Behavior Frontiers

# 2023-2024 | BENEFITS GUIDE

DECEMBER 1, 2023 - NOVEMBER 30, 2024

# TABLE OF CONTENTS


Benefit Highlights and Eligibility pg. 3

Medical pg. 4-6

Health Savings Account pg. 7

Dental pg. 8

Vision pg. 8

Life and AD&D pg. 9

BanePlus Package pg. 10

Cost of Coverage pg. 11

Plan Costs pg. 12

Sydney Mobile App pg. 13

Employee Assistance Program pg. 13

Travel Assistance Program pg. 13

Anthem Additional Resources pg. 14

How to Find a Provider pg. 15

How to Enroll Using One Point pg. 16-19

Annual Notices and Disclosures pg. 20-27


**If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.**

Please see page 21 for more details.

# CONTACT INFORMATION

## MEMBER SERVICE NUMBERS

### Anthem Blue Cross

| | |
|---|---|
| Medical Member Services | **(800) 888-8288** |
| Dental Member Services | **(877) 567-1804** |
| Vision Member Services | **(866) 723-0515** |

### Mutual of Omaha

| | |
|---|---|
| Life and AD&D Member Services | **(800) 775-8805** |
| Employee Assistance Program | **(800) 316-2796** |

## HELPFUL WEBSITES/EMAIL ADDRESSES

Anthem Blue Cross **www.anthem.com/ca/**

Mutual of Omaha **www.mutualofomaha.com**

Mutual of Omaha EAP **www.mutualofomaha.com/eap**

Travel Assistance **www.mutualofomaha.com**

## BENEFITS SERVICE CENTER

Toll Free **(855) 367-4114**

Email **benefitservices@behaviorfrontiers.com**

Website **http://behaviorfrontiers.myboltonbenefits.com**

**Or Scan this QR Code to acces the Behavior Frontiers Benefit Website:**

SCAN ME

# OPEN ENROLLMENT

Open Enrollment occurs one time each year. During this time, you may add or remove dependents from your coverage, enroll for the first time, change your coverage level, or change your benefit elections, without experiencing a qualifying event. All benefit enrollments and elections made during this time will be effective December 1, 2023, and will remain in effect throughout the plan year, until November 30, 2024.

## Benefits Highlights

An overview of the benefit plan offerings for the 2023-24 plan year are as follows:

- Medical
- Dental
- Vision
- Basic Life/AD&D
- Employee Assistance Program (EAP)
- BenePlus
- Travel Assistance Program

## Changing Benefits Mid-Year

During the year, you can change your benefit elections only if you experience a qualifying event. You must notify HR within 30 days from the qualifying event to make any changes to your benefits.

Examples include changes in:

- Marital status (marriage, divorce, legal separation)
- Number of dependent children (birth, adoption)
- Employment status (part-time to full-time, or vice versa)
- Eligibility status (change in hours, job loss)

## When Can You Enroll?

Medical, Dental, Vision, Basic Life and AD&D: Employees and dependents, if applicable, are eligible for coverage on the employee's date of hire.

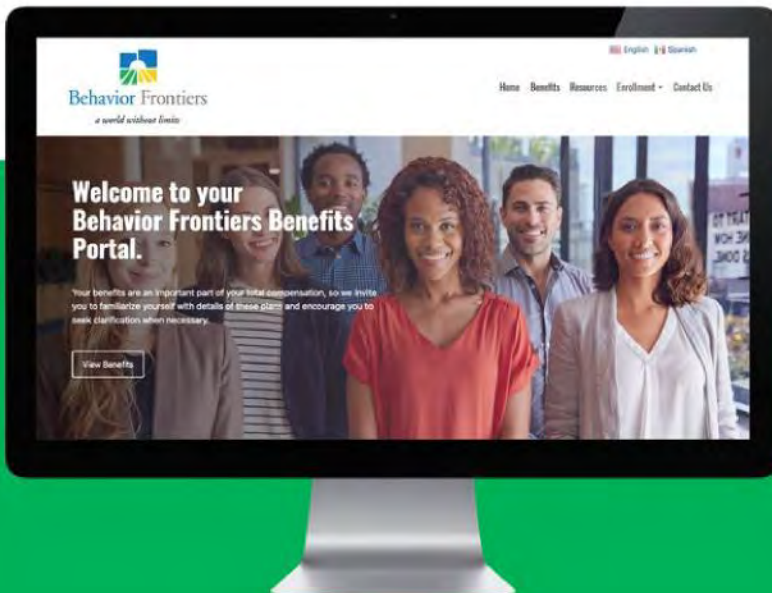
EAP and Travel Assistance Program: All employees are automatically enrolled.

## Eligibility

Medical, Dental, and Vision: Employees who work a minimum of 30 hours per week are eligible to enroll.

Basic Life and AD&D: Employees who work a minimum of 30 hours per week are automatically enrolled.

EAP and Travel Assistance Program: Accessible to all employees, regardless of hours worked.




## BENEFITS WEBSITE

Visit our employee benefits website, an online destination for you to find benefits information, carrier forms, educational resources and enrollment information. This site will allow you to quickly access the information you need to make an informed decision about choosing your benefit plans.

http://behaviorfrontiers.myboltonbenefits.com/

# MEDICAL

Behavior Frontiers offers five choices of medical insurance plans, two HMO plans, two PPO plans, and one High Deductible Health Plan (HDHP). Each of our medical insurance plans offer different levels of deductibles, copayments, and out-of-pocket maximums.

## Anthem HMO Plan

If you elect coverage in either of the HMO plans you are required to choose a Primary Care Physician (PCP) who is part of the Anthem network as your personal doctor. Each family member covered through your plan can choose his or her own PCP and can change them at any time. All care must be provided or authorized by the PCP. To search the provider list online, visit www.anthem.com/ca.

| | Value HMO Plan (CA Only) | Classic HMO Plan (CA Only) |
|---|---|---|
| | California Care HMO Network | Select HMO Network |
| Calendar Year Deductible | None | None |
| Calendar Year Out-of-Pocket Maximum | $3,500 single<br>$7,000 family | $2,500 single<br>$5,000 family |
| Physician Office Visit | $35 copay | $30 copay |
| Specialist Office Visit | $55 copay | $50 copay |
| LiveHealth Online | No charge | No charge |
| Preventive Care | No charge | No charge |
| Urgent Care | $35 copay | $30 copay |
| Diagnostic X-Ray/Lab | No charge | No charge |
| Outpatient Surgery | $375 copay | $250 per visit |
| Inpatient Hospital | $750 per day, up to 3 days | $500 per admit |
| Emergency Room **(Waived if Admitted)** | $150 copay | $125 copay |
| Pharmacy Deductible | $150 individual / $450 family | None |
| **Generic (Tier 1a/1b)** | $5/$20 | $5/$15 |
| **Preferred (Tier 2)** | $40 (after deductible) | $30 |
| **Non-Preferred (Tier 3)** | $60 (after deductible) | $50 |
| **Specialty (Tier 4)** | 30% up to $250 max (after deductible) | 30% up to $250 max |

Copays and coinsurance percentages shown in the above plan descriptions represent the amount paid by the member.

1. Members are responsible for all charges above Anthem's allowable amounts when using non-network providers.
2. Additional $500 copay required if you do not receive preauthorization from Anthem for non-emergency visit

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## Anthem PPO Plans

When you enroll in either of the Anthem PPO plans, you are free to seek medical care from both in and out-of-network providers. There is no requirement that you select a PCP or receive PCP-authorized referrals to specialists. To receive the highest level of coverage under the plan, simply obtain care from an in-network provider.

| | Classic PPO Plan | | Solution PPO Plan | |
|---|---|---|---|---|
| | In-Network | Out-of-Network[1] | In-Network | Out-of-Network[1] |
| Calendar Year Deductible | $500 single<br>$1,500 family | $1,500 single<br>$4,500 family | $1,500 single<br>$3,000 family | $4,500 single<br>$9,000 family |
| Calendar Year Out-of-Pocket Maximum | $4,000 single<br>$8,000 family | $12,000 single<br>$24,000 family | $5,000 single<br>$10,000 family | $15,000 single<br>$30,000 family |
| Physician Office Visit | $30 copay | 40% after deductible | $20 copay | 40% after deductible |
| Specialist Office Visit | $50 copay | 40% after deductible | $40 copay | 40% after deductible |
| LiveHealth Online | No charge | No charge | No charge | 40% after deductible |
| Preventive Care | No charge | 40% after deductible | No charge | No charge |
| Urgent Care | $30 copay | 40% after deductible | $20 copay | 40% after deductible |
| Diagnostic X-Ray/Lab | 20% after deductible | 40% after deductible | 20% after deductible | 40% after deductible |
| Outpatient Surgery | 20% after deductible | 40% after deductible, benefit limited to $350 max per visit | 20% after deductible | 40% after deductible |
| Inpatient Hospital | 20% after deductible | 40% after deductible, benefit limited to $1,000 max per day[2] | 20% after deductible | 40% after deductible |
| Emergency Room (Waived if Admitted) | $150 copay, then 20% after deductible | | $150 copay, then 20% after deductible | |
| Retail Prescriptions | 30-day supply | 30-day supply<br>All tiers: 50% up to $250 | 30-day supply | 30-day supply<br>All tiers: 50% up to $250 max |
| Generic (Tier 1a/1b) | $5/$15 | | $5/$20 | |
| Preferred (Tier 2) Non- | $30 | | $40 | |
| Non-Preferred (Tier 3) | $50 | | $60 | |
| Specialty (Tier 4) | 30% up to $250 max | | 30% up to $250 max | |

Copays and coinsurance percentages shown in the above plan descriptions represent the amount paid by the member.

1. Members are responsible for all charges above Anthem's allowable amounts when using non-network providers.
2. Additional $500 copay required if you do not receive preauthorization from Anthem for non-emergency visit

# MEDICAL

Behavior Frontiers offers five choices of medical insurance plans, two HMO plans, two PPO plans, and one High Deductible Health Plan (HDHP). Each of our medical insurance plans offer different levels of deductibles, copayments, and out-of-pocket maximums.

## Anthem HDHP Plan

A High Deductible Health Plan (H.D.H.P.) is a PPO which allow the same freedom as the other PPOs. You do not need to elect a PCP or obtain PCP-authorized referrals to specialists. You can seek medical care from both in and out-of-network providers. The difference is your overall annual contributions will be lower on the High Deductible Health Plan (HDHP) plan, you must meet the deductible before the copays and co-insurance start kicking in, which means you should expect to pay out of pocket for your prescriptions and doctor visits at the beginning of the year. The exception to this is your preventative services, which the plan will cover at 100% as long as you go to an in-network provider. The High Deductible Health Plan (H.D.H.P.) is a medical plan which allows you to open a Health Savings account

| | Solution HDHP (H.S.A.) Plan | |
|---|---|---|
| | In-Network | Out-of-Network[1] |
| Calendar Year Deductible | **$3,000 single**<br>**$6,000 family** | **$9,000 single**<br>**$18,000 family** |
| Calendar Year Out-of-Pocket Maximum | **$5,000 single**<br>**$10,000 family** | **$15,000 single**<br>**$30,000 family** |
| Physician Office Visit | **0% after deductible** | **30% after deductible** |
| Specialist Office Visit | **0% after deductible** | **30% after deductible** |
| LiveHealth Online | **No charge** | **30% after deductible** |
| Preventive Care | **No Charge** | **30% after deductible** |
| Urgent Care | **0% after deductible** | **30% after deductible** |
| Diagnostic X-Ray/Lab | **0% after deductible** | **30% after deductible** |
| Outpatient Surgery | **0% after deductible** | **30% after deductible** |
| Inpatient Hospital | **0% after deductible** | **30% after deductible**<br>**$1,000 copay if no preauthorization** |
| Emergency Room<br>(Waived if Admitted) | **0% after deductible** | |
| Prescription Deductible | **Combined with Medical Deductible** | **Combined with Medical Deductible** |
| Generic (Tier 1a/1b) | **$5/$15** | **All tiers: 30% up to $250** |
| Preferred (Tier 2) | **$40** | |
| Non-Preferred (Tier 3) | **$60** | |
| Specialty (Tier 4) | **30% up to $250 max** | |

Copays and coinsurance percentages shown in the above plan descriptions represent the amount paid by the member.

1. Members are responsible for all charges above Anthem's allowable amounts when using non-network providers.
2. Additional $500 copay required if you do not receive preauthorization from Anthem for non-emergency visit

# HEALTH SAVINGS ACCOUNT (H.S.A.)

## Health Savings Account (HSA)

A Health Savings Account (HSA) is a special savings account that is paired with a high-deductible health plan (HDHP), also referred to as a "consumer-driven health plan". This type of plan encourages participants to be wise healthcare consumers and utilize lower cost options wherever possible. HDHPs are designed to help you save money and pay for qualified medical expenses. This type of a plan is meant to have a cumulative effect on cost savings.

- Deposit money into your HSA via pre-tax payroll contributions
- Save on taxes by lowering your federal taxable income
- Use your HSA to pay for qualified medical expenses such as deductibles, copays and coinsurance
- Invest your savings in mutual funds

## How much can you contribute to your HSA in 2023

Individual only $3,850

Annual catch-up contribution $1,000 if age 55 or older

Individual + spouse, children, or family $7,750

## Reminders:

- Yearly contributions should be made by your tax filing deadline.
- Distributions from your HSA and contributions made for or during the previous year need to be reported on IRS form 8889. This is important because it needs to match what is reported on the 1099-SA form.
- For catch-up, eligible spouses over 55 can only make catch-up contributions to his/her account

# DENTAL

**Behavior Frontiers offers a Dental PPO plan through Anthem Blue Cross which gives you the ability to obtain dental care services from the dentist of your choice. In order to receive the highest level of coverage under the plan, simply obtain care from an in-network provider.**

| | Dental PPO Plan | |
|---|---|---|
| | In-Network | Out-of-Network[1] |
| Calendar Year Deductible | $50 single<br>$150 family | $50 single<br>$150 family |
| Waived for Preventive Care? | Yes | Yes |
| Calendar Year Maximum Benefit | $1,500 per person | $1,500 per person |
| Diagnostic/Preventive - Oral Exams, Routine Cleanings/Most X-Rays, Sealants | No charge | 30% |
| Basic Services - Fillings, Root Canals, Scaling and Root Planing, Extractions, Periodontal Surgery | 10% after deductible | 50% after deductible |
| Major Services - Crowns, Dentures | 40% after deductible | 50% after deductible |
| Orthodontia - Child Only (through age 18) | 50% after deductible | 50% after deductible |
| Orthodontia - Lifetime Maximum | $1,000 per person | |

Coinsurance percentages shown in the above plan descriptions represent the amount paid by the member.
1. Members are responsible for all charges above Anthem's allowable amounts when using non-

# VISION

**Behavior Frontiers offers a Vision plan through Anthem Blue Cross. You will get the best value from your vision care plan when you visit an Anthem Blue Cross network provider.**

| | Blue View Vision Plan | |
|---|---|---|
| Frequency Limits | | |
| Exam | Every 12 months | |
| Frames | Every 24 months | |
| Lenses | Every 12 months | |
| Contacts | Every 12 months | |
| | In-Network | Out-of-Network Reimbursement |
| Exam | $10 copay | Up to $49 |
| Frames | $130 allowance then 20% off any remaining balance | Up to $50 |
| Single Vision Lenses | No charge | Up to $35 |
| Bifocal Lenses | No charge | Up to $49 |
| Trifocal Lenses | No charge | Up to $74 |
| Elective Contact Lenses (Non-Disposable) | $130 allowance then 15% off any remaining balance | Up to $92 |
| Medically Necessary Contact Lenses | No charge | Up to $250 |

# BASIC LIFE AND AD&D

Although we don't like to think about it, should death occur, the survivors left behind could face serious financial hardships. Your family might need an alternative source of income to pay off your bills and meet their ongoing financial responsibilities. That is the purpose of life insurance - to provide funds for those left behind.

It is also possible that an accident could cause serious injury – the loss of limbs or eyesight, for example. There is special insurance coverage which pays benefits if an accident causes loss of life, limb or sight – it is called accidental death and dismemberment (AD&D) insurance. AD&D pays an additional benefit in the event of your accidental death or dismemberment. It also provides benefits for certain accidental injuries. As an eligible employee of Behavior Frontiers, you are provided with **$25,000 of life and AD&D** insurance through Mutual of Omaha, at no cost to you.

Note: In order for your beneficiary to receive a benefit in the event of a death claim, an employee must have worked a minimum of 30 hours or more per week.

## NAMING YOUR BENEFICIARY

You may name anyone you wish as the beneficiary who will receive your life and AD&D insurance benefits in case of your death*. You can designate your beneficiary(ies) when you initially enroll or by contacting the Behavior Frontiers Benefits Service Center. Once you have selected your beneficiary, your designation will remain unchanged until you update it. You may change your beneficiary as often as you wish.

*Subject to state regulations and other limitations; you may wish to consult an attorney for details.

# BenePlus Package

BenePlus is available for all employees. This is an employer paid benefit, but you must opt in. You will have the opportunity to enroll outside open enrollment; please check with HR for details.

## Teladoc ($0 visit fee)

Feel better now! 24/7 access to a doctor is only a call or click away—anytime, anywhere with a $0 visit fee for general medical issues. With Teladoc, you can talk to a doctor by phone or online video to get a diagnosis, treatment options and prescription, if medically necessary. Save time and money by avoiding crowded waiting rooms in the doctor's office, urgent care clinic or ER. Just use your phone, computer, smartphone or tablet to get a quick diagnosis by a U.S.-licensed physician.

## Teladoc Mental Health ($0 visit fee)

Teladoc Mental Health provides confidential therapy on your terms with virtual access to licensed therapists for only $0 per visit. You and your family members 13 and older can establish an ongoing relationship with a licensed therapist through video or phone sessions, and get support for anxiety, depression, stress, grief, PTSD, family or marriage issues, and more.

## Telephonic EAP

Professional counseling and work/life support to help you cope with the ups and downs of life.

ACCESS YOUR BENEFITS ON THE GO!
With the My Benefits Work™ mobile app & portal

## NBFitness

Stay active for just $28 per month! NBFitness provides you with extreme flexibility in membership choices, direct access to a national network of nearly 12,000 participating gym partners, and 9,000+ workout videos. You can switch gyms anytime, and you'll pay the monthly charges directly on the Active&Fit Direct website.

## New Benefits Rx

Teladoc Mental Health provides confidential therapy on your terms with virtual access to licensed therapists for only $0 per visit. You and your family members 13 and older can establish an ongoing relationship with a licensed therapist through video or phone sessions, and get support for anxiety, depression, stress, grief, PTSD, family or marriage issues, and more.

## Lab Testing

Know your numbers! Help monitor your health with 10% to 80% off typical costs of routine lab work. Lab benefit not available in NJ, NY, and RI.

## NBDeals

NBDeals is your one-stop shop for exclusive discounts from 500+ merchants, with new deals added weekly.

## NBTravel

Experience more. Spend less. Enjoy deep discounts on hotels, flights, activities, and more

# COST OF COVERAGE

## How You Pay for Health Care Costs

### PREMIUM:

A premium is the total cost for your medical insurance. You and Behavior Frontiers share this cost. You pay your portion through pre-tax payroll deductions.

### COPAY:

A copay is a set payment you make for a specific service.

### COINSURANCE:

When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, in the Classic PPO plan, after you satisfy your deductible, you will pay 20% coinsurance for most medical care that you receive from preferred providers.

### DEDUCTIBLE:

A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits. For example, if you are enrolled in the Solution PPO plan, you must pay as much as $1,500 per person for covered care over the course of the calendar year before the plan pays any benefits.

### OUT-OF-POCKET MAXIMUM:

The annual out-of-pocket maximum protects you from major medical expenses. This is the most you would pay, including your deductible, for eligible expenses during a year. Once you reach the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services. For example, if you are enrolled in the Classic PPO plan, your calendar year out-of-pocket maximum for in-network care is $4,000 per person to a maximum of $8,000 per family.

## Your Total Cost of Care

Remember, your total health care cost for the year is the combination of your out-of-pocket expenses when you access medical care and the premium contributions you make for coverage.

Premiums
\+ Out-of-Pocket Costs

= Total Cost of Health Care

Depending on your personal situation, the plan with the lowest deductible may not be the best plan for you. Be sure to take a good look at the total cost of your expected care before making your plan decisions for the year.

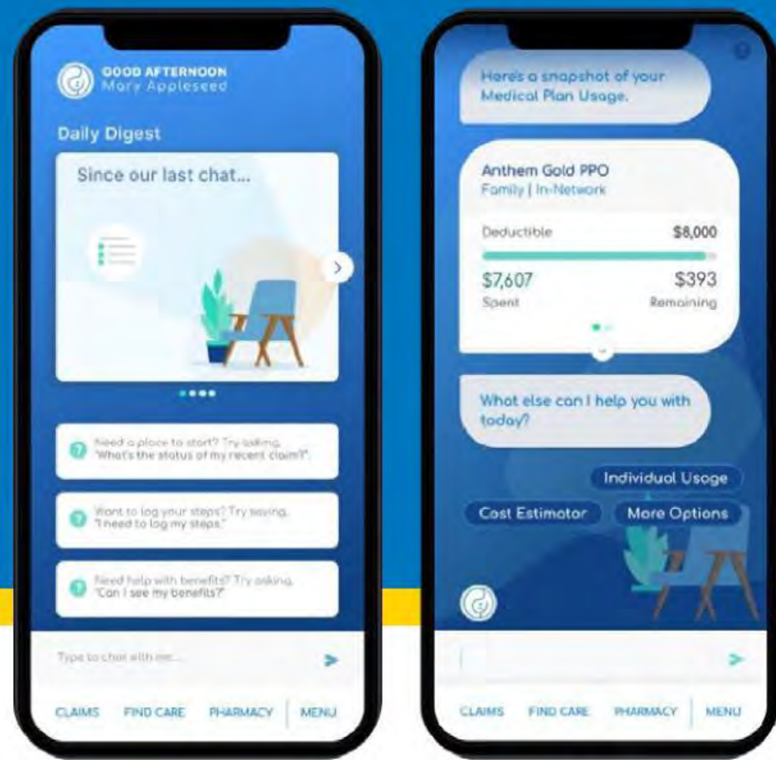
# PLAN COSTS

The following chart shows the amounts you will pay for coverage under each plan this year.

| Benefit | You Pay Per Month | You Pay Per Pay Period |
|---|---|---|
| **Value HMO (CA Care Network)** | | |
| Employee | $158.68 | $73.24 |
| Employee + Spouse | $793.40 | $366.18 |
| Employee + Child(ren) | $581.85 | $268.54 |
| Employee + Family | $1,269.46 | $585.90 |
| **Classic HMO (Select HMO Network)** | | |
| Employee | $155.21 | $71.63 |
| Employee + Spouse | $776.05 | $358.18 |
| Employee + Child(ren) | $569.13 | $262.67 |
| Employee + Family | $1,241.71 | $573.10 |
| **Classic PPO** | | |
| Employee | $314.41 | $145.11 |
| Employee + Spouse | $1,392.42 | $642.65 |
| Employee + Child(ren) | $1,033.09 | $476.81 |
| Employee + Family | $2,200.77 | $1,015.74 |
| **Solution PPO** | | |
| Employee | $246.21 | $113.64 |
| Employee + Spouse | $1,231.10 | $568.20 |
| Employee + Child(ren) | $902.81 | $416.68 |
| Employee + Family | $1,969.62 | $909.06 |
| **Solution HDHP (HSA)** | | |
| Employee | $191.45 | $88.36 |
| Employee + Spouse | $957.29 | $441.83 |
| Employee + Child(ren) | $702.02 | $324.01 |
| Employee + Family | $1,531.56 | $706.88 |
| **Dental PPO** | | |
| Employee | $9.62 | $4.44 |
| Employee + Spouse | $41.71 | $19.25 |
| Employee + Child(ren) | $44.70 | $20.63 |
| Employee + Family | $80.04 | $36.94 |
| **Blue View Vision** | | |
| Employee | $7.25 | $3.35 |
| Employee + Spouse | $14.50 | $6.69 |
| Employee + Child(ren) | $14.86 | $6.86 |
| Employee + Family | $22.12 | $10.21 |

# MEET SYDNEY, **ANTHEM'S** MOBILE APP

**With Sydney, you can find everything you need to know about your Anthem benefits -- personalized and all in one place. Sydney makes it easier to get things done, so you can spend more time focused on your health. Sydney is:**




Simple – Ready for you to use quickly, easily and seamlessly, with one-click access to benefits info, Member Services, wellness resources and more.

Smart – Sydney acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. Plus, you can use the chatbot to get answers quickly.

Personal – Get alerts, reminders and tips directly from Sydney. Get doctor suggestions based on your needs. The more you use it, the more Sydney can help you stay healthy and save money.

### Finding a Provider

The best way to find a provider is using the Sydney App. The app will have your specific plan information saved and will help you find a provider that is in-network and close by. Simply click the "Find Care" button at the bottom of the app to begin your search for a doctor, dentist or any other provider or facility that you need.

# EMPLOYEE RESOURCES

### Employee Assistance Program (EAP)

You and your family members — spouse or partner, dependent children, parents and in-laws — will receive confidential support and services specifically designed to help with issues that may arise personally or professionally. The Mutual of Omaha EAP provides direct, hands-on help to address many types of problems such as marriage and family counseling, substance abuse, stress management, grief and loss, financial consultation and much more.

An EAP counselor is available around the clock for emergency and crisis situations. Simply call (800) 316-2796 to speak with an advisor. You may be eligible for 3 face-to-face sessions per issue, free of charge. You can also visit www.mutualofomaha.com/eap.

### Travel Assistance Program

As an eligible employee, you, your spouse or partner, and your dependent children will have automatic access to Travel Assistance This service provides certain types of medical, legal and financial assistance 24 hours a day, 365 days a year, when more than 100 miles away from home. Travel and financial services include:

- Hospital admission assistance
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Referrals to Western-trained, English-speaking medical providers
- Passport replacement assistance
- And more

# ANTHEM ADDITIONAL RESOURCES

## Anthem Blue Cross Special Offers

With Special Offers through Anthem, you can get discounts on products and services that help promote better health and well-being. Here are just some of the vendors offering discounts to Anthem members:

Vision and hearing

- Glasses.comTM and 1-800-CONTACTS®
- Premier LASIK
- Nations Hearing

Fitness and health

- Active&Fit DirectTM
- Jenny Craig®
- SelfHelpWorks

Family and Home

- 23andMe
- Safe Beginnings®
- ASPCA Pet Insurance

Medicine and treatment

- Puritan's Pride
- Allergy Control products
- National Allergy® supply

To learn more, log in to anthem.com/ca and select "Discounts".

## Future Moms

Ever wish you had a go-to source for all of your questions about pregnancy? Now, you do. Future Moms is a program that can answer your questions, help you make good choices and follow your health care provider's plan of care. And it can help you have a safe delivery and a healthy child.

Sign up as soon as you know you're pregnant. Just call toll free at (800) 828-5891.

## 24/7 NurseLine

Whether it's 3 a.m. or a lazy Sunday afternoon with the family, health issues can crop up at the most inconvenient times and places.

What if you had a nurse in your back pocket — someone knowledgeable you could talk to any time of the day or night, 365 days a year? That's why Anthem Blue Cross offers 24/7 NurseLine, a resource you call when life throws you a curve ball. The registered nurses can help you with your baby's fever, give you allergy relief tips and advise you where to go for care.

To access the 24/7 NurseLine, call (800) 337-4770.

## LiveHealth Online

Have you ever been at work and didn't feel well? Maybe you had a fever or a sore throat but you didn't have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It's so convenient, almost 90% of people who've used it feel they saved two hours or more and would use it again in the future. To start using LiveHealth Online, all you need to do is sign up at livehealthonline.com or download the app.

Sign up for free today and get:

1. 24/7 access to doctors. They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed.2 It's a great way to get care when your doctor isn't available.
2. Medical care when you need it. For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.
3. Convenience. Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less. Doctors using LiveHealth Online typically charge $49 or less per visit, depending on your health plan.

## ConditionCare

ConditionCare is a program that gives you resources and tools to help you take care of certain health conditions. When you enroll in ConditionCare, you get:

- 24/7 toll-free access to a nurse coach who can answer questions about your condition.
- A health screening and follow-up calls to help you reach personal health goals.
- Educational guides, newsletters, tips and tools on how to take care of your health.

The program aims to help members with:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart Disease or Heart Failure

To join, call toll-free at (866) 962-0957

# HOW TO FIND A PROVIDER

**To find an in-network provider, follow the steps listed below:**

## MEDICAL

1. Go to www.anthem.com/ca and select "Find Care"
2. Select a plan for basic search
3. Under, "Select the type of plan or network", choose Medical Plan or Network
4. Under, "Select the state where the plan or network is offered" select the state you live in
5. Under, "Select how you get health insurance" choose Medical (Employer-Sponsored)
6. Under, "Select a plan /network", choose the network of the plan you are searching for:

- **For the Anthem Value HMO Plan (California Care Network):** Blue Cross HMO (CACare) - Large Group
- **For the Anthem Classic HMO Plan (Select HMO Network):** Select HMO
- **For the Anthem Classic, Solution, and HDHP PPO Plans:**
- **If you are in** California **select:** Blue Cross PPO (Prudent Buyer)-Large Group
- **If you are** not located in California **select:** National PPO (BlueCard PPO) (Employer-Sponsored)

## Dental

1. Go to www.anthem.com/ca and select "Find Care"
2. Select a plan for basic search
3. Under "Select the type of plan or network", choose Dental Plan or Network
4. Under "Select the state where the plan or network is offered", select the state you live in
5. Under "Select how you get health insurance", choose Dental
6. Under "Select a plan or network", choose Dental Complete

## Vision

1. Go to www.anthem.com/ca and select "Find Care"
2. Select a plan for basic search
3. Under "Select the type of plan or network", choose Vision Plan or Network
4. Under "Select the state where the plan or network is offered", select the state you live in
5. Under "Select how you get health insurance", choose Vision
6. Under "Select a plan or network", choose Blue View Vision

# BENEFITS SERVICE CENTER

Employees of Behavior Frontiers can call a convenient, toll-free number to reach experienced benefits administrators and licensed insurance professionals for information on benefits, eligibility, claims assistance and how to enroll in the online enrollment system.

Employees of Behavior Frontiers have access to the Benefits Service Center from 9:00 am to 5:00 pm Pacific Time, Monday through Friday (excluding holidays). Spanish speaking representatives are available.

Toll Free: (855) 367-4114

Email: benefitservices@behaviorfrontiers.com

# HOW TO ENROLL USING ONEPOINT

**With our benefits website and our online enrollment system (powered by OnePoint), you can view our benefit offerings, learn about the plans, their costs, and select what is best for you and your family. You will have instant access to all of your benefits and personal information and can visit the site at any time during the year to view your plan selections. Follow the easy steps outlined on the next pages to complete your enrollment.**

## Start at Our Benefits Website

To view our plan options, learn more about what each plan has to offer and review costs, start at our benefits website. Go to:

http://behaviorfrontiers.myboltonbenefits.com/

**Once you have accessed the benefits website review your plan options, eligibility and more.**

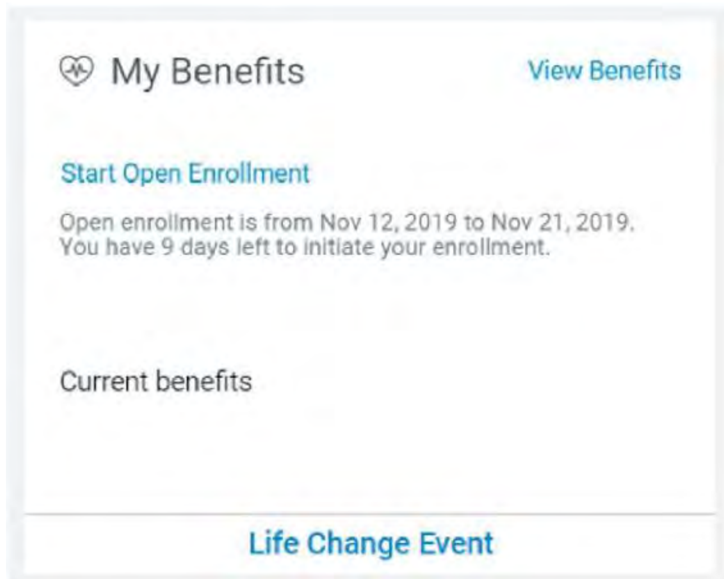
**When you are ready to enroll, select "Enrollment Instructions" from the "Enrollment" drop down menu at the top right of the screen. Click on the "Enroll Now" button to log into the OnePoint enrollment system where you will complete your enrollment.**

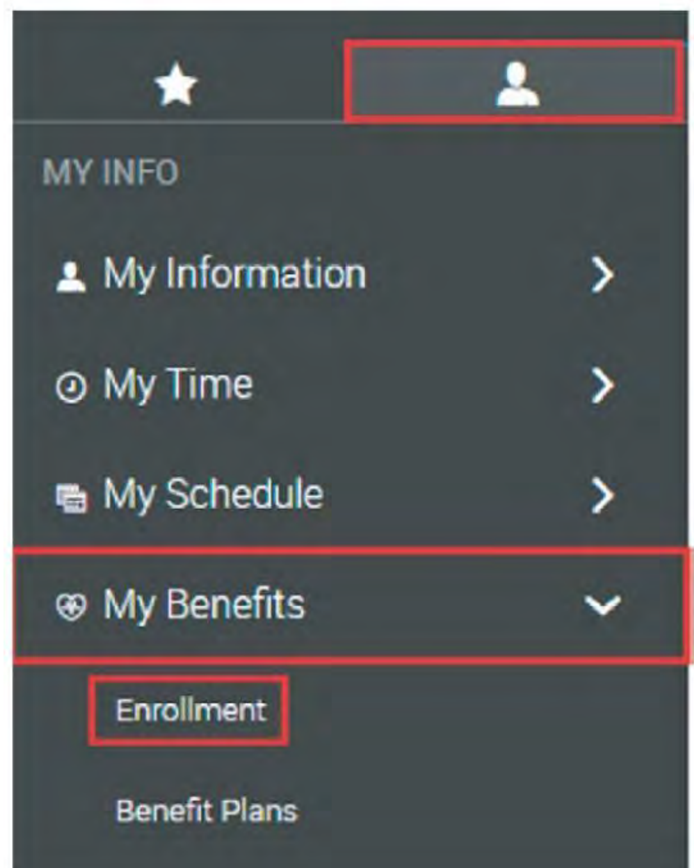
**You can also log on tosecure.onehcm.com/ta/bfllc.login to log in directly.**

## Access Benefit Selection

**You can access the benefit enrollment process on your dashboard in the My Benefits widget. Depending on your employee status the link may say "Start New Employee Enrollment" or "Start open Enrollment".**

**You can also access the benefits selection process from the Hamburger Menu on the top-left corner, by selecting My Benefits > Enrollment.**



# Selecting Benefits

Once you have initiated the applicable enrollment process, navigate through each tab to select/waive benefits By clicking the blue “Continue” button in the top right.

Benefit Plan Tabs: Each of the benefit tabs will provide a detail of the benefit plans offered by your employer and will allow you to select/waive appropriate coverages.

Waive Benefits: If you would like to waive coverage, simply click the check box in the top left next to “Waive all Medical”.

Selecting Coverage: Before you can select a plan to enroll in, you must select the coverage option you would like to select from the dropdown box (Employee Only, Employee + Spouse, Employee + Child(ren) or Employee + Family).

Once you have selected your desired coverage level, you can check the box to the left of the plan name to select the benefit plan.

Add Account Dependent: If you selected a coverage option with a spouse/dependent, you will be prompted to Select your Spouse/Children after you have selected the benefit plan.

Fill in Required Info

EXPAND ALL

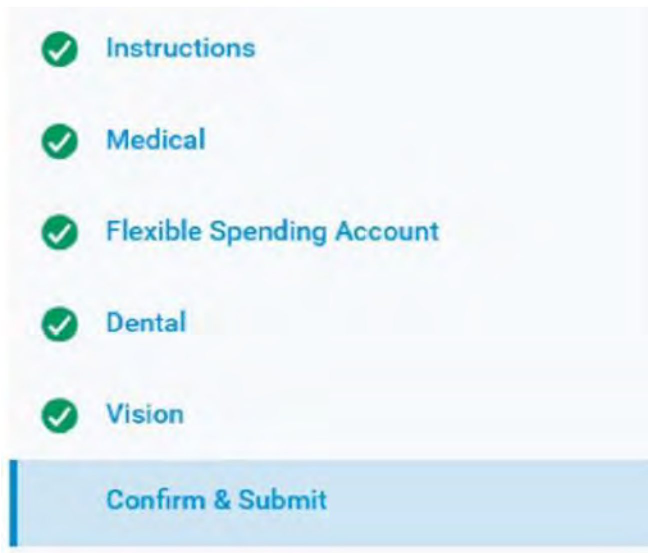
Select Your Spouse

Select Your Children

CANCEL SAVE AND SELECT

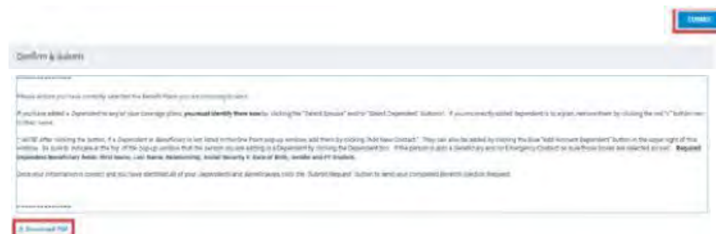
If your Spouse/Children information is not yet in the system, click “Add Contact” to enter their required information.

As you go through the enrollment process and successfully select coverage options on each tab, a green check mark will appear for each tab.

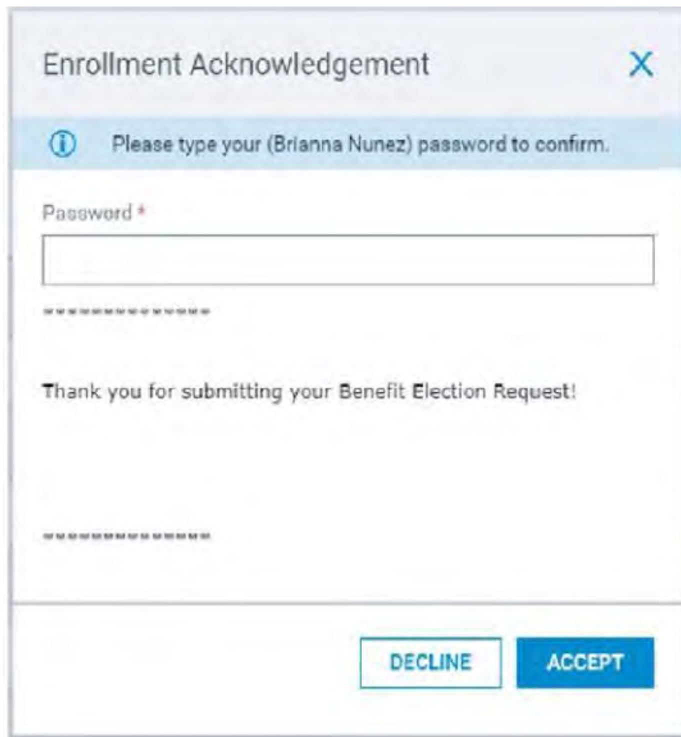



The Confirm & Submit page will display a summary of your waived/selected plans. Carefully review your benefit selections. If your selections are accurate, click “Submit” in the top right.

You can also download and print a copy of your benefit selections by clicking “Download PDF”.



Once you click “Submit, you will be prompted to enter your password. Your password will serve as your electronic signature. Once you have entered your password. Click “Accept”.



# Important Notices

## Notice: 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 stopped contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you 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, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

## Notice: The Newborns' and Mothers' Health Protection Act (NMHPA)

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

## Notice: Woman's Health and Cancer Rights Act (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

## Notice: Consolidated Omnibus Budget Reconciliation Act (COBRA)

### Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become 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 and other members of your family when group health coverage would otherwise end. For more 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-of-pocket 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 it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- **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 of the following qualifying events:

- **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."**

### When is COBRA Continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- **The end of employment or reduction of hours of employment;**
- **Death of the employee; or**
- **The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).**

**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 provide this notice to the contact person shown at the end of these notices.**

### 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 of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work (for fully insured plans issued in California, coverage generally last for 36 months). 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 which this 18-month period of COBRA continuation coverage can be extended:

### Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

### Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### 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, 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 employees, after the Medicare initial enrollment period, you have 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 https://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 information at the end of these notices. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 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

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Notice: Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under the Uniformed Services Employment Reemployment Rights Act of 1994 (USERRA), employees are provided with broad protection in terms of their reemployment upon completion of military service.

### REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- **You ensure that your employer receives advance written or verbal notice of your service;**
- **You have five years or less of cumulative service in the uniformed services while with that particular employer;**
- **You return to work or apply for reemployment in a timely manner after conclusion of service; and**
- **You have not been separated from service with a disqualifying discharge or under other than honorable conditions.**

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

### RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

**If you:**

- **Are a past or present member of the uniformed service;**
- **Have applied for membership in the uniformed service; or**
- **Are obligated to serve in the uniformed service;**

**then an employer may not deny you:**

- **Initial employment;**
- **Reemployment;**
- **Retention in employment;**
- **Promotion; or**
- **Any benefit of employment**

**because of this status.**

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

**HEALTH INSURANCE PROTECTION**

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

**ENFORCEMENT**

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm.**
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

## Notice: 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, **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, 2023. Contact your State for more information on eligibility.**

| ALABAMA – Medicaid | CALIFORNIA – MEDICAID |
|---|---|
| WEBSITE: http://www.myalhipp.com<br>PHONE: (855) 692-5447 | WEBSITE:<br>HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM<br>http://dhcs.ca.gov/hipp<br>PHONE: (916) 445-8322<br>Fax: (916) 440-5676<br>EMAIL: hipp@dhcs.ca.gov |
| **ALASKA – Medicaid** | **COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)** |
| THE AK HEALTH INSURANCE PREMIUM PAYMENT PROGRAM<br>WEBSITE: http://myakhipp.com/<br>PHONE: (866) 251-4861<br>EMAIL: CustomerService@MyAKHIPP.com<br>MEDICAID ELIGIBILITY:<br>WEBSITE: https://health.alaska.gov/dpa/Pages/default.aspx | HEALTH FIRST COLORADO WEBSITE: https://healthfirstcolorado.com/<br>HEALTH FIRST COLORADO MEMBER CONTACT CENTER:<br>(800) 221-3943 / STATE RELAY 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+CUSTOMER SERVICE: (800) 359-1991 / STATE RELAY 711<br>HEALTH INSURANCE BUY-IN PROGRAM (HIBI):<br>https://www.mycohibi.com/<br>HIBI CUSTOMER SERVICE: (855) 692-6442 |
| **ARKANSAS – MEDICAID** | **FLORIDA – MEDICAID** |
| WEBSITE: http://myarhipp.com/<br>PHONE: (855) MyARHIPP (855-692-7447) | WEBSITE:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>PHONE: (877) 357-3268 |
| **GEORGIA – MEDICAID** | **LOUISIANA – MEDICAID** |
| GA HIPP WEBSITE:<br>https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>PHONE: (678) 564-1162, Press 1<br>GA CHIPRA WEBSITE:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>PHONE: (678) 564-1162, Press 2 | WEBSITE: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>MEDICAID HOTLINE: (888) 342-6207<br>LAHIPP PHONE: (855) 618-5488 (LaHIPP) |

| INDIANA – MEDICAID | MAINE – MEDICAID |
| --- | --- |
| HEALTHY INDIANA PLAN FOR LOW-INCOME ADULTS 19-64<br>WEBSITE: http://www.in.gov/fssa/hip/<br>PHONE: (877) 438-4479<br>ALL OTHER MEDICAID<br>WEBSITE: https://www.in.gov/medicaid/<br>PHONE: (800) 457-4584 | ENROLLMENT WEBSITE:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>PHONE: (800) 442-6003<br>TTY: Maine Relay 711<br>PRIVATE HEALTH INSURANCE PREMIUM WEBPAGE:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>PHONE: (800) 977-6740<br>TTY: Maine Relay 711 |
| **IOWA – MEDICAID AND CHIP (HAWKI)** | **MASSACHUSETTS – MEDICAID AND CHIP** |
| MEDICAID WEBSITE: https://dhs.iowa.gov/ime/members<br>PHONE: (800) 338-8366<br>HAWKI WEBSITE: http://dhs.iowa.gov/hawki<br>PHONE: (800) 257-8563<br>HIPP WEBSITE:<br>https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | WEBSITE: https://www.mass.gov/masshealth/pa<br>PHONE: (800) 862-4840<br>TTY: 711<br>EMAIL: masspremassistance@accenture.com |
| **KANSAS – MEDICAID** | **MINNESOTA – MEDICAID** |
| WEBSITE: https://www.kancare.ks.gov/<br>PHONE: (800) 792-4884<br>HIPP PHONE: (800) 967-4660 | WEBSITE:https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>PHONE: (800) 657-3739 |
| **KENTUCKY – MEDICAID** | **MISSOURI – MEDICAID** |
| KENTUCKY INTEGRATED HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (KI-HIPP) WEBSITE:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>PHONE: (855) 459-6328<br>EMAIL: KIHIPP.PROGRAM@ky.gov<br>KCHIP WEBSITE: https://kidshealth.ky.gov/Pages/index.aspx<br>PHONE: (877) 524-4718<br>KENTUCKY MEDICAID WEBSITE: https://chfs.ky.gov/agencies/dms | WEBSITE: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>PHONE: (573) 751-2005 |
| **MONTANA – MEDICAID** | **NORTH DAKOTA – MEDICAID** |
| WEBSITE: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>PHONE: (800) 694-3084<br>EMAIL: HHSHIPPProgram@mt.gov | WEBSITE: https://www.hhs.nd.gov/healthcare<br>PHONE: (844) 854-4825 |
| **NEBRASKA – MEDICAID** | **OKLAHOMA – MEDICAID AND CHIP** |
| WEBSITE: http://www.ACCESSNebraska.ne.gov<br>PHONE: (855) 632-7633<br>LINCOLN: (402) 473-7000<br>OMAHA: (402) 595-1178 | WEBSITE: http://www.insureoklahoma.org<br>PHONE: (888) 365-3742 |
| **NEVADA – MEDICAID** | **OREGON – MEDICAID** |
| MEDICAID WEBSITE: https://dhcfp.nv.gov/<br>MEDICAID PHONE: (800) 992-0900 | WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>PHONE: (800) 699-9075 |
| **NEW HAMPSHIRE – MEDICAID** | **PENNSYLVANIA – MEDICAID** |
| WEBSITE: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>PHONE: (603) 271-5218<br>TOLL FREE NUMBER FOR THE HIPP PROGRAM:<br>(800) 852-3345 Ext. 5218 | WEBSITE:<br>https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>PHONE: (800) 692-7462<br>WEBSITE: Children's Health Insurance Program (CHIP) (pa.gov)<br>PHONE: (800) 986-KIDS (5437) |
| **NEW JERSEY – MEDICAID AND CHIP** | **RHODE ISLAND – MEDICAID AND CHIP** |
| MEDICAID WEBSITE:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>MEDICAID PHONE: (609) 631-2392<br>CHIP WEBSITE: http://www.njfamilycare.org/index.html<br>CHIP PHONE: (800) 701-0710 | WEBSITE: http://www.eohhs.ri.gov/<br>PHONE: (855) 697-4347 or (401) 462-0311 (Direct Rite Share Line) |

| NEW YORK – MEDICAID | SOUTH CAROLINA – MEDICAID |
|---|---|
| WEBSITE: https://www.health.ny.gov/health_care/medicaid/<br>PHONE: (800) 541-2831 | WEBSITE: https://www.scdhhs.gov<br>PHONE: (888) 549-0820 |
| **NORTH CAROLINA – MEDICAID** | **SOUTH DAKOTA - MEDICAID** |
| WEBSITE: https://medicaid.ncdhhs.gov/<br>PHONE: (919) 855-4100 | WEBSITE: http://dss.sd.gov<br>PHONE: (888) 828-0059 |
| **TEXAS – MEDICAID** | **WASHINGTON – MEDICAID** |
| WEBSITE: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>PHONE: (800) 440-0493 | WEBSITE: https://www.hca.wa.gov/<br>PHONE: (800) 562-3022 |
| **UTAH – MEDICAID AND CHIP** | **WEST VIRGINIA – MEDICAID AND CHIP** |
| MEDICAID WEBSITE: https://medicaid.utah.gov/<br>CHIP WEBSITE: http://health.utah.gov/chip<br>PHONE: (877) 543-7669 | WEBSITE: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>MEDICAID PHONE: (304) 558-1700<br>CHIP PHONE: (855) MyWVHIPP (699-8447) |
| **VERMONT– MEDICAID** | **WISCONSIN – MEDICAID AND CHIP** |
| WEBSITE: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>PHONE: (800) 250-8427 | WEBSITE:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>PHONE: (800) 362-3002 |
| **VIRGINIA – MEDICAID AND CHIP** | **WYOMING – MEDICAID** |
| WEBSITE:<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>MEDICAID & CHIP PHONE: (800) 432-5924 | WEBSITE: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>PHONE: (800) 251-1269 |

**To see if any other States have added a premium assistance program since July 31, 2023, or for more information on *Special Enrollment Rights*, contact either:**

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
(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

**OMB Control Number 1210-0137 (Expires: 1/31/2026)**

### Notice (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection –Primary Care Designation (HMO)

Your group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

### Notice (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection –Obstetrics & Gynecological care (HMO)

You do not need prior authorization from your group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, see the contact information at the end of these notices.

## NOTICE: Grandfathered Plans

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

For more information, contact:

Claudia Lopez
Director of HR
100 N. Pacific Coast Highway, Suite 1400 El Segundo, CA 90245
310.856.0800
clopez7@behaviorfrontiers.com

# Notice: HIPAA Notice of Privacy Practice

**Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

| | |
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| **Your Rights** | **You have the right to:**<br>• Get a copy of your health and claims records<br>• Correct your health and claims records<br>• Request confidential communication<br>• Ask us to limit the information we share<br>• Get a list of those with whom we've shared your information<br>• Choose someone to act for you<br>• File a complaint if you believe your privacy rights have been violated |
| **Your Choices** | **You have some choices in the way that we use and share information as we:**<br>• Answer coverage questions from your family and friends<br>• Provide disaster relief<br>• Market our services and sell your information |
| **Our Uses and Disclosures** | **We may use and share your information as we:**<br>• Help manage the health care treatment you receive<br>• Tun our organization<br>• Pay for your health services<br>• Help with public health and safety issues<br>• Do research<br>• Comply with the law<br>• Respond to organ and tissue donation requests and work with a medical examiner or funeral director<br>• Address workers' compensation, law enforcement and other government requests<br>• Respond to lawsuits and legal action |

## Your Rights

**When it comes to your health information, you have certain rights.**
This section explains your rights and some of our responsibilities to help you.

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| **Get a copy of health and claims records** | • You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct health and claims records** | • You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not. |
| **Ask us to limit what we use or share** | • You can ask us not to use or share certain health information for treatment, payment or our operations.<br>• We are not required to agree to your request, and we may say "no" if it would affect your care. |
| **Get a list of those with whom we've shared information** | • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.<br>• We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |
| **File a complaint if you feel your rights are violated** | • You can complain if you feel we have violated your rights by contacting us using the information on page 9.<br>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.<br>• We will not retaliate against you for filing a complaint. |

## Your Choices

**For certain health information, you can tell us your choices about what to share.**
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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| **In these cases, you have both the right and choice to tell us to:** | • Share information with your family, close friends, or others involved in payment for your care<br>• Share information in a disaster relief situation<br>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. |
| **In these cases we never share your information unless you give us written permission:** | • Marketing purposes<br>• Sale of your information |

## Our Uses and Disclosures

**How do we typically use or share your health information.**
We typically use or share your health information in the following ways.

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| **Help manage the health care treatment you receive** | • We can use your health information and share it with professionals who are treating you. | **Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services. |

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| **Run our organization** | • We can use and disclose your information to run our organization and contact you when necessary.<br>• We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. | **Example:** We use health information about you to develop better services for you. |
| **Pay for your health services** | • We can use and disclose your health information as we pay for your health services. | **Example:** We share information about you with your dental plan to coordinate payment for your dental work. |
| **Administer your Plan** | • We may disclose your health information to your health plan sponsor for plan administration. | **Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge. |

# How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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| **Help with public health and safety issues** | We can share health information about you for certain situations such as:<br>• Preventing disease<br>• Helping with product recalls<br>• Reporting adverse reactions to medications<br>• Reporting suspected abuse, neglect or domestic partner<br>• Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | • We can use or share your information for health research |
| **Comply with the law** | • We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law. |
| **Respond to organ and tissue donation requests and work with a medical examiner or funeral director** | • We can share health information about you with organ procurement organizations.<br>• We can share health information with a coroner, medical examiner or funeral director when an individual dies. |
| **Address workers' compensation, law enforcement and other government requests** | • For workers' compensation claims<br>• For law enforcement purposes or with a law enforcement official<br>• With health oversight agencies for activities authorized by law<br>• For special government functions such as military, national security and presidential protective services |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order or in response to a subpoena. |

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

## Effective date of this Notice

January 1, 2023

Behavior Frontiers

*a world without limits*

While every effort has been made to be as accurate as possible in developing the enclosed information, the official plan documents prevail in all cases. This is not a legal document. It is a brief summary of benefits and is not considered “Evidence of Coverage.” Please refer to the policy/plan documents for a complete description of the controlling terms, coverages, exclusions, limitations and conditions of coverage. In case of any discrepancy between this information and the policy/plan documents, the policy/plan documents will prevail.

Behavior Frontiers reserves the right to terminate, suspend, withdraw, or modify the benefits described in the policy/plan documents in whole or in part, at any time. No statement in this or any other document, and no oral representation should be construed as a waiver of this right. This summary is the confidential property of Behavior Frontiers.