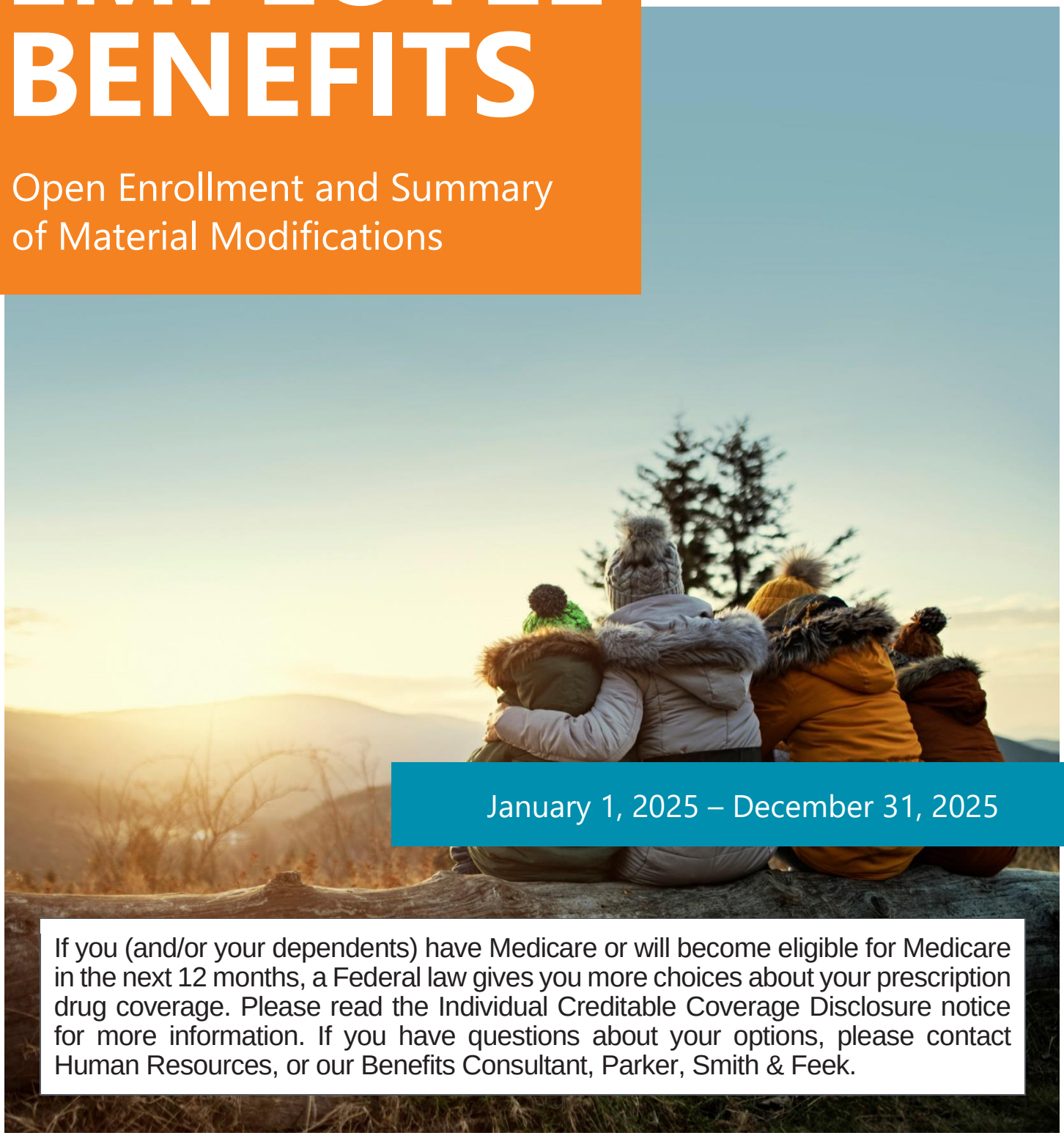
EMPLOYEE BENEFITS

Open Enrollment and Summary of Material Modifications



January 1, 2025 – December 31, 2025

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please read the Individual Creditable Coverage Disclosure notice for more information. If you have questions about your options, please contact Human Resources, or our Benefits Consultant, Parker, Smith & Feek.

Table of Contents

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. For specific tax or legal advice, please consult with your own tax or legal advisor for assistance. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

WELCOME TO MATANUSKA-SUSITNA BOROUGH

Our health care plan renews January 1st each year. Every year we review our benefit plan offerings, consider what we offer, the cost for the year and what we can afford. We consider our levels of benefits, our insurance company performance, and the cost to both you and the company. Based on this review, and in consultation with our benefit consultant, we have made the following decisions for our benefit offerings for this plan year:

- Allied will continue to administer our medical, pharmacy, dental, flexible spending, health reimbursement accounts, and behavioral health benefits
- CVS/Caremark will continue to provide our pharmacy benefit management
- Capstone Clinics will continue to provide primary and urgent care services
- Vision Service Plan (VSP) will continue to provide our vision benefits
- Group life/AD&D will continue to be administered by MetLife
- Transcarent will continue to provide Telehealth, Surgery Care, Oncology Care, and Virtual Physical Therapy programs
- Employee Assistance Programs (EAPs) will continue to be provided by Allied Care Solutions and TELUS Health

We are committed to providing employees with a comprehensive benefit program that provides health care coverage for you and your family. Our benefit plan is an important part of Matanuska-Susitna Borough's total compensation strategy: we value you and your contribution to our organization. We endeavor to maintain the comprehensive benefits package that we have all come to appreciate.

