | | PPO Network | Premier and Out of Network* | PPO Network | Premier and Out of Network* |
| Diagnostic | | | | | |
| Comprehensive Evaluation | Once every 60 months. | | | | |
| Periodic Oral Evaluation | Twice every 12 months. | | | | |
| Consultation | Once every 12 months. | 100% | 100% | 100% | 100% |
| Panoramic or Full Mouth X- rays | Once every 60 months. | | | | |
| Bitewing X-rays | Twice every 12 months. | | | | |
| Single Tooth X-rays | As needed. | | | | |
| Preventive | | | | | |
| Teeth Cleaning | Twice every 12 months. | | | | |
| Fluoride Treatments | Twice every 12 months for members under age 19. Also covered for members age 19 and over who have had a recent cavity and are at risk for decay. | 100% | 100% | 100% | 100% |
| Space Maintainers | Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth. | | | | |
| Sealants | Unrestored permanent bicuspid and permanent molars, once per 48 months per tooth for members to age 19. | | | | |
| Application of caries arresting medicament | Twice per tooth per 12 months. | | | | |
| Restorative | | | | | |
| Fillings (Silver and White) | Once every 24 months per surface per tooth. | | | | |
| Inlays | Once every 60 months per surface per tooth, covered as an alternate benefit as silver filling and the patient is responsible for paying the difference between the silver filling and the Delta Dental negotiated fee for the inlay where permitted by state law. For non-participating providers, the patient may be responsible for paying up to the provider's full submitted charge for the inlay. | 100% | 100% | 80% | 80% |
| Protective Restorations | Once per tooth. | | | | |
| Stainless Steel Crowns | Once every 24 months per tooth (on primary teeth only). | | | | |
| Oral Surgery | | | | | |
| Extractions | Once per tooth. | 100% | 100% | 80% | 80% |
| General Anesthesia | General Anesthesia and IV sedation allowed with covered surgical impacted wisdom teeth only (up to one hour). | | | | |
| Periodontics (on natural teeth only) | | | | | |
| Periodontal Surgery | One surgical procedure per quadrant in 36 months. | 100% | 100% | 80% | 80% |
| Scaling and Root Planing | Once in 24 months, per quadrant. No more than 2 quadrants per date of service. | | | | |
| Periodontal Cleaning | 4 times every 12 months following active periodontal treatment. Not to be combined with preventive cleanings. | 100% | 100% | 100% | 100% |
| Bone Grafts/GTR | No more than 2 teeth per quadrant per 36 months on natural teeth. | | | | |
| Endodontics | | | | | |
| Root Canal Treatment | Once per tooth. | 100% | 100% | 80% | 80% |
| Root Canal Retreatment | Once per tooth after 24 months have elapsed from initial treatment. Limited to deciduous teeth. | | | | |
| Vital Pulpotomy | | | | | |
| Prosthetic Maintenance | | | | | |
| Bridge or Denture Repair | Once per bridge/denture per 12 months, after 24 months of initial insertion. | | | | |
| Crown or Onlay Repair | Once per tooth per 12 months after 24 months of initial placement. | 100% | 100% | 80% | 80% |
| Rebase or Reline of Dentures | Once per denture within 36 months. | | | | |
| Recement of Crowns, Onlays & Bridges | Once per crown, onlay or bridge. | | | | |
| Adjunctive Services | | | | | |
| Occlusal Guards | One appliance per 60 months. | 100% | 100% | 80% | 80% |
| Emergency Dental Care | | 100% | 100% | 80% | 80% |
| Palliative treatment | Three occurrences in 12 months.. | | | | |
| Prosthodontics | | | | | |
| Dentures | Once within 60 months (age 16 and older). | | | | |
| Fixed Bridges | Once within 60 months (age 16 and older). | | | | |
| Implants | Once per tooth per 60 months. (Pre-estimate recommended). | 100% | 100% | 50% | 50% |
| Implant Abutments | Once per 60 months. | | | | |
| Major Restorative | | | | | |
| Crowns or Onlay | When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older). | 100% | 100% | 50% | 50% |
| Cast Posts/Buildups | Once per tooth per 60 months only benefitted to retain a crown. | | | | |
| Orthodontics: Covered at 100% of Maximum Plan Allowance charges up to age 19. $1,000 separate LIFETIME maximum. Orthodontic treatment must be administered/supervised by a licensed dentist | | | | | |

