B&B Maintenance
Employee Benefits Enrollment Guide
August 1, 2019 - July 31, 2020

Welcome to Enrollment for your 2019 Benefits!

B&B Maintenance offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. This year, our medical benefits will be remaining with ***United Healthcare*** effective August 1st, 2019. Dental, Vision, Life, and Short Term Disability will also remain with ***Humana and Principal.***

B&B Maintenance Benefits Package

You may elect coverage in these optional benefits:

- Medical
- Voluntary Dental
- Voluntary Vision

Once you become eligible (1st of the month following 2 months), you will become eligible and will be enrolled in the following benefits which are 100% paid by B&B Maintenance:

- Life and Accidental Death and Dismemberment Insurance – 24 hour coverage
- Short Term Disability – Non Occupational

The plans being offered are as follows:
Option 1 is an HMO plans which utilizes a Local Network of providers. You and your family members must designate a Primary Care Provider (PCP) and follow ***Electronic*** referrals to obtain services outside of your assigned physician's office.

- **Option 1** is a Small Local HMO Network of providers – **NAVIGATE** Network

Option 2 is a PPO plan which you must utilize the contracted provider to receive the higher level of benefits. There is no need to assign yourself to a primary care physician.

- **Option 2** is part of the National Large Network of providers – **CHOICE PLUS** Network

Note: All plans include a NEW Virtual Visits (Teledoc) covered at a $0 copay!

Who is Eligible?

If you are a full-time employee, and work at least **30 hours** per week, you are eligible to enroll in the benefits described in this guide. The following family members are eligible as well:

- Your Spouse
- Your dependent child(ren) who are age 26 or younger (until end of the month of 26th birthday)
- Your spouse's dependent child(ren) who are age 26 or younger (until end of the month of 26th birthday)
- Dependent child of any age who is physically or mentally handicapped (provided they meet certain requirements)

How to Enroll

Open enrollment is the one time each year that you can enroll in the group's benefits plans. Please make sure you complete your Benefit Election Form within your Benefit Guide in its entirety.

Once you have made your elections, you will not be able to change them until next year's open enrollment period unless you experience a qualifying life event.

Election forms are due to HR by July 15th, 2019.

How to Make Changes

Outside of open enrollment, if you experience a qualified life event, you are allowed to make changes to your benefits. Qualified life events include: marriage, divorce, legal separation, domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you/your spouse/domestic partner, commencement or termination of adoption proceedings, or change in spouse's or domestic partner's benefits/employment status.

IMPORTANT NOTE REGARDING YOUR ELECTION:

After your initial enrollment, you are only eligible to make changes to your benefit elections during open enrollment. However, you will be allowed to make changes during the year if you experience a Qualified Event (change in family status) such as:

- Loss or gain of other coverage
- Loss or gain of eligibility of a covered dependent
- Death of your covered spouse or child
- Birth or adoption of a child
- Marriage, divorce or legal separation
- Switch from part-time employment to full-time employment

You will have 30 days from a qualified event to make changes to your current coverage

Medical Benefits – United Healthcare

Having access to high-quality, affordable health care is a great concern for most people. That's why B&B Maintenance is pleased to continue offering employees and their families' medical coverage through UHC. All plan options feature doctor's visits, preventive care, hospitalization and emergency care.

Carrier	United Healthcare		
Plan Name	HMO Plan BFC7 Rx:EU	PPO Plan BDQT Rx:455	
Network	Navigate	ChoicePlus	
PRE-TAX MONTHLY EMPLOYEE CONTRIBUTIONS			
Employee Only	$121.00	$125.00	
Employee + Spouse	$591.00	$613.00	
Employee + Child(ren)	$518.00	$538.00	
Family	$807.00	$839.00	
Benefits	In-Network	In-Network	Out-of-Network
Coinsurance	80%	80%	50%
Deductible			
Individual	$1,000	$5,000	$10,000
Family	$2,000	$10,000	$20,000
Out-of-Pocket Maximum			
Individual	$4,000	$6,500	$20,000
Family	$8,000	$13,000	$40,000
Ded. & Med. Copays Included	Yes	Yes	
Lifetime Maximum	Unlimited	Unlimited	
Hospital Services			
Inpatient Hospital	80% after Deductible	80% After Ded.	50% After Ded.
IP Additional Ded/Copay	N/A	N/A	N/A
Outpatient Hospital	80% after Deductible	80% After Ded.	50% After Ded.
OP Additional Ded/Copay	N/A	N/A	N/A
Emergency Room	$250 Copay, then 80%	$250 Copay, then 80%	
Urgent Care	$75 Copay	$50 Copay	50% After Ded.
Routine Services			
Office Visit	$20 Copay (if <19, No Charge)	$0 Copay	50% After Ded.
Specialist Office Visit	$40 Copay	$100 Copay	50% After Ded.
Virtual Visits	$0 Copay	$0 Copay	Not Covered
Preventive Care	100%	100%	50% After Ded.
Prescription Drugs			
Deductible	None	$250 - Individual / $500 Family	
Retail (30 Day Supply)	$10 Copay - Tier 1 $40 Copay - Tier 2 $75 Copay - Tier 3 $125 Copay - Tier 4	$5 Copay - Tier 1 $50 Copay - Tier 2 $100 Copay - Tier 3 $250 Copay - Tier 4	
Mail-Order (90 Day Supply)	2.5 X Copay	2.5 X Copay	
Rx Out-of-Pocket Maximum			
Individual	Included in Medical OOP	Included in Medical OOP	
Family	Included in Medical OOP	Included in Medical OOP	

Please refer to the respective Summary of Benefits and Coverage (SBC) for Full plan details. Your SBC will be sent to you directly by United HealthCare.

