BROAD REACH
HEALTHCARE

# Something in Common

## *Health Plan Renewal & Open Enrollment Edition*

**June 2023**

**Group Insurance Open Enrollment**



**Changes to Learn About Include:**

- ✓ **Employee Contributions to both HMO Plans DROP!**
  - ❖ **HMO $3,650 plan DECREASE $2.88 - $70.51 per week**
  - ❖ **HMO $3,500 plan DECREASE $0.93-$107.86 per week**

  *Exact amount of change depends on single/dependent/family plan – see detail on pages 4 & 5*

- ✓ **Key Plan Design Changes:**
  - ➢ HMO & PPO $3,650: Added MGBHP "Easy Tier"
  - ➢ **HMO $3,000 increased deductible** to $3,500/ $7,000
  - ➢ **BUT Broad Reach HRA Funding Increased** to $2,000/ $4,000 for a **net deductible DECREASE**

- ✓ **Health Reimbursement Account (HRA):** If you are in the HMO $3,500 plan, the **HRA pays more in 2023**:
  - the last $2,000 (individual) or
  - The last $4,000 (Plus Spouse, Plus Child(ren), or Family) of deductible expenses.
- ✓ **Health Savings Account (HSA):** If you are in the HMO $3,650 or PPO $3,650, you can use the HSA to set aside additional pre-tax dollars to pay for your healthcare expenses. *See pages 8-9 for details.*
- ✓ **Delta Dental**– **Decrease in employee contributions** of $0.35-$0.89 per week. *See detail on page 13.*

**Continuing Features:**

- ✓ **"On Demand" Urgent Care** – No Appointment Needed!
- ✓ **Enhanced Perks** – Still a free pair of sneakers … and more!
- ✓ **Flexible Spending Account** (FSA) – Helps manage copays with pre-tax dollars. Carrier Change- HRCTS will administer our FSA, HRA, and HSA for 2023
- ✓ **Robust Options & Other Extras**

**In-Person Insurance / Benefits Fair Friday, 05/05/2023 from 11AM-3:30PM**
**Liberty Commons Center Courtyard**
**Info ■ Lunch ■ Raffle**

# Do I Need to Take Action?

## YES, if…

**-> You want to make a change in medical or dental.**

**-> You want to enroll or continue in the Health FSA or Dependent Care FSA,** you **MUST** submit an enrollment form

**-> If you want to enroll in the Health Savings Account (HSA)** you **MUST** submit an enrollment form. ***Even if you are not adding to the company contribution, you must submit an HSA enrollment form.***

## But NO, if…

**You want to just stay enrolled in the most similar plan as of 6/1/23 or carry your dental forward as it has been and make no HSA or FSA contribution.**

## How?

Links to these forms are on the employee portal of broadreachhealth.org/employee-portal. Paper copies are in the LC + VIC break rooms and BRH admin office. They can also be mailed USPS on request.

**Submit the form by email** to HRHelp@BroadReachHealth.org **or to a drop box at LC lobby, VIC RSA office, or BRH admin office**.

All enrollment, change and/or waiver forms **MUST** be submitted to Human Resources by 5/10/2023 or completed at the in-person benefits fair on 5/5/2023.

HRHelp@BroadReachHealth.org

## For the June 1st, 2023 – May 31st, 2024 Plan Year, the following benefits are available to all benefit eligible employees:

### MEDICAL COVERAGE

**Medical plans continue through Mass General Brigham Health Plan!**

- **The are three plan choices with varying deductibles**:
  - HMO $3,500, HMO $3,650 HSA 10%, PPO $3,650 HSA 10%
  - HMO plans require a primary care physician and use of in-network providers only
  - PPO plans allow access to both in and out of network providers with differing member out of pocket cost depending on the network status of the provider you choose
- **The MGBHP medical program continues to tier certain services on the HMO $3,500 and now the HMO $3,650 and PPO $3,650 plans based on which provider you go to.**
  - Services subject to tiering include: Inpatient medical services, outpatient diagnostic imaging and X-ray services, outpatient hi-tech imaging services, outpatient surgery, outpatient short term rehabilitation services.
  - Lower costing hospital providers include, but are not limited to: Cape Cod Hospital, Falmouth Hospital, Beth Israel Deaconess Medical Center (Plymouth location), South Shore Hospital.
  - Higher costing hospital providers include, but are not limited to: Mass General Hospital, Boston Medical Center, Boston Children's Hospital, Tufts Medical Center, Brigham and Women's Hospital
  - You can confirm which tier your provider falls into by logging on to massgeneralbrighamhealthplan.org or calling MGBHP at 866-414-5533
- **Health Reimbursement Account (HRA):** You will automatically be enrolled in the HRA through HRCTS if you elect the HMO $3,500 medical plan.
  - Broad Reach Healthcare will reimburse employees:
    - Individual: The last $2,000 of deductible expenses
    - Individual Plus Spouse, Plus Child(ren) or Family: The last $4,000 of deductible expenses

    *(See page 10 for more details)*
- **Health Savings Account (HSA):** You will be eligible to elect the HSA if you enroll in the HMO $3,650 HSA 10% or PPO $3,650 HSA 10%
  - Broad Reach Healthcare will contribute the below amounts to your HSA:
    - Individual: $250
    - Individual Plus Spouse, Plus Child(ren) or Family: $500

    *(See pages 8-9 for more details)*

### DENTAL COVERAGE

- Dental Coverage continues to be offered through Delta Dental.
- No changes to benefits and a decrease to employee contributions!

### FLEXIBLE SPENDING ACCOUNTS (FSA)

- If you want to participate in this plan you must enroll during open enrollment. Your current annual FSA election amount does not continue automatically.

## Annual Open Enrollment— through May 10th!

Open Enrollment is the only time during the year that you can make changes to your medical and / or dental election without experiencing a "Qualifying Event". Medical and Dental coverage, and any changes, are effective June 1, 2023.

### OPEN ENROLLMENT CHANGES CAN INCLUDE:

- Enrolling in the Medical, Dental, Flexible Spending, and /or Health Savings Account plans
- Dropping / Waiving your Medical and / or Dental coverage
- Adding / dropping coverage for your dependents

**Enrollment forms must be returned to Barbara Madler by: May 10, 2023**

Mass General Brigham Health Plan

# Medical & Prescription Drug Benefits

Medical Coverage continues through MGB Health Plan. MGB Health Plan is committed to changing health care through outstanding service and other benefits. Under the HMO plans, you receive benefits when you use a network provider and obtain appropriate referrals. You will not have coverage (except for emergencies) if you use out of network services**. You will need a Primary Care Provider (PCP) to coordinate care. Referrals to specialists are required.** All services except for preventive care are subject to the deductible. Some services require a copay or coinsurance after the deductible. You must pay all provider costs up to the deductible amount before the plan begins to pay. However, you can use your HSA funds to offset initial out of pocket expenses.