*Additional Benefit Information*

| |
|---|
| Deductible waived for periodontal cleanings. |
| *Dependent Eligibility - Eligible dependents up to age 26.* |
| Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds $300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the services are covered under your dental coverage. |

This plan is eligible for Rollover Maximum: Rollover Max dollars do not apply to orthodontic services. To qualify for Rollover Max, you must receive at least one cleaning or oral exam in the plan year. You must be enrolled for dental coverage before the 4th quarter of the calendar year and your paid claims must not exceed the maximum "threshold" amount.

| Your calendar year maximum benefit amount. | If your total yearly claims don't exceed this threshold amount... | Then you can roll over this amount to use next year, and beyond. | Your accumulated rollover total is capped at this amount. |
|---|---|---|---|
| $1,500 | $700 | $500 | $1,250 |

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non- participating maximum plan allowance and the full fee charged by the dentist.

## Delta Dental PPO *Plus Premier*™

DELTA DENTAL®

### Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental PPO *Plus Premier* subscriber, you have access to two of Delta Dental's extensive national networks—Delta Dental PPO, with more than 350,000 dentist locations and Delta Dental Premier, the largest dental network in the country with more than 450,000 dentist locations. Three out of four dentists nationwide participate in one or both of these networks.

You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees, but will be subject to the out-of-network co-insurance level shown on the front of this summary.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists and will receive the in-network co-insurance level shown on the front of this summary.

If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at http://www.deltadentalma.com/members/discounts-on-covered-services/

Dental Services of Massachusetts, Inc. is an independent licensee of the Delta Dental Plans Association. ®Registered marks and ™Trademarks of the Delta Dental Plans Association. ©2023 DSM.

### Learn more at deltadentalma.com

Visit the member area of **www.deltadentalma.com** to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at **www.deltadentalma.com**. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:
**Delta Dental of Massachusetts**
800-872-0500
www.deltadentalma.com

465 Medford Street, Ste. 400
Boston, MA 02129

DELTA DENTAL

# Give Your Employees Even More to Smile About!

## Delta Dental of Massachusetts' Right Start 4 Kids℠ Removes Cost Barriers to Dental Care

Dental coverage is important to your employees and your business.

It helps keep their smiles healthy and contributes to their overall health and well-being, and that of their families. And offering them great Delta Dental coverage can play a big role in your recruiting and retaining employees.

Keeping your employee's smiles health also pays off in higher productivity, as employees with poor oral health miss more work due to unplanned dental visits[1] The problem is even more stark with children where children with poor oral health were 3 times more likely to miss school for things like tooth pain.[2]

Delta Dental now offers our unique Right Start 4 Kids option for Delta Dental PPO *Plus Premier*™ dental plan – making it even easier – and more affordable – for them to take care of their children's oral health.

**Right Start 4 Kids provides 100% coverage for diagnostic, preventive, basic and major services for children up to their 13th birthday with a participating provider.**

The best part is they can use the same in-network dentists from the Delta Dental PPO™ and Delta Dental Premier® networks and we will apply the benefits automatically - there is no extra paperwork to fill out. They can also see non-participating dentists, but their costs will likely be higher.*

The Right Start 4 Kids benefit is available with PPO *Plus Premier*™ contributory plans beginning Jan. 1, 2022. Groups with less than 100 enrolled subscribers will automatically receive this benefit upon plan renewal. Groups with 100 or more enrolled subscribers may choose this option upon plan renewal. To do so, reach out to your account executive or broker for more information.

