32BJ SEIU
Stronger Together

It's Open Enrollment Time!

2022
Benefits Guide

You only have until December 4 to enroll in BOLR BMCA Full-Time Benefits for 2022!

OPEN ENROLLMENT FORMS

The forms that you need to complete for enrollment are on the next few pages of this Guide. See the instructions at the top of each form to help you understand which forms you need to complete and mail back to the Fund Office.

And be sure to review the rest of the Guide to help you with your enrollment for coverage in 2022. We have updated the Guide to make it easier to use this year.

Questions? Contact the Fund Office.

NEW PARTICIPANTS/MEMBERS:
If adding dependents to your coverage, you must complete the dependent enrollment form and provide the proper documentation of their dependent status to ensure their enrollment into the Plan.

IMPORTANT INSTRUCTIONS:
Complete this form and return it to the Fund Office if you are adding dependents to your coverage. This form has two sides. **Remember to complete both sides and sign and date on the second page of this form.**

Side A

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND
DEPENDENT ENROLLMENT FORM

Please complete the information requested on both sides of this form to add or maintain your dependent child/children to the Plan. For natural child/children or stepchild/stepchildren, please attach a copy of the certified birth certificate naming both parents. For adopted child/children, please supply adoption documentation. Additional documentation such as a Qualified Medical Child Support Order may be required. If you elect to cover your dependent child/children, you will be responsible for 100% of the monthly premium cost for your dependents. For 2022, the monthly premium for dependent children will be $434 per month. The cost is the same whether you enroll one or more children. The premiums will be deducted from your paycheck on a pretax basis, should your employer agree to do so. If your employer does not agree to take a premium deduction, you will be required to make payment directly to the Fund. See the authorization on Side B of this form. **To update your dependent's Primary Care Physician (PCP) information, call 800-275-2583 or go to www.ibxpress.com and login or register yourself to update a PCP and download a temporary ID card.**

Participant/Member's Name	Participant/Member's Social Security Number

1. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	**Apartment #**	**City**	**State**	**Zip Code**	**Telephone #**	

2. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	**Apartment #**	**City**	**State**	**Zip Code**	**Telephone #**	

3. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	**Apartment #**	**City**	**State**	**Zip Code**	**Telephone #**	

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND
DEPENDENT ENROLLMENT FORM *continued*

Side B

For each dependent you have named, please let us know whether this dependent has coverage under another group health plan beside your group health plan with SEIU Local 32 BJ, District 36. **Print** yes or no in Column 2. If you wrote yes, please complete columns 3 through 7.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Name of Covered dependent	Is this dependent covered under another group health plan?	Name of Subscriber or Policyholder	Relationship to Subscriber/ Policyholder	Name of Carrier or Health Plan	Group Number	Participant's Name

Authorization—Important!

I certify that the information on both sides of this form is correct and acknowledge that if I, the Fund participant or my dependents willfully misuse or misrepresent any information about eligibility for any other group health coverage provided either through the course of their own employment or coverage provided from another source (i.e. parent, stepparent or spouse's health coverage), the Fund has the right to terminate benefits for myself and my dependents. Furthermore, should my dependents acquire group health coverage through their own employment, that of a spouse, parent or stepparent, I will immediately notify the Fund Office.

My signature below indicates that I have read and understood this enrollment form and the descriptive materials made available to me by the SEIU Local 32BJ, District 36 BOLR Welfare Fund. I request to arrange for the above coverage and direct my employer to deduct any required contributions from my pay. Should my employer not take the premium deduction from my pay, I understand that I will be required to make the full premium payment no later than the 15th of each month. Should I fail to make payment in a timely manner, my dependent child/children coverage will terminate. I understand that these elections will remain in effect unless I have a qualified change in family status or change my status during the annual open enrollment. I certify that the information on this form is complete and accurate to the best of my knowledge. I understand that if this information changes in the future, I am obligated to notify the Fund Office within 31 (or 90 days from the birth of a child). Failure to do so may affect benefit coverage.

Signature: _____ Date: _____

IMPORTANT INSTRUCTIONS: Only complete this form and return it to the Fund Office if you are waiving Fund coverage for yourself.

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND

1515 Market Street, Suite 1020, Philadelphia, PA 19102

Proof of Other Coverage Form—Member

Complete This Form to Opt Out of Medical Coverage

In order to waive coverage, you must complete this form to provide proof that you have other medical coverage. **Note: You do not need to complete this form if you're waiving dental coverage only. If you opt out of coverage for yourself, your dependents will automatically waive their coverage as well.**

Please complete this form **ONLY IF** you elect to "Opt-Out" as your medical plan choice. Attach a copy of the identification card from your other insurance coverage. Please return this form, along with your Enrollment Form, to the Fund Office. Thank you for your cooperation.

My Other Medical Coverage Is Provided Through:

Employer Name or Plan: _____

The insurance carrier is: (for example, Blue Cross/Blue Shield or HMO name):

_____

Your Authorization

By signing this form, I am rejecting the medical coverage offered under the SEIU Local 32BJ, District 36 BOLR Welfare Fund for 2022 and certify that I have the medical coverage indicated above.