**If you are currently enrolled in the HMO $3,650 HSA Plan 10% your coverage will automatically carry over effective 6/1/2023 unless you submit a change or waiver form to Human Resources by 5/10/2023.**

## Find Doctors Today

MGB Health Plan offers access to a full range of primary and specialty physicians and hospitals through a broad network of providers across Massachusetts. Members can visit massgeneralbrighamhealthplan.org/find-provider to find a primary care provider or other network providers near your home or work, or call 866-414-5533.

| HMO $3,650 HSA Plan 10% | | |
|---|---|---|
| | In Network | |
| **Deductible** | | |
| Individual | $3,650 | |
| Family | $7,300 | |
| **Out of Pocket Maximum** | | |
| Individual | $6,650 | |
| Family | $13,300 | |
| **Office Visit** | | |
| Preventive Care | $0 | |
| PCP Office Visits | $0 after deductible | |
| Specialist Visits | $0 after deductible | |
| Mental Health Visit | $0 after deductible | |
| Emergency Room | $0 after deductible | |
| Urgent Care | $0 after deductible | |
| **Outpatient Medical Care:** | **Tier 1 (Lower Cost)** | **Tier 2 (Higher Cost)** |
| Lab | 10% coinsurance after deductible | |
| X-Ray | 10% coinsurance after deductible | 30% coinsurance after deductible |
| High-Tech Imaging (CT, MRI, PET) | 10% coinsurance after deductible | 30% coinsurance after deductible |
| **Inpatient / Outpatient Care:** | **Tier 1 (Lower Cost)** | **Tier 2 (Higher Cost)** |
| Inpatient Hospital | 10% coinsurance after deductible | 30% coinsurance after deductible |
| Day Surgery | 10% coinsurance after deductible | 30% coinsurance after deductible |
| **Prescription Drugs:** | | |
| **Retail Rx Copay:** Low Cost Generic / Generic / Preferred Brand / Non-preferred Brand | | |
| Copays | $5 / $25 / $50 / $100 / $150 / $200 | |
| **Mail Order Rx Copay:** Low Cost Generic / Generic / Preferred Brand / Non-preferred Brand | | |
| Copays | $10 / $50 / $100 / $300 | |

| **Weekly Conributions** | **through 5/31/23** | **effective 6/1/23** | | | |
|---|---|---|---|---|---|
| | **Allways HMO 3650 HSA** | **MGB HMO 3650 HSA** | **Weekly Savings** | **Annual Savings** | |
| Individual | $51.88 | $49.00 | -$2.88 | -$149.76 | -6% |
| Individual + Spouse | $195.40 | $127.00 | -$68.40 | -$3,556.80 | -35% |
| Individual + Child(ren) | $190.51 | $120.00 | -$70.51 | -$3,666.52 | -37% |
| Full Family | $214.54 | $145.00 | -$69.54 | -$3,616.08 | -32% |



*The above is an overview of benefits. A detailed description of all benefits is available in the Summary of Benefits and Coverage and Subscriber Certificate.*

Mass General Brigham Health Plan

# Medical & Prescription Drug Benefits

Medical Coverage continues through MGB Health Plan. MGB Health Plan is committed to changing health care through outstanding service and other benefits. Under the HMO plans, you receive benefits when you use a network provider and obtain appropriate referrals. You will not have coverage (except for emergencies) if you use out of network services**. You will need a Primary Care Provider (PCP) to coordinate care. Referrals to specialists are required.** Some services such as Labs, X-rays, Inpatient Hospitalization and Day Surgery are subject to the deductible and require a copay or coinsurance. However, your HRA will pay the last $2,000 or last $4,000 of your deductible, dependent on your enrollment tier.

**If you are currently enrolled in the HMO $3,000 plan your coverage will automatically carry over to the HMO $3,500 plan effective 6/1/2023, unless you submit a change or waiver form to Human Resources by 5/10/2023.**

## Find Doctors Today

MGB Health Plan offers access to a full range of primary and specialty physicians and hospitals through a broad network of providers across Massachusetts. Members can visit massgeneralbrighamhealthplan.org/find-provider to find a primary care provider or other network providers near your home or work, or call 866-414-5533.

| HMO $3,500 HRA Plan | | | |
|---|---|---|---|
| | In Network | | |
| **Deductible** | **Before HRA** | **HRA Funding** | **After HRA** |
| Individual | $3,500 | $2,000 | $1,500 |
| Family | $7,000 | $4,000 | $3,000 |
| **Out of Pocket Maximum** | | | |
| Individual | $8,150 | | |
| Family | $16,300 | | |
| **Office Visit** | | | |
| Preventive Care | $0 | | |
| PCP Office Visits | $40 copay | | |
| Specialist Visits | $55 copay | | |
| Mental Health Visit | $40 copay | | |
| Emergency Room | $250 after deductible | | |
| Urgent Care | $55 copay | | |
| **Outpatient Medical Care:** | **Tier 1 (Lower Cost)** | **Tier 2 (Higher Cost)** | |
| Lab | $100 copay after deductible | | |
| X-Ray | $125 copay after deductible | $250 copay after deductible | |
| High-Tech Imaging (CT, MRI, PET) | $225 copay after deductible | $750 copay after deductible | |
| **Inpatient / Outpatient Care:** | **Tier 1 (Lower Cost)** | **Tier 2 (Higher Cost)** | |
| Inpatient Hospital | $1,000 copay after deductible | $2,000 copay after deductible | |
| Day Surgery | $750 copay after deductible | $2,000 copay after deductible | |
| **Prescription Drugs:** | | | |
| **Retail Rx Copay:** Low Cost Generic / Generic / Preferred Brand / Non-preferred Brand | | | |
| Copays | $5 / $25 / $50 / $100 / $150 / $200 | | |
| **Mail Order Rx Copay:** Low Cost Generic / Generic / Preferred Brand / Non-preferred Brand | | | |
| Copays | $10 / $50 / $100 / $300 | | |

| **Weekly Conributions** | **through 5/31/23** | **effective 6/1/23** | | | |
|---|---|---|---|---|---|
| | **Allways HMO 3000** | **MGB HMO 3500** | **Weekly Savings** | **Annual Savings** | |
| Individual | $88.93 | $88.00 | -$0.93 | -$48.36 | -1% |
| Individual + Spouse | $233.60 | $148.00 | -$85.60 | -$4,451.20 | -37% |
| Individual + Child(ren) | $227.76 | $140.00 | -$87.76 | -$4,563.52 | -39% |
| Full Family | $277.86 | $170.00 | -$107.86 | -$5,608.72 | -39% |



*The above is an overview of benefits. A detailed description of all benefits is available in the Summary of Benefits and Coverage and Subscriber Certificate.*

Mass General Brigham Health Plan

# Medical & Prescription Drug Benefits

Medical Coverage continues through MGB Health Plan. MGB Health Plan is committed to changing health care through outstanding service and other benefits. Under the PPO plans, you have access to in and out of network doctors. All services except for preventive care are subject to the deductible. You must pay all provider costs up to the deductible amount before the plan begins to pay. However, you can use your HSA funds to offset initial out of pocket expenses.

