Employee Benefits Guide

2021

This booklet is intended as a high level overview and is informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

Important Contacts

BENEFIT CONSULTANT

HYLANT

Be prepared: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

Questions About	Contact	Phone	Website
Medical	Medical Mutual of Ohio	800-382-5729	www.medmutual.com
Telemedicine	Express Care Online – The Cleveland Clinic	866-320-4573	clevelandclinic.org/eco
Dental	Delta Dental	800-524-0149	www.deltadentalmi.com
Life/AD&D	Medical Mutual of Ohio	1-800-382-5729	www.medmutual.com
Short Term Disability	Medical Mutual of Ohio	1-800-382-5729	www.medmutual.com
Employee Assistance Program	Lighthouse Telehealth LLC	419-475-5338 800-422-5338	
Flexible Spending Account (FSA)	iSolved	866-370-3043	www.isolvedbenefitservices.com

We've created a benefit package that helps you protect you and your family. We know the health care decisions you make are very important. You deserve all the information you need to make the right choices for you and your family.

The purpose of this guide is to give you a high-level overview of our health, dental, and life benefit programs. This document may also serve as a Summary of Material Modifications made to those plans. For more detailed information, refer to the summary plan documents available from Human Resources. Thank you for your hard work.

Table of Contents

If you (and/or) your dependents have Medicare or will become eligible for Medicare In the next 12 months, a Federal law give you more choices about your prescription Drug coverage. Please see page 25 for more details.

ELIGIBILITY

We are pleased to offer you health and welfare benefits that are designed to protect you and your family while you are employed with our organization.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical/ Rx	√	Up to age 26
Dental	√	Up to age 23

DEPENDENT VERIFICATION

You may be asked to provide Human Resources proof of dependent eligibility, which may include one or more of the following:

- Marriage Certificate
- Birth Certificate
- Affidavit of Qualifying Adult
- Adoption Certificate
- Placement Certificate
- Document of Guardianship
- Other as necessary

SPOUSAL COVERAGE

MTS Seating has a policy regarding spousal coverage under the MTS sponsored medical plan. In the event that ALL of the following apply, your spouse will be prohibited from obtaining spousal coverage under the MTS plan.

- MTS employee is married; and
- MTS Employee's spouse is employed; and
- Spouse's employer offers a group medical insurance plan; and
- Spouse's employer's payroll contribution for their employer's group medical insurance plan requires that spouse contributes 50% or less of the total annual premium.

NEW HIRE COVERAGE

As a new employee, it is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event.

Waiting Period: 90 days for medical, dental, disability, life and AD&D insurance.

Benefits Effective: First day after waiting period is completed.

TERMINATION OF COVERAGE

If employment is terminated, benefits will end at midnight day of termination.

COBRA CONTINUATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

Learn More

WELCOME BABY! Don't forget to notify Human Resources within 30 days of birth of a newborn to add dependent(s) to the plan.

MAKING CHANGES DURING THE YEAR

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You must notify Human Resource of such change(s) within the noted days from the event as shown in the below table. Failure to notify Human Resources within the timeframe noted (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. Qualifying events may require documentation of the event such as marriage certificate, birth certificate, divorce decree, etc. to finalize the event change. For questions, please see your Human Resource representative.

Qualifying Event	Timeframe to Notify Human Resources*
Marriage, divorce or legal separation	30 days
Birth, adoption or placement for adoption	30 days
Death of a dependent	30 days
Change in your Spouse's employment status	30 days
Change in coverage status under your spouse's plan	30 days
A loss of eligibility for other health coverage	30 days
Change in dependent child's status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them	30 days
Judgment, decree or court order allowing you to add or drop coverage for a dependent child	30 days
Change in eligibility for Medicare or Medicaid	60 days
Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	60 days
Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	60 days

** days from the qualifying event*

TURNING AGE 65 AND BECOMING MEDICARE ELIGIBLE

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (Medical Insurance), which does have a fee involved, would coordinate as secondary coverage to your Group Health medical plan.

Medicare will allow you to delay your enrollment in Medicare Part B until you officially retire, without a late enrollment penalty (enrollment in Medicare Part A is optional). Employees more typically enroll in Part A and defer Part B until retirement. For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

BENEFICIARY DESIGNATION

In addition to electing or making benefit changes during open enrollment, it is important to designate a beneficiary for your life insurance. Your beneficiary is the person(s) who will receive your life insurance benefits when you die. If you have a beneficiary in place, or if your family situation has changed, now is the time to ensure all information on record is correct.

If you do not name a beneficiary, your benefits will automatically go to your estate. For additional information contact Human Resources.