Please keep in mind that our health plan is a self-funded plan. This means that MSB assumes the financial risk for providing health care benefits, rather than paying an insurance company to assume this risk. Your health care claims are "processed" by Allied, however the money they use to make those payments comes directly from MSB, which is funded by the premiums paid by both the company and you.

The following is an overview of plan changes, open enrollment information and plan costs for employees. Please take a few minutes to review this information so you can make the best health care coverage decisions for you and your family. For more detailed information, please review the specific plan documents.

Eligibility Requirements

Employee	Dependents	Waiting Period
Full-time employees working at least 40 hours per week Part-time employees working less than 40 but more than 30 hours per week	Your legal spouse Dependent children may be covered until age 26	1st of the month coincident with or next following date of eligibility

For new employees, this is your chance to enroll in the Matanuska-Susitna Borough Employee Benefits Plan. You must enroll yourself and your dependents within 30 days of becoming eligible for benefits. You can enroll eligible dependents at the same time you enroll yourself. If you don't enroll, or you waive coverage, you'll receive the employer sponsored benefits shown below:

- Basic Life Insurance and AD&D
- Employee Assistance Plan

Once you're enrolled in benefits, you generally aren't allowed to make changes until the next annual Open Enrollment. Open Enrollment is your one chance each year to review your coverage and make changes to your benefits. It's also your chance to enroll if you declined coverage when you first became eligible. Open Enrollment changes take effect on January 1st each year.

Other than during Open Enrollment, you can make changes to your benefits during the year only if you experience a qualifying status change. Please refer to the Special Enrollment section later in this document (page 23).

Open Enrollment

This is the time of year to add or drop coverage for any eligible family members. If you do not enroll an eligible spouse or child now because they have coverage through another employer, you may only add that person on our plan during next year's Open Enrollment period, unless you experience a qualified family status change. Please refer to the Special Enrollment section later in this document (page 23).

What Do I Have To Do?

- If you are not making any changes, you don't have to do anything.
- This is your opportunity to add coverage for your spouse and children who were previously eligible but not enrolled. Ask Human Resources for an enrollment form.
- This is also your opportunity to switch Plan Options between Option 1, Option 2, or Option 3. Please note that any family members you cover will be enrolled on the same plan as you. You will need to fill out a new enrollment form.
- If you wish to drop coverage for yourself or any dependents, now is the time to do so. Please ask Human Resources for an enrollment change form.
- If you wish to participate in the Health FSA you must turn in your election form.

ALL FORMS MUST BE COMPLETED AND RETURNED TO **CINDY LOYER BY 5 P.M. NOVEMBER 22, 2024.**

Where Do I Go If I Have Questions?

- See page 5 for customer service numbers and websites for the carriers.
- Cindy Loyer, 907-861-8423, or **cindy.loyer@matsugov.us**

Benefits Advocacy – Here To Help

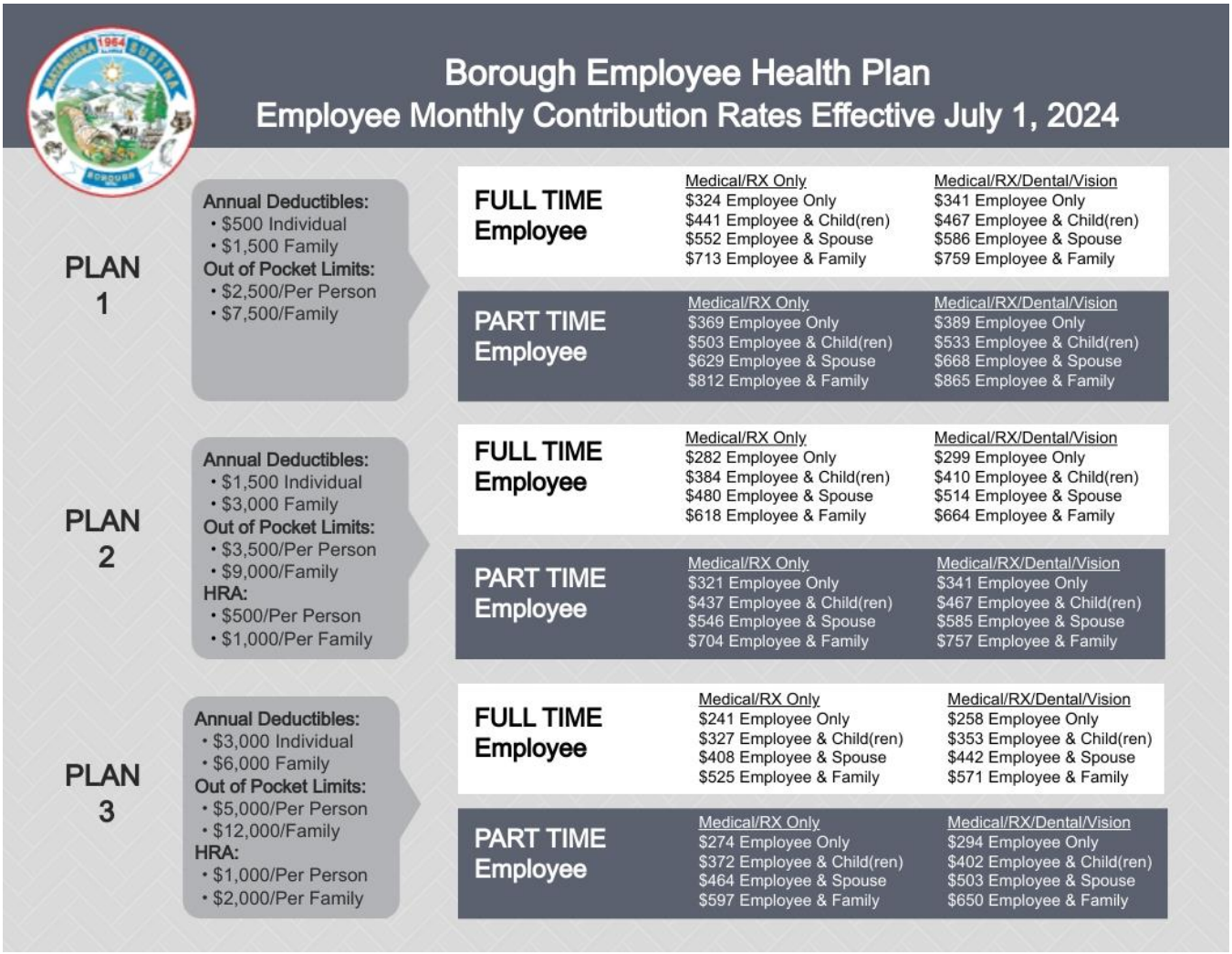
Parker, Smith & Feek, Inc.