Note: HMO plan requires that referrals are submitted electronically – please remind your PCP

Voluntary Dental Benefits – Humana

Dental care is an important part of total health care. To help avoid costly and uncomfortable treatments, prevention is the key.

Dental Low Plan only covers preventive and basic procedures
Dental High Plan covers major services; however, new enrollees without previous coverage will have a 12 month waiting period on Major services.

Carrier	Humana			
Plan Name	Preventive Plus U&C 14 - Low		U&C 14 - High	
Network	Humana PPO		Humana PPO	
PRE-TAX MONTHLY EMPLOYEE CONTRIBUTIONS				
Employee Only	$21.39		$38.28	
Employee + Spouse	$48.45		$76.57	
Employee + Child(ren)	$56.86		$97.63	
Family	$89.53		$135.91	
Benefits	In-Network	Out of Network	In-Network	Out of Network
Individual Deductible	$50	$50	$50	$50
Family Deductible	$150	$150	$150	$150
Annual Plan Maximum	$1,000	$1,000	$1,000	$1,000
Benefits				
REIMBURSEMENT LEVEL	Neg. Discounts	90% U&C	Neg. Discounts	90% U&C
Type I - Diagnostic & Preventive	100%	100%	100%	80%
Deductible Waived for Type I	Yes	Yes	Yes	Yes
Type II - Basic Service	80%	80%	80%	80%
Type III - Major Services	N/A	N/A	50%	50%
Service Category				
Cleanings	100%	80%	100%	80%
Exams	100%	80%	100%	80%
Sealants	100%	80%	100%	80%
Simple Extractions	80%	80%	80%	80%
Fillings	80%	80%	80%	80%
Endodontic Coverage	N/A	N/A	50%	50%
Periodontic Coverage	N/A	N/A	50%	50%
Crowns, Inlays, Outlays	N/A	N/A	50%	50%
Dentures	N/A	N/A	50%	50%
Bridges	N/A	N/A	50%	50%
Implants	N/A	N/A	50%	50%

To avoid unnecessary out of pocket costs and ensure your procedure will be covered, please obtain a pre-estimate for services.

To find a dentist in Humana's Dental PPO Network, log on to Humana.com or call (800) 233-4013

Voluntary Vision Benefits – Humana

The **Vision** plan offers In-Network benefits and Out-of-Network Allowances. The following chart shows how the plan works and how each type of service is covered:

Carrier Plan Name	Humana IL Vision 160	
Network Name	VCN	
PRE-TAX MONTHLY EMPLOYEE CONTRIBUTIONS		
Employee Only	$10.17	
Employee + Spouse	$20.33	
Employee + Child(ren)	$19.32	
Family	$30.36	
Benefits	In Network	Out of Network
Eye Exam Copay	$10 Copay	
Material Copay	$10 Copay	
Eye Exams		
Frequency	Every 12 months	
Benefit	100% after Copay	Up to $10
Lenses		
Frequency	Every 12 months	
Single Vision	100% after Copay	Up to $25
Lined Bifocal	100% after Copay	Up to $40
Lined Trifocal	100% after Copay	Up to $60
Lenticular	100% after Copay	Up to $100
Frames		
Frequency	Every 24 months	
Benefit	$160 Allowance	Up to $80
Contact Lenses (in leiu of frames)		
Frequency	Every 12 months	
Elective Benefit	$160 Allowance	Up to $128

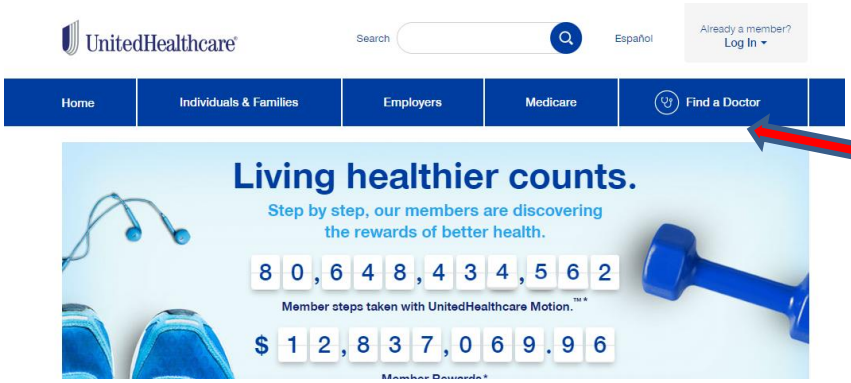
Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

