



# BENEFIT GUIDE



JUNE 1, 2026 - MAY 31, 2027



Dear valued employee,

We are happy to provide you with this Benefit Guide to summarize your employee benefits for the 2026-2027 plan year.

MBI Direct Mail + Digital, Inc. recognizes that benefits are an important part of your life as an employee. Our benefits program will help you choose what works best for your needs and your budget.

This document is not just an enrollment guide; it is a resource for you and your family to use throughout the year. Inside you will find a summary of each benefit plan and helpful tips you may not have known about in the past. This guide is designed to break down the insurance benefits to help you make an informed decision regarding the selection and management of the services and benefits provided to you as an employee of MBI Direct Mail + Digital, Inc.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 24-25 for more details.

# CONTENTS

4.....	Summary of Benefits & Coverage (SBC) Notice
5.....	Eligibility
6.....	Enrollment
7.....	Employee Navigator
8.....	Medical Insurance
13.....	Know your Options
14.....	What is a Preventive Exam?
16.....	Dental Insurance
17.....	Vision Insurance
18.....	Voluntary Life and AD&D Insurance
22.....	Terms to Know
23.....	Mandatory Notices
24.....	Medicare Part D Creditable Coverage Disclosure
32.....	Contacts



## IMPORTANT NOTICE TO EMPLOYEES:

This Benefit Guide provides a general description of the various benefits available to you through the MBI Direct Mail + Digital, Inc. Employee Benefits program. The details of these plans and policies are contained in the official plan and policy documents.

This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

# SUMMARY OF BENEFITS & COVERAGE (SBC) NOTICE

Attached are your Federally Mandated Summary of Benefits and Coverage (SBC) documents for all offered medical plan options. In the following pages you will find simpler formatted, easy to understand plan summaries which provide a general description of the various benefits available to you through the MBI Direct Mail + Digital, Inc. Employee Benefits Program.

To access your SBCs you may scan or click the QR code below with your phone.



If you would prefer a printed copy, please contact your HR department.

# ELIGIBILITY



## FOR YOU

All full-time employees working an average of **30 hours** per week are eligible to enroll in benefits. For specific details, please refer to the plan documents.

New full-time employees' benefits for all lines of coverage will begin on the **1st of the month following 60 days of full-time employment.**

## FOR YOUR FAMILY

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

**Examples of Eligible Dependents includes:**

- Legal spouse
- Dependent children
- Disabled children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

## DEPENDENT COVERAGE

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

### Spouse Verification Documentation:

Marriage certificate

### Child Verification Documentation:

Birth certificate, court document awarding custody or requiring coverage

You can provide these documents to  
Human Resources.

The adult child's spouse is not eligible for coverage. In some circumstances and for a limited time period, the newborn of an enrolled adult dependent may be covered. For adult children age 26, the State of Florida has adopted legislation allowing for extended coverage up to age 30, but under more limited conditions such as the child must reside in Florida or be a part-time or full-time student and must be unmarried with no dependent child(ren) of his/her own. In addition, they cannot be covered under another group or franchise plan, student or individual plan, or be Medicare eligible.



# ENROLLMENT

When can I apply for my benefits?

- During your initial new hire eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event



## MID-YEAR ENROLLMENT CHANGES – Section 125 Cafeteria Plan

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.



IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event.

Changes must be reported within 30 days of the actual event.

### Some common qualifying events may include:

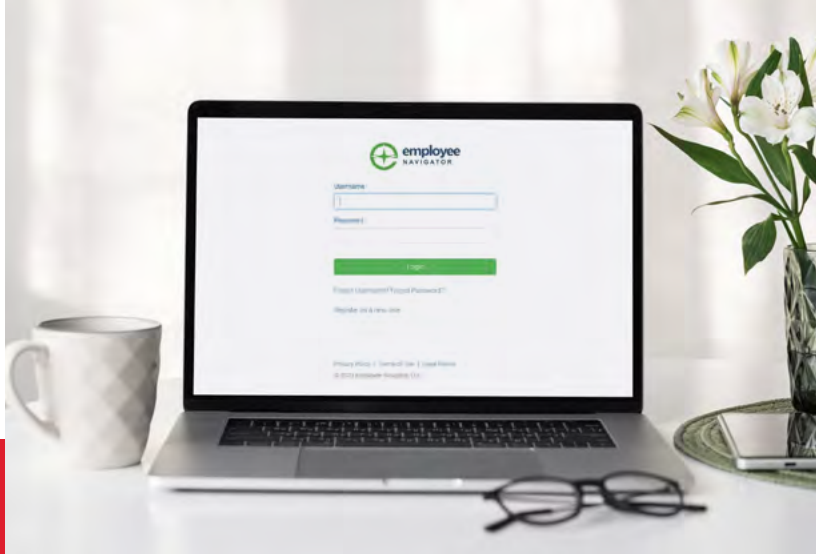
- Marriage, divorce or death of a spouse or child
- Birth, adoption or change in legal custody of a child
- Gaining or Losing of other coverage including a change in your spouse's employment status affecting benefits
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

To determine if any of these apply to you, please check with your Human Resources representative.

The IRS does not consider financial hardship a qualifying event to drop coverage.

### **PLEASE NOTE:**

Group life insurance coverage over \$50,000 may generate imputed income, which is taxable to the employee—regardless of whether premiums are paid pre- or post-tax. While this income is generally not subject to federal income tax withholding, employers must report it and withhold applicable FICA taxes. This is not tax advice. If you have questions, please refer to [IRS – Group-term life insurance](#).



## COMPANY ID: MBI Direct Mail

MBI Direct Mail + Digital, Inc. utilizes Employee Navigator as our online benefit platform. We encourage all employees to utilize the system to make benefit elections, demographic and address changes, and other qualifying event elections. Below are the instructions on how to register as a new user and how to access Employee Navigator for returning users.