**If you are currently enrolled in the PPO $3,650 HSA Plan 10% your coverage will automatically carry over effective 6/1/2023 unless you submit a change or waiver form to Human Resources by 5/10/2023.**

## Find Doctors Today

MGB Health Plan offers access to a full range of primary and specialty physicians and hospitals through a broad network of providers across Massachusetts. Members can visit massgeneralbrighamhealthplan.org/find-provider to find a primary care provider or other network providers near your home or work, or call 866-414-5533.

| PPO $3,650 HSA Plan 10% | | |
|---|---|---|
| | In Network | Out of Network |
| **Deductible** | | |
| Individual | $3,650 | $7,300 |
| Family | $7,300 | $14,600 |
| **Out of Pocket Maximum** | | |
| Individual | $6,650 | $13,300 |
| Family | $13,300 | $26,600 |
| **Office Visit** | | |
| Preventive Care | $0 | |
| PCP Office Visits | $0 after deductible | |
| Specialist Visits | $0 after deductible | |
| Mental Health Visit | $0 after deductible | |
| Emergency Room | $0 after deductible | |
| Urgent Care | $0 after deductible | |
| **Outpatient Medical Care:** | **Tier 1 (Lower Cost)** | **Tier 2 (Higher Cost)** |
| Lab | 10% coinsurance after deductible | |
| X-Ray | 10% coinsurance after deductible | 30% coinsurance after deductible |
| High-Tech Imaging (CT, MRI, PET) | 10% coinsurance after deductible | 30% coinsurance after deductible |
| **Inpatient / Outpatient Care:** | **Tier 1 (Lower Cost)** | **Tier 2 (Higher Cost)** |
| Inpatient Hospital | 10% coinsurance after deductible | 30% coinsurance after deductible |
| Day Surgery | 10% coinsurance after deductible | 30% coinsurance after deductible |
| **Prescription Drugs:** | | |
| **Retail Rx Copay:** Low Cost Generic / Generic / Preferred Brand / Non-preferred Brand | | |
| Copays | $5 / $25 / $50 / $100 / $150 / $200 | |
| **Mail Order Rx Copay:** Low Cost Generic / Generic / Preferred Brand / Non-preferred Brand | | |
| Copays | $10 / $50 / $100 / $300 | |

| Weekly Deductions | PPO $3,650 |
|---|---|
| Employee | $114.00 |
| Employee + Spouse | $298.00 |
| Employee + Child(ren) | $290.00 |
| Family | $385.00 |



*The above is an overview of benefits. A detailed description of all benefits is available in the Summary of Benefits and Coverage and Subscriber Certificate.*

# Health Reimbursement Account (HRA)

A Health Reimbursement Account (HRA) is offered through HRCTS to compliment your medical plan. The enrollment in the HRA is automatic. For the 2023/2024 plan year, Broad Reach Healthcare will pay a portion of the deductible for all employees enrolled in the **HMO $3,500 plan. An HRA is an arrangement under which an employer pays for / reimburses eligible employees for certain medical expenses up to a specific amount per year. The HRCTS HRA will automatically reimburse the last $2,000 of the deductible for individual coverage, and the last $4,000 of the deductible for individual and spouse, individual and child(ren) and family coverage.** *When the employee is reimbursed by HRCTS, the employee must still pay the provider's bill from that reimbursement!*

| **HRA Plan Design - Employer Pays Some of the Deductible** | |
|---|---|
| Individual | $2,000 (available towards the last $2,000 of the Deductible) |
| Individual Plus Spouse, Individual Plus Child(ren) & Family | $4,000 (available towards the last $4,000 of the Deductible) |


**Example 1**: You are enrolled in single coverage on the HMO $3,500 plan and have an inpatient hospital stay. The cost of the visit is $6,000 and is subject to the deductible. The following is a breakdown of how payment will be handled:

- Single Deductible: $3,500
- Employee Responsibility: First $1,500
- Broad Reach Healthcare HRA Deductible Funding: Second $2,000
- Remaining Balance of $2,500: paid 100% by the Plan

**Example 2**: You are enrolled in family coverage (HMO) and have an inpatient hospital stay. The cost of the visit is $10,000 and is subject to the deductible. The following is a breakdown of how payment will be handled:

- Family Deductible: $7,000
- Employee Responsibility: First $3,000
- Broad Reach Healthcare HRA Deductible Funding: Last $4,000
- Under a family contract, you are capped at a $7,000 per family deductible. The remaining balance of $3,000 will be covered 100% by the Plan

**How Does Your HRA Work?**

1. **Visit Provider**
   - Visit your provider and present your insurance ID card.
2. **Provider Sends Claims to MGB Health Plan**
   - Your provider will send claims to MGB Health Plan for processing. These claims are then sent to HRCTS and appear in your account.
3. **Pay Expenses Out-Of-Pocket**
   - You will then be reimbursed for eligible claims until your HRA funds are gone.

**Note –** the HRA reimburses the last $2,000 of your deductible for individual coverage and the last $4,000 of the deductible for individual and spouse, individual and child(ren) and family coverage. Once you pay 100% of all costs subject to the deductible, the HRA will automatically reimburse you for eligible expenses.

HRC TOTAL SOLUTIONS

# Healthcare Flexible Spending Account (FSA)

## NEED HELP WITH DEDUCTIBLES AND COPAYS?

They can be hard enough to understand, but even harder to pay!

The Flexible Spending Account (FSA) is an optional plan where employees set aside pre-tax money to be used for eligible medical expenses like copays and deductibles. Administrative costs are covered by the company, and participants receive debit cards to use for transactions at the point of sale (such as pharmacy and doctor's offices) or you may submit bills to be reimbursed.

## IMPORTANT INFORMATION

**How do I access my account?**

You can access your online account with HRCTS by visiting: www.hrcts.com . Click on the Log In button and select Create username and password to create unique HRCTS credentials.

**If you who want to enroll or continue in the Health FSA or Dependent Care FSA, you MUST submit an enrollment form and return to Human Resources by 5/10/2023.**

FSA is for HMO $3,500 participants only!

## MEDICAL FSA

- Employees are eligible to contribute on a pre-tax basis for qualified medical, dental, and vision expenses up to **$3,050.**
- Funds can be used for out of pocket costs such as copayments, deductibles, dental co-insurance, glasses, contacts, and other healthcare related items.

***If you will be in HMO $3650 or PPO $3650, you make what would have been your Medical FSA contributions through HSA (see next page).***

## DEPENDENT CARE

- Employees are eligible to contribute up to $5,000 on a pre-tax basis for qualified dependent care expenses tax-free.
- Funds can be used for out of pocket costs such as daycare, preschool and elderly care.
- To qualify for a DCRA, the IRS requires that the dependent care is necessary for you and your spouse to work, look for work or attend school full-time, along with other requirements.


## WILL I RECEIVE A DEBIT CARD?

- If you have enrolled in a healthcare account, you will receive a HRCTS Reimbursement Account Card.
- The card will be mailed to your home address.
- If you need additional cards for eligible healthcare dependents, you can order cards through your online account.

