BJC Services, Inc
Benefits Summary Guide

Plan Year December 1, 2020 to November 30, 2021

At BJC Services we realize that employees are our most valuable resource. We are pleased to offer our eligible full-time employees with an excellent benefit program that is designed to fit your needs!

The purpose of this booklet is to give you an outline of benefit offerings. We encourage you to carefully review this information to educate yourself about your options and help you to choose the best coverage. Choosing the right plan ensures that you receive the health benefits and services that matter to you.

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The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact your Human Resources Department.

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Frequently Asked Questions:

Q: **Who is Eligible for benefits?**
A: If you are an employee working 20 hours per week or more, and you have met your New Hire Waiting Period (90 days), you are eligible to enroll in the benefits described in this guide. Eligible dependents include your spouse, children and stepchildren. The medical, dental and vision plans cover eligible non-spousal dependents until the end of the year in which they turn 26.

Q: **What benefits are offered?**

- Medical & Prescription – United HealthCare
- Dental – Unum
- Vision – MetLife
- Life Insurance – One America
- Short Term Disability – One America
- Voluntary Life – One America

Q: **What changes have been made for the new plan year?**
A: BJC Services has made the following updates for the upcoming plan year:

- Your deductibles and out of pocket maximums on the medical coverage with United Healthcare are increasing for the 2020 plan year, please review the Benefit Summary in Benefits Connect and at myuhc.com for plan details. This will, however, result in lower deductions per paycheck.

Q: **When can I change my benefits?**
A: Once you've made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified event. Qualified events include: marriage, divorce, legal separation, birth or adoption of a child, a change in child's dependent status, death of a spouse, child, or other qualified dependent, or a change in spouse's benefits or employment status. Changes must be made within thirty days of the qualifying event.

Q: **How do I Enroll?**
A: BJC Services has partnered with Benefits Connect to provide you with an on-line enrollment experience. To log into Benefits Connect and complete your open enrollment follow the below steps:

1. Open your web browser and go to enroll.benefitsconnect.net.
2. At the home screen, you will see a username and password box. Your user name is the first six letters of your last name, followed by the first letter of your first name, which is then followed by the last four digits of your social security number.
3. Your initial password is your social security number. Please note, only use the digits, no spaces or dashes.
4. Click Sign In to enter and enroll.

Please note that all eligible employees must log into the site to enroll in benefits or to waive benefits.

Q: Who do I contact with questions about my benefits?

A: You may contact Jan Jennings at BJC Services with questions regarding your benefits, via phone at 586-783-4559 or email at jjennings@bjconstructioninc.com.

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Medical and Prescription Drugs

BJC Services is excited to continue offering United Health Care (UHC) as the group's medical plan carrier this year. Your deductible and out of pocket maximums have increased this year. Please be sure to review the complete benefit summary. The deductible and coinsurance continue to accrue each year beginning on January 1st. To view a provider directory, go to www.myuhc.com and use the Find a Doctor feature.

Note: A more detailed benefit summary is provided on the Benefits Connect on-line enrollment site, as well as in this packet.

Services	United HealthCare BH-LQ / RX548	
	In-Network	**Out-of-Network**
Deductible - **Individual** - **Two Person or Family**	$2,500 $5,000	$7,500 $15,000
Coinsurance after Deductible	80% after deductible, for most services	50% after deductible, for most services
Out of Pocket Max - **Individual** - **Two Person or Family**	$5,500 $11,000	$15,000 $30,000
Preventive Care	100% covered	n/a
Office Visit	100% covered	50% coinsurance after deductible
Specialist Visit	$100 copay	50% coinsurance after deductible
Urgent Care	$50 copay	50% coinsurance after deductible
Emergency Room	$250 copay; then 80% coinsurance after deductible	$250 copay; then 80% coinsurance after deductible
Hospitalization	80% coinsurance after deductible	50% coinsurance after deductible; prior authorization required
Surgery (not including reconstructive / bariatric surgery)	80% coinsurance after deductible	50% coinsurance after deductible; prior authorization may be required
Prescription Drugs: - **Tier 1** - **Tier 2** - **Tier 3** - **Tier 4** - **Mail Order (90 day supply)**	$5 $50 $100 $250 2.5X Retail Copays	$5 $50 $100 $250 N/A
Prescription Drug Provisions: UHC has created a drug "formulary" that reflects which drugs belong to each Tier. A copy of the formulary list can be found on www.uhc.com.		

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Dental Coverage

BJC Services is pleased to offer Dental coverage again through UNUM this year. To find an in-network provider, visit www.unumdentalcare.com and click on Find a Dentist.

Members who go to nonparticipating dentists are responsible for any difference between the approved amount (Reasonable and Customary) and the dentist's charge.

Note: A more detailed benefit summary is provided on the Benefits Connect on-line enrollment site, as well as in this packet.

