boon®

2024 Enrollment Guide

KeyStaff, Inc.

boongroup.com

Welcome!

Welcome to your health plan provided by **KeyStaff, Inc.**!

Plan Enrollment Options

We are pleased to offer you these great plan options to fit your healthcare needs:

SmartMEC

You have the option to enroll in the **SmartMEC** plan. SmartMEC offers you and your family affordable minimum essential coverage that covers 100% of the government's listed Preventive and Wellness Benefits.

SmartMVP Silver

If you desire a higher level of coverage, you have the option to enroll in the **SmartMVP Silver** plan. SmartMVP Silver is a minimum value plan that includes minimum essential coverage and a wide range of health care services, including, but not limited to: doctor visits, prescription, diagnostic services, hospital stays and more.

Weekly Cost	SmartMEC	SmartMVP Silver		
		Less than $13.99/hr	$14.00 - $15.99/hr	$16.00 +
Employee Only	$10.82	$23.50	$34.93	$40.70
Employee & Spouse	$26.71	$145.45	$156.19	$161.96
Employee & Child(ren)	$35.56	$107.34	$118.08	$123.85
Employee & Family	$52.23	$200.96	$211.70	$217.47

Enrollment Instructions

Please fill out the enclosed enrollment form(s) to add any eligible dependents or update any relevant information and submit by the enrollment deadline. You can submit your form by one of the following methods:

- Submit the form to your **HR Department**

Enrollment Deadline

Open Enrollment

- Forms must be submitted during the open enrollment period.
- Benefits will become effective **12/29/2023**.

New Hire Employees

- Forms must be submitted **within 30 days of your date of hire**.
- Benefits will become effective **the 1st Friday following 60 days of employment.**

Questions? Member Services is here to help!

Please do not hesitate to contact **Boon Member Services** at **866 868 4139** for any questions pertaining to your plan. Representatives are available to assist you **Monday – Friday 6:00 am – 7:00 pm and Saturday – Sunday 9:00 am – 12:00 pm, Central Time**.

We appreciate your participation and look forward to serving you.

Thank you!

Boon Administrative Services, Inc.
6300 Bridgepoint Parkway,
Bldg. 3, Suite 200
Austin, TX 78730
866 868 4139

SmartMEC

Minimum Essential Coverage Benefit Plan

Plan Overview

Plan Coinsurance	**100%**
Individual Deductible	**$0**
Individual Coinsurance Limit	**$0**
Lifetime Maximum	**Unlimited**
ACA Required Preventive Care / Screening	**100%**

MEC Coverage Overview

Routine Physical Exam		**Flu and Pneumonia Vaccines**	
Well Woman Exam (Annual)		**Bone Density Test**	
Annual Mammogram		**Routine Immunizations**	
Annual Pap Smear and Other Routine Lab		**Well Baby / Well Child Care Exam**	
Breast Thermography		**Counseling**	Obesity & Healthy Eating
Contraception	FDA approved contraceptive methods		Treating Depression
	Sterilization procedures		Alcohol & Drug Abuse
	Patient education and counseling		Smoking Cessation
	Does not include abortifacient drugs		Domestic & Interpersonal Violence
Cancer Screenings	Cervical Cancer		Sexually Transmitted Diseases
	Breast Cancer	**Routine Lab, X-Rays, Diagnostic Testing, & Other Medical Screenings**	Blood Pressure
	Colorectal Cancer		Diabetes
	Lung Cancer		Cholesterol

The recommendations and guidelines may be found here:

www.uspreventiveservicestaskforce.org/ or www.healthcare.gov/preventive-care-benefits/

Benefit Overview of plan features. Please see Plan Documents for complete description of benefits, exclusion, limitations, and conditions of coverage. Plan features and availability may vary by location and are subject to change.

SmartMEC Plan

Administered by Boon Administrative Services, Inc.

Minimum Essential Coverage Plan - with Dependents

The following is a brief description of the benefits provided. For more detailed information and the frequency and ages for each benefit, please refer to the Schedule of Benefits.

This plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: www.uspreventiveservicestaskforce.org/ or at www.healthcare.gov/preventive-care-benefits/

Preventive Care Services for Adults

Charges for covered Preventive Services as listed below:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
2. Alcohol Misuse screening and counseling;
3. Aspirin use for men and women of certain ages;
4. Blood Pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal Cancer screening for adults over 50, including bowel preparation medications, physician charges, facility charges, anesthesia charges, specialist consultation prior to preventive colonoscopy if recommended by attending provider and polyp biopsy associated with preventive colonoscopy;
7. Depression screening for adults;
8. Type 2 Diabetes screening for adults with high blood pressure and adults who are overweight;
9. Diet counseling for adults at higher risk for chronic disease;
10. Fall Prevention, to include physical therapy and Vitamin D supplementation in community dwellings, ages 65+;
11. Hepatitis B screening for non-pregnant adults and adolescents;
12. Hepatitis C screening for adults at high risk;
13. HIV screening for all adults at higher risk;
14. Immunizations for adults-doses, recommended ages, and recommended populations vary: Hepatitis A; Hepatitis B; Herpes Zoster; Human Papillomavirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Tetanus, Diphtheria, Pertussis; and Varicella;
15. Lung Cancer screening for adults ages 55-80 who smoke 30 packs per year
16. Obesity screening and intensive, multicomponent behavioral interventions including counseling as specified in the Schedule of Benefits;
17. Prostate screening including exam and Prostate Specific Antigen (PSA) test for men age 50 and over or age 40 with risk factors;
18. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
19. Syphilis screening for all adults at higher risk;
20. Tobacco Use screening for all adults and cessation interventions for tobacco users;
21. Well Adult Routine Physical Exams.

Preventive Care Services for Children

Charges for covered Preventive Services as listed below:

1. Alcohol Misuse screening and counseling for adolescents;
2. Anemia / Iron Deficiency screening for Children;
3. Autism screening for Children at 18 and 24 months;
4. Behavioral assessments / Well-Child visits for Children of all ages as specified in the Schedule of Benefits;
5. Blood Pressure screening for Children as specified in the Schedule of Benefits;
6. Cervical Dysplasia screening for sexually active females;
7. Congenital Hypothyroidism screening for newborns;
8. Depression screening for Children at doctor's discretion;
9. Developmental screening for Children as specified in the Schedule of Benefits;
10. Dyslipidemia (Cholesterol) screening for Children at higher risk of lipid disorders as specified in the Schedule of Benefits;
11. Fluoride Chemoprevention as specified in the Schedule of Benefits;
12. Gonorrhea preventive medication for the eyes of all newborns;
13. Hearing screening for all newborns;
14. Height, Weight and Body Mass Index measurements for children as specified in the Schedule of Benefits;
15. Hematocrit or Hemoglobin screening for Children;
16. Hemoglobinopathies or sickle cell screening for newborns;
17. HIV screening for adolescents at higher risk;
18. Immunizations for Children from birth to age 18 - doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis; Haemophilus influenza type b; Hepatitis A; Hepatitis B; Human Papillomavirus; Inactivated Poliovirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Rotavirus; and Varicella
19. Iron supplements for Children ages 6 to 12 months at risk for anemia;
20. Lead screening for children at risk of exposure;
21. Medical History for all children throughout development as specified in the Schedule of Benefits;
22. Obesity screening and counseling as specified in the Schedule of Benefits;
23. Oral Health risk assessment for young Children as specified in the Schedule of Benefits
24. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
25. Prenatal and related preventative care related to the pregnancy of a dependent child;
26. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
27. Skin cancer behavioral counseling for children 10-24 who have fair skin
28. Tobacco screening, counseling and cessation interventions for children and adolescents
29. Tuberculosis screening for children at doctor's discretion for children at high risk; and
30. Vision screening for all Children.

