
2027

Krapf Group

Employee Enrollment Guide



Medical Plan Benefit



MEC	
Covered Benefits	
Deductible (single/family)	\$0/\$0
Coinsurance	100%
Out-of-Pocket Maximum (single/family)	\$0/\$0
PPO Network	Open Access Solution
ACA Required Preventive Care/ Screening/Immunization Benefits (MEC)	Covers 100% of the government's listed Preventive and Wellness Benefits
RealTime Telemed	
Telemedicine	Not Covered
TeleVet	Not Covered
Geo Fencing Rx	Not Covered
Behavioral Health	Not Covered
Choices Transparency Program	Not Covered
Life Guides	Unlimited Access
New Edge Health	Unlimited GLP-1 Access @ KeySolution Member Exclusive Pricing
Fully Insured Indemnity Benefits	
Inpatient Hospital Daily Indemnity Benefit	N/A
Outpatient Physician Office Visit Daily Indemnity Benefit	N/A
Outpatient Diagnostic X Ray and Lab Daily Indemnity Benefit	N/A
Daily Prescription Drug Benefit	N/A
Emergency Room Visit Daily Indemnity Benefit	N/A
*covers illness and accidents	
Employee Group Term Life	N/A

MEC Benefit Summary

This list below summarizes some but not all services. Please reference the US Preventive Services Task Force website for the entire list.

Covered Preventive Services for Adults (ages 18 and older)

1. Abdominal Aortic Aneurysm one time screening for age 65-75
2. Unhealthy Alcohol or Drug use screening and counseling
3. Anxiety screening in adults
4. Aspirin use for adults ages 50-59 to prevent Cardiovascular Disease and Colorectal Cancer when prescribed by a physician
5. Blood Pressure screening for all adults
6. Cholesterol screening for adults
7. Colorectal Cancer screening for adults starting at age 45 and continuing until age 75. This does not include Cologuard or FIT-DNA testing. Cologuard or FIT-DNA testing is not covered under the Plan.
8. Depression screening for adults
9. Type 2 Diabetes screening for adults
10. Diet counseling for adults
11. Fall Prevention to include physical therapy to prevent fall in community dwellings age 65 and older
12. Hepatitis B screening for adults
13. Hepatitis C screening for adults at high risk and one time for everyone between the ages of 18 and 79 years old.
14. HIV screening for all adults
15. Immunization vaccines for adults: Covid 19, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Mpox, Pneumococcal, RSV, Tetanus, Diphtheria, Pertussis, and Varicella
16. Lung Cancer Screening for adults age 50-80 who are at high risk because they smoke 20 packs a year (or have quit in the past 15 years)
17. Obesity screening and counseling for all adults
18. Sexually Transmitted Infection (STI) prevention counseling and screening for adults
19. Skin Cancer behavioral counseling for adults to age 24 with fair skin
20. Tobacco Use screening, counseling and cessation interventions for all adults
21. Syphilis screening for all adults
22. Latent tuberculosis infection screening for all adults.
23. Statin preventive medication for adults ages 40-75 years with no history of cardiovascular disease, 1 or more cardiovascular disease risk factors and a calculated 10 year cardiovascular disease event risk of 10% or greater.

24. Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis (PrEP) for person considered at high risk of HIV acquisition per USPSTF guidelines on identification of persons at high risk. The USPSTF recommends that the following persons be considered for PrEP: 1) Men who have sex with men, are sexually active, and have one of the following characteristics: (a) A serodiscordant sex partner (i.e. in a sexual relationship with a partner living with HIV), (b) Inconsistent use of condoms during receptive or insertive anal sex, or (c) A sexually transmitted infection (STI) with syphilis, gonorrhea, or chlamydia within the past 6 months; 2) Heterosexually active women and men who have 1 of the following characteristics: (a) A serodiscordant sex partner (i.e. in a sexual relationship with a partner living with HIV), (b) Inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk (i.e. a person who injects drugs or a man who has sex with men and women), or (c) An STI with syphilis or gonorrhea within the past 6 months; and 3) Persons who inject drugs and have 1 of the following characteristics: (a) Shared use of drug injection equipment or (b) risk of sexual acquisition of HIV (see above). It is important to note that men who have sex with men and heterosexually active persons are not considered to be at high risk if they are in a mutually monogamous relationship with a partner who has recently tested negative for HIV. In addition, all persons being considered for PrEP must have a recently documented negative HIV test result. Prior authorization is required. If you have questions about the prior authorization process, please contact the Plan Supervisor. The following additional services are covered when provided to assess whether to start/re-start PrEP or keep a person on PrEP medications:
 - HIV testing – Prior to or at the start of PrEP and every 3 months while taking PrEP
 - Hep B Testing – Prior to or at start of PrEP
 - Hep C Testing – Prior to or at the start of PrEP and thereafter
 - Creatinine testing – At the start of PrEP and while on PrEP
 - eCrCl or eGFR calculations - At the start of PrEP and while on PrEP
 - Pregnancy Testing – Persons with childbearing potential - At the start of PrEP and while on PrEP
 - STI Screening and Counseling - At the start of PrEP and while on PrEP. Includes testing for syphilis. Includes multiple anatomic site testing for gonorrhea and chlamydia
 - Adherence Counseling – On a “Regular” basis
 - Office visits associated each of the above services if the service (a) is not billed separately from the office visit, and (b) the primary purpose of the visit is the delivery of the recommended service

The Plan covers PrEP related services at frequencies that are consistent with CDC guidelines.

Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Aspirin for pregnant women at high risk for preeclampsia.
3. Bacteriuria urinary tract or other infection screening for pregnant women
4. BRCA counseling and genetic testing for women at higher risk
5. Breast Cancer Mammography screenings every 1 to 2 years for women age 40 and over, including additional screenings (e.g., another mammogram, an MRI or an ultrasound) and diagnostic pathology screening evaluations as needed to complete the screening process.
6. Breast Cancer Chemoprevention counseling as well as breast cancer testing and medications for women with increased risk for breast cancer
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
8. Cervical Cancer screening
9. Chlamydia Infection screening
10. Contraception: For adolescent and adult women Food and Drug Administration-approved, granted, or cleared contraceptive methods (including during the post-partem period), sterilization procedures, and patient screening, education and counseling and follow-up care (including management, evaluation, and changes) and the removal, continuation and discontinuation of contraceptive),,, not including abortifacient drugs
11. Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes
12. Domestic and interpersonal violence screening and counseling for all women
13. Folic Acid supplements for women who may become pregnant when prescribed by a physician
14. Gestational diabetes screening
15. Gonorrhea screening for all women
16. Hepatitis B screening for pregnant women
17. Human Immunodeficiency Virus (HIV) screening and counseling
18. Human Papillomavirus (HPV) DNA Test: HPV DNA testing every three years for women with normal cytology results who are 30 or older
19. Osteoporosis screening age 65 and older and postmenopausal women at increased risk
20. Hypertension screening in pregnant women with blood pressure measurements throughout pregnancy.
21. Routine prenatal visits for pregnant women
22. Rh Incompatibility screening for all pregnant women and follow-up testing
23. Tobacco Use screening and interventions for all women and expanded counseling for pregnant tobacco users
24. Sexually Transmitted Infections (STI) counseling
25. Syphilis screening
26. Urinary Incontinence screening
27. Well-woman visits to obtain recommended preventive services
28. Perinatal Depression counseling interventions for pregnant and postpartum persons at risk.
29. Anxiety screening in adolescent women and adult women, including but not limited to, those who are pregnant or postpartum.
30. Healthy weight and weight gain in pregnancy behavioral counseling interventions for pregnant persons.

Covered Services for Children

1. Alcohol and Drug Use assessments
2. Anxiety screening in children and adolescents age 8 to 18.
3. Autism screening for children limited to two screenings up to 24 months
4. Behavioral assessments for children limited to 5 assessments up to age 17.
5. Bilirubin concentration screening for newborns
6. Blood screening for newborns
7. Blood Pressure screening
8. Cervical Dysplasia screening
9. Congenital Hypothyroidism screening for newborns
10. Depression screening for adolescents age 12 and older
11. Developmental screening for children under age 3, and surveillance throughout childhood
12. Dyslipidemia screening for children.
13. Fluoride Chemoprevention to include supplements for children without fluoride in their water source when prescribed by a physician and fluoride varnish to primary teeth through age 5.
14. Gonorrhea preventive medication for the eyes of all newborns
15. Hearing screening for all newborns and 3 additional screenings at periodic ages up to age 21
16. Height, Weight and Body Mass Index measurements for children.
17. Anemia screening for children
18. Hemoglobinopathies or sickle cell screening for newborns
19. Hepatitis B screening for adolescents
20. HIV screening for adolescents
21. Immunization vaccines for children from birth to age 18 —doses, recommended ages and recommended populations vary: Covid 19, Diphtheria, Tetanus, Pertussis, Hemophilus influenza Type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, RSV, Rotavirus, and Varicella
22. Iron supplements for children ages 6 to 12 months when prescribed by a physician
23. Lead screening for children
24. Maternal depression screening for mothers of infants at 1, 2, 4 and 6 month visits
25. Medical History for all children throughout development ages: 0 to 11 mos., 1 to 4 yrs., 5 to 10 yrs., 11 to 14 yrs., 15 to 17 yrs.
26. Obesity screening and counseling
27. Oral Health risk assessment for young children up to age 10.
28. Phenylketonuria (PKU) screening in newborns
29. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
30. Skin Cancer behavioral counseling for adolescents age 10 and up who have fair skin
31. Syphilis screening for adolescents
32. Tobacco Use screening, counseling and interventions to prevent initiation of tobacco use
33. Tuberculin testing for children
34. Vision screening for all children

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KeySolution Enrollment Form

1. Enrollee Information

Group Name:		Plan Coverage Effective Date:	
Last Name:		Date you became a Full time Employee:	
First Name:		Date of Birth (DOB):	
Sex: ☐ M ☐ F	SS #:	No. Hours Work/per week:	
Home Phone #:		Work Phone #:	
Street Address:		City:	State: Zip:

Plan Selection (per your enrollment guide):

☐ MEC Plan		
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Beneficiary of Life Insurance (If applicable):

Full Name:	Address:	City, State Zip:
Phone #:	Date of Birth:	Relationship:

2. Dependent Information

I would like to be covered under this plan along with the following dependents:					
☐ Spouse ☐ Domestic Partner	Last Name:	First:	SS#:	DOB:	☐ Male ☐ Female
Last Name:		First:	SS#:	DOB:	☐ Male ☐ Female
☐ Child ☐ Disabled ¹ ☐ Court Ordered ²					
Last Name:		First:	SS#:	DOB:	☐ Male ☐ Female
☐ Child ☐ Disabled ¹ ☐ Court Ordered ²					
Last Name:		First:	SS#:	DOB:	☐ Male ☐ Female
☐ Child ☐ Disabled ¹ ☐ Court Ordered ²					
Last Name:		First:	SS#:	DOB:	☐ Male ☐ Female
☐ Child ☐ Disabled ¹ ☐ Court Ordered ²					

¹For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.

²If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

I hereby apply for benefit plan participation for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by Key Benefit Administrators. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

☐ I am waiving/declining coverage for myself and my dependents

Employee (print name): _____ Employee Signature: _____ Date: _____