UNUM Elite Dental Plan		
Services	**In-Network**	**Out-of-Network**
Deductible Individual / Family	$50 / $150	
Preventative Services Exams, Bitewing X-rays, Cleanings, Sealants	100%	100%
Basic Services Fillings (amalgam), simple extractions, non-surgical periodontics, endodontics, and repairs to crowns, denture and bridges.	80%	80% of reasonable and customary
Major Services Inlays, onlays, crowns, bridges, dentures and endosteal implants.	50%	50% of reasonable and customary
Annual Maximum Benefit	$1000	
Orthodontia	50% up to $1000 lifetime annual max for dependents up to age 19	
Waiting Period	One Year for Orthodontia	

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Pediatric Dental Coverage

BJC Services offers Pediatric Dental coverage, as mandated by The Affordable Care Act, for children under the age of 19. Pediatric dental coverage is through United Healthcare. In cases where there is a benefit that can be paid under the standard dental plan and pediatric dental plan, benefits will be paid according to the plan that offers the most benefit to the insured.

The cost of the pediatric dental coverage is covered within the medical plan cost.

Pediatric Dental PPO		
Services	**In-Network**	**Out-of-Network**
Preventative Services Exams, Bitewing X-rays, Cleanings, Sealants	100% after medical deductible	50% after medical deductible
Basic Services Space Maintainers, Minor Restorative Services and Periodontal Maintenance	80% after medical deductible	50% after medical deductible
Major Services Endodontics (root canal treatment), Periodontics (gum disease treatment), and Major Restorative Services.	50% after medical deductible	50% after medical deductible
Annual Maximum Benefit	None	
Orthodontia Medically Necessary Only	50% coinsurance, after medical deductible; Preauthorization required	

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Vision Coverage

BJC Services will continue to offer Vision coverage through MetLife this year. You'll want to verify whether your vision provider participates in-network in order to receive the most comprehensive benefits. Go to www.metlife.com/vision to determine participating providers.

Note: A more detailed benefit summary is provided on the Benefits Connect on-line enrollment site, as well as in this packet.

	Vision	
Services	**In-Network**	**Out-of-Network**
Frequency	Exams: Once every calendar year Lenses: Once every calendar year Frames: Once every two calendar years	
Vision Exam	$10 Copay	Reimbursement up to $45
Standard Lenses	$25 copay	Reimbursed up to $30
Frames	$130 retail frame allowance	Reimbursement up to $70
Contact Lenses : In lieu of eyeglass lenses & frames **Elective** **Medical Necessary**	$25 copay $130 allowance 100% Covered	 Reimbursement up to $105 Reimbursement up to $210

Pediatric Vision Coverage

Like the dental coverage, BJC Services offers pediatric vision coverage for dependents up to the age of 19 through United Healthcare, using the Spectera Eyecare Network. To find a participating provider, visit www.myuhcvision.com. In cases where there is a benefit that can be paid under the standard vision plan and pediatric vision plan, benefits will be paid according to the plan that offers the most benefit to the insured. The cost of the pediatric vision coverage is covered within the medical plan cost.

Pediatric Vision	
Services	**In-Network**
Eye Exam	$10 copay, covered once every calendar year
Prescription Lenses	$25 copay, covered every calendar year
Frames	$130 allowance, covered once every calendar year

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Life and AD&D Insurance

BJC Services provides full-time employees with **$15,000** in group life and accidental death and dismemberment (AD&D) insurance through OneAmerica. BJC Services pays the full cost of this benefit.

Employees who want to supplement their group life insurance benefits have the ability to purchase additional coverage at their own cost.

- ***Employees****:* You can purchase coverage on yourself in increments of $10,000, to a maximum of $500,000, not to exceed 5x your annual salary. The first $100,000 in voluntary coverage is guaranteed issue, which means that no medical questions will be asked for any election up to that amount. Anything over that amount would require evidence of insurability. Further, if you decline when you are first eligible and you want to enroll at a subsequent time, all amounts requested would be subject to evidence of insurability.
- ***Spouses****:* For your eligible spouse, you can elect either up to 100% of the amount that you have insured on yourself, in increments of $5,000, with a maximum benefit of $250,000. The guaranteed issue amount for spouses is $25,000. All requests for amounts over $25,000 would be subject to evidence of insurability. Again, if you decline when your spouse is first eligible and you want to enroll at a subsequent time, all amounts requested would be subject to insurability.
- ***Children****:* For your eligible children, you can elect up increments of $5,000, with a maximum of $10,000. All amounts are guaranteed. Premium is the same regardless of how many children are covered.

Disability Insurance

BJC Services provides full-time employees with the opportunity to elect short-term disability income benefits through OneAmerica. BJC pays 50% of the premium and the employee is responsible for the other 50%. The premium for the plan is $0.47 per $10 of coverage. Payroll deductions will be post-tax deductions.

In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive disability benefits if you are receiving workers' compensation benefits.