### RIGHT START 4 KIDS

Coverage for age 12 and under

100% coverage for covered services (preventive, basic, major)*

No deductible

Does not apply to orthodontics; orthodontic coinsurance applies

Annual benefit maximum applies

Exclusions and limitations apply

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

**Sample PPO *Plus Premier* Right Start 4 Kids Plan Design**

**Age 12 and under**

| Benefit | Right Start 4 Kids Benefit* |
|---|---|
| Deductible | None |
| Preventive/Diagnostic Coinsurance | 100% |
| Basic Restorative Coinsurance | 100% |
| Major Restorative Coinsurance | 100% |

1 Kelekar U, Naavaal S. Hours Lost to Planned and Unplanned Dental Visits Among US Adults. Prev Chronic Dis 2018;15:170225. DOI: http://dx.doi.org/10.5888/pcd15.170225external icon

2 American Journal of Public Health - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222359/

SP1381 (10.21)

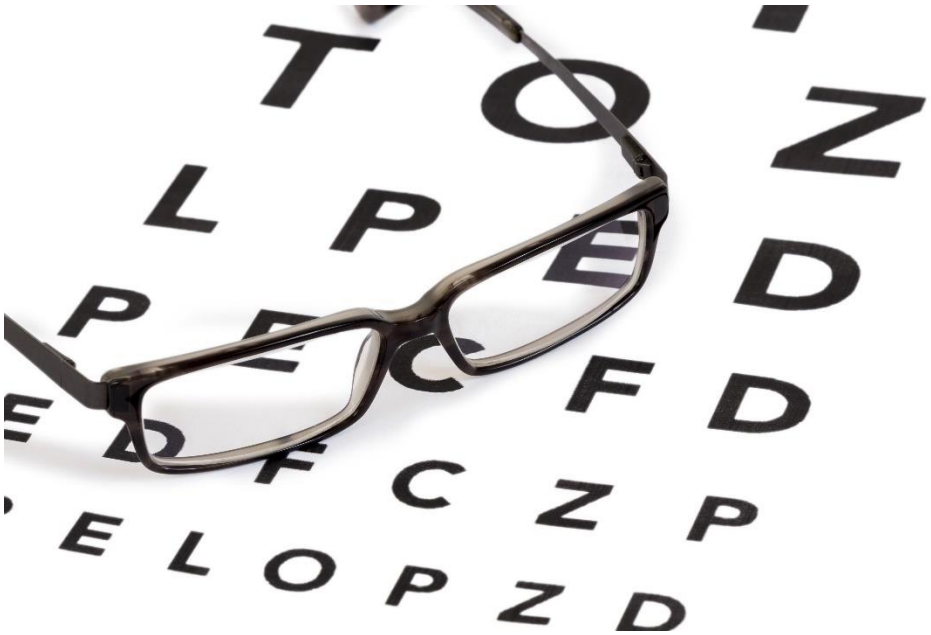
# Vision

Are you really seeing your best? Or are you simply used to the view? With good vision, your experiences are clearer, sharper and brighter.

Vision examinations not only determine the need for corrective eye wear but also may help detect other general health problems such as glaucoma, cataracts, and diabetes. Plus, eye exams for children can help detect problems that can impact learning and development.

Dollar for dollar, you get the best value from your vision care plan when you visit a Fidelity Security Life Insurance Company network doctor. If you decide not to see an EyeMed doctor, the Out of Network plan copays will still apply. The choice is yours—either way, your vision benefits are a tremendous part of your overall benefits package.

| Benefit Description | Fidelity Security Life Insurance Company EyeMed Vision | |
|---|---|---|
| | In Network | Out-of-Network |
| Copay (per person) | Examination - Not covered<br>Materials - $25 copay | Examination - Not covered<br>Materials - Varies per service |
| Frequency Limits | Exams - Not covered<br>Lenses - 12 months<br>Contacts - 12 months<br>Frames - 24 months | |
| Exams | Not covered | Not covered |
| Single Vision Lenses | $25 copay | Up to $42 |
| Bifocal Lenses | $25 copay | Up to $78 |
| Trifocal Lenses | $25 copay | Up to $130 |
| Frames | $140 Allowance; 20% off bal. over $140 | Up to $82 |
| Contact Lenses (instead of prescription glasses) | $0 copay | Up to $200 |



# Health Savings Account (HSA)

An HSA, or Health Savings Account, is a unique tax-advantaged account that can be used to pay for current or future healthcare expenses. When combined with a high-deductible health plan, it offers savings and tax advantages that a traditional health plan can't duplicate. With an HSA, employees will have:

- A tax-advantage savings account that they can use to pay for eligible medical expenses as well as deductible, co-insurance, prescriptions, vision, and dental care.
- Unused funds will roll over year to year. There's no "use it or lose it" penalty.
- Potential to build more savings through investing. Employees can choose from a variety of HSA self-directed investment options with no minimum balance required.
- Additional retirement savings. After age 65, funds can be withdrawn for any purpose without penalty but may be subject to income tax if not used for qualified medical expenses.