To find a dentist in Humana's Vision PPO Network, log on to Humana.com or call (866) 995-9316

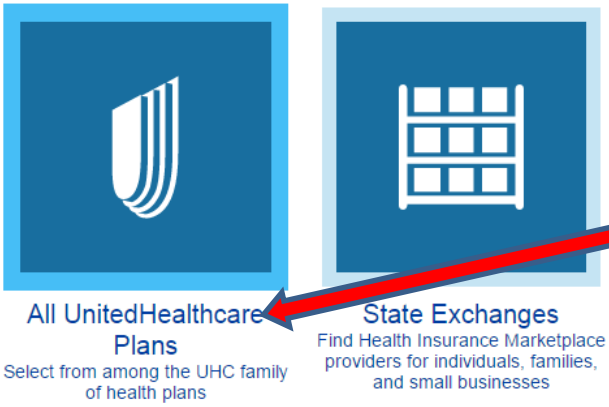
Find a Provider with United Healthcare

1. Go to www.uhc.com



Click the Tab – “Find a Doctor”

Click the Link – “Find Physician, Hospital or Health Care Facility”



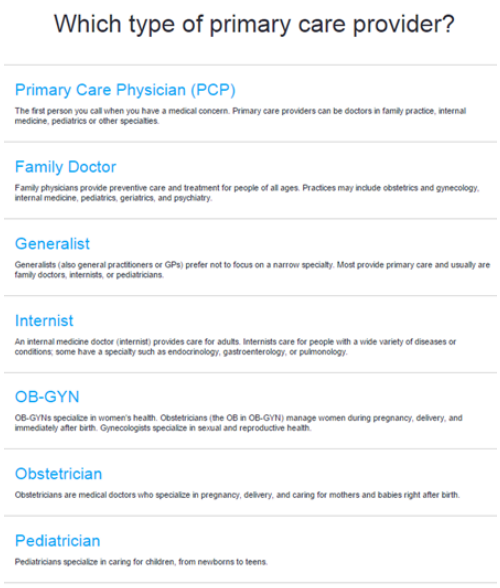
Click “Medical Directory” and then “All United Healthcare Plans”

2. On the next page you will choose:

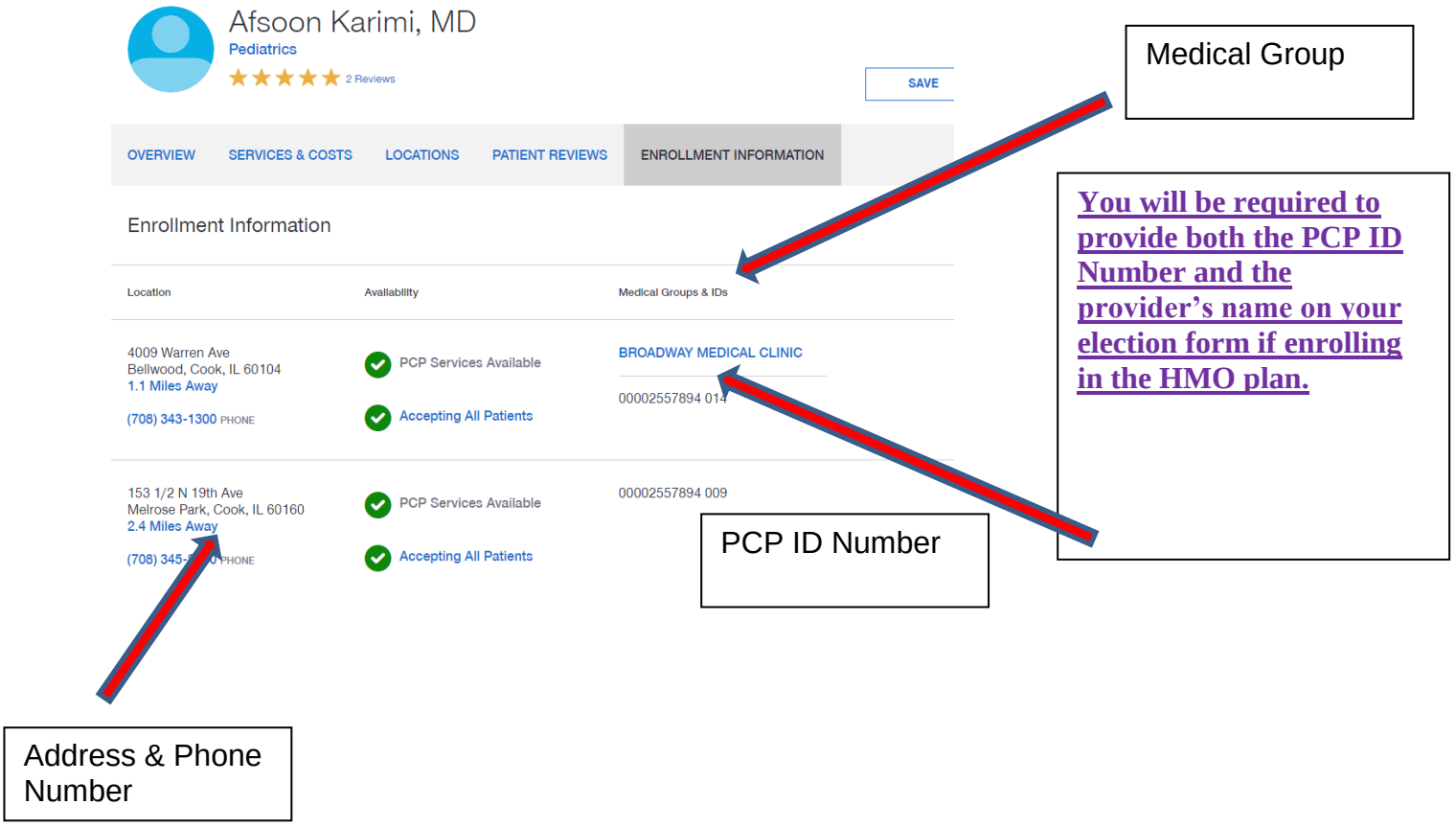
CHOICE PLUS – if you are enrolled in the Large PPO plan / **CORE** -- if you are in the small **PPO** / **NAVIGATE HMO** – if you are enrolled in the HMO Plan