### NEW USERS

1. You will receive a **registration email**
2. Use the link in the email to create your Employee Navigator profile
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the **Agree** button
7. **PRINT** the confirmation for your records



### RETURNING USERS

1. You will receive a **Welcome Email**
2. Login to [ioa.employeenavigator.com](http://ioa.employeenavigator.com)
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the **Agree** button
7. **PRINT** the confirmation for your records



# MEDICAL INSURANCE

## FLORIDA BLUE / FLORIDA HEALTH CARE PLANS

IN-NETWORK MEDICAL BENEFITS	FHCP TN2 Med Low**	Blue Options 05773 Med High
Deductible (Individual / Family)	\$5,000/\$10,000	\$2,500/\$7,500
Is deductible Calendar year or Policy year?	Calendar year	Calendar year
Is deductible Embedded or Non Embedded	Embedded	Embedded
Out of pocket maximum (Individual / Family)	\$8,200/\$16,400	\$6,350/\$12,700
Coinsurance	20%	20%
Prescription drugs	Please refer to SBC for Rx Copays	\$10/\$50/\$80 /\$250
Mail order drugs (90 day supply)	Please refer to SBC for Rx Copays	\$25/\$125/\$200 / N/A
<b>PHYSICIAN OFFICE VISITS</b>		
Primary Care Physician	\$0 visits 1-3, \$30 thereafter	\$35
Virtual visit	\$0	\$0 PCP / \$85 SPC
Specialist	*\$60	\$85
Referral needed for specialist?	Yes	No
<b>PREVENTIVE CARE</b>		
Routine adult physical exams	Covered 100%	Covered 100%
Well woman exams		
Routine mammograms and colonoscopy		
Well child exam & immunizations		
<b>DIAGNOSTIC / LABORATORY</b>		
Independent clinical Lab (Blood work)	\$0	\$0
Independent diagnostic testing facility (X-rays)	Deductible + Coinsurance	\$50
Advanced imaging (MRI, PET, CT Scan, Nuclear Medicine)	Deductible + Coinsurance	\$350
<b>HOSPITALIZATION / OUTPATIENT SERVICES</b>		
Inpatient hospitalization (Facility)	Deductible + Coinsurance	\$300 + Ded + Coin
Outpatient surgical care (Hospital facility)	Deductible + Coinsurance	Deductible + Coinsurance
Ambulatory surgical center	Deductible + Coinsurance	\$300
Emergency room	\$350	\$350
Urgent care	\$100	\$100
<b>OUT-OF-NETWORK BENEFITS</b>		
Deductible (Individual / Family)		\$5,000/\$15,000
Out of pocket maximum (Individual / Family)	N/A	\$13,000/\$26,000
Coinsurance		50%
<b>EMPLOYEE SEMI-MONTHLY PAYROLL DEDUCTIONS</b>		
Employee only	\$155.38	\$214.63
Employee + Spouse	\$628.32	\$729.13
Employee + Child(ren)	\$470.67	\$616.58
Employee + Family	\$909.35	\$1,131.08

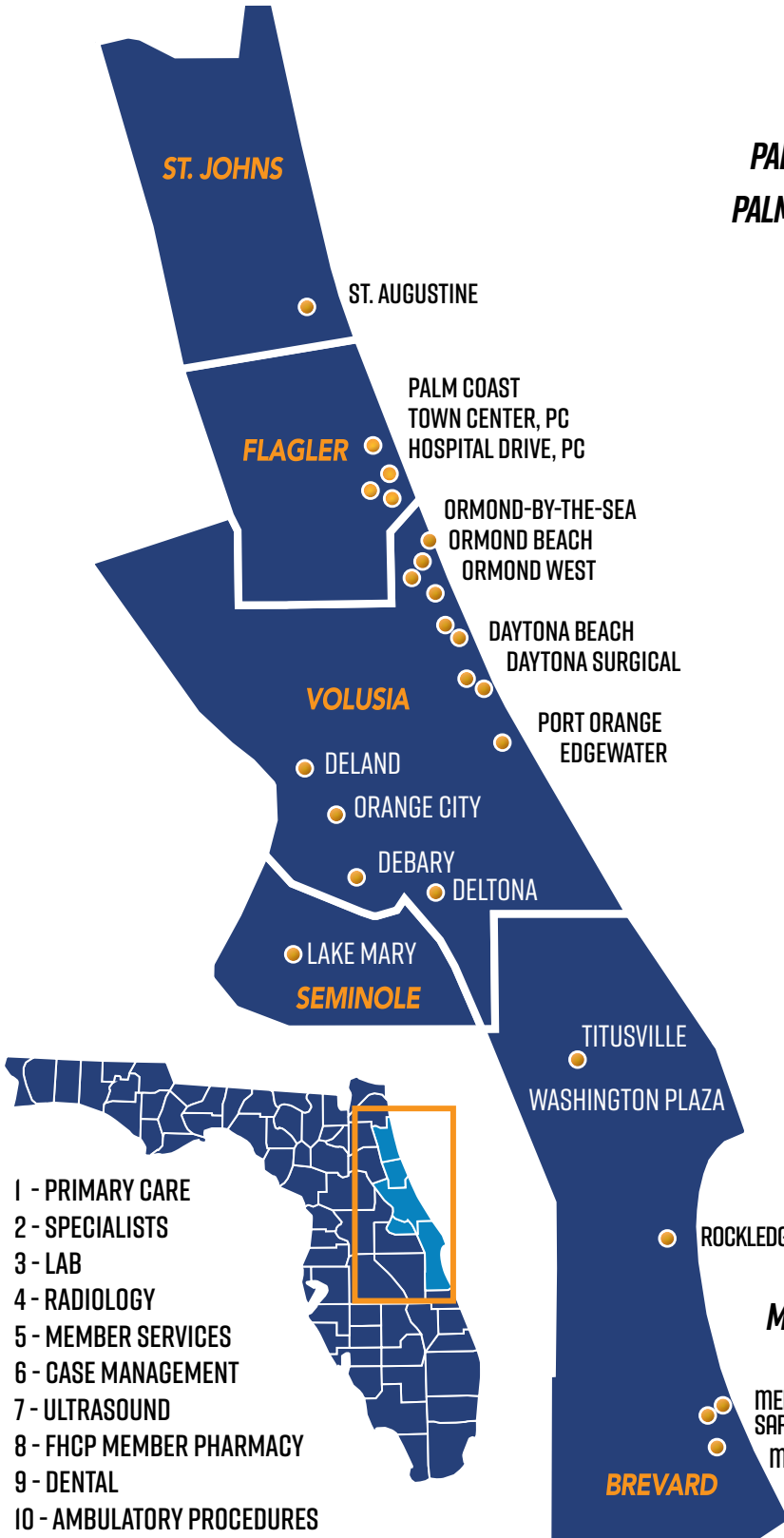
\*Referral needed for specialist

\*\* Only available in select FL counties: St. Johns, Flager, Volusia, Seminole and Brevard.