Your Signature: _____ Date: _____

Please print name: _____

Special Enrollment Rights

You may enroll for medical coverage during the year if you get married, acquire a new dependent, or lose your other medical coverage. To be eligible for this special enrollment, you must send a written request to the Fund Office within 31 days of the event (or 90 days from the birth of a child).

IMPORTANT INSTRUCTIONS: Only complete this form and return it to the Fund Office if you are waiving Fund coverage for your dependents.

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND

1515 Market Street, Suite 1020, Philadelphia, PA 19102

Proof of Other Coverage Form—Dependents

Complete This Form to Opt Out of Coverage for Dependents Only

In order to waive coverage for your dependent(s), you must complete this form and provide proof that the dependent(s) has/have coverage elsewhere.

Remember: If you opt out of coverage for yourself, your dependents will automatically waive their coverage as well. This form is for waiving coverage for your dependents only.

Attach a copy of the identification card from your other insurance coverage.

Please return this form to the Fund Office. Thank you for your cooperation.

Dependents' Coverage is Provided Through:

Employer Name or Plan: _____

Your Authorization

By signing this form, I am rejecting the coverage offered for my dependent(s) under the SEIU Local 32BJ, District 36 BOLR Welfare Fund for 2022 and certify that my dependent(s) has(have) the coverage indicated above.

Please list the names and dates of birth of the dependent(s) you are disenrolling:

Dependent's Name: _____ Date of Birth: _____

Dependent's Name: _____ Date of Birth: _____

Dependent's Name: _____ Date of Birth: _____

Participant Signature: _____ Date: _____

Please print name: _____

Special Enrollment Rights

You may enroll for medical coverage during the year if you get married, acquire a new dependent, lose your other medical coverage, or experience another form of a qualified change of status. To be eligible for this special enrollment, you must send a written request along with appropriate documentation to the Fund Office within 31 days of the event (or 90 days from the birth of a child).

IMPORTANT INSTRUCTIONS: You must complete both sides of this form, sign, date, and return it to the Fund Office.

Side A

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
DEMOGRAPHIC CENSUS FORM

PLEASE PRINT AND COMPLETE ALL INFORMATION ON BOTH SIDES OF THE FORM. WE MUST HAVE BOTH YOUR DEMOGRAPHIC INFORMATION AND BENEFICIARY INFORMATION COMPLETED, SIGNED, AND DATED. INCOMPLETE INFORMATION COULD CAUSE A DELAY IN PROCESSING YOUR CLAIMS.

Full Name (Last, First, MI)	Social Security Number	Date of Birth	Marital Status	Gender	Language

Street Address (include Apt # if applicable)	City	State	Zip Code	Primary Physician Name	Physician Adress

Home Phone No. (include area code)	Cell No. (include area code)	Email Address

Name of Employer	Date of Hire	Union Start Date	Job Classification

Dependent Information (Last, First, MI) of each dependent	Social Security No.	Date of Birth	Gender	Relationship to participant (spouse, son, daughter)

Name of Other Insurance Carrier	Name of Insured	Policy/Group No.	Identification number

Insurance Carrier's Address	City	State	Zip Code	Phone No. (include area code)

Signature of Fund Participant	Date	___Yes, I would accept updates about my benefits via text ___ No, Don't update me about my benefits via text

Side B

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
BENEFICIARY INFORMATION FORM *continued*

Beneficiary- Your beneficiary may be any person or persons you choose to name. However, if you are married, there may be certain benefits payable only to your spouse, unless your spouse consents to a different designation in writing at the time of retirement. This beneficiary designation form will apply to any Death Benefits available from the various Funds. Proceeds are paid to contingent beneficiary(ies) only if there are no surviving primary beneficiary(ies). If multiple primary and contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. Please be sure to complete the form in full, sign and date the form. This form will be invalid unless you sign and date it certifying your designation.

Participant's Name	Social Security Number	Date of Birth	Name of Employer
Participant's Address	**City**	**State**	**Zip Code**

Primary Beneficiary(ies) Information (You can name up to four primary beneficiaries)

Beneficiary's Name	Address	Telephone No.	Relationship to Participant	Social Security No.	Benefit Percentage Must equal 100%

Contingent Beneficiary(ies) Information (Contingent beneficiaries will only receive a benefit if there are no surviving primary beneficiaries)

Beneficiary's Name	Address	Telephone No.	Relationship to Participant	Social Security No.	Benefit Percentage Must equal 100%

Please Print Participant's Name	Participant's Signature	Date

What's Inside

Open Enrollment Overview

October 2021

In this Guide and the accompanying materials, you will find the information, forms and instructions that you need to enroll for BOLR BMCA Full-Time benefits coverage in 2022.

Open Enrollment is your annual opportunity to review your coverage and make changes to the benefits you elect or the dependents you cover. Outside of Open Enrollment, you are only permitted to make changes if they are the result of a qualified life change (a "qualifying event") as described below. Please review the enclosed materials and consider your and your family's needs before making enrollment decisions. If you want to make changes to your dependent status, return your completed BMCA Full-Time Enrollment form to the Fund Office no later than December 4, 2021.

If you wish to keep the same benefit options and coverage you have now, you don't need to do anything. For those who currently have dependent children on the Plan, please complete the Dependent Enrollment Form authorizing the dependent premium deduction for 2022.