MSB has also partnered with Parker, Smith & Feek to provide you and your family with individualized assistance with insurance problems you are unable to resolve directly with the carriers. This includes claims issues, eligibility questions, network problems and general healthcare or insurance questions.

PARKER SMITH & FEEK

Your Account Manager	Email	Phone
Shelly Tuttle	smtuttle@psfinc.com	907-865-6833

How Much Do I Have To Pay?



Please note that when your contributions are taken out of your paycheck on a pre-tax basis, as allowed by Section 125 of the Internal Revenue Code. IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status. This means you may not drop coverage for a dependent during the year unless there is a qualified change in family status.

What's Changing?

- **Flexible Spending Account**: See page 18.

Contact Information

Refer to this list when you need to contact a benefits vendor.
For general information, contact Human Resources.

Medical, Dental and Flexible Spending Arrangement (FSA)	Allied	866-455-8727	**www.alliedbenefit.com** Group: A22206
Prescription Drugs / Rx Mail Orders	CVS / Caremark	866-818-6911	**www.caremark.com**
Vision	Vision Service Plan (VSP)	800-877-7195 800-428-4833 (TTY/TDD)	**www.vsp.com**
Telehealth, Surgery Care, Oncology Care, & Virtual Physical Therapy	Transcarent	844-423-2163	**www.transcarent.com**
Health Reimbursement Arrangement (HRA)	Allied	800-288-2078 (Press 4, then choose 3)	**www.alliedbenefit.com** **FlexQuestions@alliedbenefit.com**
Employee Assistance Program (EAP)	TELUS Health	888-319-7819	**one.telushealth.com** Username: metlifeeap Password: eap
Employee Assistance Program (EAP)	Allied Care Solutions	800-440-1440	**www.alliedbenefit.com/caresolutions** Username: MatSu
Primary and Urgent Care	Capstone Clinic	907-357-9590	**www.capstoneclinic.net**
Advanced Imaging Services MRI / CT / PET Scans	Allied Care	866-458-2995	
Life Insurance and AD&D	MetLife	800-METLIFE 800-638-5433	**www.metlife.com**
Human Resources	Cindy Loyer	907-861-8423	**Cindy.loyer@matsugov.us**
Benefits Advocacy	Shelly Tuttle	907-865-6833	**smtuttle@psfinc.com**

For more information about your benefit options, forms, and highlights, please visit **https://psfinc.egnyte.com/fl/v6QbH02RWc**.

MEDICAL COVERAGE

Allied

Benefits Summary

The plan encourages you to use in-network providers by charging you lower co-pays and co-insurance amounts. In-network providers agree to bill Allied directly and to accept a negotiated fee as payment in full. Out-of-Network providers have not and you may have to pay amounts above Premera's allowable charge (also called balance billing). To find a list of in-network providers, go to **www.alliedbenefit.com/ProviderNetworks** and search for providers in the **Aetna Signature Administrator** Network. The deductible and out-of-pocket maximum are on a calendar-year basis and reset every January 1st.

DON'T FORGET YOUR ANNUAL EXAM.

PREVENTIVE CARE IS COVERED 100%.

Remember: When you receive services in Anchorage, Alaska Regional Hospital, Surgery Center of Anchorage, Alaska Surgery Center, and Alpine Surgery Center are the ONLY PPO facilities. All other hospitals, surgery centers, and imaging centers are considered Out-of-Network.

You and your physician are encouraged, but not required, to contact Allied Care to obtain pre-notification and authorization for other services as well. Failure to follow the pre-notification process for these services will not result in a penalty, but the services may not be covered if they are not determined to be medically necessary.
The maximum benefit payable for dialysis-related claims shall be the Usual and Reasonable charge for covered services and/or supplies, less deductible and coinsurance.