3. This page gives you options for selecting doctors and/or specialists.

4. The next page will allow you choose the type of PCP.



5. On this page you will see information on the physician, such as PCP ID number, address, phone number, Designation Tier and Medical Group affiliation under the “Enrollment Information” tab.



Find a Provider with Humana

Dental

- Go to www.humana.com
- Locate the green heading ‘Find a doctor or pharmacy’ and click ‘search’
- Change the search type at the top from ‘medical’ to ‘dental’ and click ‘go’
- Set the coverage type as ‘PPO’ and enter your zip code
- Set the network as ‘PPO/Traditional Preferred’ and set if you want to search name, specialty or all

Vision

- Go to www.humana.com
- Locate the green heading ‘Find a doctor or pharmacy’ and click ‘search’
- Change the search type at the top from ‘medical’ to ‘vision’ and click ‘go’
- Select that you have ‘Vision coverage through your employer or purchased on your own
- Select ‘Humana Vision (Humana Insight Network)’
- Enter your zip code and complete search

When you need a referral (HMO ONLY)

If you need to see another network physician, such as a specialist, you must get an ***electronic referral*** from your PCP. All services must be coordinated by your PCP. Visits to physicians other than your PCP without an ***electronic referral*** will not be covered.

You do not need an ***electronic referral*** to see the following providers as long as they are in your Navigate network.

- Obstetricians/gynecologists (OB/GYN)
- Behavioral health or substance abuse disorder clinicians
- Convenience care clinics
- Urgent care centers

Emergencies are covered anywhere in the world, including non-network hospitals. HMO participants must notify their PCP within 48 hours of the emergency visit.

LabCorp

LabCorp is United Healthcare's National Lab provider. If you have lab services performed at your doctor's office or at the hospital, as long as they are sent to Labcorp they will be covered in network. If you need to find a LabCorp facilities please visit www.myuhc.com.

How to register on myuhc.com®

By registering on myuhc.com, you can find the answers to your health and benefits questions and the information you need in one easy-to-use, convenient location online.

Registration is quick and simple:

1. Go to **myuhc.com.**
2. Click the ***Register Now*** button.
3. Enter name, date of birth and account numbers from your health plan ID card or your Social Security number and date of birth.
4. Create a Username and Password.
5. Enter your email address and optional phone numbers, and choose security questions.
6. Review and agree to the website policies, and be sure to keep the email opt-in checked so you receive relevant news and wellness information.

By registering, if applicable, you will also receive Health Statements, Explanation of Benefits, Claim Letters, Regulatory Notices and other important information electronically. You may choose to receive free paper communications at any time by changing your Mailing Preferences.

On myuhc.com you can:

- Check past and current statements and claim status.
- Review eligibility and look up benefits.
- Find a hospital or doctor, including UnitedHealth Premium® designated physicians.
- Print a temporary health plan ID card or request a replacement card.
- Compare hospitals for quality and cost at the procedure level.
- "Chat" with a nurse online in real-time.
- Take a health assessment and participate in online programs that help you set goals to achieve health objectives.
- Learn about health conditions, symptoms and the latest treatment options.
- Use the Personal Health Record to organize and store all your health data in one convenient, confidential place.

Start managing your health care benefits online today at myuhc.com.