Questions?

Should you have any questions, please do not hesitate to contact the Benefit Funds Office. You can contact us at (215) 568-3262, Extension 1400 or (800) 338-9025, Extension 1400 (outside the local calling area). You can also come to the SEIU Local 32 BJ, District 36 Fund Office located at 1515 Market Street, Suite 1020, Philadelphia, PA 19102 to speak to one of our representatives. Make sure to call us first before you come in.

IMPORTANT: Status Change Reminder

You may ONLY add or remove dependents or make any other changes to your benefits coverage outside of Open Enrollment if you experience a qualifying event. A qualifying event means that you or your dependent experiences a life change that affects the administration of your benefits. Examples include getting married, giving birth, or getting divorced. In these cases, you may need to add or remove dependents from your Fund coverage.

For all qualifying events, you must provide documentation of the status change (such as a birth or marriage certificate). **The Fund Office MUST receive the documentation within 31 days of the qualifying event (90 days for the birth of your child).** Please review your Summary Plan Description or contact the Fund Office for more information on qualifying events.

Note: If you have a qualifying event and need to complete a new census/beneficiary form to reflect the status change, please contact the Fund Office.

Need a form? Check the front of this Guide!

All the forms that you need for enrollment are included at the front of this guide. Each form will tell you the conditions under which you should fill it out. Only complete the forms that apply to you. Tear each completed form on the perforated edge and mail to the Fund Office using the return envelope included in this guide.

REMEMBER: Choose carefully! Once Open Enrollment is over, you will not be able to change your elections until the next Open Enrollment period in the Fall of 2022, for coverage effective January 1, 2023, unless you have a qualified status change.

This document and the materials in your enrollment packet provide a summary description of your SEIU Local 32BJ, District 36 BOLR Welfare Fund benefits and the changes that will be effective January 1, 2022. These materials supplement other descriptions of your Plan benefits. The changes described in these documents and the enclosed materials are effective as of January 1, 2022. The Fund hopes to continue the Plan and the benefits mentioned in these documents and described in your benefits booklet indefinitely, but reserves the right to amend, suspend or terminate the Plan, in whole or in part, at any time and for any reason. Neither receipt of this enrollment packet nor enrollment in any of the benefits offered under the Plan constitutes a contract of employment. Please read these documents carefully and keep this important information with your other benefit materials for future reference.

Basic Facts

Who's Eligible?

You are eligible for the BOLR BMCA Full-Time Plan if you work in covered employment, and your employer is required through a collective bargaining agreement to make contributions on your behalf to the Fund.

If you are eligible to participate in the BOLR BMCA Full-Time Plan, you may also enroll your eligible dependents for medical, dental, and vision benefits. Your eligible dependents include:

- Children from birth to age 26
- Stepchildren up to age 26
- Adopted children (from the date of placement in your home) up to age 26
- Children placed for adoption
- Children over age 26 incapable of sustaining employment by reason of mental impairment or physical handicap

Any child for whom you gratuitously assume support will not be considered a dependent.

Enrolling Dependents

You must complete and submit the following information to enroll your dependents into the Plan:

- **Dependent Enrollment Form** (remember to complete both sides)
- **Document Dependent Status**—examples of documentation include:
  - Valid state birth certificate naming both parents for natural or stepchildren under age 26
  - Proof of adoption for a legally adopted child under the age of 26
  - If required to add your children under age 26 as a result of a Qualified Medical Child Support Order, please provide a copy of the Order
  - Proof of Social Security number
  - If you have a child who must remain on your coverage beyond age 26 by reason of physical or mental impairment as a result of which they are unable to support themselves, the Fund Office requires documentation of their disability on a periodic basis.

If you choose to remove a dependent from the Plan, you must complete the Opt-Out form and submit proof of other health coverage for that dependent to the Fund Office.

Any change you make to your dependent status must be completed and returned to the Fund Office in the enclosed self-addressed stamped envelope by December 4, 2021. If you do not add or drop a dependent during open enrollment, you must wait to do so until you or your dependent experiences a qualifying event.

There is a dependent premium payment required to cover your dependents. The cost for the 2022 monthly premium will be $434.

Qualified Medical Child Support Order (QMCSO)

If you are required to provide child support and healthcare coverage under a Qualified Medical Child Support Order (QMCSO), contact the Fund Office for an explanation of the information required. A QMCSO is any judgment, decree, or order issued by the court requiring you to provide healthcare coverage for a child. For additional information regarding the procedures for administration of QMCSOs, contact the Fund Office.

Medical Benefits

Important Reminders:

The benefits described in this Guide are effective January 1, 2022.

Deductibles, copayments, coinsurances, and maximums are combined for both in-network and out-of-network benefits, where applicable.

When you use an out-of-network provider, you are responsible for the difference between what the provider billed and what your insurance paid.

Precertification Requirements

Certain services must be approved as medically necessary before you receive treatment. This is called precertification. Some services requiring precertification include:

- ALL nonemergency hospital admissions
- Elective inpatient surgery
- Select durable medical equipment
- Home healthcare
- Inpatient hospice care
- MRI/MRA
- CT/CTA scan
- PET scan

Note: This is not a complete list of services. Blue Cross may change the precertification requirements from time to time. Contact Blue Cross Member Services for more information.