This information summarizes the MBI Direct Mail + Digital, Inc. medical benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

# FLORIDA HEALTH CARE PLANS

## LOCATIONS AND SERVICES



<b>ST. AUGUSTINE</b>	1, 3, 8, 13
<b>PALM COAST</b>	1, 2, 3, 4, 7, 8, 10, 13
<b>PALM COAST TOWN CENTER</b>	1, 2, 3, 4, 7, 8
<b>PALM COAST HOSPITAL DRIVE</b>	1
<b>ORMOND-BY-THE-SEA</b>	1
<b>ORMOND BEACH</b>	1, 2, 3, 4, 7, 8, 11, 12, 13
<b>ORMOND WEST</b>	1, 2, 7
<b>HOLLY HILL</b>	3, 5, 8, 13
<b>DAYTONA BEACH</b>	1, 2, 3, 4, 7, 8, 9, 12, 13, 14
<b>DAYTONA SURGICAL</b>	2, 10
<b>PORT ORANGE</b>	1, 2, 3, 4, 7, 8, 12, 13
<b>SUMMER TREES, PO</b>	2, 8, 13
<b>EDGEWATER</b>	1, 2, 3, 4, 7, 8, 12
<b>DeLAND</b>	1, 2, 3, 4, 7, 8, 12
<b>ORANGE CITY</b>	1, 2, 3, 4, 7, 8, 10, 12, 13, 14
<b>ORANGE CITY EAST</b>	1, 2
<b>DELTONA</b>	1, 3, 8, 10, 13
<b>DEBARY</b>	2
<b>LAKE MARY</b>	1, 3, 4, 6, 7, 8, 11, 13, 14
<b>LAKE MARY WEST</b>	1
<b>TITUSVILLE</b>	1, 2, 3, 8
<b>WASHINGTON PLAZA, TITUSVILLE</b>	13
<b>ROCKLEDGE</b>	1, 3, 8
<b>MELBOURNE SARNO ROAD</b>	1, 3, 8
<b>MELBOURNE</b>	1, 8
<b>PALM BAY</b>	1, 2, 3, 4, 7, 8, 13, 14

- 1 - PRIMARY CARE
- 2 - SPECIALISTS
- 3 - LAB
- 4 - RADIOLOGY
- 5 - MEMBER SERVICES
- 6 - CASE MANAGEMENT
- 7 - ULTRASOUND
- 8 - FHCP MEMBER PHARMACY
- 9 - DENTAL
- 10 - AMBULATORY PROCEDURES
- 11 - WELLNESS & EDUCATION CENTER
- 12 - EXTENDED HOURS CARE CENTER
- 13 - WELCOME CENTER & SALES
- 14 - INFUSION



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LAST UPDATED 12-30-24  
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# FHCP Preferred Pharmacies

## St. Augustine

200 Southpark Blvd., Ste. 206  
St. Augustine, FL 32086  
(904) 295-3677  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Palm Coast

309 Palm Coast Pkwy.  
Palm Coast, FL 32137  
(386) 446-9447  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Town Center

145 City Place, Ste. 100  
Palm Coast, FL 32164  
(386) 302-0977  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Daytona Beach

350 N. Clyde Morris Blvd.  
Daytona Beach, FL 32114  
(386) 248-0832  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## DeLand

937 N. Spring Garden Ave.  
DeLand, FL 32720  
(386) 736-7318  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Deltona

1925 Providence Blvd.  
Deltona, FL 32725  
(386) 317-8968  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Edgewater

239 N. Ridgewood Ave.  
Edgewater, FL 32132  
(386) 423-4212  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Holly Hill

1510 Ridgewood Ave.  
Holly Hill, FL 32117  
(386) 676-7120  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 5:00 p.m.

## Orange City

2777 Enterprise Rd.  
Orange City, FL 32763  
(386) 774-5961  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Ormond Beach

473 S. Nova Rd.  
Ormond Beach, FL 32174  
(386) 481-6145  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Port Orange

740 Dunlawton Ave., Ste. 150  
Port Orange, FL 32127  
(386) 767-0563  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Summer Trees

1657 Taylor Rd., Ste. 102  
Port Orange, FL 32128  
(386) 317-8537  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Lake Mary

707 Platinum Point  
Lake Mary, FL 32746  
(407) 732-7950  
Mon.-Fri.: 8:30 a.m. to 7:00 p.m.

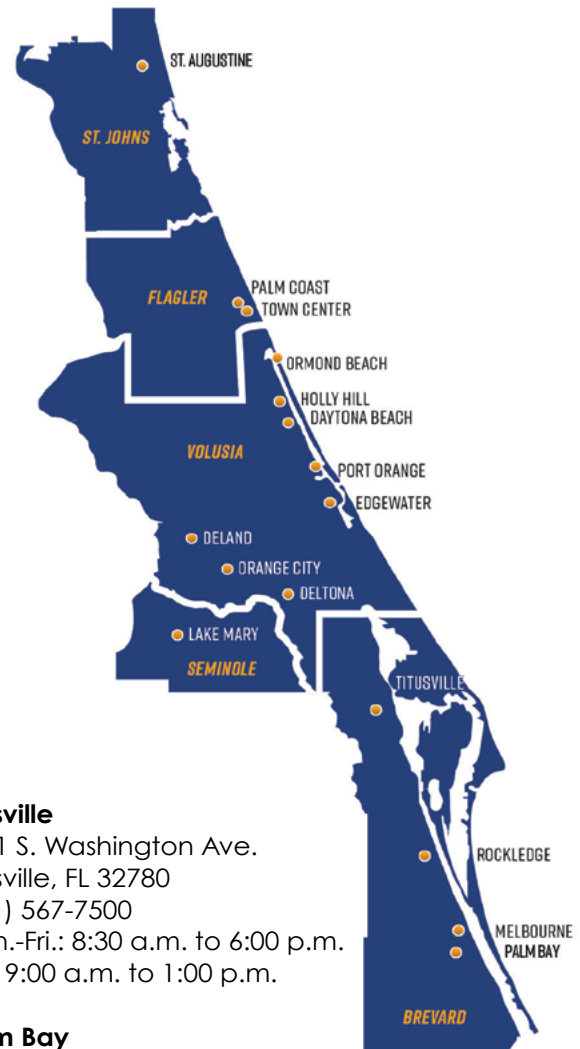
## Melbourne

785 N. Wickham Rd., Ste. 104  
Melbourne, FL 32935  
(321) 567-7505  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Rockledge

1954 Rockledge Blvd., Ste. 107  
Rockledge, FL 32955  
(321) 567-7503  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

All FHCP Preferred Pharmacies listed are closed on Sunday



## Titusville

1021 S. Washington Ave.  
Titusville, FL 32780  
(321) 567-7500  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## Palm Bay

5151 Babcock Street NE  
Palm Bay, FL 32905  
(321) 567-7765  
Mon.-Fri.: 8:30 a.m. to 6:00 p.m.  
Sat: 9:00 a.m. to 1:00 p.m.

## FHCP Mail Order

P.O. Box 11696  
Daytona Beach, FL 32120  
(386) 676-7126 or (800) 232-0216

FHCP Medicare's pharmacy network includes limited lower-cost, preferred pharmacies in Brevard, Flagler, Seminole, St. Johns and Volusia counties, Florida. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-833-866-6559 (TTY user call 1-800-955-8770) or consult the online pharmacy directory at [www.fhcpmedicare.com](http://www.fhcpmedicare.com). HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association. FHCP Medicare is administered by Florida Health Care Plan, Inc.