**Who is eligible to open an HSA?**
The main requirement for opening an HSA is having a high-deductible health plan that meets IRS guidelines for the annual deductible and out-of-pocket maximum. To be an eligible individual and qualify for an HSA, you must also meet the following requirements.

- You are not covered by any other non-HDHP health plan, such as a spouse's plan, that provides any benefits covered by your HDHP plan.
- You are not enrolled in Medicare.
- You do not receive health benefits under TRICARE.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You cannot be claimed as a dependent on another person's tax return.
- You are not covered by a general purpose health care flexible spending account (FSA) or health reimbursement account (HRA). Alternative plan designs, such as a limited-purpose FSA or HRA, might be permitted.

**Are there limits to how much I can contribute to my HSA?**
Yes. The IRS determines the maximum amount that can be contributed to an HSA during the calendar year. Please note: If you enroll in Medicare mid-year, you will need to pro-rate your HSA contributions.

| | 2024 IRS Limits | |
|---|---|---|
| | **Single Plan** | **Family Plan** |
| Maximum Contribution Limit | $4,150 | $8,300 |
| Catch-up Contribution (55+) | $1,000 | $1,000 |

**Are health insurance premiums considered IRS-qualified medical expenses?**
Generally, health insurance premiums ARE NOT considered IRS-qualified medical expenses, UNLESS they are for:

- Qualified long-term care insurance,
- COBRA health care continuation coverage
- Health care coverage while an individual is receiving unemployment compensation

For individuals over 65, the following premiums ARE considered IRS-qualified medical expenses:

- Medicare Parts A, B, D, Medicare HMA
- Employee portion paid for employer-sponsored health insurance
- Employee portion paid for employer-sponsored retiree health insurance

**Who is responsible for making sure HSA funds are only used to pay for IRS-qualified medical expenses?**
As the HSA accountholder, you are responsible. So, it's important to keep records of the IRS-qualified medical expenses you pay for with your HSA in order to exclude those dollars from your gross income.

### Can my HSA funds ever be taxed?

HSA funds that are used to pay for non IRS-qualified medical expenses are considered part of your gross income and subject to an additional 20%. Exceptions include HSA distributions that are made after an accountholder's death, disability, or after they turn 65.

### HSA Tax Benefits

There are three key tax benefits to a Health Savings Account (HSA). Money goes into and comes out of an HSA tax-free (as long as funds are used to pay for qualified medical expenses).

1. Contributions to an HSA are tax-free.
2. Earnings to an HSA from interest and investments are tax-free.
3. Distributions from an HSA to pay for qualified medical expenses are tax-free.

### Employer Contribution Schedule

| SQUARE ONE HSA CONTRIBUTION | FIRST HSA CONTRIBUTION JULY | SECOND HSA CONTRIBUTION JANUARY |
|---|---|---|
| Single Plan - $1,000 | $500 | $500 |
| Family Plan - $2,000 | $1,000 | $1,000 |

# HEALTH EQUITY MEMBER PORTAL (HSA)

## Logging in to your portal the first time:

1. Go to my.healthequity.com, click “Begin Now.”
2. Enter the information requested on the “Find your account” screen.
3. Enter the information asked for on the “Verify your identity” screen.
4. On the “Set up your login” screen:
5. Pick a user/login name of at least six characters with numbers and letters on the “Set up your login” screen.
6. Choose a password of at least eight characters with an uppercase letter, a lowercase letter and a number.
7. Follow password creation recommendations as listed in the log in screen
8. On the “Your email settings” screen, enter your email address.
9. Click the box to agree to the terms of the web site and save the agreement.

## Logging in to your portal after your first login:

1. Go to my.healthequity.com.
2. Log in with the username and password you created the first time you logged in.

# Income Protection Benefits

If something were to happen to you, how financially secure would you and your loved ones be?

Through Lincoln Financial, Square One offers Basic Life, Accidental Death and Dismemberment (AD&D), Short Term Disability Insurance at affordable group rates and the convenience of payroll deduction. Long-Term Disability Insurance is provided at no cost to you.