Emergency Room visits for non-emergency issues incur a $200 penalty. A visit to the ER is the most expensive type of outpatient care; utilizing the ER in a non-emergent situation is a poor use of your health benefits and can be very costly.

Transcarent

Transcarent offers domestic medical tourism services with discounts on high dollar surgical treatments. Transcarent connects you with top-rated facilities and surgeons for certain procedures including orthopedic, cardiac and women's health, to name a few. **First class travel costs are covered for you and a companion, and you pay a $0 deductible and $0 coinsurance for these surgical services**. Please refer to the flyer included in the enrollment packet for more detailed information.

You are not required to use Transcarent for your surgery, but you must contact Transcarent to learn about your options prior to proceeding with a non-urgent surgical procedure. Failure to contact Transcarent will incur a $200 penalty.

Oncology Care

Through Oncology Care, you can expect live, human support from the moment you begin your journey. Transcarent is there to make the process as easy and seamless for you as possible. You can call a Health Guide to connect with the Oncology Support team of experience oncology nurses for ongoing guidance during and after your cancer treatment. You can also communicate via in app messaging to learn about the program, to receive support for your treatment, and to understand the steps through your treatment journey. The cost of this program is covered by Matanuska-Susitna Borough at 100% so you pay zero. All members and their covered dependents on the health plan are eligible for the Oncology Care program. You can register online at **www.Transcarent.com**, download the mobile app or call 844-423-2163 to get started. See attached benefit highlights for more information.

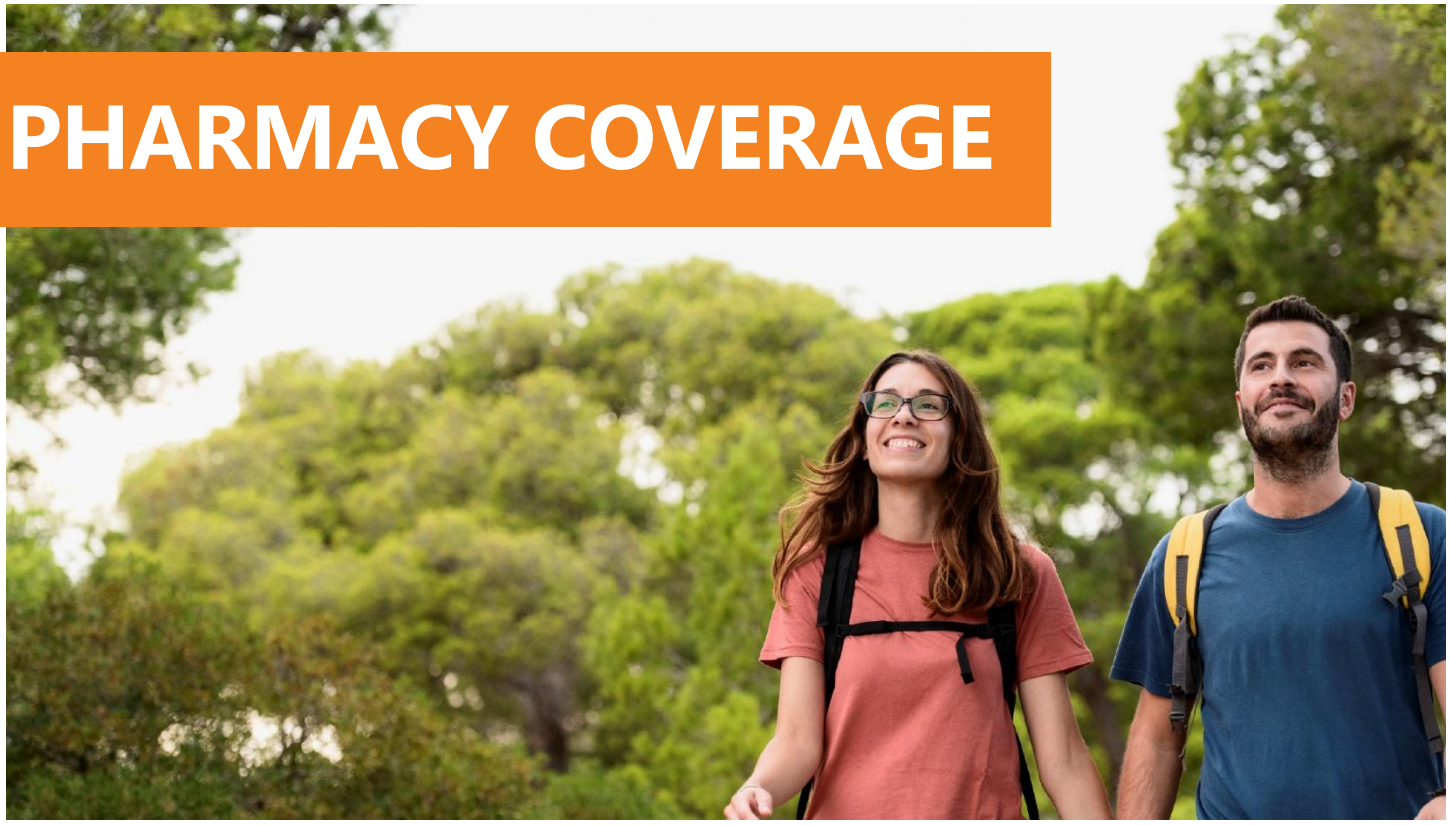
Capstone Clinic

You and your covered family members can receive primary care and urgent care at Capstone clinics. The services are not subject to the deductible, and you pay $0 copay. This applies to services performed by primary care providers, including preventive physicals, management of chronic conditions, and acute care such as treatments of minor injuries and illnesses. Services performed by specialists will be subject to deductible and coinsurance.