Last Updated On 09/15/23



**Florida  
Health Care  
Plans®**



An Independent Licensee of the Blue Cross and Blue Shield Association

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# GOOD CHANGES are HAPPENING...

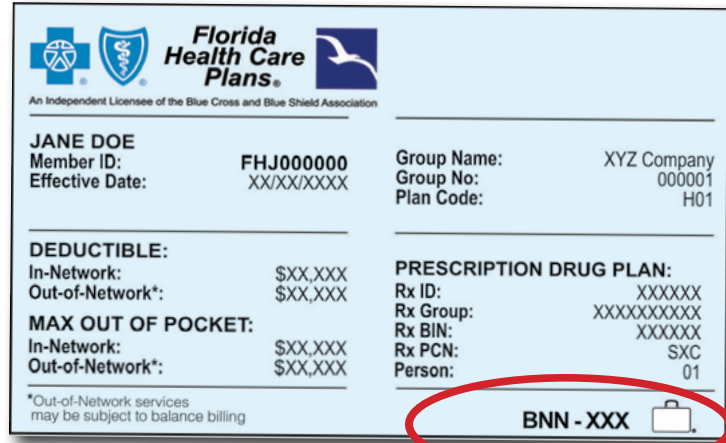
## at FHCP with our BNN Products

We've removed all references to BNN as a Narrow Network because it simply isn't true. Beginning immediately, BNN is simply that... BNN.

In addition to BNN providing access to a new network of care throughout Brevard County, BNN also includes FHCP's HMO network in Volusia, Flagler, St. Johns, and Seminole counties.

If you are enrolled in a BNN Plan, it will be displayed on your Member ID card.

Remember to show your card when you visit any FHCP in-network provider. Your card will identify you as having access to this network of additional providers.



## What's Included in the BNN?

BNN provides a network of care throughout FHCP's service area and specifically in Brevard County.



## URGENT CARE CENTERS

- Medfast Urgent Care
- Restore Health Urgent Care
- Surfside Urgent Care

## PHARMACIES

- All FHCP Pharmacies
- All Health First Pharmacies
- Select Walgreens Pharmacies \*\*

\*\* Full pharmacy list can be found in the [Provider Directory](#).

## HOSPITALS

- Cape Canaveral Hospital
- Holmes Regional Medical Center
- Palm Bay Medical Center
- Parrish Medical Center
- Viera Hospital

## LABS

- All FHCP Care Center
- Melbourne Medical Lab
- Parrish Medical Center
- Quest Diagnostics

## How Do I Learn More?

Contact Member Services at  
**386-615-4022 or 1-877-615-4022.**  
You may also email us at  
**memberservices@fhcp.com.**

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# Take charge of your health!

## Ready to get started on a better, healthier you?

Complete your **Better You Strides Personal Health Assessment (PHA)** and receive a **customized health and wellness plan that sets the stage for your wellness journey.**

When you complete your Personal Health Assessment you'll get:

- **A personal health journey.** This customized plan is designed with you in mind—to help you reach your health and wellness goals.
- **A personal wellness report.** You'll know exactly what health issues you may need to address, as well as recommendations and activities to help you tackle them.
- **A health care provider report.** This snapshot of your overall health makes it easier for you to discuss your health with your doctor.

The results of your assessment will always be kept private and confidential, so you won't have to worry about your information being shared.

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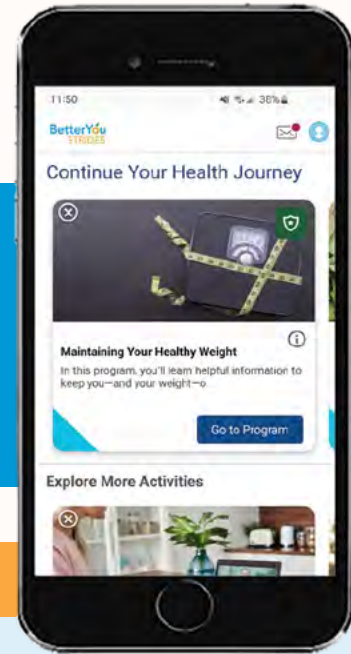
Florida Blue has entered into an arrangement with Onlife to provide members with care decision support services, information and other services. Please remember that all decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, are solely your responsibility and the responsibility of your physicians and other health care providers. The programs mentioned above are subject to change.

Florida Blue and Florida Blue HMO are Independent Licensees of the Blue Cross and Blue Shield Association.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).

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## Get started now!

There are two ways to complete your **Personal Health Assessment.**

- 1 Download the AlwaysOn Wellness mobile app through **Google Play** or the **Apple App Store.**

**OR**

- 2 Log in to your member account on **FloridaBlue.com**. In the top navigation bar, click **My Rewards**. From the drop-down menu, select **Better You Strides**. Select Allowable Activities and scroll until you find your list of rewardable activities. Click **Complete a Health Assessment.**

*Florida Blue*   
Your local Blue Cross Blue Shield

# KNOW YOUR OPTIONS

## 5 Healthcare Options

to help you make the best decision for your medical needs

### Virtual Visits \$

24/7/365 access to a doctor through the convenience of phone or video consults

You can receive care for:

Cough, cold & flu • Allergies • Skin problems

• Sinus problems • Minor fevers

### Convenience Care Clinic \$

Your condition is not urgent or an emergency

You can receive care for:

Cough, cold & flu • Pink eye • Urinary tract infections

Ear infections • Head lice • Insect bites

Minor burns, cuts, and scrapes • Sprains and strains

### Doctor's Office \$\$

Routine care or treatment for a current health issue

You can receive care for:

Routine checkups • Immunizations • Preventive services

Manage medications

### Urgent Care Center \$\$\$

You need medical care fast for a non-emergent medical issue

You can receive care for:

Migraines • Severe back pain • Vomiting and diarrhea

Minor broken bones • Asthma attacks • Severe cough

Animal bites • Wounds requiring stitches

### Emergency Room \$\$\$\$

For a true medical emergency that results in serious jeopardy to your health, impairment of bodily functions or organs

You can receive care for:

Head trauma or loss of consciousness • Chest pain

Numbness or difficulty speaking • Severe abdominal pain

Coughing or vomiting blood • Severe bleeding and burns





## WHAT IS A PREVENTIVE EXAM?

also called a “Physical,” “Wellness Exam” or “Annual Exam”

A Preventive Exam is a scheduled medical evaluation of an individual that focuses on preventive care. It includes age and gender-appropriate history, a physical examination, a review of risk factors and plans to reduce them, and the ordering of appropriate immunizations, screening laboratory tests, ultrasound or diagnostic procedures.

