boon®

2025
Benefits At A Glance

KeyStaff, Inc.

boongroup.com

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

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 + HealthiestYou

SmartMEC offers affordable minimum essential coverage (MEC) benefits that covers all of the government's listed Preventive and Wellness Benefits. **HealthiestYou** offers 24/7 telehealth services.

- Providers in your area can be found by visiting the **First Health PPO** network website: **www.firsthealthlbp.com**
- **HealthiestYou is the telehealth provider for SmartMEC**. Download the app, visit **www.healthiestyou.com**, or you may call customer service at **855 894 9627** for assistance.

SmartMVP Silver

If you desire a higher level of coverage, you have the option to enroll in **SmartMVP Silver**. SmartMVP Silver is a ***minimum value plan*** that includes MEC benefits as well as a wide range of health care services, including doctor visits, prescription, diagnostic services, hospital stays and more.

- **Caremark** is the prescription carrier for your plan. If you have questions or need assistance, please contact Member Services or visit the Caremark website: **www.caremark.com**

Weekly Cost	SmartMEC + HY	SmartMVP Silver		
		Less than $13.99/hr	$14.00 - $15.99/hr	$16.00 +
Employee Only	$11.82	$23.51	$96.49	$34.26
Employee & Spouse	$27.70	$145.50	$218.48	$156.25
Employee & Child(ren)	$36.55	$107.41	$180.39	$118.16
Employee & Family	$53.22	$201.07	$274.05	$211.82

Enrollment Instructions

Please fill out the enclosed enrollment form to enroll yourself and any eligible dependents or update any relevant information. If you choose to waive coverage, please fill out the enclose waiver. ***Forms must be submitted by the enrollment deadline***.

Submit your form to:

- **HR Department**

Enrollment Deadline

Open Enrollment

- **Forms must be submitted: during the open enrollment period**
- **Benefits will become effective: 12/27/2024**

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** 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 Member Services
866 868 4139
Monday – Friday 6:00 am – 7:00 pm &
Saturday – Sunday 9:00 am – 12:00 pm, Central Time

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%**
CVS Prescription Discount Card	**Included**
HealthiestYou Telehealth Services	**Included**

MEC Coverage Overview

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<tr><td colspan="2">Routine Physical Exam</td><td colspan="2">Flu and Pneumonia Vaccines</td></tr>
<tr><td colspan="2">Well Woman Exam (Annual)</td><td colspan="2">Bone Density Test</td></tr>
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<tr><td rowspan="4">Contraception</td><td>FDA approved contraceptive methods</td><td>Treating Depression</td></tr>
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<tr><td>Patient education and counseling</td><td>Smoking Cessation</td></tr>
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<tr><td rowspan="4">Cancer Screenings</td><td>Cervical Cancer</td><td>Sexually Transmitted Diseases</td></tr>
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<tr><td colspan="4">The recommendations and guidelines may be found here:</td></tr>
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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.

SmartMVP Silver Plan Overview

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.

Self-Funded Medical Benefits for SmartMVP Silver	In-Network	Out-of-Network
Plan Coinsurance	100%	40%
Individual / Family Deductible	$0 / $0	$500 / $1,000
Individual / Family Maximum Out of Pocket	$3,150 / $12,700	No Maximum
Lifetime Maximum	Unlimited	Unlimited
Preventative Care/Screening/Immunization Services (MEC)	100% Covered	100% Covered
Doctor's Office & Specialist Office Visits		
Non-Specialist Visit	$15 copay	Deductible and Coinsurance
Specialist Visit	$25 copay	Deductible and Coinsurance
Prescription Drug Benefit		
Generic Prescription	$15 copay	Deductible and Coinsurance
Preferred Brand Prescription	$25 copay	Deductible and Coinsurance
Non-Preferred Brand Prescription *(Specialty Drugs excluded)*	$75 copay	Deductible and Coinsurance
Emergency Room	$400 copay	Same as In-Network
Urgent Care	$200 copay	Deductible and Coinsurance
Outpatient Laboratory and Professional Services Copay *(Not covered if services are provided at a hospital)*	$15 copay	Deductible and Coinsurance
Outpatient X-rays and Diagnostic Imaging *(Not covered if services are provided at a hospital)*	$15 copay	Deductible and Coinsurance
Outpatient Imaging (CT, PET scans, MRI) Copay *(Not covered if services are provided at a hospital)*	$400 copay	Deductible and Coinsurance
Hospitalization including Mental Health & Substance Abuse ***(MHSA)*** *(Room & Board Only)*		
Plan Coinsurance	60%	Deductible and Coinsurance
Per Admission Copay	$500	$500
Maximum number of covered days per Plan Year	10 days	10 days
Disease Management	Included	
Medicare Reference Reimbursement @ 130%	Included for services rendered in hospitals and inpatient facilities	

All plan co-insurance amounts are stated as a percentage of Reasonable and Appropriate Fees.
"Reasonable and Appropriate" fees shall be limited to covered expenses which are identified aseligible for payment by the Plan Administrator in accordance with the terms of this Plan.

"Reasonable and Appropriate" amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, amounts the Provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization ("PPO") network, average wholesale price (AWP) and/or manufacturer's retail pricing (MRP), the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. Medicare rates plus 30% are generally considered to be the Reasonable and Appropriate (and thus Maximum Payable Amount); however, the Plan Administrator may in its discretion, taking into consideration specific circumstances and negotiated terms, deem a greater amount to payable.

The above benefits are per Participant per Plan Year.

SmartMEC Plan

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 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

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.

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.

SmartMVP Silver Only

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:

"YOUR EMPLOYER"
ATTN: COBRA Administration
Comerica Lock Box
PO Box 671227
Dallas, TX 75267-1227
888-835-3310

SmartMEC - Non-Credible Coverage

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 - Credible Coverage

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)**.

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, 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
Website: https://www.in.gov/medicaid/ or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864, Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/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://kynect.ky.gov
Phone: 1-877-524-4718

KENTUCKY | Medicaid (continued)
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 & 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:
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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY | Medicaid & CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 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
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA | Medicaid & 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:
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 & CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/
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/

UTAH | Medicaid & CHIP (continued)
CHIP Website:
http://health.utah.gov/chip

VERMONT | Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA | Medicaid & 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 & 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, 2024, or for more information on special enrollment rights, contact either:

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

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

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6300 Bridgepoint Parkway,
Bldg. 3, Suite 200
Austin, TX 78730
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