Don't Forget About Preventive Care

Throughout the COVID-19 pandemic, millions of Americans pushed preventive care to the side. Hesitancy leaving home is understandable, even to go to the doctor.

We don't know yet what COVID-19 has in store for us. But one thing is for certain: it's important to make routine exams, tests, and screenings a priority in 2022. Preventive care can catch chronic diseases and infections like cancer, diabetes, and heart disease before they turn into serious health problems. Early detection increases the chances of your recovery.

The first step is to schedule your annual physical with your primary care physician (PCP). Ask which tests and screenings you're due for. For example, the American Cancer Society recommends that individuals start receiving screens for colorectal cancer at age 45. Regular cholesterol testing checks for signs of coronary artery disease. And annual well woman visits can catch breast cancer early.

Preventive care is easy and affordable. Most preventive services are covered at 100% as long as you see an in-network provider.

Important Terms

Annual Copayment Maximum—

is the most you will pay out of your pocket in copayments for in-network services you receive during the year. Once you reach your annual maximum, the plan pays 100% of the cost for in-network services for the rest of the year.

Blue Distinction Center + —

Blue Cross-designated outpatient surgical centers specializing in knee and hip replacement. Blue Distinction Centers + meet high standards of quality, cost, expertise, effectiveness and efficiency.

Coinsurance—

is the percentage of eligible costs that you pay for services, after the deductible has been paid.

Copayment—

is the flat dollar amount you pay for some medical services at the time care is received.

Deductible—

is the portion of your covered expenses that you pay each year before your medical plan begins to pay benefits for specified services.

In-Network Providers—

are a select group of providers and facilities that have agreed to charge negotiated fees for their services. When you use these providers, you are receiving "in-network care."

Medically Necessary Expenses—

are covered by the plans if they are services or supplies considered to be necessary and appropriate and covered by the plan. Some services and supplies are not covered at all, while the benefits for other services (such as chiropractic care) are limited. In addition, the expense must be incurred while the patient is covered under the plan, unless specifically provided otherwise.

Out-of-Network Providers (High Option Plan only)—

are doctors, healthcare providers or facilities that are not part of the select group of providers under the High Option Plan.

Patient-Centered Medical Home (PCMH)—

Blue Cross has identified certain doctors, including PCPs, who participate in a Patient-Centered Medical Home (PCMH). A PCMH is an office or group of doctors who work together to better coordinate and personalize your care. Getting care at a PCMH and selecting a PCMH doctor as your PCP will save you money.

Primary Care Physician (PCP)—

is sometimes referred to as a "family doctor." This is the doctor who provides first contact when you have a health concern. The PCP also provides continuing care and referrals to specialists as needed. Blue Cross has designated certain doctors as "PCPs"; you must consult your Blue Cross Physician Directory to select an eligible PCP.

Benefit Summary

BENEFIT	IN-NETWORK/REFERRED	OUT-OF-NETWORK/ SELF-REFERRED
HOSPITAL INPATIENT[1]	100%	70% of allowed amount, after deductible Up to 70 days per calendar year
Inpatient Physician Services	100%	70% of allowed amount, after deductible
Knee and Hip Replacement[1,2] Blue Distinction Center + All other facilities	 100% 70%	 Not Covered Not Covered
Emergency Room	100% after $100 copay visits 1 & 2, visits 3 or more 100% after $200 copay Waived if admitted	100% after $100 copay visits 1 & 2, visits 3 or more 100% after $200 copay Waived if admitted
Urgent Care	100% after $40 copay	70% of allowed amount, after deductible
Skilled Nursing Facility[1] *Up to 60 days per year*	100%	Not Covered
Doctor's Office PCMH PCP	100% after $10 copay	70% of allowed amount, after deductible
Doctor's Office non-PCMH PCP and Specialists	100% after $20 copay	70% of allowed amount, after deductible
Preventive Care for Adults and Children[3]	100%	70% of allowed amount, no deductible
Routine GYN Exam/Pap Smear *(one per year)*	100%	70% of allowed amount, no deductible
Mammogram	100%	70% of allowed amount, after deductible
Pediatric Immunizations	100%	70% of allowed amount, after deductible
Surgery[1] (pre-certification may be required for some outpatient surgeries)	100%	70% of allowed amount, after deductible
Lab/Pathology Outpatient[4]	100%	70% of allowed amount, after deductible
Outpatient diagnostic x-ray/ radiology[1,4,5]	100%	70% of allowed amount, after deductible
Home Health Care[1] *Up to 200 visits per calendar year*	100%	70% of allowed amount, after deductible
Physical/Occupational Therapy[4,5] **Speech Therapy** *Up to 30 visits per modality, per calendar year*	100% after $20 copay	Not covered
Cardiac or Pulmonary Rehabilitation *Up to 36 visits per modality, per calendar year*	100% after $20 copay	70% of allowed amount, after deductible