UnitedHealthcare®

United HealthCare Employee Resources

Mail Service Member Select Program

The ideal blend of cost-saving performance and flexibility

Leverage the power of OptumRx® Mail Service Pharmacy

Increasing mail service usage is a proven strategy for controlling rising pharmacy costs. Yet when it comes to mail service programs, many employers are sensitive about employee satisfaction. The Mail Service Member Select℠ program provides an effective balance between achieving cost savings through greater mail service usage and providing employees a choice in how they receive their maintenance medications.

A more flexible mail service solution

The new Mail Service Member Select program allows employers to capitalize on the many advantages of a mail service benefit, while giving members the flexibility to fill their maintenance medications via mail service or at a retail pharmacy. Members are automatically enrolled in Mail Service Member Select and can begin realizing the benefits of mail service pharmacy immediately. If members choose not to participate in the program, they will need to take an active step to disenroll in order to continue filling their maintenance drugs at a local pharmacy at their retail cost share amount. The ability to disenroll from mail service helps maintain member satisfaction, while continuing to help manage pharmacy benefit costs.

How Mail Service Member Select works

Mail Service Member Select allows members two retail pharmacy fills of their maintenance medication* before a decision is required. Members must either enroll their maintenance medications in the OptumRx Mail Service Pharmacy or they can disenroll their medications from mail service and continue to refill their maintenance prescriptions at a retail pharmacy. If no decision is made, and the member continues to fill maintenance medication prescriptions at a retail pharmacy, the member may pay 100% of the drug cost until a decision is made.

With Mail Service Member Select, members may disenroll from mail service for one year at a time by notifying OptumRx by phone or online through their pharmacy benefit website. This decision must be confirmed annually. Members who disenroll may continue filling maintenance medications at their standard cost.

Member communication and education

Members are notified of the Mail Service Member Select program by phone and by mail after their initial fill at a retail pharmacy. The communications explain the benefits of OptumRx Mail Service Pharmacy and their options to disenroll from the program. After the second retail fill, they are contacted again with similar communications. Members will receive an annual notification letter about 30 days prior to the expiration date informing them they will need to renew their option another year if they wish to continue filling at retail.

The many benefits of the mail service pharmacy include:

Cost savings: Members may pay less for their medication with an up to three-month supply through OptumRx Mail Service Pharmacy.

Convenience: Members receive home delivery of their medication with free standard shipping. This means fewer trips to the retail pharmacy.

24/7 access: Members can speak with a pharmacist who can answer questions anytime, any day.

Please Note…

- RX Pre-Authorization: You/your Doctor may need to obtain UHC's preauthorization to obtain certain drugs (specialty) before they are dispensed
- RX Step Therapy: You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain higher costing drugs.
- Tier 1 contraceptives are covered at No Charge.
- **Please reach out to HR if you would like a copy of the 2018 UHC Drug List to check that your medication is covered by your pharmacy plan.**

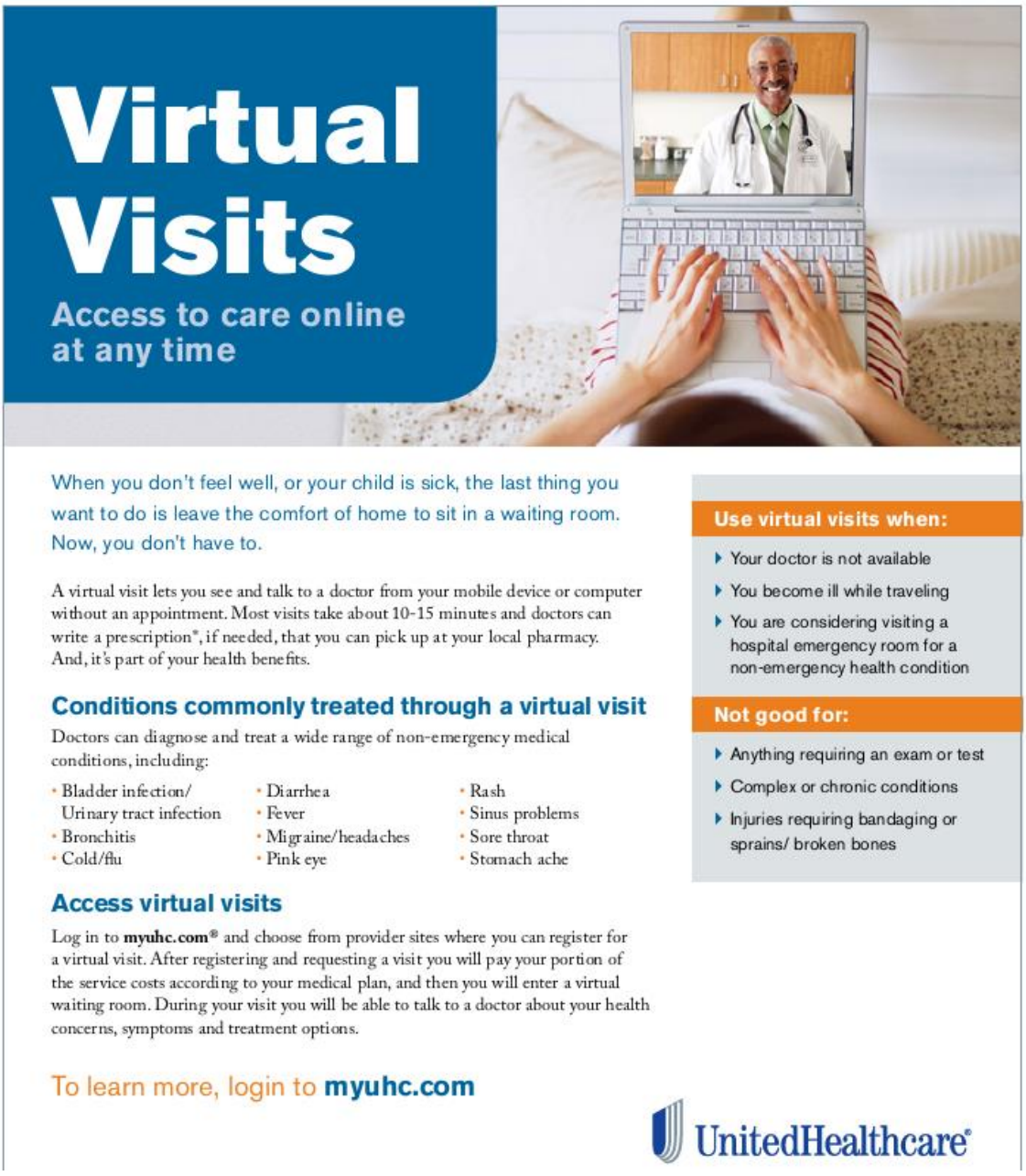
Please visit myuhc.com or call the toll-free member phone number on the back of your ID card for more information on your prescription drugs or how to set up mail order through OptumRx.