COST OF COVERAGE SUMMARY

2020/21 WEEKLY PAYROLL DEDUCTIONS

	Employee	Employee + Spouse	Employee + Child	Family
MEDICAL				
MedFlex HMO	$11.54	$24.23	$21.92	$34.62
SuperMed Plus PPO	$24.23	$50.88	$46.04	$72.69
DENTAL				
	100% Employer Paid			
SHORT TERM DISABILITY				
	100% Employer Paid			
LIFE AND AD&D				
	100% Employer Paid			

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to pay for many of the benefits we offer with “before-tax” dollars (e.g., medical, dental and vision coverage). By paying premiums with “before-tax” dollars, you may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections made during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Refer to the preceding page of this guide for information on what constitutes a qualifying event, and the associated timeframe you have to notify Human Resources if you intend to make a change.

MEDICAL COVERAGE

ABOUT PREVENTIVE CARE:

Most preventive care services are covered 100% at no cost to you. Preventive care services include regular checkups, screenings, vaccinations and healthy lifestyle programs. Preventive care and healthy lifestyle choices are small steps that can improve the well-being of you and your family.

BENEFITS AT-A-GLANCE

	MedFlex HMO		SuperMed Plus	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
DEDUCTIBLES				
Individual	$ 650	N/A	$650	$1,300
Family	$ 1,300	N/A	$1,300	$2,600
COINSURANCE				
Plan Pays	80%	N/A	80%	50%
You Pay	20%	N/A	20%	50%
Coinsurance Maximum (single/family)	$5,700/$11,400		$5,700/$11,400	
OUT OF POCKET MAXIMUM				
Individual	$6,350	N/A	$6,350	Unlimited
Family	$12,700	N/A	$12,700	Unlimited
COMMONLY USED SERVICES				
Physician Visit	$30 copay	Not Covered	$30 copay	50% after deductible
Specialist Visit	$40 copay	Not Covered	$40 copay	50% after deductible
Preventive Care Services	100% coverage	Not Covered	100% coverage	50% after deductible
Urgent Care Visit	$40 copay	Not Covered	$40 copay	$40 copay
Emergency Room	$150 copay	$150 copay	$150 copay	$150 copay
Diagnostic Labs & X-Rays	20%	Not Covered	20% after deductible	50% after deductible
Hospitalization	20% after deductible	Not Covered	20% after deductible	50% after deductible
Mental Health*	20% after deductible	Not Covered	20% after deductible	50% after deductible
Substance Abuse*	20% after deductible	Not Covered	20% after deductible	50% after deductible

PRESCRIPTION DRUGS - 30 DAY SUPPLY AT RETAIL PHARMACY**		
Walgreens Advantage Network		
Generic	$10 copay	$10 copay
Preferred Brand	30%, max of $750	30%, max $750
Non-Preferred Brand	50%, max of $1500	50%, max $1,500

*See Summary Plan Document for additional details. You may also contact the plan administrator with questions regarding benefits.
**90-day mail order available.
90-day mail order is mandatory for maintenance medications

IMPORTANCE OF A PRIMARY CARE PHYSICIAN (PCP)

YOUR PARTNER IN HEALTH

Primary care doctors may provide you medical care over a long period of time, help you stay healthy, coordinate your care and recommend other providers, such as specialists, when needed.

CHOOSE THE RIGHT PCP

Choosing a doctor is a very important decision requiring care and consideration. Take advantage of the tools and resources through your medical plan such as provider directories for network providers, maps, and quality ratings to research your options. Asking friends, co-workers or relatives is also helpful when selecting a PCP. For information on specific physicians' training, specialties and board certification you can also visit the American Medical Association at www.ama-assn.org.

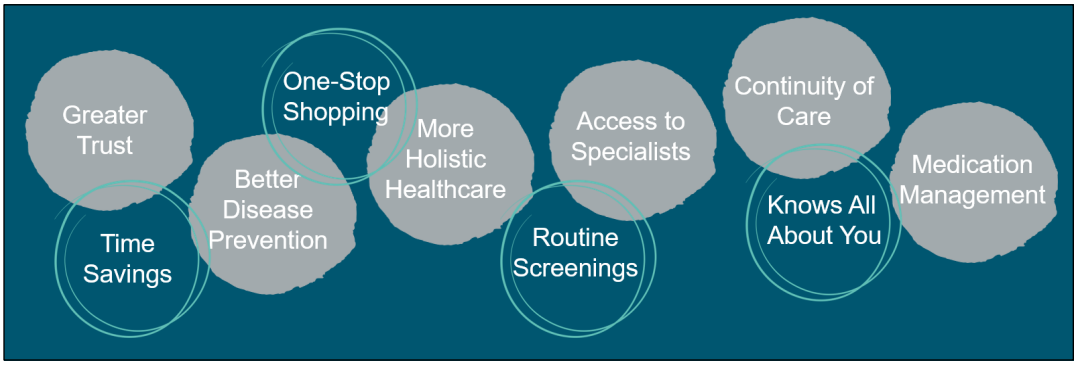
Once you have made your selection, it is important to call your primary care physician for an appointment to establish yourself as a patient. This is a valuable step that may prevent potential wait time in scheduling future appointments.