### What does this mean?

A Preventive Exam is an annual exam covering all prevention and health maintenance issues related to age, sex, and family history; it is a “Well Exam”. A Preventive Exam is NOT a follow-up visit or a problem-based visit; it cannot be expected to deal with everything bothering you since your last visit.

### A SECOND Service May Be Necessary

If time and the provider’s judgment allow, new problems or chronic disease follow-up issues may be addressed as a SECOND service during a Preventive Exam visit.

**NOTE:** Your insurance plan may require a co-pay or apply charges to your deductible for a SECOND service provided during a Preventive Exam visit.

For more information on Preventive Health such as free services offered to you, visit [www.hhs.gov/healthcare/about-the-aca/preventive-care/index](http://www.hhs.gov/healthcare/about-the-aca/preventive-care/index)



# PRESCRIPTIONS RX

There are other sources to help cover the cost of antibiotics, HBP medicine, cholesterol, or supplies for diabetes.



Works with or without insurance

Create an account at [CostPlusDrugs.com](https://www.costplusdrugs.com) and have your prescription from your provider submitted to [CostPlusDrugs.com](https://www.costplusdrugs.com).

The prescription will be sent via mail if it is one they carry. You must determine this before submitting your prescription as availability changes frequently.

A complete list of drugs is available at [CostPlusDrugs.com/medications](https://www.costplusdrugs.com/medications)



Works with or without insurance

\$5 per month

(For Prime members only)

You must create an account at [amazon.com](https://www.amazon.com) or use your current Amazon Prime membership. Your provider must submit your prescription to Amazon.

The prescription will be sent via mail if it is one they carry. You must determine this before submitting your prescription as availability changes frequently.

A complete list of drugs is available at [pharmacy.amazon.com/how-it-works](https://www.pharmacy.amazon.com/how-it-works)



Outside of Insurance - leverages coupons for your prescription drug up to 50% off.

You must download the app and create an account at [GoodRx.com](https://www.goodrx.com). The app is FREE!

The downfall of GoodRx purchases is they do NOT accumulate toward your deductible or OOP expense as they are not run through the insurance. The upside is you can generally go to local retail merchants that may already have your Rx on file or easily transfer it from another retail pharmacy (e.g. Walgreens to CVS, etc).

A complete list of drugs is available at [goodrx.com](https://www.goodrx.com) or the GoodRx app.

Mail order Rx

Mail order Rx

Local Rx

# DENTAL INSURANCE

GUARDIAN



Scan or click the QR code to access the carrier's website >>>



## BENEFITS SUMMARY

Annual deductible (Individual/Family)  
 Annual benefit maximum  
 Orthodontia lifetime maximum  
 Waiting period  
 Out-of-Network is MAC or UCR?

	BASE	BUY-UP
Annual deductible (Individual/Family)	\$50 / \$150	\$25/\$75
Annual benefit maximum	\$1,250	\$1,250
Orthodontia lifetime maximum	\$1,000	\$1,000
Waiting period	None	None
Out-of-Network is MAC or UCR?	MAC (Maximum Allowable Charge)	90th% UCR (Usual, Customary, and Reasonable)
	IN-NETWORK	OUT-OF-NETWORK

## PREVENTIVE SERVICES - DEDUCTIBLE WAIVED

Oral evaluations  
 Prophylaxis: cleanings  
 Fluoride treatment (Child only)  
 Bitewing X-rays, Full mouth X-rays  
 Sealants  
 Space maintainers

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Oral evaluations	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Prophylaxis: cleanings	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Fluoride treatment (Child only)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Bitewing X-rays, Full mouth X-rays	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Sealants	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Space maintainers	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%

## BASIC SERVICES

Amalgam restorations (Silver fillings)  
 Resin based restorations (Anterior and posterior)  
 Extractions (Routine and surgical)  
 Endodontic treatments  
 Periodontic treatments

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Amalgam restorations (Silver fillings)	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible
Resin based restorations (Anterior and posterior)	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible
Extractions (Routine and surgical)	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible
Endodontic treatments	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible
Periodontic treatments	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible

## MAJOR SERVICES

Crowns  
 Dentures  
 Bridges

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Crowns	Plan pays 50% after deductible	Plan pays 25% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible
Dentures	Plan pays 50% after deductible	Plan pays 25% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible
Bridges	Plan pays 50% after deductible	Plan pays 25% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible

## ORTHODONTIA SERVICES

Diagnostics and treatments (Child to age 19)

	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Diagnostics and treatments (Child to age 19)	50%	50%	50%	50%

## EMPLOYEE SEMI-MONTHLY PAYROLL DEDUCTIONS

	BASE	BUY-UP
Employee only	\$11.13	\$17.40
Employee + Spouse	\$25.27	\$39.41
Employee + Child(ren)	\$32.11	\$46.47
Employee + Family	\$46.23	\$68.46

This information summarizes the MBI Direct Mail + Digital, Inc. Dental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

# VISION INSURANCE

GUARDIAN/ VSP



Scan or click the QR code to access the carrier's website

## BENEFIT SUMMARY

	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Eye Examination	\$10	\$39 allowance	12 Months
Materials Copay	\$25	--	
Eyeglass Frames	Up to \$130 allowance and 20% off amount over allowance.	\$46 allowance	

## STANDARD EYEGLASS LENSES

Single Vision	Covered 100% after \$25 Copay	\$23 allowance	12 Months
Bifocal		\$37 allowance	
Trifocal		\$49 allowance	
Lenticular		\$64 allowance	

## CONTACT LENSES (IN LIEU OF EYEGLASSES)

Elective	Up to \$130 Allowance	\$120 allowance	12 Months
Medically Necessary	Covered 100% after \$25 Copay	\$210 allowance	

## EMPLOYEE SEMI-MONTHLY PAYROLL DEDUCTIONS

Employee Only	\$3.21
Employee + Spouse	\$5.77
Employee + Child(ren)	\$6.08
Employee + Family	\$9.60



Elective Contact Lenses are in lieu of glasses (lenses & frames). You are not eligible for glasses under our plan until 12 months after you receive contacts and vice versa.

This information summarizes the MBI Direct Mail + Digital, Inc. Vision benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

# VOLUNTARY LIFE AND AD&D INSURANCE



METLIFE

Scan or click the QR code to access the carrier's website >>>

## BENEFITS SUMMARY

EMPLOYEE	SPOUSE	CHILD
Benefit increment: \$10,000	Benefit increment: \$5,000	Benefit increment: \$1,000, \$2,000, \$4,000, \$5,000 or \$10,000
Minimum benefit: \$10,000	Minimum benefit: \$5,000	Minimum benefit: \$1,000
Maximum benefit: \$500,000	Maximum benefit: \$100,000, cannot exceed 50% of EE benefit	Maximum benefit: \$10,000
Guarantee issue amount: \$150,000	Guarantee issue amount: \$25,000	Guarantee issue amount: \$10,000

### PLEASE NOTE:

Remember to update your beneficiary information. Your beneficiaries may receive proceeds up to 2 times the base amount if your cause of death is a result of an accident.