BENEFIT	IN-NETWORK/REFERRED	OUT-OF-NETWORK/ SELF-REFERRED
Durable Medical Equipment[1] *Select items require precertification*	100%	Not Covered
Ambulance		
Emergency Transport	100%	100% of allowed amount, no deductible
Non-Emergency Transport[1]	100%	70% of allowed amount, after deductible
Maternity		
First OB visit	100%	70% of allowed amount, after deductible
Hospital	100%	70% of allowed amount, after deductible
Chiropractic (Spinal Manipulation)[5] *Up to 10 visits per calendar year*	100% after $20 copay	70% of allowed amount, after deductible
Dialysis/Radiation[1]**/Chemotherapy**	100%	70% of allowed amount, after deductible
Nutrition Counseling *6 visits per year*	100%	70% of allowed amount, after deductible
Nutritional formulas & Modified Solid Food Products[1] *Precertification may be required*	100%	70% of allowed amount, after deductible
Outpatient Private Duty Nursing[1] *Up to 360 hours per calendar year*	90%	70% of allowed amount, after deductible
Hospice Care[1] *Up to 210 days per lifetime*	100%	Not Covered
Behavioral Health and Substance Abuse Program Services Provided by MHC, Inc. — Call (800) 255-3081		
Inpatient[6,7]	100%	70% of allowed amount, after deductible Up to 70 days per calendar year
Partial Day/Intensive Outpatient[6,7]	100%	70% of allowed amount, after deductible
Outpatient[6]	100% after $20 copayment	70% of allowed amount, after deductible
Deductible (annual)		
Individual	$0	$250
Family	$0	$500
Annual Out-of-pocket maximum		
Individual	$6,750	$6,750
Family	$13,500	$13,500
Lifetime maximum	None	None

[1] *Precertification required for these services. Please contact the member services department of Keystone HPE (Independence Blue Cross) for more information on those services requiring pre-certification.*

[2] *Treatment received at a Blue Distinction Center + facility for knee and hip replacement is covered at 100%; treatment received at a Blue Distinction Center or other any other participating Keystone facility or AmeriHealth designated facility is covered at 70%. There is no coverage for knee/hip replacements done out-of-network.*

[3] *Must go to your chosen Primary Care Physician (PCP).*

[4] *Must go to the PCP-designated site for care to be considered in-network.*

[5] *Referral from Primary care Physician (PCP) Required.*

[6] *In-network services administered by MHC, Inc. not Keystone or AmeriHealth. Contact MHC for a listing of network providers.* ***Do not*** *use your Keystone/AmeriHealth ID card for Behavioral Health or Substance Abuse Conditions.*

[7] *Precertification required for these services. Contact MHC for more information about pre- certification of services related to Behavioral Health/Substance Abuse Treatment.*

Prescription Drug Benefits

Prescription drug coverage, provided through CVS Caremark, starts automatically when you enroll in medical coverage under the Plan. You can get up to a 30-day supply of medication by going to any network pharmacy and showing your CVS Caremark Prescription Drug ID card. You can get up to a 90-day supply of maintenance medications by going directly to any CVS Pharmacy or by using the CVS Caremark Mail Order Pharmacy. **You will not be eligible for prescription drug benefits if you opt out of the medical plan.**

90-day retail fills available only at CVS Pharmacies.

Using the CVS Caremark Mail Order Pharmacy for maintenance medications will save you money.

Your Copays

Each time you fill a prescription, you will pay a copay depending on the classification of the drug. There are three tiers of prescription drugs:

- **Generic**—Prescription drugs that are the lower-cost equivalents of brand-name drugs. They are approved by the U.S. Food and Drug Administration and have the same active ingredients as their brand-name equivalents.
- **Formulary**—A list of brand-name drugs chosen by a panel of physicians and pharmacists. The drugs on the formulary are carefully chosen for their effectiveness, safety and cost.
- **Non-formulary**—Brand-name drugs not on the formulary. *You pay 100% of the cost of non-formulary drugs.*

If your prescription is for:	Retail (30-day supply)	Retail (90-day supply)*	Home Delivery (90-day supply)
	You Pay		
Generic Drugs	$7	$14	$14
Formulary Brand-Name Drugs	$22	$44	$44
Non-Formulary Drugs	You pay 100% of the cost.		

**To fill a prescription for a 90-day supply of medication at a retail pharmacy, you must use a CVS Pharmacy.*

Your Annual Out-of-Pocket Maximum

There is an Annual Out-of-Pocket Maximum limit for prescription drug expenses. Once you reach the Annual Out-of-Pocket Maximum, the Plan pays 100% of your prescription drug costs. Your copays apply to the Annual Out-of-Pocket Maximum. Expenses paid for drugs not covered under the Prescription Drug Plan do not apply. There is a separate Annual Out-of-Pocket Maximum for medical benefits.

The Prescription Drug Annual Out-of-Pocket Maximums are:

- Single: $1,950
- Family: $3,900

What's a Formulary?

A formulary is a list of generic and brand-name drugs. The formulary was developed by a committee of physicians and pharmacists at CVS Caremark. The committee regularly reviews and updates the formulary based on the latest information available about each drug's effectiveness.

You can find the current formulary by signing up at **www.caremark.com**.

Dental Benefits

Regular, professional dental care is not only essential to good health, but it also can prevent serious or costly problems. That's why our Dental Plan, provided through Delta Dental, covers a full range of dental services, including diagnostic and preventive care.