You have the choice of three medical plans: Option 1, Option 2, or Option 3. The following table is a summary of all plans. You choose your plan each year during Open Enrollment.

Aetna Network – Participating Providers	Option 1	Option 2 – HRA Low	Option 3 – HRA High
Annual Deductible *Individual* *Maximum per family*	 $500 $1,500	 $1,500 $3,000	 $3,000 $6,000
Out-of-Pocket Maximum *Individual* *Maximum per family*	 $2,500 $7,500	 $3,500 $9,000	 $5,000 $12,000
Preventive Care *Routine Exam / Laboratory Services*	Covered in full	Covered in full	Covered in full
Physician Services *Office Visits / Inpatient*	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 80% after deductible
Virtual Care – Transcarent	Cost waived	Cost waived	Cost waived
Outpatient X-Ray and Laboratory Services	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 80% after deductible
Emergency Services *(Subject to penalty for non-emergent utilization)*	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 80% after deductible
Hospital Services *Inpatient and Outpatient*	Paid at 80% after deductible Deductible does not apply	Paid at 80% after deductible Deductible does not apply	Paid at 80% after deductible Deductible does not apply
Outpatient – Mental/Nervous Disorders and Substance Abuse Treatment *40 visits per calendar year*	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 80% after deductible
Spinal Manipulations / Massage / Physical / Speech Therapy *Combined 25 visits per calendar year*	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 80% after deductible
HRA Contribution	N/A	$500 ind. / $1,000 fam.	$1,000 ind. / $2,000 fam.
Non-Participating Providers/Services			
OON Deductible *Individual* *Maximum per family*	 $500 $1,500	 $1,500 $3,000	 $3,000 $6,000
OON Out-of-Pocket Maximum *Individual* *Maximum per family*	 $5,000 $15,000	 $7,000 $18,000	 $10,000 $24,000
Out-of-Network Coinsurance	60% - 80%	60% - 80%	60% - 80%

PHARMACY COVERAGE



CVS / Caremark

Benefits Summary

The coinsurance is the same for a 34-day supply at a retail or a 3-month supply at mail order. However, because the maximum per script stays the same, you may save money on more expensive medications by using mail order or at the CVS pharmacy located within Target. Mail order is especially economical for maintenance prescriptions. The plan provides 100% coverage for up to a 90-day supply after the payment is applied noted below. **All high-cost specialty medications will be subject to additional review to help ensure appropriate use and dosage.**

Employee inquiries and all member services regarding their prescriptions are answered and handled directly by CVS/Caremark. Caremark Customer Care can be reached at 866-818-6911 and you can access your prescription information via **www.caremark.com**.

Whether you enroll in Plan Option 1, Option 2, or Option 3, the following pharmacy benefits apply:

	Retail (34-day supply)
Generics	You pay 10%, up to $75 per script
Formulary Brand	You pay 20%, up to $150 per script
Non-Formulary Brand	You pay 30%, up to $300 per script
Specialty Drugs (Limited to 30-day supply per fill. Prior authorization required)	You pay 15%, up to $150 per script
Prescription Out-of-Pocket Maximum	$4,000 per participant / $6,000 per family
Notice regarding Medicare Part D	Our medical plans offer what is called "creditable coverage," which means a Medicare-eligible person will not have to buy a Medicare Part D supplement for prescription drugs and will not be subject to the 1% per month late enrollment charge assessed by Medicare for purchasing Part D at a later date. If you have questions about your options, please contact Human Resources.

There is no coverage for prescriptions from a pharmacy not in the network.

VIRTUAL AND TELEPHONIC CARE

Transcarent

Virtual care provides 24/7 access to a board certified, licensed family practice doctor or pediatrician via text or video and can be used for many of your medical issues. It replaces expensive visits and long wait times at the ER or urgent care clinic to diagnose and treat those acute, non-emergent medical issues that may arise such as:

- Cold and flu
- Sore throat
- Rashes
- Allergies
- Headaches
- Bronchitis
- UTI
- Fever
- Asthma
- And much more!

Doctors can also write short term prescriptions and will send the script electronically to the pharmacy of your choice. After the visit, at your request, the doctor will send electronic chart notes to your primary care doctor. Virtual care is not a substitute for a primary care doctor.

Skip the long wait times at the ER or urgent care with Telehealth!

Connect with a board-certified, emergency medicine doctor, family practice doctor, or pediatrician via text or video for questions or non-emergency issues, anytime and anywhere in the U.S. After the visit, you will receive a progress note from your visit directly stored in your app, and your Transcarent Health Guide will follow up with you.

Wait, it gets better... there is no cost to you!* And if you require follow-up after your initial visit, you have unlimited visits for the next 7 days with the doctor at no additional cost. Doctors can also write short-term prescriptions—sent electronically to the pharmacy of your choice.

*Based on current law, coinsurance/copayments are waived for high-deductible plans through Dec. 31, 2022. Beginning Jan. 1, 2023, employees on high-deductible plans pay $0 after their deductible has been met.

Treat acute, non-emergent medical issues:

- Cold and flu
- Sore throat
- Rashes
- Allergies
- Headaches
- Bronchitis
- UTI
- Fever
- Asthma
- and much more!

Care delivery options start as text, then switch to video chat if desired

Text | Video Chat | Phone Call

transcarent

Get Everyday Care Today!

Scan the QR code, search "Transcarent" in the app store, or talk to a Health Guide:

(844) 423-2163

DENTAL COVERAGE

Allied

Benefits Summary

There is no deductible applicable to this Dental Plan. The Matanuska-Susitna Borough will cover your dental visits according to the following schedule:

	Schedule of Benefits
Preventive Care (oral exams, x-rays, cleanings, sealants)	Paid at 100%
Basic Services (fillings, oral surgery, simple extractions, root canals)	Paid according to the schedule below
Major Services (crown installation, bridgework, dentures, inlays)	Paid at 50%
Maximum Annual Benefit (per person)	$3,000
Orthodontics	Paid at 75%; Lifetime max of $3,000 per person

Charges incurred by a Late Enrollee for Class B services until 6 months from the date their coverage begins and Class C services until 12 months from the date their coverage begins will not be covered. This limitation will not apply to covered charges due solely to an injury suffered while covered under the Plan.

You, as the subscriber, must obtain preventive care services each Calendar Year as recommended by your dentist before the dental coinsurance is increased for Class B (Basic/Restorative Services) according to the following percentage:

	Schedule of Benefits – Class B
Until the end of the Calendar Year (In which coverage became effective)	Paid at 60%
During the first full Calendar Year	Paid at 70%
During the second full Calendar Year	Paid at 80%
During the third full Calendar Year	Paid at 90%
During each Calendar Year thereafter	Paid at 100%

Coinsurance amounts are based off the subscriber's plan coverage start date.

VISION COVERAGE

Vision Service Plan

Benefits Summary

Contracted providers agree to bill VSP directly and to accept a negotiated fee as payment in full. If you use a non-VSP provider, you will need to submit a claim to VSP and you will be reimbursed up to the scheduled amounts.

	VSP Signature Network	All Other Providers
Vision Exam *Every Calendar Year*	$0 copay	$50 allowance
Eyeglass Lenses *Every Calendar Year*	$0 copay	$50 allowance
Frames *Every Calendar Year*	$0 copay, $200 allowance for most frames	$70 allowance
Contact Lenses *Every Calendar Year* *In lieu of Glasses*	Up to $60 copay, $250 allowance	$105 allowance

See benefit highlights for additional information.

HOW MSB HELPS YOU PAY YOUR MEDICAL DEDUCTIBLE

Health Reimbursement Accounts

You must be enrolled in Plan Option 2 or Plan Option 3 to take advantage of the HRA

A Health Reimbursement Account (HRA) allows MSB to set aside funds for you to spend on qualified medical expenses. Money not used in one calendar year can be rolled over from year-to-year up to your Plan Out-of-Pocket Maximum. MSB will contribute the following amounts to each employee's account for:

Individual	Family
Plan Option 2: $500 Plan Option 3: $1,000	Plan Option 2: $1,000 Plan Option 3: $2,000

Contributions made by MSB will be available in full on January 1. Please note: Should you terminate coverage you will no longer have access to these funds unless you elect COBRA.

For those who change medical plans, MSB will contribute the additional funds to your HRA to make you whole with the total amounts listed above.

The HRA is integrated with the FSA and pays in the following order:

- Eligible expenses are paid from the FSA first. Only when the FSA has a zero balance does the HRA pay.

	HRA	
What is the account?	**Health Reimbursement Arrangement:** An HRA is an employer-funded account that reimburses you for out-of-pocket medical expenses that are incurred through the HRA Medical Plan.	
Who is eligible	Employees enrolled on the HRA Medical Plan.	
Company Funds (Annual) *Individual* *Maximum per family*	Plan Option 2 $500 $1,000	Plan Option 3 $1,000 $2,000
Funding Availability	100% of your annual funds are available on January 1. Any unused funds are carried over, up to your Plan Out-of-Pocket Maximum.	
Maximum Employee Contributions	N/A: An HRA cannot be funded by employee contributions. Please see the Health FSA for information on tax-free medical reimbursements.	
Eligible Expenses	Your out-of-pocket expenses for any service that is covered under the HRA Medical Plan. Includes deductible, coinsurance and copays.	
Non-eligible expenses	Any item that is not covered under the HRA Medical Plan.	
Interaction with Flexible Spending Account (FSA)	The FSA will reimburse eligible expenses before the HRA is exhausted.	

FLEXIBLE SPENDING ARRANGEMENTS

Allied

What's Changing

The IRS has increased the annual limit on the Health FSA. In 2025, you can set aside up to $3,300 per year pre-tax to pay for certain IRS-approved healthcare (medical, dental, vision) expenses not covered by the insurance plan.

The federal government takes about 30% of each dollar that you earn in FICA and Federal Income tax. The remaining 70% is your net income. With an FSA you can set aside money from your paycheck, before the federal government takes their 30%, to pay for medical, dental, vision and day care expenses. You pay less in taxes, and your money buys more medical (including dental and vision) services than before.

On January 1st of each year, you may elect to set aside a certain amount of money to cover medical, dental and vision expenses and/or dependent care.

Health Care FSA

This program allows you to set aside up to $3300 per year so that you can pay for certain IRS-approved medical care expenses not covered by the insurance plan or Health Reimbursement Arrangement (HRA) with pre-tax dollars. Some examples include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Chiropractic services
- Acupuncture
- Prescription copays
- Dental services and orthodontia
- Over-the-counter medication
- Menstrual products

If you are currently participating in the healthcare account and cannot use up the balance of your account by January 1, 2025, you will be allowed an additional 2½ months to incur expenses. You must incur expenses by March 15, 2026 and file for reimbursement by April 30, 2026. Please see the information from Allied for more information and the enrollment form.

IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status.

Note: Due to IRS regulations, domestic partners and their children are not eligible for health care reimbursement.

Dependent Care FSA

Similar to the Health Care FSA, you may also use pre-tax dollars to pay for qualified dependent care. Expenses can be for your dependent children 12 and under, and in some cases elder care, and must be so you can work, actively look for work or be a full-time student. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

The annual maximum amount you may contribute into the Day Care FSA is $5,000 per calendar year (or $2,500 if married and filing separately). This limit is set by the IRS and is a calendar year limit.

Note: Election changes are also allowed when there is a change in cost or coverage of your childcare provider.

LIFE INSURANCE

Life and AD&D Insurance

MetLife

MSB purchases life and accidental death and dismemberment (AD&D) insurance for all full-time employees.

Benefits	In the event you should pass away, your beneficiary will receive a maximum of $50,000. If death is the result of an accident (as defined by the contract), then the beneficiary(ies) will receive an additional $50,000. A scheduled benefit is paid for amputation or paralysis of limbs. Coverage is also provided in the amount of $2,000 in the event your Dependent Spouse should pass away and $1,000 in the event your Dependent Child should pass away.

REMINDER: IF YOU RECENTLY HAD A FAMILY STATUS CHANGE, THIS IS A GOOD TIME TO UPDATE YOUR BENEFICIARY INFORMATION.

EMPLOYEE WELLBEING

Employee Assistance Program

TELUS Health

The Employee Assistance Program (EAP) is a completely free and confidential counseling program that helps you and/or your family members address life issues, big or small. Benefits are offered to all employees and immediate family members, and can help with:

- Marital and family concerns
- Difficult relationships
- Depression
- Substance abuse
- Grief and loss
- Financial entanglements
- Other personal stressors
- Many other issues

Visit **one.telushealth.com** to:

- Find information about parenting, retirement, finance, and more
- Locate schools, camps, eldercare/childcare providers
- Use financial calculators and retirement planners
- Read books, articles and guides
- Watch videos or listen to audio files

Allied Care Solutions

This is a secondary program available to all employees and immediate family members of MSB. This Employee Assistance Program (EAP) is a completely free and confidential counseling program that helps you and/or your family members address life issues, big or small. You have access to up to 5 counseling sessions. Benefits are offered to all employees and immediate family members, and can help with:

- Marital and family concerns
- Difficult relationships
- Depression
- Substance abuse
- Grief and loss
- Financial entanglements
- Other personal stressors
- Many other issues

Visit **www.alliedbenfit.com/caresolutions** (username MatSu) to:

- Find information about parenting, retirement, finance, and more
- Locate schools, camps, eldercare/childcare providers
- Use financial calculators and retirement planners
- Read books, articles and guides
- Watch videos or listen to audio files

Choose how to get assistance

- In-the moment support with a licensed clinician by phone
- Web portal
- eConnect® Mobile App
- Text Therapy via Textcoach®
- Animo via web portal or mobile app
- Navigator via web portal or mobile app

Contact Allied Care Solutions anytime, around-the-clock, 365 days a year by phone, web, or mobile app.

Call 1-800-440-1440

Log in at www.alliedbenefit.com/caresolutions (username: MatSu)

Email, Chat, or Text via Mobile App scan the QR code to download the app (username: MatSu)

IMPORTANT LEGAL INFORMATION

Healthcare Reform

The Affordable Care Act (ACA) is complex and you may have questions about how it impacts you, your family and your benefits. There are three items you should know.

First, the individual mandate (the requirement that all individuals have health insurance) remains in place. What has changed is the penalty associated with it. As of January 1, 2019, the ACA tax penalty is repealed and you won't have to pay anything if you don't enroll.

Second, the Health Insurance Marketplace still exists. You can shop for and enroll in insurance plans through the exchange and still apply for income-based subsidies.

Third, for most people, the plans we offer are considered affordable for most employees and you may not be eligible for the federal subsidies available in the Health Insurance Marketplace, even if you choose not to enroll in MSB's plan.

Effective 2023, the IRS updated how eligibility for subsidies are calculated. This means your spouse and/or child(ren) may be eligible for less expensive coverage on the Health Insurance Marketplace as eligibility for a subsidy is now based on your monthly premium contribution to enroll family members in MSB's plan. Be sure to complete a thorough evaluation of the Health Insurance Marketplace's plan benefit designs and networks when comparing insurance coverage.

Please refer to your Notice of Health Insurance Marketplace Coverage for general information. For additional information on Marketplace options in your area and subsidy calculators, go to **www.healthcare.gov** or call 1-800-318-2596.

Annual Reminders

Special Enrollment

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), allows a Special Enrollment period in addition to the regular Open Enrollment period. Only the following individuals may enroll outside the Open Enrollment period:

- Individuals who previously waived coverage under this program because they had other coverage and then involuntarily lost the other coverage. Enrollment must occur within 30 days of the loss of other coverage;
- New dependents due to marriage, birth, adoption or placement for adoption. The eligible employee and other dependents who previously did not elect to be covered under the employer's health care plan may also enroll at the time the new dependent is enrolled. Enrollment must occur within 30 days of date of marriage, or 30 days of a birth, adoption or placement for adoption;

- A court has ordered coverage be provided for a spouse or minor child under this plan and request for enrollment is made within 30 days after issuance of such court order;
- If employee and/or dependent(s) become ineligible for Medicaid or the Children's Health Insurance program and request coverage under our plan within 60 days of termination (Please read the Medicaid and the Children's Health Insurance Program notice for more information); or
- If employee and/or dependent(s) become eligible for the state premium assistance program and request coverage under our plan within 30 days after eligibility is determined.

Notice Regarding the Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact Human Resources for more information.

HIPAA Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes your rights with regard to your personal health information. You received a copy of the Matanuska-Susitna Borough Group Health Plan Privacy Notice when you were hired. This notice describes how medical information about you may be used and disclosed, and how you can access that information.

If you have any questions regarding the HIPAA Privacy Notice, or would like another copy, please contact Human Resources.

COBRA

COBRA continuation coverage is a temporary continuation of coverage under our employee benefit plan. Please contact Human Resources for a copy of the General Notice of COBRA Continuation Rights. This notice explains your rights and obligations to receive COBRA benefits.

We are not always aware when a COBRA event takes place, unless notified by you. The most common examples are divorce, or when a child exceeds the maximum age. When such an event occurs, the Notice of Qualifying Event must be postmarked within 60 days of the qualifying event for the affected person to be eligible for COBRA continuation. If you have questions about COBRA please contact Human Resources.

Important Notice from Matanuska-Susitna Borough about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Matanuska-Susitna Borough 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. MSB has determined that the prescription drug coverage offered by the Matanuska-Susitna Borough Employee Benefit 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?

Plan Participants who also are eligible for Medicare have the following three options concerning prescription drug coverage:

- You may stay in the Plan and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period (October 15–December 7 of each year); or (2) if you lose Plan coverage. This is the best option for most Plan participants who are eligible for Medicare.
- You may stay in the Plan and also enroll in Medicare prescription drug coverage at this time. The Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer,

and thus the value of your Medicare prescription drug coverage will be greatly reduced. Your current coverage under the Plan pays for other health benefits as well as prescription drugs and will not change if you choose to enroll in Medicare prescription drug coverage.

- You may reject all coverage under the Plan and choose coverage under Medicare as your primary and only payer for all medical and prescription drug expenses. If you do so, you will not be able to receive coverage under the Plan, including prescription drug coverage, unless and until you are eligible to reenroll at the next enrollment period for which you are eligible, if any. Your current coverage pays for other types of health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current health and prescription drug benefits if you reject coverage under the Plan and choose to enroll in Medicare, including a Medicare prescription drug plan, as your primary and only payer.

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 MSB 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 November 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 MSB 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:	January 1
Name of Entity/Sender:	Matanuska-Susitna Borough
Contact—Position/Office:	Cindy Loyer
Address:	350 East Dahlia Avenue
	Palmer, AK 99645
Phone Number:	907-861-8423

Premium Assistance under Medicaid and the Children's Health Insurance Program

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (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 July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: **http://myalhipp.com/**
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com/**
Phone: 1-866-251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: **http://myarhipp.com/**
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: **http://dhcs.ca.gov/hipp**
Phone: 916-445-8322
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/
State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: **https://www.in.gov/medicaid/**
Family and Social Services Administration
http://www.in.gov/fssa/dfr/
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: **Iowa Medicaid | Health & Human Services**
Medicaid Phone: 1-800-338-8366
Hawki Website: **Hawki - Healthy and Well Kids in Iowa | Health & Human Services**
Hawki Phone: 1-800-257-8563
HIPP Website**: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: 1-855-459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kynect.ky.gov**
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: **https://www.mass.gov/masshealth/pa**
Phone: 1-800-862-4840
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid

Website: **https://mn.gov/dhs/health-care-coverage/**
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: 573-751-2005

MONTANA – Medicaid

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: 1-800-694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid

Website: **http://www.ACCESSNebraska.ne.gov**
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: **http://dhcfp.nv.gov**
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NEW JERSEY – Medicaid and CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: **http://www.njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: **https://medicaid.ncdhhs.gov/**
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: **https://www.hhs.nd.gov/healthcare**
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: **http://www.insureoklahoma.org**
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**
Phone: 1-800-692-7462
CHIP Website: **Children's Health Insurance Program (CHIP) (pa.gov)**
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: **http://www.eohhs.ri.gov/**
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: **https://www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: **http://dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services**
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: **https://medicaid.utah.gov/upp/**
Email: **upp@utah.gov**
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: **https://chip.utah.gov/**

VERMONT– Medicaid

Website: **Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access**
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: **https://www.hca.wa.gov/**
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: **https://dhhr.wv.gov/bms/**
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**
Phone: 1-800-251-1269

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Service
www.cms.hhs.gov
1-877-267-2323, menu option 4, ext. 61565g