SmartMEC Plan

Administered by Boon Administrative Services, Inc.

Preventive Care Services for Women, Including Pregnant Women

Charges for covered Preventive Services as listed below:

1. Anemia screening on a routine basis for pregnant women;
2. Aspirin for treatment of pre-eclampsia in pregnant women;
3. Bacteriuria urinary tract or other infection screening for pregnant women;
4. BRCA counseling about genetic testing for women at higher risk;
5. Breast Cancer Mammography screenings every year for women over 40;
6. Breast Cancer Chemoprevention counseling for women at higher risk;
7. Breastfeeding comprehensive support and counseling from trained providers, as well as the purchase of breast pumps, for pregnant and nursing women;
8. Cervical Cancer screening for sexually active women;
9. Chlamydia Infection screening for younger women and other women at higher risk;
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures (including facility charges, physician charges and anesthesia charges), and patient education and counseling, not including abortifacient drugs;
11. Depression screening for pregnant and postpartum women as provided in the schedule of benefits
12. Domestic and interpersonal violence screening and counseling for all women;
13. Folic Acid supplements for women who may become pregnant;
14. Gestational diabetes screening for women 24 to 28 weeks pregnant, and at first prenatal visit, and those at high risk of developing gestational diabetes;
15. Gonorrhea screening for all women at higher risk;
16. Hepatitis B screening for pregnant women at their first prenatal visit;
17. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
18. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
19. Osteoporosis screening for women; 1 time per year, women age 65 years and older; 1 per year for younger women if recommended by a physician.
20. Rh Incompatibility screening for all pregnant women and followup testing for women at higher risk;
21. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users;
22. Sexually Transmitted Infections (STI) counseling for sexually active women;
23. Syphilis screening for all pregnant women or other women at increased risk; and
24. Well-woman visits to obtain recommended preventive services, including prenatal visits as specified in the Schedule of Benefits.

Limitations and Exclusions

Some health care services are not covered by the Plan. The following is an example of services that are generally *not covered*. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage.

Any medical service, treatment, or procedure not specified as covered under this Plan.

Charges for the treatment of illness or disease, or charges other than those that are:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

SmartMEC Plan

Limitations and Exclusions

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Any medical service, treatment, or procedure not specified as covered under this Plan.

Charges incurred from a Provider who is not part of the Preferred Provider Organization (Out-of-Network Provider).

Charges:

- For injury or sickness, except for prenatal care as required by the Affordable Care Act
- In excess of any Plan maximums
- For services provided by a family member
- For services that are not actually rendered
- Payable by the government
- For treatment that is Experimental or Investigational
- Incurred prior to coverage
- Incurred by other persons
- That are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration
- Incurred for care outside of the United States

Dental Procedures.

Government-Operated Facilities.

1. That are furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments; and
2. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: This exclusion does not apply to treatment of non-service related disabilities. This exclusion does not apply where otherwise prohibited by law;

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness resulting from that Participant's voluntary taking of or being under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician.

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay.

Non-Prescription Drugs. For drugs that can be purchased over-the-counter and without a Physician's written prescription, except for prenatal vitamins and as required by the Affordable Care Act.

Office Visits, Physical Examinations, Immunizations, and Tests when required solely for the following:

- Sports
- Camp
- Employment
- Travel
- Insurance
- Marriage
- Legal Proceedings

Rehabilitative Therapies

Routine Foot Care

SmartMEC Plan

Limitations and Exclusions *(continued)*

- Abortion, except in the case of rape or incest or if the life of the mother is endangered by continuing the pregnancy.
- Applied Behavioral Analysis
- Cosmetic Surgery
- Custodial Care
- Charges:
  - From provider error
  - In excess of any Plan maximums
  - For services provided by a family member
  - Payable by the government
  - For injury or sickness from a hazardous pursuit or hobby
  - Injury while taking part in an illegal activity
  - Incurred prior to coverage
  - Incurred for non-emergency care outside of the United States
- Dental services and X-rays
- Education or Training Program
- Experimental and investigational procedures
- Equipment or changes to a home, workplace or vehicle to impact mobility or access
- Eye Refractions, eyeglasses, contact lenses
- Foot care, other than for diabetes
- Growth or height treatment or medications
- Home Births
- Hypnosis
- Immunizations for travel or work
- Implantable Drugs and associated devices.
- Infertility services, including artificial insemination, injectable infertility drugs, advance reproductive technology including IVF, ZIFT, GIFT, and ICSI
- Long term rehabilitation therapy
- Non-emergency services outside of the United States
- Non-medically necessary services or supplies
- Nutritional supplies or food item
- Occupational injury or illness
- Orthotics, except for the treatment of diabetes
- Over the counter medications, except as required by the Affordable Care Act
- Private Duty Nursing on an in-patient basis
- Private Duty Nursing
- Services for sexual dysfunction, including therapy, supplies, counseling or prescription drugs other than those listed as being covered.
- Sex change service, drugs or supplies
- Strength and Performance - Services, devices and supplies to enhance strength, physical condition, endurance or physical performance
- Therapies and tests other than those listed as being covered
- Vitamins, except for prenatal vitamins
- Weight: Any treatment, Drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity.

Get the Most From Your Benefits With First Health Network Providers

As a member of a health plan that offers you the First Health Network for your medical care, you have access to a national network of providers and great savings. Using providers that participate in the First Health Network is the easiest way to maximize your benefits.

The First Health Network

By going to a First Health provider, you can reduce your out-of-pocket expenses and stretch your benefit dollars. In addition:

- The First Health Network provides access to one of the nation's largest and most respected networks. You have access to more than 5,000 hospitals, over 90,000 ancillary facilities, and over 1 million health care professionals across all 50 states, plus the District of Columbia and Puerto Rico.
- Network doctors are carefully selected to promote quality outcomes.
- You have no paperwork because network doctors and hospitals file claims for you.
- Your medical ID card displays the First Health Network logo so your provider identifies you as a participating plan member.

Maximize Your Benefits

Unlike non-participating doctors and hospitals, First Health Network providers have agreed to provide services for discounted fees. Therefore, you can stretch your benefits and reduce your out-of-pocket expenses by using participating First Health Network providers.

Compare network and non-network costs

The following example shows how benefits would be calculated when an in-network provider is used, versus an out-of-network provider. This example is for illustration purposes only and is not specific to your plan of benefits.

Example - Office Visit

	First Health provider	Non-network provider
Your office visit	$250.00	$250.00
Provider discount	- $150.00	$0
Total charge with discount applied	$100.00	$250.00
Plan covers	$80.00	$125.00
Your total responsibility	$20.00	$125.00

Find a Network Provider

The most convenient way to find a doctor, hospital or other health care service provider participating in the First Health Network is by searching our online provider directory at **www.firsthealthlbp.com**. The electronic provider directory, available 24 hours a day, 7 days a week, includes the most detailed provider information available and is constantly updated. You can also call your administrator for assistance in locating a provider, at **1-866-868-4139**.

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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 your employer 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.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Your employer has determined that the prescription drug coverage offered by your employer's plan is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. **This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from your employer's plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible**.

3. You can keep your current coverage from your employer's plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.

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**.

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

Since the coverage under your employer's plan is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, the current coverage offered to you and your dependents by your employer's plan will not be affected.

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 your employer 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)**.

SmartMVP Silver

SmartMVP Silver Buy-Up Plan

Benefit Overview of plan features. Please see Plan Summary for detailed information about the benefits and exclusions that shall prevail over the terms of this benefit overview.