WHAT DOES A PCP DO?

A primary care provider is your main healthcare provider in nonemergency situations. Starting with preventive care, he or she coordinates the care you need and helps you address health issues before they become a more serious problem. PCPs conduct regular checkups, routine screenings and immunizations, provide patient education, offer advice on preventing disease, as well as overseeing specialty care, lab tests and hospitalization.

BENEFITS OF HAVING A PCP

In addition to the benefits and cost-savings of having an in-network provider, a PCP will help you navigate the healthcare system so you can concentrate on your health. Even if a plan doesn't require you to have a PCP, it's a good idea to choose one. Because of routine tests and regular visits, your PCP will know how to help you stay focused on self-care.



Learn More

ESTABLISH A RELATIONSHIP WITH YOUR PCP

Having a well-established, trusting relationship with your doctor is crucial to your long-term health, and can also save you money in the long run. Research shows that patients who have a good relationship with their doctor receive better care and are happier with the care they receive.

Tell your doctor about your health history, your family's health history, symptoms, medications and any allergies you have. If you do not share relevant information, your doctor may not ask or may assume there is nothing important he or she needs to know. Withholding information may make it difficult for your doctor to determine the best care route for you to take. The more comfortable you are, the more you'll share — and that can be good for your health in the long run.

Your doctor works hard to keep you healthy, but quality healthcare is a team effort. Make sure to ask questions if you don't understand what your doctor is recommending. This is especially important to do before receiving health services. Not every plan is the same, so it's important to ask questions to avoid confusion and unexpected costs later. If you are confused about anything your doctor recommends, don't be afraid to ask questions.

TELEMEDICINE

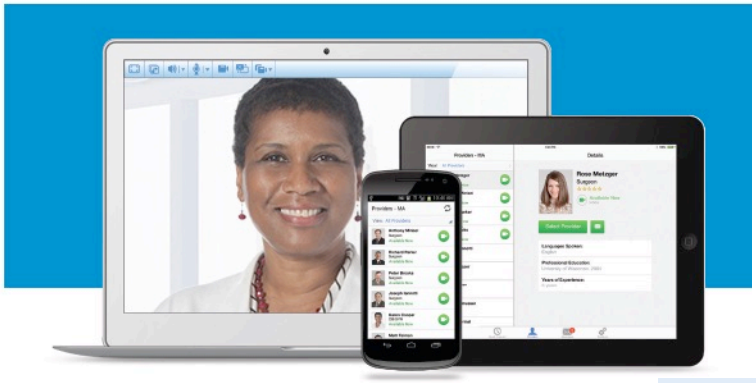
ACCESS AND CONVENIENCE

We understand it may not always be convenient to go to the doctor, which is why we offer you the opportunity to video chat with a doctor for non-emergency situations with 24/7/365 access. It's an affordable and convenient option for quality medical care.

clevelandclinic.org/eco | 866-320-4573 | Express Care Online

Cleveland Clinic
Express Care **Online**

Learn More



24/7 care you need right now, from home – or anywhere via your smartphone, tablet or computer.

What We Treat

Express Care **Online** is for you, if you need treatment for the following conditions:

ADULT PATIENTS

- Cough and cold symptoms
- Yeast infections
- Sinus infections
- Seasonal allergies
- Earaches
- Skin rashes
- Bronchitis
- Minor trauma, burns or lacerations
- Minor back and shoulder pain
- Asthma
- Urinary tract infections
- Minor medical concerns

PEDIATRIC PATIENTS

(6 to 17 years old)

- Bronchitis
- Conjunctivitis
- Cough and cold symptoms
- Minor medical concerns
- Seasonal allergies
- Sinus infections
- Skin rashes

EMERGENCY ROOM OR URGENT CARE

KNOW WHERE TO GO

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility or a doctor's office.

If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition?