## HOW DOES YOUR FSA WORK?

1. **Visit Medical/Dental/Vision/Rx Provider**
   - Visit your provider and present your insurance ID card.
2. **Provider Bills for Services**
   - Your provider will send claims to MGB Health Plan for processing or may bill you directly. ***Wait until bill is received to make a payment.***
3. **Pay Your Provider**
   - Use your HRCTS Reimbursement Account Card or pay online using the HRCTS member portal or mobile app.
4. **Qualify Your Expense**
   - In some instances, you may be asked to provide an itemized receipt or explanation of benefits (EOB) to verify that an expense is eligible.

HRC TOTAL SOLUTIONS

# HEALTH SAVINGS ACCOUNT

**The HSA allows you to save up to $3,850 as an individual & $7,750 as a family on a pre-tax basis to pay for qualified expenses**

**(2023 Limits for Employer & Employee contributions combined)**

**Qualified Expenses include*:**

Deductibles

Copays

Coinsurance

Acupuncture

Hearing Aids

Chiropractic Care

Dental Costs

Vision Costs

Contact Lenses

Glasses/Frames

Lasik

Over the counter medications (prescription required)

Prescription Sunglasses

Cobra Premiums

*This is a sample of qualified expenses. For a full list you can view IRS publication 502

For more information on your HSA please visit HealthEquity:

healthequity.com

**What is a Health Savings Account (HSA)?**

- A Health Savings Account (HSA) is a tax-advantage medical savings account that works with a qualified high deductible health plan. Both the HMO $3,650 HSA 10% or the PPO $3,650 HSA 10% are qualified medical plans. The HSA allows you to contribute funds on a pre-tax basis to save for current and future medical expenses – putting you in charge of how you spend your health care dollars.

**Broad Reach Healthcare will contribute to your HSA!**

BR contributions will be made each pay period (it's not a lump sum)!

  - Individual: $250 annually ($4.81/wk)
  - Individual Plus Spouse, Plus Child(ren) or Family: $500 annually ($9.61/wk)

- In addition to your employer contribution, you can contribute:
  - Individual: $3,600
  - Individual Plus Spouse, Plus Child(ren) or Family: $7,250
  - A "catch-up" contribution (if over age 55): $1,000

  Note: HSA Elections may need to be pro-rated based on hire date

**How a Health Savings Account works:**

- **Save it:** An HSA allows you to start saving for health expenses by contributing funds tax-free. There are three ways you can save: Pre-tax contributions, tax-free interest and investment earnings, and tax-free payments for qualified expenses.
- **Use it:** As you save money into your HSA, you can use your debit card to pay for things like prescriptions, deductibles and copays – as long as it is a qualified healthcare expense.
- **Never lose it:** Unused funds roll over from year to year, and unlike an FSA, there are no "use-it-or-lose-it" rules. So if you change jobs, change health care plans or retire it does not matter, it is yours…for life!

**Are you eligible for an HSA?**

- To be eligible for an HSA you:
  - Must be enrolled in a qualified high deductible health plan
    - The HMO $3,650 HSA 10% or the PPO $3,650 HSA 10% are both qualified plans
  - Cannot be claimed as a dependent on another person's tax return
  - Cannot be enrolled in Medicare
  - Cannot have other non-qualified healthcare (including VA benefits)
  - **Cannot be enrolled or have a balance in an FSA (including through your spouse)**

**PLEASE NOTE: HSA's are governed by the IRS and have many tax implications. Anyone joining the HSA is strongly encouraged to review their personal situation with their tax advisor. See page 9 for additional considerations.**



*~ HSA Limits listed above are set by the IRS and are for the 2023 calendar year*

HRC TOTAL SOLUTIONS

# HEALTH SAVINGS ACCOUNT - CONTINUED

| Is an HSA right for you? | |
|---|---|
| **Advantages** | **Things to Consider** |
| Triple Tax Advantage<br>• All money deposited goes in tax free<br>• Money grows tax free<br>• Tax-free spending for qualified expenses | Unexpected health care costs may exhaust savings |
| Money not used rolls over to the next year – works just like a regular savings account – NOT "use it or lose it"! | Unable to contribute after age 65 (saved funds can still be used) |
| Balances above $2,000 can be invested | Penalties for non-compliance (up to 20%) |
| Account is owned by you and is portable | Recordkeeping |
| No penalty after age 65 for non-qualified expenses | Can't be enrolled in FSA (even through a spouse) |
| While there is an annual contribution limit, there is no limit on the account balance | Mid-year changes may impact contribution limits |

## IMPORTANT RULES AND REGULATIONS

- **Talk with your tax advisor to understand your individual/family tax situations and how they relate to HSA contributions and withdrawals. IRS Publication 969 governs these rules.** Save your receipts! The IRS may request validation of any HSA withdrawals you have made.
- Because the account is owned by you, you are solely responsible for the confirmation of expenses and are not required to send receipts to their employer or administrator (must save them in case of IRS audit!).

## BELOW ARE A FEW SCENARIOS TO BE AWARE OF:

**Retiree / Medicare Lookback**

If you enroll in Medicare after age 65, there may be an impact on HSA contributions. When you sign up for Medicare, you will be enrolled retroactively for up to 6 months of benefits, or back to your 65th birthday if that has taken place within the last six months. To avoid a tax penalty and income taxes, you should stop contributing to your HSA at least 6 months before you apply for Medicare. However, you do have the option to decline the 6 month retroactive enrollment but must be very specific with Social Security when enrolling. More information can be found at www.medicare.gov.

**Adult child dependents:**

- ACA rules define a dependent to age 26 and does not require them to be a tax dependent
- The IRS rules go to age 19 or 24 if a F-T Student and they must be a tax dependent
- A scenario could exist where an employee's adult dependent(s) are covered on the medical plan, but the employee's HSA cannot be used to cover medical expenses for those dependents
- Your child would need to establish a separate HSA and use their own pre-tax dollars or you could contribute post tax dollars to their account. Since it is a family election the child is eligible to contribute up to the family HSA max.

**Child Dependents of Divorced Parents**

- Under some circumstances, a child of divorced/separated parents can be treated as a dependent of both
- In this case, each parent can use their HSAs to pay for qualified expenses for the child, even if the other parent claims the child as a dependent

The parent can use HSA funds to pay qualifying expenses for the child if:

- the child is in the custody of one or both parents for more than half the year;
- the child receives more than half of his or her support during the year from his or her parents;
- the child's parents: are legally divorced/separated; are separated under a written agreement; always lived apart during the last six months of the year
- this does not apply if the child's exemption is being claimed under a multiple support agreement

Mass General Brigham Health Plan

# Easy Tier Hospital Network Plan

The Easy Tier Hospital Network plans give you the same comprehensive, high-quality coverage as you've come to expect from MGB Health Plan. This plan divides their hospital network into higher and lower cost tiers. With Easy Tier, you always have full access to their broad hospital network, but your costs —including copayments, coinsurance, and deductibles—will vary depending on which hospitals you choose. This plan does not tier primary care providers or specialists.