Healthy Savings Discounts

- United HealthCare is sponsoring a Healthy Savings program in the Greater Chicagoland designated to make it easier and more affordable for members to purchase healthy foods which may improve their health.
  - Register your card online at www.healthysavingsUCH.com
  - Shop for the promoted items at participating Illinois Jewel-Osco, Mariano's and Shop 'n Save grocery stores along with Niemann Foods, Inc and Country Market stores.
  - Scan your Healthy Savings card during checkout. Savings are instant!
  - Members can experience discounts of over $150 per month

Virtual Visits

- Virtual Visits will let you visit a virtual provider group, see and speak to a doctor 24 hours a day/7 days a week using your mobile phone, tablet or computer.
- During the virtual visit, members can obtain a diagnosis and a prescription, which can be sent to your local pharmacy.
- Virtual visits are covered under member health plans and subject to the plan benefits
- For more information regarding Virtual Visits, contact United HealthCare's Customer Service Department at **(800) 357-0978.**



United HealthCare Employee Resources

Simply Engaged

- Register by logging in to www.myuhc.com to access the Rewards Program through Overview Rally. Rally shows you how to make simple changes to your daily routine, set smart goals and stay on target
- Allows you earn rewards through the following health and wellness actions.
    - Participate in biometric screenings
    - Complete an online health survey via myuhc.com within 90 days of start of program
    - Visit a participating fitness center
    - Complete a telephone-based health coaching program
    - Complete at least 3 Missions through the Rally experience
    - Use myHealthcare Cost Estimator on myuhc.com

Find Network Laboratories to Save Money

- Using a network laboratory
    - You may not know what laboratory your doctors or providers use, but it is important that they send you or your lab samples to a participating laboratory within the UHC network.
- Talk to your Doctor when you need lab work
    - Take an active role in your healthcare and learn which laboratories participate in our network.
    - To locate a laboratory in the UnitedHealthcare Network, visit myuhc.com or call the customer service number on your health plan ID card.
    - Your doctor can access a list of participating laboratories by visiting www.unitedhealthcareonline.com

Care24 Services

- Employee Assistance Program (EAP) available 24 hours a day, 7 days a week which can be accessed by calling (888) 887-4114.
    - This trusted source of information and support lets you speak directly with an experienced registered nurse or master's-level specialist any time. Simply Call the Care24 toll-free number whenever you have a health-related question. Registered nurses can help you with questions about health conditions or symptoms and provide information that can help you choose appropriate care, for your needs.
        - ✓ Find a doctor in your area for specific medical treatments.
        - ✓ Health coaching can help you improve your health and save money
        - ✓ Emotional Support from master's-level specialists is available when you need help dealing with life's challenges.
        - ✓ The health information library consists of more than 1,100 messages to provide you with useful health and wellness information.
    - Myuhc.com offers customer service, information on hospitals and doctors, pharmacy services, health news, resources and more. You can also chat with a live nurse for personal online conversations, 24 hours a day.

Important Notices

Federal regulations require B&B Maintenance to provide benefit eligible employees with the following important annual notices.