Enrollment in the Dental Plan is optional—enroll in the plan if you (or your dependents) need coverage. You may enroll in the Dental Plan even if you waive medical coverage, and you may enroll for a different coverage level. For example, you could enroll for employee-only medical coverage but enroll for family dental coverage.

Chart of Dental Benefits

Deductible	None
Annual Maximum Benefit	$1,000 per person per year
Preventive and Diagnostic Care • Oral exam, cleaning, bitewing X-rays (twice a year); full-mouth X-rays every 36 months • Fluoride treatments up to age 19 (once a year) • Sealants or space maintainers up to age 14	100%
Basic Restorative • Fillings	100%
Major Restorative • Repairs of existing crowns • Inlays, onlays, crowns, cast restorations • Bridges and dentures	50%
Endodontics • Root canal	80%
Periodontics • Gum treatment	80%
Orthodontia	50% $1,000 lifetime maximum

Under the Vision Plan, there is no limit to the number of times you may use your ID card to get eye care services or eyewear. However, you cannot use your card combined with any special offers, such as coupons or special promotions.

How Using a Participating Dentist Can Save You Money

This is an example of how using a Delta Dental network dentist can save you money.

Procedure: Crown	If you use a participating dentist	If you use a non-participating dentist
Dentist's fee	$900	$900
Delta Dental's contracted rate (eligible expense)	$700	$700
Plan pays (50% of contracted rate)	$350	$350
You pay	$350	$550 (difference between Delta's contracted rate and the dentist's $900 fee)

Note: This chart is for illustration purposes only. Actual costs will vary.

Predetermine Benefits for Treatment Over $300

If your treatment is expected to cost $300 or more, ask your dentist to "predetermine benefits" with Delta Dental before treatment starts (this means evaluating whether the suggested treatment is appropriate and determining how much the Plan will pay for the care). With predetermination, you know exactly how much the Plan will pay—and how much you will pay. That way, you can make financial arrangements before the treatment begins.

To predetermine benefits, your dentist needs to send a claim form to Delta Dental describing the proposed treatment and the estimated charges. Delta Dental will send you a statement showing the services that will be covered and how much the Plan will pay. You can review the treatment plan with your dentist and agree on the services to be performed. After treatment is completed, return the original statement, with dates of services and necessary signatures, to Delta Dental for payment.

Please review your Summary Plan Description for a complete list of dental limitations and exclusions.

Vision Benefits

How the Plan Works

You have the option to receive eye care from a National Vision Administrator (NVA) participating provider or any other eye care specialist. However, you receive maximum benefits when you use a participating eye doctor or optometrist.

- **When you use a participating provider,** you receive maximum benefits because the Plan pays the full cost or a large portion of the cost for most routine services.
- **When you use a non-participating provider,** the Plan will reimburse you for exams, eyeglass frames, and lenses or contact lenses. You pay the full cost when you receive services. Then, you must file a claim to be reimbursed for the Plan's share of the cost.

What the Plan Pays

When you receive services from an NVA-participating provider, the Plan pays for the cost of an eye exam once every 24 months.

The Plan also pays for one new pair of lenses and frames or contact lenses, up to $120 every 24 months (or every 12 months for children under 19).

When you receive services from a non-participating vision provider, the Plan will pay up to $30 for an eye exam once every 24 months (or every 12 months for children under 19).

The Plan also pays up to $60 for lenses and up to $60 for frames, or up to $120 for contact lenses, once every 24 months for children and adults.

Expenses Not Covered

The Vision Plan does not cover:

- Fundus photography;
- Medical or surgical treatment of the eyes;
- Services or materials provided as a result of Worker's Compensation Law or obtained by any governmental agency or program; or,
- Plain or prescription sunglasses.

Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

Today, life insurance is more than a "peace of mind benefit"—it is one of life's necessities.

Life insurance is designed to offer protection to your family, or anyone who counts on your income, if you die. Accidental Death and Dismemberment (AD&D) insurance pays a benefit to you if you suffer an accidental loss of a limb or your eyesight, and pays a benefit to your beneficiary(ies) if you die as the result of a covered accident.

Dependents are not eligible for life and AD&D insurance coverage.

Employee Only Benefit	
Death, Natural	$25,000
Death, Accident	$25,000 (in addition to above)
Dismemberment Benefits	Specific amount determined by loss

This life insurance benefit is generally only payable if you die while in active covered employment.

Any AD&D benefit payable as a result of your accidental death is equal to the amount of your life insurance and is paid in addition to your life insurance benefit.

The amount of AD&D benefit depends on the type of accidental loss. See your Summary Plan Description, or call the Fund Office for details.

Exclusions and certain limitations may apply. See your Summary Plan Description for a complete list of exclusions and limitations.

Don't Forget—Your Beneficiary

To make sure any benefits are paid to the person you want, you must name your beneficiary—and keep your beneficiary designations up to date as your life changes. If you are newly eligible, or have changes in your dependent status, complete a Demographic Census/Beneficiary Information form. Contact the Fund Office if you need a new form. Return the form to the Fund Office.

Disability Benefits

If you are a full time employee and your employer makes an additional contribution to the Fund for disability benefits, you are eligible for disability benefits. Disability benefits provide you and your family with a supplemental weekly payment if you become disabled and cannot work due to a non-work-related illness or injury.

The specific time allowance for disability is determined by the diagnosis and established disability guidelines. However, no disability can exceed the maximum benefit of 26 weeks due to illness or 52 weeks due to an accident. For disability benefits to be considered, you must complete a disability claim form, and you must provide documentation from a legally qualified doctor certifying that you are disabled and unable to perform your normal work duties. Please note: MHC providers can also certify disability.

If you're eligible, you'll receive a weekly benefit of $210 per week for employees who work 40 or more hours per week or $175 per week for employees who work between 30 and 39 hours per week. This benefit only applies while you are disabled and remain under the direct, regular care of a legally qualified doctor or your care is being managed by a MHC Mental Health/Substance Abuse provider.

Your disability claim begins on the second working day after you visit your doctor as a result of your disability. Your disability claim due to an accident begins on the first day after you visit your doctor as a result of your disability. Disability benefits will not be paid for any period in which you missed work before you visited your doctor.

For more information about disability benefits, see your Summary Plan Description or call the Fund Office at (215) 568-3262 or (800) 338-9025 outside the local calling area.

The physician certifying your disability MUST be a network physician.

"Legally qualified physician" includes Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Dental Surgery (DDS), Doctors of Dental Medicine (DMD), or Doctors of Podiatric Medicine (DPM).

Any claim for disability must be filed with the Fund Office within 60 days from the initial date of your disability. Be sure that all sections are completed and signed by you , your employer and your attending physician before submitting to the Fund Office.

Important Notices

SEIU Local 32 BJ, District 36 BOLR Welfare Fund ("the Fund") is required to provide the following important notices to you. Please review them carefully so you understand your rights and responsibilities.

HIPAA Special Enrollment Rights

If you are declining enrollment in the health insurance plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends and provide supporting documentation. In addition, if you have a new dependent as a result of marriage, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the health insurance plan, provided that you request enrollment within 31 days after the marriage, adoption, or placement for adoption. If you have a new dependent as a result of birth, you may be able to enroll yourself and your dependents in the health insurance plan, provided that you request enrollment within 90 days after the birth.

The Fund will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in Fund coverage. Note that this 60-day extension applies **only** to enrollment opportunities due to Medicaid/CHIP eligibility changes.

Enrollment materials must be completed and all proof of dependent status provided to the Plan within 31, 60 or 90 days of the request for Special Enrollment. If you are unable to complete the enrollment materials and provide proof of dependent status within the time frame (for example, if additional time is needed to obtain a birth certificate for a newborn), the deadline may be extended.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and your eligible dependents may continue medical coverage for up to 18 months if coverage ends because:

- You terminate employment for any reason (other than gross misconduct), or
- You have a reduction in work hours.

COBRA also allows for your eligible dependents to continue their medical coverage for up to 36 months if coverage would otherwise end because:

- You die,
- You and your spouse divorce or legally separate,
- You become eligible for Medicare, or
- Your dependents are no longer eligible for coverage under the medical plan.

You and your dependents generally may elect to continue coverage anytime within the first 60 days after coverage ends or 60 days from the date the notice is received, whichever is later. Continued coverage takes effect on the first of the month following the date of the event that caused coverage to end, as long as you pay the necessary premium. You may only continue the coverage that was in effect one day prior to the event. However, you may make changes to your elections each year during the annual open enrollment period. If the medical plan changes, those changes will also apply to coverage under COBRA.

To receive coverage under COBRA, you and/or your eligible dependents are required to make a timely election and make monthly premium payments.

Newborns' and Mothers' Health Protection Act

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. In the case of a plan participant who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician 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; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedema

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for other benefits under the plan.

HIPAA Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the SEIU Local 32 BJ, District 36 BOLR Welfare Plan (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. You may also obtain a copy of the Privacy Notice by contacting the Fund Office at 215-568-3262, Extension 1400 or 800-338-9025, Extension 1400 (outside the local calling area).

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the SEIU Local 32 BJ, District 36 BOLR Welfare Fund 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 prescription 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 prescription 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. **The SEIU Local 32 BJ, District 36 BOLR Welfare Fund has determined that the prescription drug coverage offered by SEIU Local 32 BJ, District 36 BOLR Welfare 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 at least as good as standard Medicare prescription drug 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 15 through December 7. 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 Prescription Drug Plan?

Whether or not you enroll in a Medicare prescription drug plan, your current prescription drug coverage will continue as long as you continue to meet the eligibility requirements of the SEIU Local 32BJ, District 36 BOLR Welfare Plan. Your current coverage pays for other health expenses in addition to prescription drugs, and, provided you continue to meet the Fund's eligibility rules, you will still be eligible to receive all of your health and prescription drug benefits even if you choose to enroll in a Medicare prescription drug plan.

If you enroll in a Medicare prescription drug plan and you are an active participant, your coverage with this Plan will be primary and Medicare will pay on a secondary basis after this Plan has paid its benefits.

If you decide to join a Medicare drug plan and drop your current SEIU 32BJ, District 36 BOLR Welfare Fund coverage, you will only be able to get it back if you meet the Fund's eligibility and enrollment rules, including special enrollment rules.

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 SEIU Local 32 BJ, District 36 BOLR Welfare Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SEIU Local 32 BJ, District 36 BOLR Welfare Fund 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 800-MEDICARE (800-633-4227). TTY users should call 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 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Important Information

The following chart provides important information about this Medicare Part D Notice.

Date	Provided at hire and annually thereafter
Name of Entity Sender	SEIU 32 BJ, District 36 BOLR Welfare Fund
Contact – Position/Office	John J. Rongione, Administrator
Address	1515 Market Street Suite 1020 Philadelphia, PA 19102
Phone Number	215-568-3262, Extension 1400

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 **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 **866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 855-692-5447	**FLORIDA – Medicaid** Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 877-357-3268
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**GEORGIA – Medicaid** Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 855-MyARHIPP (855-692-7447)	**INDIANA – Medicaid** Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 800-457-4584
CALIFORNIA – Medicaid Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	**IOWA – Medicaid and CHIP (Hawki)** Medicare Website: https://dhs.iowa.gov/ime/members Medicare Phone: 800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 888-346-9562
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: 800-221-3943/State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855-692-6442	**KANSAS – Medicaid** Website: https://www.kancare.ks.gov Phone: 800-792-4884

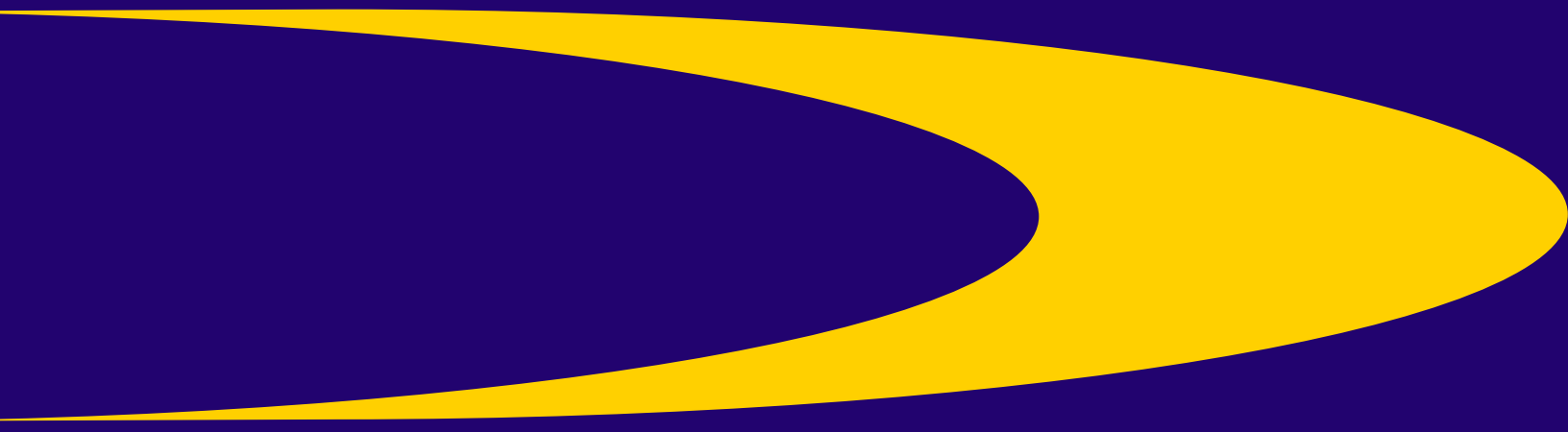
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	**NEW YORK – Medicaid** Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800-541-2831
LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)	**NORTH CAROLINA – Medicaid** Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MAINE – Medicaid Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Maine relay 711	**NORTH DAKOTA – Medicaid** Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844-854-4825
MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 800-862-4840	**OKLAHOMA – Medicaid and CHIP** Website: http://www.insureoklahoma.org Phone: 888-365-3742
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: 800-657-3739	**OREGON – Medicaid** Website: http://healthcare.oregon.gov/Pages/index.aspx www.oregonhealthcare.gov/index-es.html Phone: 800-699-9075
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**PENNSYLVANIA – Medicaid** Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 800-692-7462
MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084	**RHODE ISLAND – Medicaid and CHIP** Website: http://www.eohhs.ri.gov Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)
NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	**SOUTH CAROLINA – Medicaid** Website: https://www.scdhhs.gov Phone: 888-549-0820
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 800-992-0900	**SOUTH DAKOTA – Medicaid** Website: http://dss.sd.gov Phone: 888-828-0059
NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP Program: 800-852-3345 ext 5218	**TEXAS – Medicaid** Website: http://gethipptexas.com/ Phone: 800-440-0493
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: 800-701-0710	**UTAH – Medicaid and CHIP** Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877-543-7669

VERMONT – Medicaid Website: http://www.greenmountaincare.org/ Phone: 800-250-8427	**WEST VIRGINIA – Medicaid** Website: http://mywvhipp.com/ Toll-free phone: 855-MyWVHIPP (855-699-8447)
VIRGINIA – Medicaid and CHIP Website: http://www.coverva.org/hipp/ Phone: 800-432-5924	**WISCONSIN – Medicaid and CHIP** Website: https://dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 800-362-3002
WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 800-562-3022	**WYOMING – Medicaid** Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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



October 2021

Union Bug