## Why Easy Tier?

Easy Tier's hospital tiering can help save you money. You choose where to receive care, so you have more control over your own out-of-pocket costs. The tiering is simple and straightforward:

- **Tier 1, lower cost -** Most hospitals, hospital-affiliated facilities, and freestanding facilities fall into the lower cost tier, including popular local hospitals like Cape Cod Hospital, Falmouth Hospital, Beth Israel Deaconess Medical Center (Plymouth location) and South Shore Hospital.
- **Tier 2, higher cost -** Higher cost sharing only applies to the following hospitals and some affiliated facilities:
  - Beth Israel Deaconess Medical Center (Boston)
  - Boston Children's Hospital
  - Boston Medical Center
  - Brigham and Women's Hospital
  - Dana Farber Cancer Institute
  - Massachusetts Eye and Ear Infirmary
  - Massachusetts General Hospital
  - New England Baptist Hospital
  - Tufts Medical Center
  - UMASS Memorial Medical Center

## How Does Easy Tier Work?

With Easy Tier, your cost sharing depends on whether you go to a Tier 1 (lower cost) or Tier 2 (higher cost) location for the following services:

- Inpatient medical services
- Outpatient diagnostic imaging and X-ray, including ultrasound
- Outpatient high-tech radiology (CT Scans, MRIs, etc.)
- Outpatient surgery
- Outpatient short-term rehabilitation (cardiac, physical, occupational, and speech therapy)

***You will pay less for these services at a Tier 1 location, and you will pay more at a Tier 2 location.***

**Visit massgeneralbrighamhealthplan.org to learn more about the Easy Tier Hospital Network plans and to see a complete list of Tier 1 (lower cost) and Tier 2 (higher cost) facilities.**

Mass General Brigham

## On Demand Urgent Care ■ Without Leaving Your Home
## Exclusively for MGB Health Plan Members!

On Demand offers convenient, high-quality urgent care services for minor illnesses and injuries that are available – virtually – anytime and anywhere in the United States.

Connect to providers through a secure, interactive video visit on their tablet, smart phone, or computer. This service is for adults and children age 2 and older. Anyone under the age of 18 will need to be accompanied by an adult during their virtual visit.

Providers can diagnose, offer treatment and prescribe medication, if medically necessary, for many health conditions, including:

- Upper respiratory infections/flu/cough/cold
- Sinus symptoms
- Sore throat
- Ear ache
- Eye irritation/conjunctivitis
- Allergies
- Rashes
- Other minor injuries and minor illnesses
- Urinary symptoms (adults only)
- Mild asthma exacerbations (adults only)

On Demand is NOT for medical emergencies. For medical emergencies, call 911.

MGB Health Plan members should go to their member portal at massgeneralbrighamhealthplan.org to learn more about their benefit or to access the secure On Demand website / app.

**For a member's first visit, they will need to create an account with their MGB Health Plan Member ID, so it's good to do that ahead! Registration is quick and 100% secure.**

## Occupational Health Right at Work Continues!

You don't have to go outside for a work physical or worker's comp/workplace injury follow-up. Broad Reach's nurse-practitioner program is an easy option*. For an appointment, click https://www.broadreachhealth.org/schedule-employee-physical https://www.broadreachhealth.org/np-follow-up.

**This is a convenience option – employees always retain choice to see outside providers.*

## Find Doctors Today

Nearly 18,000 primary care providers and specialists participate with MGB Health Plan, plus 74 Massachusetts hospital locations (including Boston's best). Visit massgeneralbrighamhealthplan.org/find-provider or call 866-414-5533 to find a primary care provider or other network providers near your home.

## Mass General Brigham Health Plan Perks

As a member of MGB Health Plan, you not only have access to world-class doctors and hospitals but an abundance of value-added services.

- Telemedicine Program
- Lyra Health Partnership
- Elektra Partnership
- OnDemand Virtual Care
- Over The Counter (OTC) drug benefit
- Access 90 – Up to 90-day supply of maintenance medication
- Virgin Pulse Wellness Program
- Discounted eyewear through EyeMed
- $150 fitness benefit per individual / $300 per family
- Virtual Fitness Programs, such as Peloton
- 6-month weight loss program benefit at Weight Watchers, Jenny Craig or Noom
- Free smoking cessation program and coverage for nicotine replacement
- Reimbursement up to $130 for certain childbirth education classes
- Reimbursement for breastfeeding classes for new and expectant mothers
- One-on-one, personalized care-management programs for members who need them most
- 24/7 Nurse Advice Line
- Discounts or reimbursements on home safety products, bike helmets, and more

**To learn more about these benefits, massgeneralbrighamhealthplan.org**

**or refer to your member enrollment kit for details on how to access these perks.**

Free Sneakers!

new balance

One free pair of New Balance sneakers every 12 months, valued up to $110, from a cobranded online store, which includes styles for men, women, and children.

Free Food!

9 Miles East

**A $60 voucher 9 Miles East (the largest private meal kit company in the U.S.) to ship fresh, healthy, pre- portioned meal ingredients and recipes.**

Free Sunscreen!


**Free voucher for CVS-brand sunscreen (6 oz., Clear Sport or Regular, SPF 30 or 50), good at any participating CVS Pharmacy®**



* New Balance, 9 miles east, and CVS voucher perks – limit 1 per enrolled employee per year.

DELTA DENTAL

## Dental Coverage

Dental coverage will continue to be offered through Delta Dental. You will receive the highest benefit when you use a network dentist. You will have coverage if you use an out-of-network dentist, but you may be balanced billed.

If you are currently enrolled in a Broad Reach dental plan will automatically be enrolled into the same plan effective 6/1/2023 unless you submit a waiver form to Human Resources by 5/10/2023.

## Delta Dental Perks

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 278,000 participating dentist locations and Delta Dental Premier, the largest dental network in the country with more than 349,000 dentist locations.

| Delta Dental Plan | |
|---|---|
| | **In Network** |
| **Deductible** | |
| Individual | $50 |
| Family | $150 |
| ***Calendar Year Maximum** | $1,000 |
| **Preventive Services** | |
| Oral Exams, X-Rays, Cleanings, Fluoride, Treatment, Space Maintainers, Sealants | 100% coverage (deductible waived) |
| **Basic Services** | |
| Fillings, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency | 80% coverage |
| **Major Services** | |
| Onlays, Prosthodontics, Crowns (Initial Installation & Maintenance) | 50% coverage |
| **Orthodontics** (dependent children under age 19) | 50% coverage ($1,000 Lifetime Maximum) |

* Rollover up to $2,000

| Weekly Deductions | Delta Dental Plan |
|---|---|
| Employee | $7.00 |
| Employee + Spouse | $14.00 |
| Employee + Child(ren) | $13.00 |
| Family | $24.00 |

# Voluntary Insurance Benefits

At Broad Reach, there are a variety of voluntary benefits available. for full time employees working 27.5 hours or more per week.

- **Voluntary Life/AD&D** – offered through Unum
- **Individual Short-Term Disability** – offered through Unum
- **Accident Insurance** – offered through Unum
- **Critical Illness Insurance** – offered through Unum
- **Vision Insurance** – offered through Davis Vision
- **Auto & Homeowners** – offered through Rogers and Gray

# Retirement Benefits – 401k

The 401k plan is administered by The Principal, for all employees working 16 hours or more per week.

- Your contributions are matched by the company – 25% is added to up to 5% of your earnings.

For more information or to enroll, contact DonnaLahaie@BroadReachHealth.org or call 508 945-1611 x 205 .