SmartMVP Silver Self-Funded Medical Benefits	
Plan Coinsurance	**100%**
Individual / Family Deductible	**$0 / $0**
Individual / Family Maximum Out of Pocket	**$3,150 / $12,700**
Lifetime Maximum	**Unlimited**
Doctor's Office & Specialist Office Visits	
Office Visit Copay	**$15**
Specialist Copay	**$25**
Prescription Drug Benefit	
Generic Prescription Copay	**$15**
Preferred Brand Prescription Copay	**$25**
Non-Preferred Brand Prescription Copay (Specialty Drugs excluded)	**$75**
Emergency Room Copay	**$400**
Urgent Care Copay	**$200**
Outpatient Laboratory and Professional Services Copay *(Not covered if services are provided at a hospital)*	**$50**
Outpatient X-rays and Diagnostic Imaging *(Not covered if services are provided at a hospital)*	**$50**
Outpatient Imaging (CT, PET scans, MRI) Copay *(Not covered if services are provided at a hospital)*	**$400**
Hospitalization (Room & Board Only) including MHSA (Mental Health & Substance Abuse)	
Plan Coinsurance	**60%**
Per Admission Copay	**$500**
Maximum number of covered days per plan year	**10 days**
Preventative Care/Screening/Immunization Services (MEC)	**100% Covered**
Disease Management	**Included**
Medicare Reference Reimbursement @130%	**Included**

SmartMVP Silver Plan

Limitations and Exclusions

Some health care services are not covered by the Plan. See plan documents for a complete description of benefits, exclu-sions, limitations and conditions of coverage. The following is a list of services that are generally *not covered.*

- Abortion
- Acupuncture
- Ambulance
- Ambulatory Surgical Center
- Anesthesia
- Applied Behavioral Analysis
- Autism Spectrum Disorder, other than physician office visits
- Behavioral Health Services
- Birthing Center
- Custodial Care
- Charges:
  - From provider error
  - In excess of any Plan maximums
  - For services provided by a family member
  - Payable by the government
  - For injury or sickness from a hazardous pursuit or hobby
  - Injury while taking part in an illegal activity
  - Incurred prior to coverage
  - Incurred for non-emergency care outside of the United States
- Chemotherapy
- Consultations
- Cosmetic Services and Surgery
- Counseling
- Custodial Care
- Dental services and X-rays
- Durable Medical Equipment, except for equipment and supplies for diabetes
- Education or Training Program
- Experimental or investigational procedures
- Equipment or changes to a home, workplace or vehicle to impact mobility or access
- Eye Refractions, eyeglasses, contact lenses
- Foot care
- Growth or height treatment or medications
- Hearing Exam and hearing aids
- Home Births
- Hospice Care
- Hospital. Charges made by a Hospital for:
  - Inpatient Treatment
    - General nursing services; and
    - Medically Necessary services and supplies furnished by the Hospital, other than Room and Board
  - Outpatient Treatment
    - Treatment for chronic conditions;
    - Physical Therapy treatments;
    - Hemodialysis; and
    - X-ray, laboratory and linear therapy.
  - Pre-Admission Testing.
- Hypnosis
- Immunizations for travel or work
- Implantable Drugs and associated devices, except as required by the Affordable Care Act
- Infertility services, including artificial insemination, injectable infertility drugs, advance reproductive technology including IVF, ZIFT, GIFT, and ICSI
- Injectable Drugs
- Inpatient Charges, other than Room and Board in a hospital
- Newborn care
- Non-emergency services outside of the United States
- Non-emergency or non-urgent care provided in a hospital emergency room or by another emergency or urgent care provider
- Non-medically necessary services or supplies
- Nursing Services
- Nutritional supplies or food item
- Occupational injury or illness
- Over the counter medications, except as required by the Affordable Care Act
- Pregnancy of a Dependent Child, except for prenatal care as required by the Affordable Care Act
- Private Duty Nursing
- Prosthetics, Orthotics and supplies
- Reversal of Sterilization Procedures
- Rehabilitative therapy, including speech, physical and occupational therapy
- Services for sexual dysfunction, including therapy, supplies, counseling or prescription drugs other than those listed as being covered.
- Sex change service, drugs or supplies
- Skilled Nursing Facility
- Specialty Drugs
- Strength and Performance - Services, devices and supplies to enhance strength, physical condition, endurance or physical performance
- Surgery, except for sterilization procedures for women required under the Affordable Care Act
- Therapies and tests other than those listed as being covered
- Vision-related services or tests, except as required by the Affordable Care Act
- Vitamins, except for prenatal vitamins
- Weight: Any treatment, Drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity.

