Employees must sign page 2 →

OPEN ENROLLMENT FOR BENEFITTED EMPLOYEES ONLY

ABSOLUTE DEADLINE FOR SUBMITTING OPEN ENROLLMENT CHANGES

MAY 15, 2024 - NO EXCEPTIONS!

- Please see the website below for Summary of Benefits & Coverage (SBC) on all the plans offered.
- High Deductible Plans are paired with Health Savings Accounts (HSA) as allowed by IRS rules.
- Town's annual contribution to HSA is $1,000 individual plan and $2,000 Family plan.
- As provided by the Affordable Care Act (ACA) dependent children up to age 26 are eligible for health, vision, and dental insurance on their parent's plan regardless of student status.
- Plan descriptions and comparative summaries are available at the Treasurer's Office or at www.mmhg.org.
- Don't forget to add your preschool aged children to your dental plans. Their permanent teeth may need of preventative care.

Availability of Summary Health Information:

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: www.mmhg.org. A paper copy is also available, free of charge, by calling the Treasurer's office.

Current rates and new enrollments are effective July 1, 2024 to June 30, 2025

		Employee's **Monthly** Share*:				
NETWORK BLUE Traditional (HMO):	INDIVIDUAL:	$546.00	/month	FAMILY:	$1,454.00	/month
NETWORK BLUE N.E. RATE SAVER PLAN	INDIVIDUAL:	$492.00	/month	FAMILY:	$1,311.00	/month
NETWORK BLUE BENCHMARK PLAN	INDIVIDUAL:	$454.00	/month	FAMILY:	$1,208.00	/month
Network Blue NE HMO High Deductible	INDIVIDUAL:	$386.00	/month	FAMILY:	$1,029.00	/month
BLUE CARE ELECT Traditional PPO:	INDIVIDUAL:	$774.00	/month	FAMILY:	$1,834.00	/month
BLUE CARE ELECT RATE SAVER PLAN	INDIVIDUAL:	$716.00	/month	FAMILY:	$1,696.00	/month
BLUE CARE ELECT BENCHMARK PLAN	INDIVIDUAL:	$642.00	/month	FAMILY:	$1,524.00	/month
Blue Care Elect PPO High Deductible	INDIVIDUAL:	$558.00	/month	FAMILY:	$1,448.00	/month
HARVARD/PILGRIM Traditional (HMO):	INDIVIDUAL:	$591.00	/month	FAMILY:	$1,573.00	/month
HARVARD PILGRIM RATE SAVER PLAN	INDIVIDUAL:	$533.00	/month	FAMILY:	$1,418.00	/month
HARVARD PILGRIM BENCHMARK PLAN	INDIVIDUAL:	$503.00	/month	FAMILY:	$1,337.00	/month
Harvard Pilgrim HMO High Deductible	INDIVIDUAL:	$415.00	/month	FAMILY:	$1,080.00	/month
DELTA DENTAL:	INDIVIDUAL:	$15.73		FAMILY:	$59.16	
VISION - EyeMed:		$4.58		FAMILY:	$12.60	
		INDV+spouse: $	7.78/**month**			
		INDV+children: $	8.02/**month**			

- Vision plans are paid 100% by the employee.
- *Health & dental insurance premiums are split 50/50, The rates shown above are the **employee**'s total monthly 50% contributions (Vision-100% contribution).*
- *Eligibility documentation is required for all family plan enrollments. Please be sure to provide the necessary documents. Please call for a full list of requirements.*

It is **YOUR** responsibility to provide the necessary documents and enrollment forms to the Treasurer's office by the May 15th deadline. Please contact this office if you have any questions or concerns.

Ashling McLoughlin, Treasurer 508-763-3871 x114
Diana Knapp, Payroll Administrator 508-763-3871 x122

As required by the Affordable Care Act, please visit: www.mmhg.org to view Summary of Benefits and Charges.

All benefit eligible employees must complete this form and return it to the Treasurer's Office as proof that health insurance coverage has been offered.

Affordable Care Act
Employee Health Insurance Offer Form

Date of Offer: July 1, 2024

Employers: Please complete this section:

Employer Name: Town of Rochester FEIN: 04-6001280
Employer Address: 1 Constitution Way
City/State/Zip Code: Rochester MA 02770

1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes ☒ No ☐
2. Did you offer employer sponsored health insurance to this employee? Yes ☒ No ☐
3. If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee?
   Insurance elections are effective July 1st $386.00

Employees: Please complete this section:

Employee First Name | Middle Initial

Employee Last Name | Suffix

1. Did you accept your employer sponsored health insurance? Yes ☐ No ☐ Not Offered ☐
   If "NO", why?
   Covered by spouse ☐ Covered by parent ☐ Veteran's Coverage ☐ Other ☐
2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase your health insurance? Yes ☐ No ☐ Not Offered ☐
3. Do you have other health insurance? Yes ☐ No ☐

Employee Affidavit

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance, I may be responsible for the full costs of all medical treatment, that I may incur a penalty from the Federal Government on my Federal income tax return.

Employee Signature: Date