# 401(k) Benefits – Principal

## Eligibility
Employees are eligible to contribute after 90 days of employment. To enroll in the plan, visit principal.com/Welcome or use the Principal® app. You can also text ENROLL to 78259

## Contribution Amount
You can contribute up to 100% of your salary up to the IRS max.

## Catch-Up Contributions
Allowed if you are at least age 50 or will attain age 50 before the end of the calendar year, up to the IRS max.

## Employer Match
Employees will be eligible for the match after 12 months of employment and 1,000 hours. Broad Reach matches your contributions at $0.25 for each dollar up to 5% of earnings.

## Vesting Schedule
Employees are always 100% vested in their own contributions. The employer match 100% vests after 3 years of employment.

## Investments
The plan offers many investments to choose from. Please be sure to review your choices carefully.

## Roth 401(k)
You can contribute a percentage of your pay up on an ***after-tax basis.***

## Take Advantage of Principals Tools and Resources!
Principal has online tools that put you in the driver's seat in saving for your retirement. You can manage your account, track your savings progress, and keep moving toward your goals right from your desktop. Log in to principal.com to get started. You can discover a wealth of resources to help achieve your savings goals.
If you have questions about the retirement plan, call 1-800-547-7754 Monday through Friday, 7 a.m. - 9 p.m. (Central time), to speak to a retirement specialist at The Principal®.

**Please see the Summary Plan Description for more details on the plan.**

# Insurance Marketplace- Insurchoice

## InsurChoice

Insurchoice is an employee voluntary benefits marketplace, where you can shop for benefits, such as home and auto insurance, renters insurance, Medicare Advantage plans, and many more offerings. Once you find the benefit that best fits your needs, you can sign up directly through the marketplace and set up direct billing.

**Key benefits include:**

• **Competitive pricing:** One size doesn't fit all, so you can match yourself with the best rates and coverages from multiple insurance companies.

• **Custom-tailored coverage:** Select the products that meet YOUR needs & YOUR schedule.

For more information, visit https://digital.nfp.com/pc/BRH_IC_MP or email at InsurChoice@nfp.com

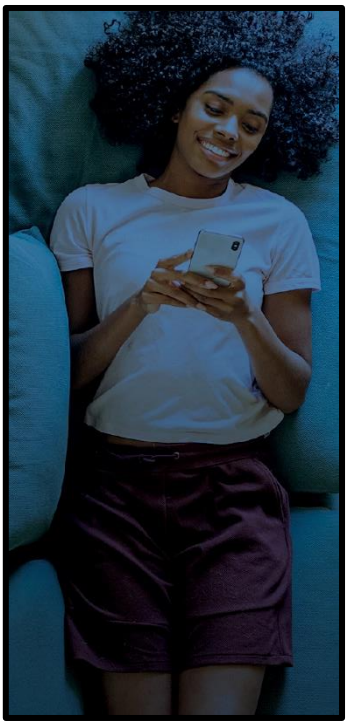
**Pick and choose the products that fit your needs for a custom experience:**