## SUMMARY OF BENEFITS

| | |
|---|---|
| Basic Life | One times annual compensation rounded to the next higher $1,000, OR maximum of $50,000. Providing you are still employed, benefits are reduced to 65% at age 70 and to 50% at age 75. Coverage terminates at retirement. |
| AD&D | Same as Basic Life Benefit. |
| Cost | Life coverage is contributory, which means that you are responsible for paying 50% of the cost through payroll deduction. Calculate your cost by dividing your annual salary by 1000 and multiplying the result by the rate of $0.14. Follow the example below to determine your monthly cost:<br><br>Example:<br>Amount of Ins: $50,000 /1000 = 50 x $0.154 = $7.70 total cost.<br>You pay 50% of the total cost or $3.85 per month |
| Long Term Disability | Up to 60% of your monthly covered earnings – to a maximum of $6,000 per month. Benefits begin after you have been absent from work for 180 days or more because of a covered accident or sickness. |
| Cost | There is no cost to you. Square One pays your Group LTD premium. |
| Eligibility of coverage | All active employees regularly working a minimum of 21 hours per week: |
| Eligibility waiting period | Benefits are effective 30 days after your date of hire. |
| Pre-existing Condition Limitation | Lincoln Financial will not provide Long Term Disability benefits caused by, contributed to or resulting from a Pre-Existing Condition; and which begins in the first 12 months after you are continuously insured under the Policy. A Pre-Existing Condition means any Injury or Sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You become insured under the Policy. |

# Income Protection Benefits

If something were to happen to you, how financially secure would you and your loved ones be?
Because the unexpected does happen, Square One provides eligible employees the opportunity to purchase Voluntary Short-Term Disability coverage at low group rates. These benefits are designed to replace a portion of your income should you become incapable of work due to a non-work related injury or illness. Because the coverage is paid 50% by the employee, the benefits are 50% tax free.

## SUMMARY OF BENEFITS

| | |
|---|---|
| STD Benefit | Weekly benefits are 66.67% of your Total Weekly Earnings, up to a maximum of $700. |
| Benefits Begin | On the 8th day for Accidents and on the 8th Day for Sickness |
| Maximum Benefit Period | Covers total disability resulting from accidents or sickness for up to 26 Weeks |
| Cost | STD coverage is contributory, meaning that you are responsible for paying for the cost of the program through payroll deduction. Calculate your cost by dividing your weekly benefit by 10 and multiplying the result by the rate of $0.163. Follow the example below to determine your cost:<br><br>Example Weekly Benefit: $350 (annual salary divided by 52 weeks); divided by 10 = 35 x $0.163 (the rate) = $5.70 per month, you pay 50% of the total cost or $2.63 per pay. |

| | |
|---|---|
| Eligibility of coverage | All active employees regularly working a minimum of 21 hours per week: |
| Eligibility waiting period | Benefits are effective after 30-days of employment. |
| Enrollment | To enroll, fill out the STD enrollment form available from your employer. |
| Evidence of Insurability | Proof of good health may be required if you decline coverage during your initial eligibility and then want coverage at a later date. Also, all late entrants and increases in coverage will also require Evidence of Insurability. |

# Flexible Spending Accounts

You can fund your out-of-pocket health care expenses with pre-tax money through a Flexible Spending Account (FSA).

## SUMMARY OF FLEXIBLE SPENDING ACCOUNT

A Flexible Spending Account (FSA) allows you to set money aside, up to $3,200, deducted pre-tax from your paycheck, into an account to reimburse you for qualified medical, dental, and vision expenses for yourself and your eligible dependents that are not reimbursed from insurance or any other source. The money you put into your account is not considered taxable income, allowing you to save money by paying less Federal, State and FICA taxes.

View an expanded list of eligible medical expenses and information about using the benefits debit card to pay for these expenses directly from your flexible spending account at www.flores247.com. An example of eligible expenses include: prescription medicines and drugs, hearing aids, orthopedic goods, prosthetic devices, doctors, dentists, orthodontics, osteopaths, chiropractors, optometrists, ophthalmologists, opticians, eyeglasses, and over-the-counter medicines and drugs (As of January 1, 2011 some over-the-counter items will require a doctor's prescription in order to be eligible under the FSA.)

### Use-it or lose-it benefit

IRS has modified the use-it or lose-it rule for health care flexible spending accounts FSAs) to allow a limited carryover up to $640 of unused funds. We have amended our FSA plan to allow members to carryover up to $640 of unused funds effective with our 2022 plan year and beyond.

IRS regulations require that Flexible Spending Account elections be made each year. Your election from last year will not automatically rollover. All employees are eligible to participate in the FSA. If you are electing FSAs for 2024, please make sure you complete the appropriate form and return it to Human Resources within 30-days of your date of hire.

### Example of tax savings

| | No FSA | FSA |
|---|---|---|
| Annual Income | $30,000 | $30,000 |
| FSA Contributions | $0 | $1,000 |
| Taxable Pay (Based on 30%) | $30,000 | $29,000 |
| Minus Taxes | $9,000 | $8,700 |
| Take Home Pay | $21,000 | $20,300 |
| Minus (Medical/Dental/Vision/Costs) | $1,000 | $0 |
| Total Take Home Pay | $20,000 | $20,300 |
| What You Saved | $0 | $300 |

**If you enroll in any of the below plans, you may enroll in the traditional health care FSA!**

**HNE HMO Essential 1000**
**HNE HMO Essential 2000**
**HNE HMO Essential 3000**

## SUMMARY OF LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

If you participate in a qualified high deductible plan and contribute to a Health Savings Account (HSA), the IRS prohibits you and your spouse from enrolling in a traditional medical flexible spending account (FSA). A Limited Purpose Flexible Spending Account (LPFSA) offers great tax savings on eligible expenses and does not interfere with your spouse's HSA eligibility. Use your LPFSA for this year's expected **dental and vision expenses** and allow your HSA to accumulate for future health care expenses. Just like a traditional health care FSA, you choose the amount to contribute to your LPFSA for the year (up to the maximum $3,200). Payroll deductions are made on a pre-tax basis, lowering your taxable income and saving you money.

**If you enroll in the HNE HMO Wise Max HDPH plan and contribute to a Health Savings Account, you can only enroll in the LPFSA!**

Eligible Dental expenses include:

- Orthodontia
- Cleanings
- Fillings

Eligible Vision expenses include:

- Eye exams, eyeglasses
- Contact lenses
- Laser vision correction surgery

Ineligible expenses include cosmetic procedures, warranties, pre-payment of services not yet rendered.

## SUMMARY OF DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

All Employees are eligible to elect to set aside a portion of their salary, up to $5,000, to pay for eligible dependent care expenses for children under age 13 or children who are physically or mentally incapable of self-care and, in some cases, elder care, so that you and your spouse, if you are married – can work, look for work, or attend school full-time.

The Dependent Care Flexible Spending Plan Year runs from July 1st through June 30th each year. Copies of the Dependent Care Flexible Spending Plan Summary are available in the Human Resources Office.

**You can participate in the dependent care FSA no matter which medical plan you enroll in, or if you waive the medical altogether!**

# Value-added Programs and Services

When you need help with work, home, personal or family issues, we offer value-added programs and services that are of no charge when you use it.

**No matter what's going on in your life, ComPsych® GuidanceResources® is here to help.**
Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a no-cost, company-sponsored benefit available to you and your dependents that offers confidential support, resources and information to get through life's challenges.

**Confidential Counseling on Personal Issues**
Your Employee Assistance Program (EAP) is a confidential counseling service to help address the personal issues you face. This service, staffed by experienced clinicians, is available by calling a toll-free phone line 24 hours a day, seven days a week. You'll receive up to three telephonic counseling sessions per issue, at no charge. Call any time with personal concerns, including:

- Relationships
- Problems with your children
- Substance abuse
- Stress, anxiety or depression
- Job pressures
- Marital conflicts
- Grief and loss
- Empty-nesting

**Information, Referrals and Resources for Work-Life Needs**
Whether you are a new parent, a caregiver for an elder, sending a child off to college, buying a car or doing home repairs, you're bound to have questions or need resource referrals. Our work-life specialists will help you sort out the issues and provide you with information based on your specific criteria. You'll receive a personalized reference package containing helpful resources and literature, covering areas such as:

- Finding child or elder care
- Planning for college
- Relocating to a new city
- Planning a party
- Shopping for the right gift
- Finding pet care
- Purchasing a car
- Home repair
- Adopting a child
- Planning a vacation

**Legal Information, Resources and Consultation**
When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, we can refer you to a qualified attorney in your area for a free initial consult at no cost and a 25% reduction in customary legal fees thereafter. Call any time with legal issues, including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

**Financial Information, Resources and Tools**
Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

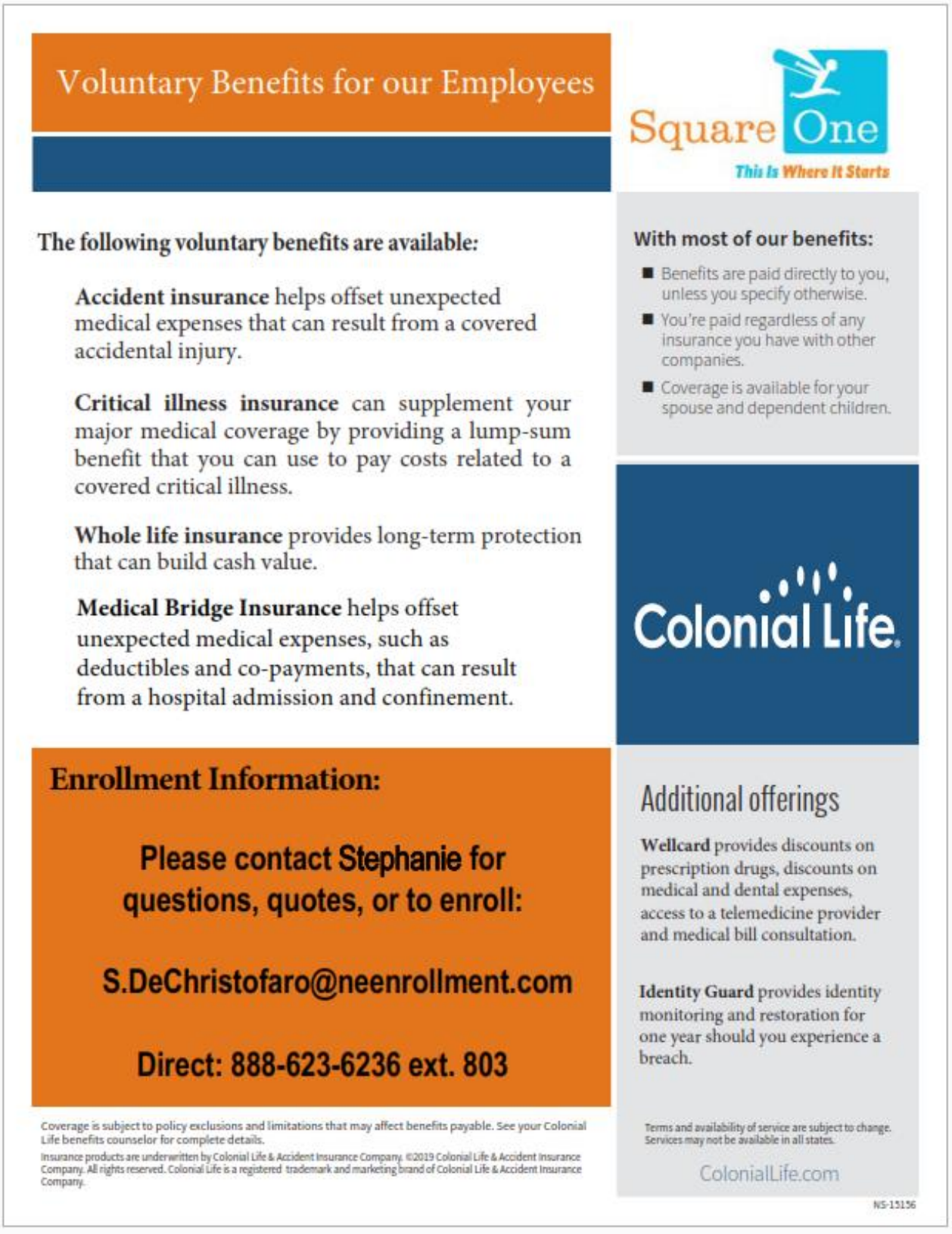
- Getting out of debt
- Retirement planning
- Credit card or loan problems
- Saving for college
- Tax questions
- Estate planning

**Online Information, Tools and Services**
GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial matters. Each time you return, you will receive personalized, relevant information based on your individual life needs. You can:

- Take an online Health Risk Assessment
- Subscribe to timely e-newsletters on topics of interest
- Review in-depth HelpSheets on a variety of topics
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools

**Call 1-888-682-4824 to speak with a specialist**
**Online: guidanceresources.com**
**Your company username: LFGsupport**
**Password: LFGsupport1**

# Voluntary Benefits with Colonial Life



# Benefit Resource Center

# Important Legal Notices Affecting Your Health Plan Coverage

## THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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.

## NEWBORNS ACT DISCLOSURE - FEDERAL

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

## NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

# PATIENT PROTECTION MODEL DISCLOSURE

Health New England generally requires 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 Health New England Member Services at 800-310-2835.

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

You do not need prior authorization from Health New England or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Health New England Member Services at 800-310-2835.

# STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

### Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

### Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

### Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a

case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

### Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## CONTACT INFORMATION

### CONTACT INFORMATION

Questions regarding any of this information can be directed to:
John Christophy
1095 Main Street, 2nd Floor
Springfield, Massachusetts United States 01103
413-858-3162
jchristophy@startatsquareone.org

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

# Your Information. Your Rights. Our Responsibilities.

*Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.*

## Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

## Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## Your Rights

**When it comes to your health information, you have certain rights.**

This section explains your rights and some of our responsibilities to help you.

**Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

**Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

- In these cases we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

## Our Uses and Disclosures

**How do we typically use or share your health information?**
We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**
We can use your health information and share it with professionals who are treating you.
*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Pay for your health services**
We can use and disclose your health information as we pay for your health services.
*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**
We may disclose your health information to your health plan sponsor for plan administration.
*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**Run our organization**
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

**How else can we use or share your health information?**
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

**Help with public health and safety issues**
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**
We can use or share your information for health research.

**Comply with the law**
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
- We can share health information about you with organ procurement organizations.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

## Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

## Important Notice from Square One About Your Prescription Drug Coverage and Medicare

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Health New England and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Health New England has determined that the prescription drug coverage offered by the Square One health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

## When Can You Join A Medicare Drug Plan?

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

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

## What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Health New England coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Health New England coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

## For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

| | |
|---|---|
| Date: | July 1, 2024 |
| Name of Entity/Sender: | Square One |
| Contact--Position/Office: | John Christophy, Human Resources Manager |
| Address: | 1095 Main Street, 2nd floor, Springfield, MA 01103 |
| Phone Number: | 413-858-3162 |

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

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

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

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

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

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**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, 2024. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program<br>Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |

| | |
|---|---|
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program<br>(HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

| GEORGIA – Medicaid | INDIANA – Medicaid |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website:<br>https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |

| MINNESOTA – Medicaid | MISSOURI – Medicaid |
|---|---|
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |

| NEVADA – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |

| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
|---|---|
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

## Paperwork Reduction Act Statement

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

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

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

# Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

## PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

## 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 in your geographic area.

## Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

## Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

## When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

## What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

## How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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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.

# 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<br>Square One | | 4. Employer Identification Number (EIN)<br>04-2103822 |
| 5. Employer address<br>1095 Main Street, 2nd Floor | | 6. Employer phone number<br>413-858-3162 |
| 7. City<br>Springfield | 8. State<br>MA | 9. ZIP code<br>01103 |
| 10. Who can we contact about employee health coverage at this job?<br>John Christophy | | |
| 11. Phone number (if different from above) | 12. Email address<br>jchristophy@startatsquareone.org | |

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

- As your employer, we offer a health plan to:
  - ☑ All employees. Eligible employees are:

    Full time employees working 30 or more hours per week
    Part time employees working 21 or more hours per week

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse – defined as your husband or wife;
    Dependent – defined as your child up to age 26, regardless of student status;
    Disabled Dependents – defined as your child over the age of 26, including eligible children of your spouse.

  - ☐ We do not offer coverage.

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

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

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

*This guide is provided to you by*

Square One

*This Is Where It Starts*

&

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(855) 874-0123

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