INDIVIDUAL COVERAGE MANDATE

- Requires most people to have "minimum essential coverage" health insurance
- Beginning in 2014, most individuals must have health insurance for themselves and their dependents that meets minimum standards of coverage, or pay an annual penalty when filing tax returns

You can enroll in your Employer's health plan, or you may want to consider visiting www.healthcare.gov for information on health plans available through the Healthcare Marketplace in your area. Your employer has determined that the medical plans being offered meet the minimum value standard, and the cost of the coverage to you is intended to be affordable. If you decline coverage considered affordable and minimum essential under the Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

MEDICARE PART D NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

Your employer has determined that the prescription drug coverage offered by the Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is 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.

ANNUAL NOTICE FOR WOMEN'S HEALTH AND CANCER ACT (WHCRA)

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 of 1998 (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;
- Prostheses; 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.

If you would like more information on WHCRA benefits, call your Plan Administrator

NON-GRANDFATHERED PATIENT PROTECTION

Your Employer's Welfare Benefit Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health insurance carrier's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Plan Administrator or your Medical carrier directly.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your Employer's Welfare Benefit Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the 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 your Plan Administrator or your Medical carrier directly.

HIPPA NOTICE OF PRIVACY

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Plan nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or discloses protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

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 dependent 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 or after the employer stops contributing toward the other coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Plan Administrator.

NEWBORNS' AND MOTHERS' HEALTH 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).

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the ABC Company Welfare Benefit Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator

WAIVER OF COVERAGE

You may decline health coverage offered by your employer**;** this is called a *waiver of coverage*. If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.

If you decline coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act ("ACA"), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace. Your employer has determined that the medical plans being offered meet the minimum value standard, and the cost of the coverage to you is intended to be affordable.

The **decision to waive coverage has consequences for you**. For example:

- You should be aware of the individual responsibility requirement taking effect in 2014 under the ACA. If you refuse the offer of the Employer's health coverage and do not obtain coverage on your own, you will be subject to a penalty.
- Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. There's a time limit for enrolling after the other coverage is lost: *you must request to enroll in your plan within 30 days of losing the other coverage.*
- If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but *you must do so within 30 days of gaining the new dependent*. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

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 August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-0562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, 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.

Important Contacts

CONNOR & GALLAGHER ONESOURCE		
Maggie Palermini	Email:	mpalermini@gocgo.com
	Phone:	(630) 810-9100 ext. 243
Joe DiPirro	Email:	jdipirro@gocgo.com
	Phone:	(630) 810-9100 ext. 116
Mike LaPointe	Email:	mlapointe@gocgo.com
	Phone:	(630) 810-9100 ext. 224

B&B MAINTENANCE HUMAN RESOURCES		
Pam Seiser	Email:	Pseiser@bbmaint.com
	Phone:	(847) 550-6060
Camille Atkus	Email:	CAtkus@bbmaint.com
	Phone:	(847) 550-6060

UNITED HEALTHCARE MEDICAL	
Employee Customer Service	**(800) 357-0978**
www.myuhc.com	

Humana	
Dental and Vision Insurance	
Customer Service:	(866) 995-9316
Website:	www.humana.com

Principal	
Life/AD&D, Disability Insurance	
Customer Service:	800.843.1371
Website:	www.principal.com

MEDICARE PART D CREDIBLE COVERAGE NOTICE

Important Notice About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. **Your Plan has determined that the prescription drug coverage offered by your Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is 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 through 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 current coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact your Human Resources Department for more information about what happens to your coverage if you enroll in a Medicare Part D prescription drug plan.

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Please contact your Human Resources Department for more information about what happens to your coverage if you enroll in a Medicare Part D prescription drug plan.

B and B Maintenance

BENEFITS ELECTION FORM – August 1, 2019 to July 31, 2020

(Please complete form in its entirety)

BENEFITS EFFECTIVE DATE:						
New Enrollment:	☐ New Hire	☐ Open Enrollment				
Special Enrollment:	☐ Adoption	☐ Court Order	☐ Dependent Add/Drop	☐ Divorce	☐ Loss/Gain of Coverage	
	☐ Marriage	☐ Newborn	☐ Other:		Date of Event:	

EMPLOYEE PERSONAL INFORMATION					
Last Name:		First Name:		Middle Initial:	
Date of Birth:		Gender:	☐ Male ☐ Female	Social Security #:	
Address:				Apt. #:	
City:		State:		Zip Code:	
Phone #		Email address:			

EMPLOYMENT INFORMATION					
Annual Salary:		Date of **FT** Employment:		☐ Maintenance ☐ Management	
Job Title:		Hours worked per week:		Class if applicable:	

MEDICAL – United Healthcare		***MONTHLY PRE-TAX* Employee Contributions**
	*HMO (Navigate) Plan BFC7 Rx:EU	PPO (ChoicePlus - National) Plan BDQT Rx:455
Employee Only	☐ $ 126.00	☐ $ 126.00
Employee + Spouse	☐ $ 746.00	☐ $ 727.00
Employee + Child(ren)	☐ $ 595.00	☐ $ 577.00
Full Family	☐ $1,196.00	☐ $1,178.00

☐ Waive Coverage - I choose to waive Medical coverage for this plan year and understand/agree to the waiver acknowledgement

**If you are electing HMO for the first time, please designate your Primary Care Provider (PCP):*

Employee:	PCP #:		PCP Name:	
Spouse:	PCP #:		PCP Name:	
Child:	PCP #:		PCP Name:	
Child:	PCP#:		PCP Name:	

DENTAL – Humana		***MONTHLY PRE-TAX* Employee Contributions**	
	Dental Preventive+ (Low)	Dental U&C 14 (High)	☐ Waive I choose to waive Dental coverage for this plan year and understand/agree to the waiver acknowledgement
Employee Only	☐ $21.39	☐ $ 38.28	
Employee + Spouse	☐ $48.45	☐ $ 76.57	
Employee + Child(ren)	☐ $56.86	☐ $ 97.63	
Full Family	☐ $89.53	☐ $135.91	

VISION – Humana		***MONTHLY PRE-TAX* Employee Contributions**
Employee Only	☐ $10.33	☐ Waive I choose to waive Vision coverage for this plan year and understand/agree to the waiver acknowledgement
Employee + Spouse	☐ $20.33	
Employee + Child(ren)	☐ $19.32	
Full Family	☐ $30.36	

EMPLOYER PAID BENEFITS – PRINCIPAL	
☒ Short Term Disability – 60% to $125 max. per week	
☒ Life and Accidental Death & Dismemberment (AD&D) $15,000 Benefit	Name your Beneficiaries – must total 100%

B and B Maintenance

BENEFITS ELECTION FORM – August 1, 2019 to July 31, 2020

(Please complete form in its entirety)

Add/Drop Dependents – Use additional page if necessary				Medical		Dental		Vision	
Name	Social Security #	DOB	M/F	Add	Drop	Add	Drop	Add	Drop

☐ I choose to **WAIVE** the Medical Coverage for this plan year and understand/agree to the following:

You may decline coverage offered by your employer, this is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's plans.

Note that after 2013, if you decline coverage considered affordable and minimum essential under the Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace. ***I understand that my employer's plan meets both requirements.***

The decision to waive coverage has consequences for you. For Example:

- Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. *You must request to enroll in your Employer's plan within 30 days of losing the other coverage.*
- If you gain a new dependent through birth adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30 day enrollment deadline, you must wait until open enrollment.

I acknowledge that ***my employer*** has offered me affordable minimum essential coverage, as defined under the ACA for the period outlined in this election form. I have read the above and I understand the consequences of my waiver of coverage.

I am declining coverage for the following reason(s): (check all that apply)

☐ Spouse/Domestic Partner's Employer Plan ☐ COBRA/State Continuation ☐ Individual Coverage (Non-Group Plan)

☐ Medicare or other Government Plan ☐ I prefer not to have coverage ☐ Other (please explain):

I authorize the applicable employee rates to be deducted through payroll for the elected coverages. And I realize that my choice will remain unchanged for the entire policy year unless I experience a qualifying event.

Signature:		Date:	
Print Name:			

BENEFICIARY DESIGNATION

B and B Maintenance

BENEFITS ELECTION FORM – August 1, 2019 to July 31, 2020

(Please complete form in its entirety)

☐ New ☐ Change PLEASE TYPE OR PRINT WITH BALLPOINT PEN

Employee's Name:		**Gender:**	☐ Male ☐ Female
Date of Birth:		**Date of Hire (Full-Time)**	
Social Security Number:			

Irrevocable Beneficiary:	☐ Yes ☐ No

Note: If you select irrevocable beneficiary, you may not change the beneficiary without the consent of the irrevocable beneficiary. An irrevocable beneficiary has a vested interest in the proceeds of the contract; therefore, the contract holder cannot exercise certain rights without the permission of the irrevocable beneficiary.

BENEFICIARY Must be completed

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. SEE BELOW FOR DETAILS.

	First Name	Last Name	Date of Birth	Social Security #	Relationship	Benefit %
Primary						
Primary						
Contingent						
Contingent						

WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia)

Signature of Employee or Member:		Date:	

Important Note for Married Employees: If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, you may name someone other than your spouse as primary beneficiary. However, payment of benefits may be delayed or disputed unless your spouse consents to waive his or her rights to any community property interest in the benefits. We have provided below a "Spousal Consent for Community Property States" for your spouse's signature. PRINCIPAL will not be liable for damages due to any delay or dispute in payment of benefits if you choose not to obtain your spouse's signature.

Spousal Consent for Community Property States: I hereby consent to the Primary Beneficiary designation by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature:		Date:		☐ Employee has no legal spouse

Primary Beneficiary: The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. If you specify benefit percentages, the total must equal 100%

Contingent Beneficiary: The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. If you specify benefit percentages, the total must equal 100%

No Beneficiary: If you do not name a beneficiary, or if no beneficiary survives you, the Insurance Company will pay death benefits in the order of survivorship shown in your group certificate