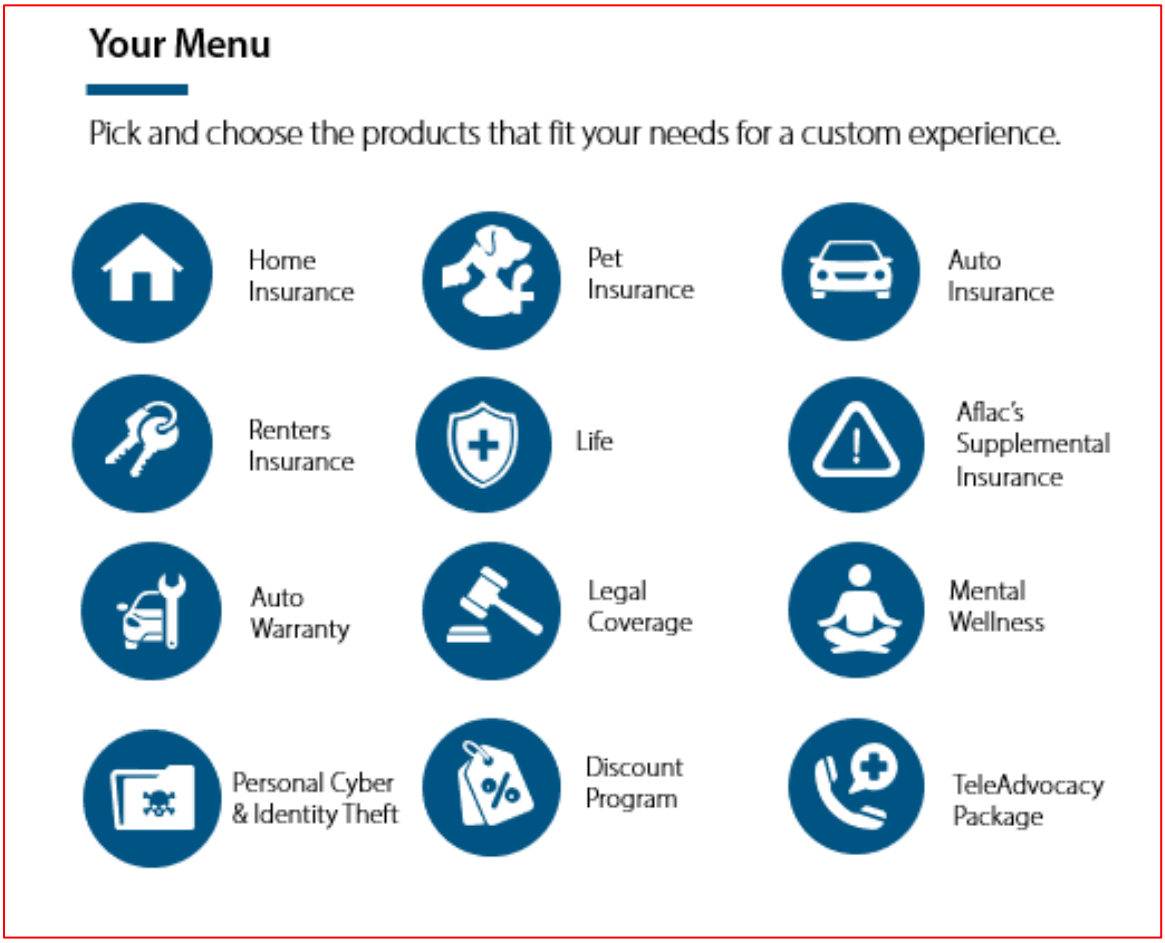
Auto & Home Insurance

Medicare Advantage

Renters Insurance

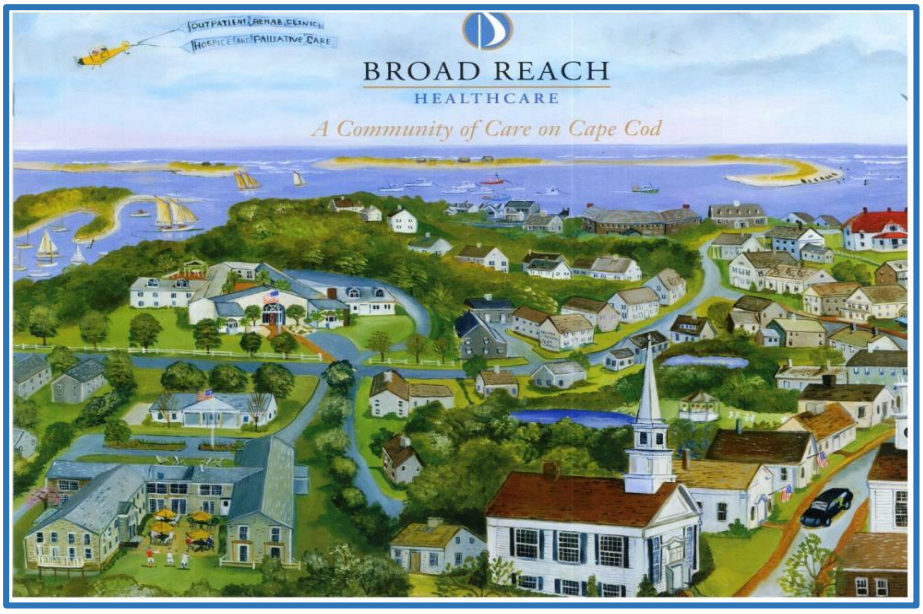
Discount programs





# Important Contacts

| | Phone | Website | Hours |
|---|---|---|---|
| **Broad Reach Human Resources** | 508-945-1611 x225 | www.broadreachhealth.org<br>hrhelp@broadreachhealth.org | *On site by appointment.* |
| **MGB Health Plan** | 866-414-5533 | massgeneralbrighamhealthplan.org | M – F: 8 am – 6 pm<br>Th: 8 am – 8 pm |
| **Delta Dental** | 800-872-0500 | www.deltadentalma.com | M – Th: 8:30 am – 8pm<br>F: 8:30 am – 4:30 |
| **HRCTS (HSA, HRA & FSA Plans)** | 603-647-1147 | www.hrcts.com | M – F: 8am – 8pm |
| **Principal 401K** | 800-547-7754 | www.principal.com | M – F: 8am – 8pm |
| **Unum** | 800-219-2396 | www.unum.com | M – F: 8am – 8pm |
| **Davis Vision** | 800-999-5431 | www.davisvision.com | M – F: 8am – 11pm<br>Sat: 9am – 4pm<br>Sun: 12pm – 4pm |
| **Principal** | 1-800-547-7754 | principal.com | M – F: 7am – 9pm |
| **Rogers & Gray Auto/Home Insurance** | 508-619-4545 | rrolles@rogersgray.com | M – F: 8:30am – 4:30pm |



# Required Notices

## Affordable Care Act (ACA) - Frequently Asked Questions
## Employees Eligible for the Company-Sponsored Medical Plan

**Q. What is the Affordable Care Act?**
A. The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010.
The ACA includes, among other things, premium and cost-sharing subsidies for those that qualify, health insurance exchanges, and mandates, including an individual mandate that, with certain exceptions, requires all individuals beginning January 1, 2014, and through the end of 2018, to have health insurance or pay a tax penalty. Under the tax reform law of 2017, the individual mandate penalty tax was repealed beginning in 2019, meaning individuals can forego coverage in 2019 and beyond without having to pay a penalty tax. Beyond that, the ACA includes subsidies to help individuals with low incomes obtain health coverage and comply with the individual mandate. Coverage through the health insurance exchange and any other plan (including an employer-sponsored group health plan), is guaranteed; even if you have a pre-existing medical condition, your cost for coverage will generally be the same as all other applicants of the same age living in the same geographic location.

**Q. Who is required to have health insurance?**
A. From 2014 through 2018, all Americans – with some exceptions – are required to have medical insurance coverage (called 'minimum essential coverage', or 'MEC') or incur a tax penalty. MEC includes a governmental plan (such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE and Veterans' health care programs), an employer-based or sponsored health plan (except for limited benefit and limited indemnity insurance, such as the Transamerica Limited Benefit Hospital Indemnity Insurance) and individual plans (both in the private market and through the exchanges). Beginning in 2019, the individual mandate penalty is repealed, meaning American citizens will not have to pay a penalty tax if they forego health insurance coverage.

**Q. What is the health insurance exchange?**
A. The health insurance exchange, sometimes called the Exchange or Marketplace, is a resource where individuals can learn about private health coverage options, compare private health insurance plans, and enroll in private health insurance coverage. The health insurance exchange also provides information on programs that help individuals with low to moderate incomes, and resources to pay for private health insurance coverage.

You can get help online at www.healthcare.gov, or call 1-800-318-2596, 24 hours a day, 7 days a week.

**Newborns' and Mothers' Health Protection Act**

Under federal law, health care plans may not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 and with the mother's consent, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

**Women's Health and Cancer Rights Act Enrollment Notice**

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

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

**Women's Health and Cancer Rights Act Annual Notice**

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your plan administrator for more information.

**HIPAA Regulations Help to Protect Your Privacy**

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) help to ensure that your health care-related information stays private. New employees will receive a Privacy Practice Notice which outlines the ways in which the medical plan may use and disclose protected health information (PHI). The notice also describes your rights. For more information, contact Human Resources.

**HIPAA 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 towards 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).

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

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

## Important Notice from Broad Reach Healthcare 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 Broad Reach Healthcare 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. Broad Reach Healthcare has determined that the prescription drug coverage offered by MGB 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 Broad Reach Healthcare coverage will not be affected. Your options are as follows:

- Retain your existing coverage and choose not to enroll in a Part D plan; or
- Enroll in a Part D plan as a supplement to the other coverage
- If your existing prescription drug coverage is under a Medigap policy, you cannot have both your existing prescription drug coverage and Part D coverage. If you enroll in Part D coverage, you should inform your Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium as of the date the Part D coverage starts.

If you do decide to join a Medicare drug plan and drop your current Broad Reach Healthcare coverage, be aware that you and your dependents may not 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 Broad Reach Healthcare 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 Broad Reach Healthcare 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: | March 2023 |
| Name of Entity/Sender: | Broad Reach Healthcare |
| Contact--Position/Office: | Human Resources |
| Address: | 390 Orleans Rd, North Chatham, MA 02650 |
| Phone Number: | (508) 945-4611 |

CMS Form 10182-CC

*According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

## General Notice of COBRA Continuation Coverage Rights

### Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

### What is COBRA continuation coverage?

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

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

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

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

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

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

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

### When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 after the qualifying event occurs. You must provide this notice to: Human Resources.