*Proceeds your beneficiaries receive are typically tax-free!*

Employee Age Band	Employee Rate per \$1,000	Spouse Rate per \$1,000
0-29	\$0.070	\$0.070
30-34	\$0.091	\$0.091
35-39	\$0.113	\$0.113
40-44	\$0.146	\$0.146
45-49	\$0.227	\$0.227
50-54	\$0.372	\$0.372
55-59	\$0.624	\$0.624
60-64	\$0.939	\$0.939
65-69	\$1.508	\$1.508
70+	\$2.850	\$2.850
<b>Child rate</b>		
	\$0.24 for \$1K	
	\$0.48 for \$2K	
	\$0.96 for \$4K	
	\$1.20 for \$5K	
	\$2.40 for \$10K	



## HOW TO CALCULATE YOUR VOLUNTARY LIFE PREMIUM

Premium is based on coverage units of \$1,000

- Formula:  $(\text{Benefit volume} \times \text{Rate cost} + \text{AD\&D rate}) / 1000 = \text{Monthly premium}$
- **Example:** 40 year old employee elects \$200,000 in coverage
- Monthly premium:  $\$200,000 \times (\$0.146) / 1,000 = \$29.20$
- Payroll deduction:  $(\$29.20 \times 12) / 24 = \$14.60$  per semi-monthly paycheck

This information summarizes the MBI Direct Mail + Digital, Inc. Voluntary Life benefits and AD&D plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

# VOLUNTARY SUPPLEMENTAL INSURANCE

## Voluntary Products

Aflac

### Helping Pay Your Bills, While You Pay Attention to You

What if one day, not very far in the future, you become disabled and you can't go to work. How would you pay for the expenses of daily life such as monthly mortgage or rent, groceries and your utilities? The bills keep on coming even if you're unable to work. That's where Aflac's short-term disability insurance policy can help make the difference. It's a source of monthly income you may need to help take care of your bills while you take care of yourself.

Why Aflac Short-Term Disability may be the best choice for you:

- It's sold on an individual basis. You choose the plan that's right for you
- based on your financial needs and income. We offer the option of guaranteed-issue,<sup>1</sup> short-term disability coverage. That means no medical questionnaire is required.
- Maternity coverage
- Aflac does not coordinate benefits. Regardless of any other disability insurance you may have, including Social Security, we will pay you directly.
- We pay you a cash benefit for each day you are disabled.

#### SORT TERM DISABILITY SCHEDULE OF BENEFITS

Benefits Begin	Options 0/7, 0/14, 14/14 Accident / Sickness
Payable Benefit Duration	3 Months
Percentage of Income Replaced	60%
Maximum Monthly Benefit	\$10,000
Pre-Existing Condition Limitation	Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

#### BIWEEKLY PAYROLL DEDUCTION CALCULATION AVAILABLE IN EMPLOYEE NAVIGATOR

Annual Income	\$29,000	\$32,000	\$34,000	\$36,000	\$38,000	\$39,000	\$41,000	\$43,000
Monthly Benefit	\$1,875	\$2,000	\$2,125	\$2,250	\$2,375	\$2,500	\$2,625	\$2,750
18-49	\$16.20	\$17.28	\$18.36	\$19.44	\$20.52	\$21.60	\$22.68	\$23.76
50-64	\$18.90	\$20.16	\$21.42	\$22.68	\$23.94	\$25.20	\$26.46	\$27.72
65-74	\$22.50	\$24.00	\$25.50	\$27.00	\$28.50	\$30.00	\$31.50	\$33.00

For more details on plan coverage, or to enroll, please contact your Aflac representative:  
Chasse Greene, 407-766-5442,  
chasse\_greene@us.aflac.com



Or, visit your benefits page at:  
<https://aflacrollment.com/MBIDIRECTMAILDIGITALINC/K24662920465>

The information in this benefit guide is presented for illustrative purposes only. Please refer to the plan document for complete details.

# Voluntary Products

Aflac

## Accident (On & Off the Job Coverage)

Group accident provides cash benefits directly to you (unless otherwise assigned) that help with out-of-pocket expense – medical and nonmedical – associated with treatment in the event of a covered accident. Coverage is also available for your spouse and/or child(ren).

**Other covered benefits include (but are not limited to):**

- Initial Treatment: \$200 per accident
- Ambulance: \$300 ground / \$2,000 air
- Hospital Admission: up to \$3,500
- ICU Admission: up to \$7,000 (builds over time)
- Hospital Confinement: up to \$500/day
- Preventive Care: \$100 annually

### ACCIDENT BIWEEKLY PAYROLL DEDUCTIONS

Employee Only	\$12.94
Employee + Spouse	\$18.20
Employee + Child(ren)	\$21.53
Employee + Family	\$27.37

## Critical Illness

Critical Illness protection provides cash benefits when an insured person is diagnosed with a covered critical illness or other specified health event. Benefits are paid directly to you (unless otherwise assigned). The plan provides a benefit upon diagnosis of covered critical illnesses, specified heart surgeries, covered hospital stays, physical therapy, and many other health events. Coverage is also available for your spouse and/or child(ren).

#### KEY BENEFITS:

- First Occurrence: Named Insured & Spouse 7,500
- Dependent Children \$10,000; lifetime maximum \$10,000 per covered person
- HOSPITAL INTENSIVE CARE UNIT BENEFIT
- Days 1–7: \$800 per day
- Days 8–15: \$1,300 per day
- Limited to 15 days per period of confinement; no lifetime maximum

### CRITICAL CARE BIWEEKLY PAYROLL DEDUCTIONS, full deductions are in employee navigator

Issue Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
18-35	\$ 7.20	\$13.80	\$12.18	\$15.66
36-45	\$10.20	\$17.94	\$14.46	\$19.92
46-55	\$13.92	\$10.61	\$18.60	\$26.58
56-70	\$17.94	\$15.79	\$24.48	\$36.54

Your paragraph text

**For more details on plan coverage, or to enroll, please contact your Aflac representative:  
Chasse Greene, 407-766-5442, [chasse.greene@us.aflac.com](mailto:chasse.greene@us.aflac.com)**

The information in this benefit guide is presented for illustrative purposes only. Please refer to the plan document for complete details.

## Hospital Indemnity

Hospital indemnity plan provides cash benefits directly to you (unless otherwise assigned) that help pay for some of the costs – medical and nonmedical – associated with a covered hospital stay due to a sickness or accidental injury. Coverage is also available for your spouse and/or child(ren).

Benefits include:

- Key Benefits
- Hospital Admission: \$500–\$2,000
- ER Visit: \$100
- Short Stay: \$100
- Rehab: \$100/day
- Additional riders available

## Cancer Protection

A Cancer Protection provides cash benefits when an insured person is diagnosed with a covered cancer. The policy pays a benefit for cancer screenings and cancer treatments, including radiation and hormonal therapy, stem cell and bone marrow transplants and surgery.

- Initial Diagnosis, Internal or Invasive Cancer- Named Insured or Spouse: \$5,000, Dependent Child: \$10,000
- Cancer Screening- One \$75 benefit per calendar year, per covered person
- Stem Cell and Bone Marrow Transplantation- \$7,000; lifetime maximum of \$7,000 per covered person

CANCER BIWEEKLY PAYROLL DEDUCTIONS	
Employee Only	\$17.58
Employee + Spouse	\$30.40
Employee + Child(ren)	\$17.58
Employee + Family	\$17.58

**For more details on plan coverage, or to enroll, please contact your Aflac representative:  
Chasse Greene, [407-766-5442, chasse\\_greene@us.aflac.com](mailto:chasse_greene@us.aflac.com)**

The information in this benefit guide is presented for illustrative purposes only. Please refer to the plan document for complete details.

# TERMS TO KNOW



SCAN OR CLICK THE QR CODE TO WATCH A SHORT VIDEO ON THE TERM YOU WOULD LIKE TO KNOW

**AD&D:** Accidental Death & Dismemberment

**ANNUAL ENROLLMENT:** Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

**CARRIER:** The insurance company.

**CLAIM:** The request for payment for benefits received in accordance with an insurance policy.

**COINSURANCE:** A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

**COPAY:** A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

**CREDITABLE:** Is the prescription drug coverage offered by an employer plan that pays, on average, the same amount as Medicare pays.

**DEDUCTIBLE:** A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

**ELIMINATION PERIOD:** This is the time period between injury or illness and the receipt of benefit payments.

**EMBEDDED DEDUCTIBLE:** An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible in order for after-deductible benefits to kick in, each individual only needs to meet the individual deductible in order for after-deductible benefits to kick in.

**EOB (Explanation of Benefits):** EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

**EVIDENCE OF INSURABILITY (EOI):** This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

**HMO:** Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

**IN-NETWORK:** Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

**MAC:** Maximum allowable charge

**MAIL ORDER PRESCRIPTIONS:** Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

**MAINTENANCE DRUGS:** A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

**NON-EMBEDDED DEDUCTIBLE:** A non-embedded deductible is also referred to as an aggregate deductible. Under an aggregate deductible, the total family deductible must be paid out-of-pocket before after-deductible benefits kick in for the health care services incurred by any family member.

**OUT-OF-NETWORK:** The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

**OUT-OF-POCKET MAXIMUM:** The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

**PARTICIPATING PROVIDER:** Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

**PCP (PRIMARY CARE PHYSICIAN):** A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

**PPO:** Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

**PREVENTIVE CARE:** Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

**REFERRAL:** A written recommendation by a physician that a member may receive care from a specialty physician or facility.

**SPECIALIST:** A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

**UCR:** Usual, customary, reasonable

# MANDATORY NOTICES

## IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

# Important Notice:

## Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **MBI Direct Mail + Digital, Inc.** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **MBI Direct Mail + Digital, Inc.** has determined that the prescription drug coverage offered by **all the medical** plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your re-enrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be canceled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

### 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 under the group plan 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

## Important Notice: Medicare Part D Creditable Coverage Disclosure

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 your Human Resources 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 the group plan coverage 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](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov) or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Contact Human Resources for more information:

MBI Direct Mail + Digital, Inc.  
Shannon Humphrey  
710 W. New Hampshire Ave.  
DeLand, FL 32720  
[shumphrey@mbidirectmail.com](mailto:shumphrey@mbidirectmail.com)  
386-626-0246

For questions about Medicare prescription drug coverage,

Grace Agency is here to help.



**Educating you about Medicare insurance options and resources to meet your health and wellness goals.**



OURS IS A KINDER AND GENTLER APPROACH TO THE WORLD OF MEDICARE INSURANCE



**800-791-4840 | [info@graceagency.org](mailto:info@graceagency.org)**

# Mandatory Notices

## HIPAA Notice of Special Enrollment Rights

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

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.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Human Resources.

## Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

## Model General Notice of COBRA Continuation of Coverage Rights

### 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."

# Mandatory Notices

## 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;
- 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: Human Resources.

## 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. 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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

## CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit

<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 or contacts identified below. 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](http://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](http://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.

# Mandatory Notices

## PLAN CONTACT INFORMATION

Plan and COBRA continuation coverage can be obtained on request:

MBI Direct Mail + Digital, Inc.

Shannon Humphrey

710 W. New Hampshire Ave.

DeLand, FL 32720

shumphrey@mbidirectmail.com

386-626-0246

## Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children’s Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [www.healthcare.gov](http://www.healthcare.gov) for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

## Women’s Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

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

# Mandatory Notices

## Patient Protection Notice

The **FHCP** plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, **FHCP** may designate one for you. For information on how to select a primary care provider, contact the plan administrator.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider: You do not need prior authorization from **FHCP** 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, contact Human Resources.

## 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](http://www.healthcare.gov).

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –**

# State Contacts

## ALABAMA – Medicaid

Website: [myalhipp.com](http://myalhipp.com) | Phone: 1-855-692-5447

## ALASKA – Medicaid

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

## ARKANSAS – Medicaid

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

## CALIFORNIA – Medicaid

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

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

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

## FLORIDA – Medicaid

Website: [www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html](http://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html)  
Phone: 1-877-357-3268

## GEORGIA – Medicaid

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

## INDIANA – Medicaid

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

## IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:  
Iowa Medicaid | Health & Human Services  
Medicaid Phone: 1-800-338-8366  
Hawki Website: [hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki](http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki)  
Hawki Phone: 1-800-257-8563  
HIPP Website: [hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp](http://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp)  
HIPP Phone: 1-888-346-9562

## KANSAS – Medicaid

Website: [www.kancare.ks.gov](http://www.kancare.ks.gov)  
Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

## KENTUCKY – Medicaid

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

## LOUISIANA – Medicaid

Louisiana Medicaid Website:  
[www.ldh.la.gov/healthy-louisiana](http://www.ldh.la.gov/healthy-louisiana)  
Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: [healthy@la.gov](mailto:healthy@la.gov)  
Louisiana Health Insurance Premium Program (LaHIPP) Website:  
[www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)  
LaHIPP phone: 1-877-697-6703  
LaHIPP email: [La.HIPP@la.gov](mailto:La.HIPP@la.gov)  
LaHIPP fax: 1-888-716-9787  
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

## MAINE – Medicaid

Enrollment Website:  
[www.mymaineconnection.gov/benefits/s/?language=en\\_US](http://www.mymaineconnection.gov/benefits/s/?language=en_US)  
Phone: 1-800-442-6003 TTY: Maine relay 711  
Private Health Insurance Premium Webpage:  
[www.maine.gov/dhhs/ofl/applications-forms](http://www.maine.gov/dhhs/ofl/applications-forms)  
Phone: 1-800-977-6740 | TTY: Maine relay 711

## MASSACHUSETTS – Medicaid and CHIP

Website: [www.mass.gov/masshealth/pa](http://www.mass.gov/masshealth/pa)  
Phone: 1-800-862-4840 | TTY: 711  
Email: [masspremassistance@accenture.com](mailto:masspremassistance@accenture.com)

## MINNESOTA – Medicaid

Website: [mn.gov/dhs/health-care-coverage](http://mn.gov/dhs/health-care-coverage)  
Phone: 1-800-657-3672

## MISSOURI – Medicaid

Website: [www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005

## MONTANA – Medicaid

Website:  
[dphhs.mt.gov/MontanaHealthcarePrograms/HIPP](http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP)  
Phone: 1-800-694-3084  
Email: [HSHSHIPPProgram@mt.gov](mailto:HSHSHIPPProgram@mt.gov)

## NEBRASKA – Medicaid

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

## NEVADA – Medicaid

Medicaid Website: [dhcfp.nv.gov](http://dhcfp.nv.gov)  
Medicaid Phone: 1-800-992-0900

# State Contacts

<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="http://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 15218 Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>
<b>NEW JERSEY – Medicaid and CHIP</b>
Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid">www.state.nj.us/humanservices/dmahs/clients/medicaid</a> Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710 (TTY: 711)
<b>NEW YORK – Medicaid</b>
Website: <a href="http://www.health.ny.gov/health_care/medicaid">www.health.ny.gov/health_care/medicaid</a> Phone: 1-800-541-2831
<b>NORTH CAROLINA – Medicaid</b>
Website: <a href="http://medicaid.ncdhhs.gov">medicaid.ncdhhs.gov</a> Phone: 919-855-4100
<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="http://www.hhs.nd.gov/healthcare">www.hhs.nd.gov/healthcare</a> Phone: 1-844-854-4825
<b>OKLAHOMA – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a> Phone: 1-888-365-3742
<b>OREGON – Medicaid and CHIP</b>
Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">healthcare.oregon.gov/Pages/index.aspx</a> Phone: 1-800-699-9075
<b>PENNSYLVANIA – Medicaid and CHIP</b>
Website: <a href="http://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a> Phone: 1-800-692-7462 CHIP Website: <a href="http://www.pa.gov/agencies/dhs/resources/chip">www.pa.gov/agencies/dhs/resources/chip</a> CHIP Phone: 1-800-986-KIDS (5437)
<b>RHODE ISLAND – Medicaid and CHIP</b>
Website: <a href="http://www.eohhs.ri.gov">www.eohhs.ri.gov</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
<b>SOUTH CAROLINA – Medicaid</b>
Website: <a href="http://www.scdhhs.gov">www.scdhhs.gov</a> Phone: 1-888-549-0820
<b>SOUTH DAKOTA – Medicaid</b>
Website: <a href="http://dss.sd.gov">dss.sd.gov</a> Phone: 1-888-828-0059
<b>TEXAS – Medicaid</b>
Website: <a href="http://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program">www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program</a> Phone: 1-800-440-0493
<b>UTAH – Medicaid and CHIP</b>
Utah's Premium Partnership for Health Insurance (UPP) Website: <a href="http://medicaid.utah.gov/upp">medicaid.utah.gov/upp</a> Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a> Phone: 1-888-222-2542 Adult Expansion Website: <a href="http://medicaid.utah.gov/expansion">medicaid.utah.gov/expansion</a> Utah Medicaid Buyout Program Website: <a href="http://medicaid.utah.gov/buyout-program">medicaid.utah.gov/buyout-program</a> CHIP Website: <a href="http://chip.utah.gov">chip.utah.gov</a>

<b>VERMONT – Medicaid</b>
Website: <a href="http://dvha.vermont.gov/members/medicaid/hipp-program">dvha.vermont.gov/members/medicaid/hipp-program</a> Phone: 1-800-250-8427
<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="http://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924
<b>WASHINGTON – Medicaid</b>
Website: <a href="http://www.hca.wa.gov">www.hca.wa.gov</a> Phone: 1-800-562-3022
<b>WEST VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://dhr.wv.gov/bms">dhr.wv.gov/bms</a> <a href="http://mywvhipp.com">mywvhipp.com</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>WISCONSIN – Medicaid and CHIP</b>
Website: <a href="http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
<b>WYOMING – Medicaid</b>
Website: <a href="http://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility">health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**

Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services**

[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

# CONTACTS



LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE
Medical	FLORIDA BLUE	Florida Blue - 1-800-352-2583 <a href="http://www.floridablue.com">www.floridablue.com</a>
Medical	FLORIDA HEALTH CARE PLANS	FHCP - 877-615-4022 <a href="http://www.fhcp.com">www.fhcp.com</a>
Dental	GUARDIAN	800-627-4200 <a href="http://www.guardiananytime.com">www.guardiananytime.com</a>
Vision	GUARDIAN/ VSP	800-216-6248 <a href="http://www.vsp.com">www.vsp.com</a>
Voluntary Life & AD&D	METLIFE	1-800-275-4638 <a href="http://www.metlife.com">www.metlife.com</a>
Voluntary Supplemental Insurance	AFLAC- MORGAN STRONG	407-489-4800 <a href="http://www.AFLAC.com">www.AFLAC.com</a>



## INSURANCE OFFICE OF AMERICA

For assistance with benefits questions, membership card issues, claims, and billing inquiries please contact one of your IOA service team members per the contact information below:

NAME - TITLE	PHONE	EMAIL
<b>Marlyn Stafford</b> <i>Account Executive</i>	407-998-5311	<a href="mailto:Marlyn.Stafford@ioausa.com">Marlyn.Stafford@ioausa.com</a>
<b>Melissa Murray</b> <i>Account Associate</i>	407-212-3560	<a href="mailto:Melissa.Murray@ioausa.com">Melissa.Murray@ioausa.com</a>



INSURANCE OFFICE OF AMERICA



BENEPLACE is a best-in-class savings platform that's reliable, budget-friendly, and focused on one thing: rewarding you with discounts on products and services from the brands you love!

Visit [ioausa.savings.beneplace.com](https://ioausa.savings.beneplace.com) to find out more.







# MBI DIRECT MAIL + DIGITAL, INC. BENEFIT GUIDE

**JUNE 1, 2026 - MAY 31, 2027**

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