EMERGENCY ROOM	**URGENT CARE**
The **emergency room (ER)** is equipped to handle life- threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.	**Urgent care centers** are not equipped to handle life-threatening injuries, illnesses or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.
You should go to the nearest ER if you experience any of the following: • Compound fractures • Deep knife or gunshot wounds • Moderate to severe burns • Poisoning or suspected poisoning • Seizures or loss of consciousness • Serious head, neck or back issues • Severe abdominal pain • Severe chest pain or difficulty breathing • Signs of a heart attack or stroke • Suicidal or homicidal feelings • Uncontrollable bleeding	Some examples of conditions that require a visit to an urgent care center include: • Controlled bleeding or cuts that require stitches • Diagnostic services (x-rays, lab tests) • Ear infections • High fever or the flu • Minor broken bones (e.g., toes, fingers) • Severe sore throat or cough • Sprains or strains • Skin rashes and infections • Urinary tract infections • Vomiting, diarrhea or dehydration

REMEMBER: Unless it is a true emergency – a serious or life-threatening condition that requires immediate treatment that is only available in a hospital – consider your options for appropriate, quality care that is efficient and economical.

DON'T PAY MORE IF YOU DON'T HAVE TO:

Convenience Care Clinics are walk-in clinics typically located in a supermarket, pharmacy or retail store, where available. Services may be provided at a lower out-of-pocket cost compared to urgent or emergency care as they are subject to primary care office visit copays and/or coinsurance. Convenience care clinics are suitable for non-life threatening immediate care. *Examples include: common infections (ear, bladder, pink eye, strep throat); minor skin conditions, allergies, and more.*

ONLINE TOOLS & RESOURCES

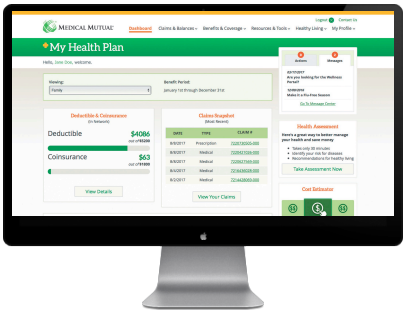
There are many programs available to help your engagement with your benefits be a positive one. To learn more, go online or call the phone number listed on the back of your ID card. Here are just a few of the tools and resources available to you and your family:

LOG ON TO WWW.MEMBER.MEDMUTUAL.COM

- Check claim status and history
- View explanation of benefits and health statements
- View claim documents
- View account balances
- View benefits and eligibility
- Find a network doctor
- Estimate treatment costs
- Search for information in the palm of your hand
- Learn about health conditions, symptoms and the latest treatment options

MY CARE COMPARE

- Your personalized online tool to make MORE informed healthcare decisions
- Gives you the knowledge to better understand your choices and have better control of your healthcare



- **Compare costs**
- **Renew provider**
- **Provider quality**
- **Shop for generic brands**

Medical Mutual Mobile App

- Provides access to you and your family's health information anytime/anywhere
- Access your ID card
- Whether you want to find physicians near you, check the status of a claim or speak directly with a nurse
- Available for Apple and Android operating systems

PHARMACY RESOURCES

SAVE ON PRESCRIPTION COSTS

Many pharmacies now offer discount prescriptions – maybe even lower than your copay.

Pharmacies nationwide sell select generic drugs at a discounted rate. Generic drugs are distributed as the equivalent to the brand name; however, you should talk to your doctor if you have questions about your prescription. You can find the best deals on your medications by identifying the pharmacies that offer these programs. Here are just a few available:

Sam's Club	Plus members can receive hundreds of generic medications at $4 or $10 for a 30-day supply, and five select prescriptions for free
Walmart	$4 for a 30-day supply and $10 for a 90-day supply of some generic medications
Walgreens	Prescriptions Savings Club where members can get over 50 medications for as low as $5 for a 30-day supply and discounts on vitamins, birth control, diabetic supplies and lifestyle medications
Rite Aid	Rx Savings Program offers members a selection of generic medications at $9.99 for a 30-day supply and $15.99 for a 90-day supply
Costco	Member Prescription Program offers savings on brand and generic medications
Meijer	Offers a variety of oral antibiotics for free
Kroger	Rx Savings Club includes reduced prices on thousands of medications of which over 100 generic medications are priced between $3 and $12 and some select medications are free
Publix	Next Best Thing to Free Program offers a 90-day supply for select generic medications for only $7.50
Giant Eagle	Offers a wide range of generic drugs at $4 or $10 per prescription as well as a 90-day supply for qualified medications

NOTE: Be sure to check with the pharmacy for current discounts and offerings

HYLANT SCRIPT NAVIGATOR

Check out Hylant Script Navigator

The Hylant Script Navigator (**http://www.hylant.medtipster.com**) is the ultimate pharmacy search engine that will help you identify discounted generic prescriptions that are available at pharmacies throughout the USA. Just log on and enter the following:

FLEXIBLE SPENDING ACCOUNT

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as your medical deductibles and copayments, prescriptions, dental expenses, eyeglasses, contact lenses and other health-related expenses that are not reimbursed by your health plan.

HOW DOES IT WORK?

You decide how much to contribute to your FSA on a plan year basis, up to the maximum allowable amount. Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the plan year.

DEBIT CARD AND CLAIM FILING

Your FSA administrator is iSolved Benefit Services. For more information visit the ISolved Benefits FSA Resource center (https://www.isolvedbenefitservices.com/resources/fsa-resource-center)

You will be issued a debit card to access the Health FSA. Transactions are to be processed like a credit card; a PIN will not be issued. Simply swipe your card at the provider's office, pharmacy, etc. It is important when utilizing the debit card to still request and keep an itemized receipt. You may receive a letter asking for a copy of the receipt. It is important that you keep your receipt per the IRS regulations. They require that all FSA reimbursements have documentation that meets or exceeds the total reimbursement amounts for the tax year. You should keep these records for at least 7 years or longer. Speak to your tax advisor for more details on how long to keep tax records.

If you do not use the debit card and you have an eligible expense that needs to be reimbursed, simply log into your web portal or mobile app to request reimbursement. When using the mobile app, you can use your phone's camera to capture the documentation.

NOTE: The debit card issued is valid for three years or until the expiration date noted on the card.

Annual Health FSA Maximum Contribution 2021 Limits	
Health FSA	$2,750

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A HEALTH FSA

- Be sure to fund the account wisely as Health FSAs are subject to a "use it or lose it" rule.
- You are permitted to carryover up to $550 of unused funds at the end of the year. Any amounts remaining in excess of $550 will be forfeited.
- You cannot take income tax deductions for expenses you pay with your Health FSA &/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.

EXAMPLES OF ELIGIBLE EXPENSES:

Unreimbursed medical expenses (deductibles, coinsurance, copays, etc.)

Dental services (excluding cosmetic services)

Orthodontia

Glasses, contacts, and eye exams

Lasik eye surgery

Note: Cosmetic services are not eligible for reimbursement

Flexible Spending Account (FSA) Worksheet

Should I enroll in my Company's Flexible Spending Account Program?

The following worksheet will help you determine how much to set aside pre-tax through the program.

The amount of your medical plan deductible: $_____

The average co-insurances you pay each year for office Visits, prescription drugs and out of pocket medical expenses: $_____

How much do you pay for eyeglasses, contact lenses and vision exams each year? $_____

How much do you pay for orthodontia expenses each year? $_____

How much will you pay for out of pocket dental expenses? $_____

The average you spend on eligible over-the-counter medical items: $_____

Any other yearly eligible expenses for which you might pay: $_____

Dependent Care Account Program

The amount of day care you normally pay annually: $_____

(For children under the age of 13, or other dependants [spouse or similar member] living in your home who require daycare or adult day care. These could include Daycare Centers, Babysitter and/or Nanny. **The current maximum amount allowed under IRS guidelines is $5,000.**)

Total Expenses: $_____

DEPENDENT FLEXIBLE SPENDING ACCOUNT

WHAT IS A DEPENDENT CARE FSA ACCOUNT?

This is a pre-tax benefit account used to pay for eligible expenses for dependents under age 13 or care for disabled spouse or dependent that allows you - or you and your spouse - to work.

DEPENDENT CARE FSA CONTRIBUTION LIMITS

Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $5,000. If you are married and file separate returns, you can each elect $2,500 for the plan year. You and your spouse must be employed, or your spouse must be a full-time student to be eligible to participate in the Dependent Care FSA.

CLAIMS REIMBURSEMENT

You may fax, mail or submit your dependent care claim to Purchasing Power for reimbursement online using your participant portal or the mobile app.

Note: You can only be reimbursed for the money you put into the account. For example: if you have contributed $200 into your Dependent Care FSA, but your after-school care was $300 for the month, you can only be reimbursed for $200.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

- Be sure to fund the account wisely as funds are “use it or lose it.”
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (unless you experience certain qualifying life events).
- You may have a have a Health Savings Account and a Dependent Care FSA.
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
    - Name (who received service)
    - Provider name (provider that delivered service)
    - Date of service
    - Type of service

EXAMPLES OF ELIGIBLE EXPENSES:

In-Home Babysitting Fees*

Before and After School Care

Day Care Facility Fees

Nanny Expenses

Summer Day Camp

Adult Care Facility Fees

**In order to receive reimbursement for in-home babysitting fees, income must be recorded by the provider.*

For a full list of eligible expenses and requirements, visit www.irs.gov/publications and refer to Publication 503.

DENTAL COVERAGE

The following is a summary of your dental benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), certificate of coverage or benefit summary. You may access a list of participating providers through the carrier's website.

BENEFITS AT-A-GLANCE

Learn More

	Delta Dental		
	PPO	**Premier**	**Out-of-Network**
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainer, etc.	100% coverage	100% coverage	100% coverage
Basic Services: minor restorative services endodontics, periodontics, oral surgery, relines and repairs	10% after deductible	20% after deductible	20% after deductible
Major Services: restorative and prosthodontics	40% after deductible	50% after deductible	50% after deductible
Orthodontics: up to age 19	50% after deductible	50% after deductible	50% after deductible
DEDUCTIBLE *Waived for Preventive Services*			
Per Person	$50	$50	$50
MAXIMUM BENEFIT LIMITS			
Annual Limit: Basic and Major Services	$1,500	$1,500	$1,500
Lifetime Limit: Orthodontics	$1,500	$1,500	$1,500

WHICH PLAN FITS: THINKING IT THROUGH…

- Do you visit a dentist for regular cleanings and maintenance?
- What kind of dental expenses will you have next year?
- Do you expect to have certain dental procedures performed?
- Do you have dependents who will require orthodontia services?
- Does your dentist participate in the network?

INCOME PROTECTION BENEFITS

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at the company. Accidental Death and Dismemberment (AD&D) insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances.

BENEFITS AT-A-GLANCE

Learn More

	LIFE AND AD&D COVERAGE Provided at no cost to you
Life Insurance and AD&D	1 times base salary (minimum $10,000, Maximum of $150,000)
Benefit Reduction Schedule	**35% at age 70** **50% at age 75**

SHORT TERM DISABILITY

Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury, including pregnancy, for a short period of time.

BENEFITS AT-A-GLANCE

Learn More

Benefit Amount	66.67% of weekly earnings
Benefit Maximum	$2,000
Benefits Begin After	1st day for accident
Maximum Benefit Period	8th day for illness

This benefit is available after 90 days of employment.

*If you waive voluntary disability coverage when you are initially eligible, you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.

ACTIVELY AT WORK REQUIREMENT

Employee Eligibility Requirements for Life Insurance:

You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

EMPLOYEE ASSISTANCE PROGRAM (EAP)



Learn More

EAP BENEFIT REMINDER

Our **EMPLOYEE ASSISTANCE PROGRAM** (EAP) is a *no cost benefit* provided to employees and eligible household dependents. This benefit is designed to provide easy access to *free*, *confidential*, *solution-focused* counseling and life coaching support to help you appropriately deal with life's issues and challenges.

EAP Can Help You Be Your Personal Best

COUNSELING & COACHING	DAILY LIVING SUPPORT & RESOURCES
• Relationships & Communication • Parenting / Child Behavior / Child Learning • Managing Stress, Anger, Depression • Coping with a Loss, Grief, or Change • Goal Setting / Motivation / Life Transitions • Care Giving Challenges / Work-Life Balance • Substance Abuse and Cessation Support • Coping with Diagnosed Illness or Pain	• 24/7 Concierge Assist-Research/Referrals • Debt & Budget Assistance • Legal Consultation with local Attorneys • Discounted Attorney Hourly Fees • Credit/Financial Counseling / ID Theft Assist • "Do It Yourself" Legal/Financial Forms • Wellness Resources, Tobacco Cessation • Self-Help Articles, Skill Builders, Webinars

Your Lighthouse Telehealth, LLC EAP benefit includes:

▸ Up to 5 EAP sessions per presenting issue(s)	▸ Direct, confidential access to EAP clinicians
▸ Accessible provider locations near work/home	▸ 24/7 telephonic crisis support
▸ In-person, Telephonic, and Online sessions, by appointment, day and evening.	Household Coverage: Spouse, unmarried child under age 26 residing with employee
▸ 24/7 Work/Life Assist and Legal/Financial Assist: Consultant to support your resource and referral requests with individualized research; No-cost legal consultation and discounted services; no-cost telephonic sessions with in-house financial educators; secure website with legal and financial resources including 100+ legal and financial forms which can be downloaded for your use.	

Lighthouse Telehealth LLC

Employee Assistance Program (EAP)

419-475-5338 or 800-422-5338

Solution-focused Counseling, Coaching, Resource Referrals, Legal/Financial Assist, and 24/7 Crisis Support.

Work/Life Resources and Legal/Financial Assist:
1-866-210-8117 www.worklifeexpress.com
User: MTS Password: worklife

HEALTH SAVINGS TIPS

STRETCHING YOUR HEALTHCARE DOLLAR

As healthcare costs continue to rise, it is increasingly important that you take an active role in decisions about your health, the care you receive and your benefits. Here are some tips to help get you the most for your money.

CHOOSE A PRIMARY CARE PHYSICIAN

Selecting a primary care physician is one of the best things you can do for your health. This person knows your health history and schedules routine screening tests that frequently help prevent and detect diseases, such as heart disease, cancer, and diabetes. Your PCP can provide necessary medical advice and identify health concerns before they become a major issue.

STAY IN-NETWORK

In-network providers have a contract with the health insurance company to provide services at reduced rates. In most cases, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

DON'T SKIP PREVENTIVE CARE

Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get the preventive screenings recommended for their age in order to detect health conditions early.

PRICE COMPARE PRESCRIPTIONS

Ask your provider for the generic version of a prescription. If you order your maintenance medications in bulk (90-day supply) through mail order, search for the least expensive pharmacy option near you, or check to ensure prescribed medications are on the plan's formulary list.

LIVE A HEALTHY LIFESTYLE

Focus on eating nutritiously, cutting down on fast food and getting more physical exercise. Take advantage of tobacco cessation programs. Take a walk at lunch to manage stress. Striving toward a healthier lifestyle and maintaining a healthy weight can drastically reduce future medical conditions and diseases.

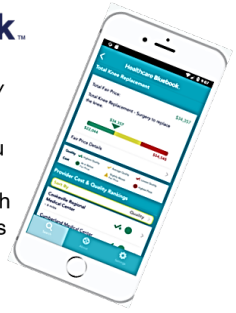
USE THE PLAN'S TOOLS & RESOURCES

Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition and can possibly save you money in the long run. Look for other available resources or programs that are designed to prevent illness and lower health costs over the long run.

Healthcare Bluebook

Healthcare price and quality transparency

Look up the fair value of the service(s) you need at **www.healthcarebluebook.com/** prior to discussing the cost with your health care provider. If the price you are quoted is more than the listed fair value, let the provider know and ask if they can match the fair value.



SEARCH - Easily search any procedure to find out how much you should be paying in your area.

COMPARE - Bluebook's Fair Price™ information and quality rankings enable smarter healthcare decisions.

SAVE – Potentially save in out-of-pocket costs every time you receive medical care.

NOTE: Always confirm the provider and / or facility is in-network

PRESCRIPTION OPIOID AWARENESS

BE INFORMED

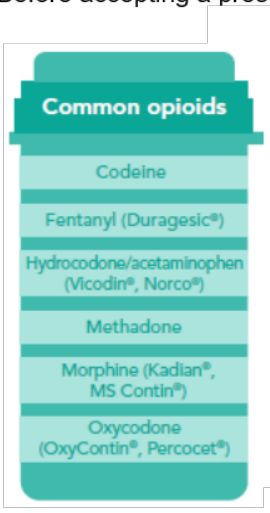
You've no doubt heard that there's a national opioid epidemic, affecting people of all ages and income levels. Someone you know – a friend, a family member or even a coworker – might be misusing, abusing or addicted to prescription painkillers.

WHAT'S AN OPIOID

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your healthcare provider to make sure you are getting the safest, most effective care.

KNOW YOUR OPTIONS

Before accepting a prescription, talk to your doctor:



· Make the most informed decision.
· Work with your doctor to create a plan on how to manage your pain.
· Know your options and consider ways to manage your pain that do not include opioids.
· Talk to your doctor about any and all side effects and concerns.
· Follow up regularly with your doctor.

IF YOU ARE PRESCRIBED OPIOIDS

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

Never take opioids in greater amounts or more often than prescribed.

Avoid taking opioids with alcohol and other substances or medications you have not discussed with your doctor.

Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).

Safely dispose of unused prescription opioids.

SIDE EFFECTS

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

Tolerance	Sleepiness/dizziness
Physical dependence	Confusion
Increased sensitivity to pain	Depression
Constipation	Itching and sweating

Low levels of testosterone
Nausea, vomiting and dry mouth

ALTERNATIVES FOR PAIN MANAGEMENT

Talk with your doctor about the benefits of using one of the below methods if you suffer from chronic pain. Some of the options may even work more effectively than opioids, depending on the type of pain. Here are some of the alternative solutions proposed by the CDC:

- Acetaminophen (Tylenol) or ibuprofen (Advil)
- Cognitive behavioral therapy—a psychological, goal-directed approach in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress
- Exercise therapy, including physical therapy
- Medications for depression or for seizures
- Interventional therapies (injections)
- Exercise and weight loss
- Other therapies such as acupuncture and massage

HOW TO GET HELP

If you believe you or a loved one may be struggling with addiction, tell your health care provider and ask for guidance or call the Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline at 1-800-662-HELP (4357). Be Informed!