**General Notice of COBRA Continuation Coverage Rights (continued)**

**How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

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

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

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

**Are there other coverage options besides COBRA Continuation Coverage?**

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

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

**If you have questions**

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

**Keep your Plan informed of address changes**

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

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

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

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

## 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>Broad Reach Healthcare | | 4. Employer Identification Number (EIN) | |
| 5. Employer address<br>390 Orleans Road | | 6. Employer phone number<br>(508) 945-4611 | |
| 7. City<br>North Chatham | 8. State<br>MA | 9. ZIP code<br>02650 | |
| 10. Who can we contact about employee health coverage at this job?<br>Mary Swaney | | | |
| 11. Phone number (if different from above)<br>508 945-1611 x212 | 12. Email address<br>MarySwaney@BroadReachHealth.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:

All full-time employees who work a minimum of 27.5 hours per week

☐ Some employees. Eligible employees are:

- With respect to dependents:

✓ We do offer coverage. Eligible dependents are:

Spouses, Dependents/Children

☐ 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.

**Premium Assistance under Medicare and the Children's Health Insurance Program (CHIP)**

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility

| **ALABAMA – Medicaid** | **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| 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 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: (678) 564-1162, Press 2 |
| **CALIFORNIA – Medicaid** | **INDIANA – Medicaid** |
| Website:<br>Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov | 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) | MONTANA – 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:<br>https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-766-9012 | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – 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://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov | Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 |
| **LOUISIANA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | 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 |
| **MAINE – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.maine.gov/dhhs/ofi/applications-forms<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: 800-977-6740.<br>TTY: Maine relay 711 | 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 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa<br>Phone: 1-800-862-4840<br>TTY: (617) 886-8102 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – 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: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |

| OKLAHOMA – Medicaid and CHIP | UTAH – Medicaid and CHIP |
|---|---|
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 | Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid and CHIP** | **VIRGINIA – Medicaid and CHIP** |
| Website: 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: https://www.coverva.org/en/famis-select<br>https://www.coverva.org/en/hipp<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 |
| **SOUTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | 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) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | 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, 2023, 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.

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OMB Control Number 1210-0137 (expires 1/31/2023)

**Pregnant Workers Fairness Act**

The Pregnant Workers Fairness Act ("the Act") amends the current statute prohibiting discrimination in employment, G.L. c. 151B, §4, enforced by the Massachusetts Commission Against Discrimination (MCAD). The Act, effective on April 1, 2018, expressly prohibits employment discrimination on the basis of pregnancy and pregnancy-related conditions, such as lactation or the need to express breast milk for a nursing child. It also describes employers' obligations to employees that are pregnant or lactating and the protections these employees are entitled to receive. Generally, employers may not treat employees or job applicants less favorably than other employees based on pregnancy or pregnancy-related conditions and have an obligation to accommodate pregnant workers.

Under the Act:

- Upon request for an accommodation, the employer has an obligation to communicate with the employee in order to determine a reasonable accommodation for the pregnancy or pregnancy-related condition. This is called an "interactive process," and it must be done in good faith. A reasonable accommodation is a modification or adjustment that allows the employee or job applicant to perform the essential functions of the job while pregnant or experiencing a pregnancy-related condition, without undue hardship to the employer.
- An employer must accommodate conditions related to pregnancy, including post-pregnancy conditions such as the need to express breast milk for a nursing child, unless doing so would pose an undue hardship on the employer. "Undue hardship" means that providing the accommodation would cause the employer significant difficulty or expense.
- An employer cannot require a pregnant employee to accept a particular accommodation, or to begin disability or parental leave if another reasonable accommodation would enable the employee to perform the essential functions of the job without undue hardship to the employer.
- An employer cannot refuse to hire a pregnant job applicant or applicant with a pregnancy-related condition, because of the pregnancy or the pregnancy-related condition, if an applicant is capable of performing the essential functions of the position with a reasonable accommodation.
- An employer cannot deny an employment opportunity or take adverse action against an employee because of the employee's request for or use of a reasonable accommodation for a pregnancy or pregnancy-related condition.
- An employer cannot require medical documentation about the need for an accommodation if the accommodation requested is for: (i) more frequent restroom, food or water breaks; (ii) seating; (iii) limits on lifting no more than 20 pounds; and (iv) private, non-bathroom space for expressing breast milk. An employer, may, however, request medical documentation for other accommodations.
- Employers must provide written notice to employees of the right to be free from discrimination due to pregnancy or a condition related to pregnancy, including the right to reasonable accommodations for conditions related to pregnancy, in a handbook, pamphlet, or other means of notice no later than April 1, 2018.
- Employers must also provide written notice of employees' rights under the Act: (1) to new employees at or prior to the start of employment; and (2) to an employee who notifies the employer of a pregnancy or a pregnancy-related condition, no more than 10 days after such notification.

The foregoing is a synopsis of the requirements under the Act, and both employees and employers are encouraged to read the full text of the law available on the General Court's website here: https://malegislature.gov/Laws/SessionLaws/Acts/2017/Chapter54

If you believe you have been discriminated against on the basis of pregnancy or a pregnancy-related condition, you may file a formal complaint with the MCAD. You may also have the right to file a complaint with the Equal Employment Opportunity Commission if the conduct violates the Pregnancy Discrimination Act, which amended Title VII of the Civil Rights Act of 1964. Both agencies require the formal complaint to be filed within 300 days of the discriminatory act.

# Definitions

**Affordable Care Act (ACA):** The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.
**Annual Maximum:** Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.
**Out-of-Pocket Maximum:** The maximum amount of coinsurance a Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of-pocket maximum.
**Coinsurance:** A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible.
**Conversion:** an Associate changes or "converts" her/his Group Life coverage to an Individual Life Insurance policy without having to answer any medical questions. Conversion is for an Associate who is leaving her/his job, reducing hours, or has reached the age when coverage may be reduced or eliminated, and still wants to maintain the protection that life insurance provides.

**Copayment:** A set dollar amount you pay for network doctors' office visits, emergency room services and prescription drugs.
**Deductible:** Total dollar amount, based on the allowed amount, you must pay out of pocket for covered medical expenses each calendar year before the plan pays for most services. The deductible does not apply to network preventive care and any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.
**Brand Formulary Drugs:** The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.
**Generic Drugs:** These drugs are usually most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand name drugs.
**Maintenance Drugs:** Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.
**Non-Formulary Drugs:** These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost.
**PDP Fee:** PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums.
**Portability:** an Associate carries or "ports" her/his current Group Life coverage after employment ends, without having to answer any medical questions. Portability is for an Associate who is leaving her/his job and still wants to maintain the protection that life insurance provides.
**Pre-tax Plan:** A plan for active employees that is paid for with pre-tax money. The IRS allows for certain expenses to be paid for with tax-free dollars. The state takes premiums out of your check before taxes are calculated, increasing your spendable income and reducing the amount you owe in income taxes. Consequently, the IRS has tax laws that require you to stay in the plans you select for a full plan year (January through December). You can only make changes during Open Enrollment or if you have a qualifying event.
**Primary Care Physician (PCP):** The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.
**Provider:** Any type of health care professional or facility that provides services under your plan.
**Network:** A group of health care providers, including dentists, physicians, hospitals and other health care providers, that agrees to accept pre-determined rates when serving members.
**Qualifying Event:** an occurrence that qualifies the Subscriber to make an insurance coverage change outside of the Open Enrollment
**Reasonable and Customary Charge (R&C):** R & C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentist's in the same geographic area for the same or similar services as determined by Delta Dental.
**Specialty Drugs:** prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions.