BZI

Employee Benefits Package
2024 Plan Year

Table of Contents

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Important Items to Remember

NEW HIRE WAITING PERIOD
New employees are eligible for company insurance benefits on the first of the month following 60 days of continuous full-time employment.

TERMINATION OF BENEFITS
When your employment with the company is terminated, your benefits will stop on the last day of that month.

ELIGIBLE EMPLOYEES
To be eligible for company benefits you must be a full-time employee working an average of 30 hours per week during the year.

DEPENDENT CHILDREN
Children under the age of 26 are eligible to be covered under the benefits. They will be taken off the plan at the end of the month in which they turn 26.

OPEN ENROLLMENT
You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc..) during this time period each year. Open enrollment will be held annually before the start of the new plan year. All changes made during this time period will take effect on the renewal date.

MAKING PLAN CHANGES DURING THE YEAR
If you have a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc.) during the year, you may be able to make changes to your plan even though it's outside of the Open Enrollment window. Please turn in all paperwork within 30 days of your Qualifying Event to ensure it is processed timely and any claims incurred will be paid. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it and provide once available.

SPECIAL ENROLLMENT NOTICE
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. However, you must request enrollment within 30 days after your or your dependents' other coverage ends.

COBRA
PLEASE NOTE: In the event your employment is terminated with the company, you will receive a packet in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 18 months. This is called COBRA coverage. Your employer DOES NOT contribute to this coverage as they may when you are employed with them. You will be responsible for 102% of the actual cost of the insurance if you wish to continue with it.

STAY IN NETWORK
To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is in network BEFORE your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure EVERY doctor/nurse/radiologist/anesthesiologist/etc. is in your network.

EXPLANATION OF BENEFITS
Commonly referred to as an "EOB". The EOB is an extremely useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

MEDICARE PART D
If you have Medicare or will become eligible for Medicare in the next 12 months, it is important to understand your rights and penalties about your prescription drug coverage before electing an employer plan. Please see Human Recourses for more information.

NEED A NEW ID CARD, REQUEST DETAILED PLAN SUMMARY, OR QUESTIONS ABOUT A CLAIM?
You can register for the insurance carrier's website where you can print out temporary ID cards and order new cards, or call the carrier at the numbers listed in the guide. Please have copies of your EOBS along with a copy of your bills ready for questions about claims. The complete Summary of Benefits is available online or printed/digitally by contacting your HR/Benefits department.

Medical Benefits

UMR, INC. | $4,000 HSA

	IN-NETWORK	OUT-OF-NETWORK
Deductible		
Single	$4,000	$13,500
Family	$8,000	$27,000
Coinsurance		
Member %	0%	20%
Out-Of-Pocket Maximum		
Single	$4,000	$13,500
Family	$8,000	$27,000
Commonly Used Services		
Primary Care Physician Office Visit	0% AD	20% AD
Specialist Office Visit	0% AD	20% AD
Urgent Care	0% AD	20% AD
Emergency Room	0% AD	0% AD
Preventive Care		
Preventive Services	Covered 100%	Not Covered
Major Medical Expenses		
Outpatient Surgery	0% AD	20% AD
Inpatient Hospitalization / Surgery	0% AD	20% AD
CT scan, PT scan, MRI	0% AD	20% AD
Prescription Drug Coverage		
Prescription Deductible	$0	$0
Retail Pharmacy	0% AD	Not Covered
Home Delivery	0% AD	Not Covered
Plan Information		
Plan Year	January 1, 2024 - December 31, 2024	
Deductible Period	January 1, 2024 - December 31, 2024	
Member Website	umr.com	
Customer Service Phone Number	800.826.9781	

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

UMR℠

Get all your answers *quick* and *easy* @ umr.com

UMR
A UnitedHealthcare Company

Make umr.com your first stop

You want managing your health care to be fast and easy, right? You got it. At umr.com, you'll find everything you want to know – and need to do – as soon as you log in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

View **My taskbar**, your personalized benefits to-do list

Check your benefits and see what's covered

Look up what you owe and how much you've paid

Find a doctor in your network

Learn about medical conditions and treatment options

Access tools and trusted resources to help you live a healthier life

Getting started

If you already have an account, go to **umr.com** and click the **Login/Register** button in the upper-right corner. If it's your first time visiting us, click the **Login/Register** button in the upper-right corner to open an account. Make sure you have your ID card handy and follow the steps to get started.

WANT A QUICK TOUR?
Use the QR code reader on your smart phone to watch a short video.

Note: *The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.*

You don't need a Ph.D. to understand your benefits

We've made it easy to find the top things people want to know. Choose **Benefits & coverage** from myMenu to find out:

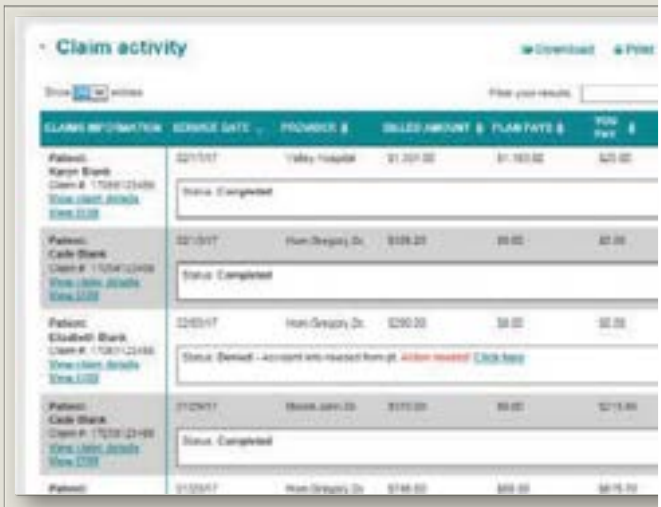
- What health care services are covered?
- What's the cost difference between an in-network and out-of-network service?
- What's your deductible, and are you close to reaching it?
- Is there a copayment for your office visit? If so, how much?

Did your dog eat your ID card?

No worries. It's easy to get a replacement online.

Just click **ID card** from myMenu to see a copy of your card. With a couple more clicks you can have a new card mailed to your home.

Can't wait for the mailman? Print a temporary copy from our desktop site. Or, use your smart phone to view your ID card or fax a copy to your doctor's office.



Fictionalized data

Buried in paperwork? A single click lets you track all your claims

Check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, click view claim details or view EOB. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure e-mail any time you have a new EOB. If you're not ready to give up paper completely, you can print out copies from our claims center.

Don't be surprised by unexpected costs

- Know the price you'll pay ahead of time. Search treatments or procedures in the **Health cost estimator**.
- Get your in-network discount. Use **Find a provider** to look up doctors and facilities near you.

Helpful apps, calculators, videos and health information all in one place

Choose **Health center** from the myMenu and select the tile shortcuts that interest you.

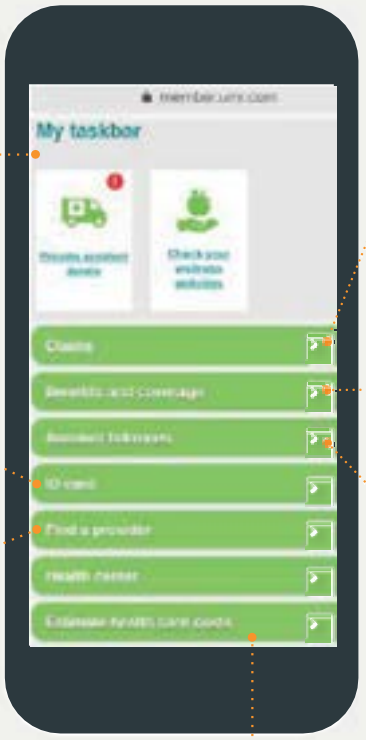
- Online health information: up-to-date and ad-free
- Our top picks for healthy eating and exercise
- Free tools, apps and calculators

Welcome to
umr.com on the go

As a UMR member you can access your benefits and claims information anytime, anywhere using your mobile device. There's no app to download. Simply log in to **umr.com**

My Taskbar
View upcoming tasks right from the homepage.

Look up claims
Look up a claim for yourself or an authorized dependent.



Check your benefits
View medical/dental benefits. And, see who's covered under your plan.

Share your ID card with your provider
Now, there's no need to carry it with you, it's at your finger tips

Find a provider
Find an in-network provider while you are **on the go"**

Access account balances
Look up balances for your special accounts including HRAs and FSAs

Estimate health care costs
See what you can expect to pay before receiving care with the Health Cost Estimator tool

Want to bookmark umr.com on your mobile device?

Phone: Touch and hold the open book icon to add

Android: Tap on the menu. Then select "Add Bookmark."

Note: The images above reflect available features within our mobile site. These features may or may not be available to all users depending on your individual and company benefits. If you are having trouble accessing or logging into our mobile site, contact the 800 number on the back of your ID card for fastest service. You can click the "Contact us" link on the home screen

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A UnitedHealthcare Company

Health Savings Account

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

A health savings account is a tax-advantaged savings account owned by an individual that can be used to pay for qualified medical expenses for the owner and their dependents. An HSA, which must be paired with a qualified High Deductible Health Plan, allows you and your employees to make pre-tax contributions to a federally-insured account that can be used to pay for qualified medical expenses.

By selecting an HSA-qualified plan, you are eligible to contribute tax-free money up to the amount listed in the graph below into an HSA. Your HSA funds can then be used tax-free to pay for qualified medical expenses. In addition, BZI will match your annual Health Saving Account contributions as shown in the graph below.

2024 CONTRIBUTIONS	IRS MAXIMUM LIMIT	EMPLOYEE ANNUAL MAX	EMPLOYER ANNUAL MAX MATCH
Single	$4,150	$2,075	$2,075
Two Party	$8,300	$4,150	$4,150
Family	$8,300	$4,150	$4,150

WHO IS ELIGIBLE FOR A HEALTH SAVINGS ACCOUNT?

» Covered by a Qualified High Deductible Health Plan (QHDHP);

» Not covered under another medical plan;

» Not enrolled in Medicare A or Medicare B benefits; and, Not eligible to be claimed on another person's tax return.

WHAT ARE THE ADVANTAGES OF A HEALTH SAVINGS ACCOUNT?

» HSA Funds belong to the employee. Any money deposited into an HSA account, including any contributions made by an employer, is owned by you.

» HSAs have a triple tax benefit.

1. When you contribute to an HSA, your contributions reduce your taxable income, meaning you pay less in taxes.
2. Any money that you put into an HSA earns tax free interest.
3. You never pay taxes on withdrawals that are used to pay for qualified medical expenses.

» HSAs are great for retirement savings. After age 65 employees can spend HSA money on non-medical items without paying a penalty. Non-medical withdrawals after age 65 are taxed as income just like withdrawals from a 401(K) or IRA.

» Use your HSA for Qualified Expenses: acupuncture, medical supplies, birth control, physical exams, chiropractic, prescriptions, contact lenses, orthodontia, dental treatment, radiology, prescription eyeglasses, stop cessation programs, fertility enhancement, surgery (non-cosmetic), hearing aids, therapy, lab work.

Please visit: irs.gov/publications/p502 for a complete listing of Covered/Non-Covered expenses and to review the full definition of each.

Your HSA is your money and you determine how it's spent for healthcare. Whatever you do not spend in a given year rolls over to the next year. If you change jobs or retire, the money goes with you.

This is only a brief summary of benefits. Please refer to the Plan Documents provided by the carrier for information regarding coverage, limitations, and exclusions. If there is a difference between this guide and the Plan Documents, the Plan Documents will prevail.