	Short Term Disability
Benefits Begin	1st day due to accident 8th day due to sickness
Benefits Payable	Up to 13 weeks
Percentage of Income Replaced	60% of pre-disability earnings
Maximum Benefit	$500 per week

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Premium Summary Information – Per Pay Period (Bi-Weekly)

Medical Plan Per Pay Period Cost	
Level	**Rate**
Single	$110.00
EE & Spouse	$252.00
EE & Child	$226.00
Family	$382.00

Dental Plan Per Pay Period Cost	
Level	**Rate**
Single	$6.32
EE & Spouse	$12.39
EE & Child	$16.81
Family	$24.82

Vision Plan Per Pay Period Cost	
Level	Rate
Single	$3.64
EE & Spouse	$7.29
EE & Child(ren)	$6.18
Family	$10.18

Rates per $1,000 of Voluntary Life & AD&D – Per Pay Period		
Age	**Employee**	**Spouse**
< 25	$0.08	$0.08
25 – 29	$0.08	$0.08
30 – 34	$0.08	$0.08
35 – 39	$0.10	$0.10
40 – 44	$0.15	$0.15
45 – 49	$0.22	$0.22
50 – 54	$0.35	$0.35
55 – 59	$0.51	$0.51
60 – 64	$0.65	$0.65
65 – 69	$1.01	$1.01
70 +	$2.61	n/a
Child Life and AD&D - $0.55 for $10,000		

STD Plan Premium Cost
$0.47 per $10 Coverage; 60% of Salary (Max $500/Week); Max Possible Payroll Deduction $5.42

Contact Information

Service Representative	Phone Number	Website / Email
Medical: United Healthcare	866-414-1959	www.myuhc.com
Dental: UNUM	866-679-3054	www.unumdentalcare.com
Vision: MetLife	855-638-3931	www.metlife.com/vision
Life & STD: OneAmerica	800-553-5318	www.oneamerica.com
Huntington Insurance: Vanessa Atkins - Account Manager	248-554-6905	vanessa.atkins@huntington.com

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2020 ERISA ANNUAL REQUIRED NOTICES

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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Jan Jennings, HR, (586) 783-4559, 46385 Continental Drive, New Baltimore, MI 48047.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under Federal law, Group Health Plans generally may not 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 Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a Group Health Plan may not, under Federal law, require that a provider obtain authorization from the Group Health Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMENS HEALTH AND CANCER ACT OF 1998

Under federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

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- prostheses and physical complications of mastectomy, including lymphedemas;
- in a manner determined in consultation between the attending Physician and the patient.

These benefits may be subject to annual deductibles and copayment provisions that are appropriate and consistent with other benefits under the plan or coverage.

MICHELLE'S LAW: HEALTH INSURANCE FOR DEPENDENT COLLEGE STUDENTS EXTENDED DURING DEPENDENT MEDICALLY NECESSARY LEAVE OF ABSENCE

The sections below describe benefit continuation during a leave of absence for seriously ill college students. For more information, contact the Plan Administrator.

Michelle's Law
Effective October 9, 2008, Michelle's Law allows seriously ill college students, who are covered dependents under the group health plan to continue coverage for up to one year while on medically necessary leave of absence.

Medically Necessary Leave of Absence The extension of coverage applies to a dependent child's leave of absence from, or any other change in enrollment at, a postsecondary educational institution (including colleges and universities) on account of a serious illness or injury from which the child is suffering while covered under the group health plan that would otherwise cause the child to lose dependent status for purposes of coverage.

Length of Continued Coverage Coverage continues until the earlier of:

(1) one year from the start of the medically necessary leave of absence, or

(2) the date on which such coverage would otherwise terminate under the terms of the health plan.

Definition of Dependent Child The child must be enrolled as a dependent under the group health plan and qualify for coverage on the basis of being a student at a postsecondary educational institution, immediately before the medically necessary leave of absence involved.

Certification by Physician Written certification must be provided to the Plan Administrator by a treating physician of the dependent child certifying that such individual is suffering from a serious illness or injury that would require a medically necessary leave of absence.

No Change in Benefits During Leave; Continued Application in Case of Changed Coverage A dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Moreover, if any changes are made to the group health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to dependent children under the plan.

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PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**

Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

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 and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

NOTICE OF PRIVACY PRACTICES

BJC Services, Inc. Group Health Plan

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you

- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

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

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

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Huntington INSURANCE

Our Responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

Other Instructions for Notice

- Effective Date of this Notice: January 1, 2020
- Privacy Official: Jan Jennings
  Human Resources
  jjennings@bjconstructioninc.com
  (586) 783-4559

INITIAL COBRA NOTICE

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Huntington INSURANCE

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources Department, BJC Services, Inc., 46385 Continental Drive, New Baltimore, MI, 48047.

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, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] 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**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

BJC Services, Inc.
Human Resources Department
46385 Continental Drive
New Baltimore, MI 48047
(586) 783-4559

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.