IMPORTANT TERMS

Balance Billing When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider typically may not balance bill you for covered services.

Brand A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs and your employer pays a higher amount when the claim is paid as well.

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The deductible typically does not apply to preventive care and certain other services.

Evidence of Insurability (EOI) A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Flexible Spending Accounts Health or Dependent Care (HCFSA or DCFSA): An account you put money into that you use to pay for certain out-of-pocket health or childcare costs with pre-tax dollars. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Funds deposited into a health FSA will be forfeited if you do not use them by the IRS deadline.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network and the member pays a lower amount for those services.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or “formulary brand.” The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.

Payroll Deduction The amount you pay out of your paycheck in order to be enrolled in the medical, dental and/or vision insurance plans and possible other offered benefits.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Section 125 such as marriage/divorce, death, termination of employment, child birth/adoption, involuntary loss of coverage, etc. which triggers an employee’s ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Usual, Customary and Reasonable (UCR) The determined going rate for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount and is used typically when services are provided by an out-of-network provider.

PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

December 1, 2020
MTS Seating
Human Resources Department
7100 Industrial Dr.
Temperance MI 48182
734-847-3875

Notice Regarding Special Enrollment Rights

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within **30 days** of the loss of that coverage. For this purpose, “loss of coverage” will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer’s Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) You or your Eligible Dependent’s Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

Notice Regarding Women’s Health and Cancer Rights Act (Janet’s Law)

On October 21, 1998, Congress passed a Federal Law known as the Women’s Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your plan administrator.

Notice Regarding Michelle's Law

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

Notice Regarding Patient Protection Rights

The Heartland Healthcare Services group health plan allows members to designate a Primary Care Provider. The following paragraphs outline certain protections under the Patient Protection and Affordable Care Act (Affordable Care Act) and only apply when the Plan requires or allows the designation of a Primary Care Provider.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Plan's network. The healthcare 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 or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the insurer.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is an additional way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

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

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers

your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86 percent of your household income for 2019, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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	**INDIANA – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	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
ALASKA – Medicaid	**IOWA – 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://dhs.iowa.gov/hawk-i** Phone: 1-800-257-8563
ARKANSAS – Medicaid	**KANSAS – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	Website: **http://www.kdheks.gov/hcf/** Phone: 1-785-296-3512

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	KENTUCKY – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: https://chfs.ky.gov Phone: 1-800-635-2570
FLORIDA – Medicaid	**LOUISIANA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
GEORGIA – Medicaid	**MAINE – Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 etc 2131	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711

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: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.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 and CHIP**
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, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – Medicaid**

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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA - Medicaid	**VERMONT - Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	**WISCONSIN – 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	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WASHINGTON - Medicaid	**WYOMING – Medicaid**
Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
WEST VIRGINIA – Medicaid	
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	

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 12/31/2020)

Medicare Notice

You must notify Heartland Healthcare Services when you or your dependents become Medicare eligible. Heartland Healthcare Services is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice(s) that follow.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Heartland Healthcare Services 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:

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.

Heartland Healthcare Services has determined that the prescription drug coverage offered by your company 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. If 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 through 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive

coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact your HR Representative. You will receive this notice each year and again, if this coverage through your company 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit U.S. Social Security Administration's at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

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).

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an associate, 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 associate, 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-associate dies;
The parent-associate's hours of employment are reduced;
The parent-associates employment ends for any reason other than his or her gross misconduct;
The parent-associate 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 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 associate;
Commencement of a proceeding in bankruptcy with respect to the employer; or
The associate's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the associate and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to:

Notification should be in writing and include official documentation of qualifying event

How is COBRA 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 associates 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 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. Please provide Social Security disability determination confirmation to iSolved.

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 associate or former associate 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.

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.

MTS Seating
Human Resources Department
7100 Industrial Dr.
Temperence MI 48182
734-847-3875

NOTICE OF RESCISSION OF COVERAGE

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available. A paper copy is also available, free of charge, by calling your benefits administrator at 734-847-3875

If you (and/or) your dependents have Medicare or will become eligible for Medicare In the next 12 months, a Federal law give you more choices about your prescription Drug coverage. Please see page 25 for more details.