boon®

How to be a Reference-Based Pricing Patient

Simple steps for using your plan
For members on 2020Choice, SmartMEC, SmartMEC 2020 or SmartMVP Silver plans.

Doctor Visits

Step 1
Choose your doctor.

You have the freedom to choose a doctor of your choice since the plan is not limited to a network.

Step 2
Schedule your appointment.

Provide your ID card information on the phone or at the provider's office.

Step 3
Go to your appointment.

Step 4
Pay any applicable copay required.

Step 5
You're done!

Emergency Room Visits

Step 1
Go to the nearest emergency room.

Step 2
Present your ID card.

Step 3
The plan will pay its portion of the plan responsibility.

Step 4
You will receive an Explanation of Benefits (EOB) in the mail and a bill from the provider. Both should indicate the same Patient Responsibility due to the provider. If you didn't pay your Patient Responsibility at the time of service, you will owe that amount.

If the provider balance bills you for amounts beyond the plan payment and your patient responsibility amount, contact your Patient Advocate immediately. Your Patient Advocate will work with you and the provider to determine a reasonable and fair amount.

Step 5
Be patient and stay engaged.

The balance bill process takes an average of nine months. However, the end result will save you money and help drive down the cost of health insurance.

Scheduled Procedures

Step 1
Schedule your procedure through your doctor. They will admit you to the hospital or facility. Provide your ID card information on the phone.

Step 2
Go to your scheduled procedure.
Pay any applicable copay required.

Step 3
The plan will pay its portion of the plan responsibility.

Step 4
You will receive an Explanation of Benefits (EOB) in the mail and a bill from the provider. Both should indicate the same Patient Responsibility due to the provider. If you didn't pay your Patient Responsibility at the time of service, you will owe that amount.

If the provider balance bills you for amounts beyond the plan payment and your patient responsibility amount, contact your Patient Advocate immediately. Your Patient Advocate will work with you and the provider to determine a reasonable and fair amount.

Step 5
Be patient and stay engaged.

The balance bill process takes an average of nine months. However, the end result will save you money and help drive down the cost of health insurance.

PROGRAM OVERVIEW

Feel better, get active and be healthier with your wellness program

Don't miss out! Your wellness program includes:

Condition coaching:

Ready to do something good for yourself? Now, it's easier than ever. This personalized coaching program can help you eat better, get more active and manage a health condition. You choose how to use the program. You can go at your own pace with online digital coaching. Or you can work with a coach in live, group coaching sessions or one to one over the phone.

MyActiveHealth website:

Managing your health can be challenging. But the tools that help you don't have to be. That's why we've made it easy to track your activity, get wellness advice, find healthy recipes and more. Whatever gets you closer to achieving your health goals. You'll find it online at MyActiveHealth.com/BoonGroup

ActiveHealth app:

Always on the go? No problem. The ActiveHealth app is ready for you wherever you are. Just search for "ActiveHealth" in your app store and download the app.

Health Actions:

Small actions matter — especially when it comes to staying at your best health. You'll get notifications from ActiveHealth with important steps to take to help you achieve your best health. We call these Health Actions. Track them online on MyActiveHealth.com/BoonGroup

Maternity support:

Pregnancy is an exciting time in your life. You may have a lot of questions or need support. Even if you're an experienced mom. This program includes support and resources just for you. You can even call and speak to a nurse coach if you want.

Case management:

Your health should be front and center. That's true whether you're managing a chronic condition or recovering from an injury. Or maybe you're dealing with another challenge. We'll pair you with an experienced nurse. Your nurse coach can help take care of the details of whatever you're facing. That leaves you free to focus on getting better.