HealthEquity®

FSA and HRA

EZ Receipts Mobile App

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Google play

Download on the App Store

Questions? We're here for you 24/7

866.346.5800 |my.HealthEquity.com

Dental Benefits

UNITEDHEALTHCARE

	IN-NETWORK PPO	OUT-OF-NETWORK PPO
Annual Deductible (Individual/Family)	$50/%150	$50/$150
Annual Benefit Maximum	$1,500	$1,500
Preventive Dental Services (cleanings, exams, x-rays)	100%	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	80%	80%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%	50%
Orthodontic Services	50%	50%
Dependent children under age 19		

Vision Benefits

UNITEDHEALTHCARE

	IN-NETWORK	OUT-OF-NETWORK
	UnitedHealthcare Insurance Company	(any qualified non-network provider of your choice)
Eye Exam — once every 12 months	100%	Up to $40
Lenses — once every 12 months		
Polycarbonate lenses for children (once every 24 months)	100%	N/A
Single Vision Lenses	100%	Up to $40
Lined Bifocal Lenses	100%	Up to $60
Lined Trifocal Lenses	100%	Up to $80
Frames — once every 24 months	Up to $130	Up to $45
Contact Lenses — once every 12 months if you elect contacts instead of lenses/ frames	100%	Up to $120

Premium Summary Page

MEDICAL				
Tier	Monthly Premium	Employer Contribution	Employee Monthly Rate	Employee Cost Per Pay Check
Employee Only	$397.38	$317.90	$79.48	$18.34
Employee + Spouse	$834.49	$542.42	$292.07	$67.40
Employee + Child(ren)	$715.28	$464.93	$250.35	$57.77
Family	$1,231.87	$800.71	$431.15	$99.50

DENTAL				
Tier	Monthly Premium	Employer Contribution	Employee Monthly Rate	Employee Cost Per Pay Check
Employee Only	$24.68	$19.00	$5.68	$1.31
Employee + Spouse	$55.00	$21.00	$34.00	$7.85
Employee + Child(ren)	$70.44	$21.00	$49.44	$11.41
Family	$106.35	$21.00	$85.35	$19.70

VISION				
Tier	Monthly Premium	Employer Contribution	Employee Monthly Rate	Employee Cost Per Pay Check
Employee Only	$5.83	$0.00	$5.83	$1.35
Employee + Spouse	$11.65	$0.00	$11.65	$2.69
Employee + Child(ren)	$12.46	$0.00	$12.46	$2.88
Family	$19.91	$0.00	$19.91	$4.59

401(k)

Empower

**Please refer to the Contributions section of your Plan's SPD or the Plan document for additional information regarding your eligibility to receive matching or other employer contributions.

Building Zone Industries LLC

EMPOWER
What's Next

2024 Annual Enrollment Notices & Disclosures

PATIENT PROTECTIONS DISCLOSURE

The UMR $4,000 HSA plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from UMR or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the UMR at 800.826.9781.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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 the plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, please call your Plan Administrator at 800.826.9781.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 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: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/ health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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 1/31/2026)

NOTICE OF CREDITABLE COVERAGE

IMPORTANT NOTICE FROM BZI 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 with BZI 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. BZI has determined that the prescription drug coverage offered by the medical 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 15 to December 7.

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 BZI coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current BZI coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with BZI and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through BZI changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

» Visit www.medicare.gov

» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

» Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	01/01/2024
Name of Entity/Sender:	BZI
Contact:	Lori Ann Barnson, HR Programs Administrator
Address:	HC 65 Box 340 1233 S Old Hwy 91 Kanarraville, UT 84742
Phone Number:	435.592.9475

HIPAA SPECIAL ENROLLMENT RIGHTS

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

Our records show that you are eligible to participate in all plans (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage 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 (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. 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.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance 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.

IMPORTANT WARNING

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

BZI®

This benefit guide prepared by

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