You can get started today. Call **877-749-6997**
or log on **MyActiveHealth.com/BoonGroup**

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GENERAL NOTICE CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**. When you become eligible for COBRA, you may also be 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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-ofpocket 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 coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to YOUR PLAN, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 days after the qualifying event occurs. 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 days after the qualifying event occurs. You must send written notice of a qualifying event to the Plan Administrator at the following address: **"YOUR EMPLOYER" – ATTN: COBRA Administration, Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227**. The notice must identify the qualifying event and the date such event occurred and include any supporting documentation available (such as a divorce decree) and the name and address of all qualified beneficiaries whose coverage is affected by the qualifying event.

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 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 this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. In the event that you become disabled prior to the 60th day of COBRA continuation coverage, you must provide a notice of such disability within 60 days of receiving a disability determination from the Social Security Administration, and in no event later than the expiration of the 18-month period of continuation coverage to the following:

"YOUR EMPLOYER", ATTN: COBRA Administration, Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227. Please include any available supporting documentation pertaining to the disability, including the Social Security Administration determination of disability.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In the event that you experience a second qualifying event while you are receiving COBRA Continuation Coverage, within 30 days of such qualifying event, please provide notice to:

"YOUR EMPLOYER", ATTN: COBRA Administration, Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227. The notice must identify the qualifying event and the date such event occurred and include any supporting documentation available (such as a divorce decree) and the name and address of all qualified beneficiaries whose coverage is affected by the qualifying event.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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 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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at 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

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For more information concerning your rights under COBRA, please contact:

Boon Administrative Service, Inc.
ATTN: COBRA Administration
Comerica Lock Box
PO Box 671227
Dallas, TX 75267-1227
888-835-3310

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 your employer's plan 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. Your employer has determined that the prescription drug coverage offered by your employer's 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 coverage through your employer's plan will not be affected.

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 your employer 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 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 Boon 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)**.

Supplemental Information

Getting started is easy!

1. If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medicines:
   - The first for a short-term supply (e.g., 30 days) to be filled right away at a participating retail pharmacy
   - The second for the maximum days supply allowed (up to a 90-day supply) with as many as three refills (if appropriate) to be mailed to CVS Caremark
2. Complete the mail service order form. You can fill out and print the form online at **Caremark.com** by clicking on New Prescriptions. An incomplete form can cause a delay in processing.
3. Mail your order form along with your prescription(s) and payment in the envelope provided, or use your own envelope to mail the form and payment to the CVS Caremark Mail Service Pharmacy address printed on the form. You can pay using an electronic check, Bill Me Later®, or credit card (VISA®, MasterCard®, Discover® or American Express®). Or you can pay by check or money order. Do not send cash.
4. Allow up to 10 days from the day you submit your order for delivery of your medicine.

If you're not in a hurry to get your medicine, then just get a 90-day prescription from your doctor to send to CVS Caremark.

Tips for saving time and money.

1. Ask your doctor about generic medicines. Research shows that you can **save an average of 30% to 80%**** when you fill your prescriptions with a generic instead of a brand-name drug.
2. If your prescription benefit program has a Preferred Drug List, print a copy of the list from Caremark.com and take it with you to your doctor's office. Using medicines on this list may save you and your prescription plan money.
3. Make sure the prescription you receive from your doctor is legible. It should include the patient's full name, the prescribing doctor's contact information and the prescription details - including the date it was written.

Caremark.com puts the power in your hands.

- Order the fastest refills
- Check drug cost
- View prescription history
- Find a participating local pharmacy
- Contact a pharmacist

Register today at **Caremark.com** to actively manage your own health and wellness. You will need information from your benefit ID card to register.

CVS CAREMARK

www.caremark.com

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount, or other charge, with the balance, if any, paid by the Plan.

**The amount of your savings will be based on your benefit plan. Source: Generic Pharmaceutical Association's Web site: www.gphaonline.org

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CVS Caremark Mail Service Pharmacy

A User's Guide

CVS CAREMARK

The advantages of mail service.

Your prescription benefit plan administered by CVS Caremark includes the use of a mail service pharmacy. If you take one or more maintenance medicines, you may save money and time with mail service and have your medicine conveniently delivered to your home, office or location of choice.

With the CVS Caremark Mail Service Pharmacy, you can:

- Receive an extended supply of medicine.
- Enjoy free regular delivery
- Speak to a registered pharmacist 24 hours a day, seven days a week
- Contact a pharmacist with your questions on Caremark.com
- Order prescription refills online or by phone anytime, day or night

Convenient refill options.

The information you receive with your medicine will show the date that you can request a refill and the number of refills you have remaining.

3 ways to refill:

- **Online –** Ordering refills at Caremark.com is convenient, fast and easy! Have your benefit ID card handy to register.
- **By Phone** – Call the toll-free Customer Care number on your prescription label for fully automated refill service. Have your benefit ID number ready.
- **By Mail –** You can also mail your refill request to CVS Caremark, but online and telephone orders tend to arrive sooner.

Allow up to 10 days from the day you submit your order for delivery of your medicine. Regular delivery is free. Overnight or second-day delivery is available for an additional charge.

Packaged for safety.

Your medicine will be mailed to you in plain, tamper-proof packaging. An order form and a return envelope are included with every delivery. All items in your order typically arrive in one package. If an item is not available, CVS Caremark will contact you to determine if you want the available items shipped or held until all items are ready.

Special handling.

Certain items require special handling and may be shipped by a faster method at no additional cost. In such cases, you may receive a call letting you know your order is being shipped.

- **Controlled substances and orders exceeding $1,200 in value** – shipped via two-day delivery service. An adult signature is required for delivery.
- **Temperature-sensitive items** – packaged and sent using special procedures, including ice packs, coolers, and/or express delivery when necessary.

What you will pay.

Your benefit materials explain your copayment* or coinsurance for mail service. You can receive up to a 90-day supply of your medicine for a copay that may be significantly less than you would pay at a participating retail pharmacy. If you are unsure of your cost, contact your benefit provider, call the toll-free number listed on your benefit ID card or in your Welcome Kit, or check drug costs on Caremark.com.

If you will be traveling.

If you need your medicine shipped to a temporary address, you can let us know by phone, on your order form or by updating your profile on Caremark.com. If you need more medicine while traveling than the quantity allowed by your prescriber or benefit plan (i.e., more than a 90-day supply), contact your benefit office for approval at least 30 days before you need a refill.

If your medicine looks different.

There may be times when a cost-saving generic drug is available to treat your condition. In this situation, you may receive the generic, unless your doctor tells us you must receive the brand-name medicine. A generic drug may look different, but all generic drugs are approved by the U.S. Food and Drug Administration to have the same active ingredients as the brand-name medicines

To learn more about your medicine.

Important information on common medicine uses, specific instructions and possible side effects is included with each order. If you need additional information, visit Caremark.com or call the toll-free number on your benefit ID card or in your Welcome Kit.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

To request special enrollment or obtain more information, contact the benefits administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you are receiving covered benefits for a Mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA).

The Act provides 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 copays, deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan as stated in the Plan Summary provided with these materials.

If you would like more information on WHCRA benefits, contact the benefits administrator.

NEWBORN'S ACT DISCLOSURE

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance from Medicaid in paying for your employer health plan premiums. The following list of states is current as of Jul. 31, 2023. 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
Website:
Health Insurance Premium Payment (HIPP) Program
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
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS | Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA 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://kidshealth.ky.gov/Pages/index.aspx
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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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: https://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. 5218

NEW JERSEY | Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/ index.html
CHIP Phone: 1-800-701-0710

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

PENNSYLVANIA | Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND | Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH | Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT | Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
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 Jul. 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

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