



2025 BENEFITS GUIDE

GDI Employees- Ford

This publication contains important information about your employee benefit program.

Please read thoroughly.

What's Inside?

This brochure includes important information on the following benefits:

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Welcome

Understanding your employee benefits doesn't have to be a scary experience. Your benefits are important, and so is your time. That's why we've created this packet to give you the straight facts you need to make the right benefit choices for yourself and your family.

Need Help?

Any time you have questions, feel free to contact HR at your location, Mary Redman **864.297.3748** (mary.redman@gdi.com) or your broker, Comprehensive Benefits **248.661.1602** (service@cbi4benefits.com).

Important Note

This brochure summarizes the GDI benefits program. The actual benefit plan provisions are contained in legal documents and contracts. If there are any discrepancies between the information in this brochure and the provisions of the legal documents and contracts, the terms of the legal documents and contracts will prevail. GDI reserves the right to modify, amend, suspend or terminate these benefits at any time. This brochure does not constitute a contract of employment.

Benefit Costs

GDI pays the full cost of many of your benefits; however, for others, you share the cost, or you pay the full cost. Pre-tax means the cost comes out of your pay before taxes are deducted. After-tax means the cost comes out of your pay after taxes are deducted.

Benefit	Your Cost	Tax Treatment
Medical & Pharmacy	No cost to you	N/A
Dental	No cost to you	N/A
Vision	No cost to you	N/A
Short Term Disability	No cost to you	N/A
Long Term Disability	No cost to you	N/A
Basic Life and Accidental Death & Dismemberment (AD&D)	No cost to you	N/A
Voluntary Life and Accidental Death & Dismemberment (AD&D)	You pay 100%	After-tax
Employee Assistance Plan	No cost to you	N/A

Eligibility

Full-time employees are eligible for all benefits on the first day of the month coinciding with or following 90 days of employment. You can also cover your spouse and eligible children. Your eligible children can continue to be covered, regardless of student or marital status, until the end of the year in which the dependent turns 26. Dependent children include biological and legally adopted children, stepchildren (child(ren) of a spouse), or foster children (child must have been placed with the employee or spouse by the court or an agency). Coverage is also extended to mentally or physically disabled children over the age of 26. If you leave GDI, your benefits will end at midnight on the last day of month following your last day of employment.

Annual Open Enrollment/Qualifying Changes During the Year

The elections you make during open enrollment will be effective **Jan. 1, 2025 – Dec. 31, 2025**. Since you pay for your benefits with pre-tax earnings, you can only make changes during the year if you have a qualifying event such as:

- Marriage or divorce
- Birth, adoption, or foster care
- A child reaches the age limit for the plan or has become eligible for other employer-based coverage
- Death of a family member
- A change in your spouse's employment status

Once you've had one of these qualifying events, you have 30 days to make changes to your coverage. The effective date of the changes will be the event date.

Medical

Summary of Medical Plan Benefits – Blue Cross Blue Shield of Michigan (BCBSM) with Health Reimbursement Arrangement (HRA) through EHIM

You Pay	In-Network	You Pay with EHIM HRA	Out-of-Network
Deductible	\$750 individual/\$1,500 family	\$650 individual/\$1,300 family	\$1,500 individual, \$3,000 family
Coinsurance	20%	10%	40%
Coinsurance Maximum	\$2,500 individual/\$5,000 family	\$1,250 individual/\$2,500 family	\$5,000 individual/\$10,000 family
Out of Pocket Maximum*	\$8,150 individual / \$16,300 family	\$1,910 individual/\$3,820 family	\$16,300 individual/\$32,600 family
Services			
Primary Care Office Visit	\$20 copay	n/a	40% after deductible
Specialist Office Visit	\$20 copay	n/a	40% after deductible
Preventive Care	Covered 100%	n/a	Not covered
Inpatient & Outpatient Hospital	20% after deductible	10% after \$650 individual/ \$1,300 family	40% after deductible
Emergency Room	\$150 copay	n/a	\$150 copay
Urgent Care	\$20 copay	n/a	40% after deductible

* The medical out-of-pocket maximum includes all applicable member payments of covered charges, including deductibles, copayments, and coinsurance.

** Preventive care services are covered as required by the Patient Protections and Affordable Care Act. Refer to the administrator plan documents for more details and limitations on clinical guidelines.

This is a brief plan description. It is not the Plan Document and does not include all of the benefits, limitations, and exclusions of the plan. More complete terms are contained in the Summary of Benefits and Coverage.

HRA Through EHIM

Employee Health Insurance Management (EHIM) is a Company that is a Third-Party Administrator (TPA). They are not an insurance company but a company that pays medical claims on behalf of GDI. GDI purchases a higher deductible plan and has EHIM pay portions of the claims. This it makes the insurance more affordable for both you and the company. The middle column above is what you pay and are responsible for when using in-network providers. See additional information on the next page.

Virtual Care

With Virtual Care by Teladoc Health, you and everyone on your plan can get virtual medical and mental health care from a smartphone, tablet or computer. Medical visits are available 24/7, anywhere in the U.S. You don't need an appointment, and the average wait time is 10 minutes. Visit bcbsm.com/virtualcare to download the Teladoc Health app. You can also call **855.838.6628** to arrange a telephone visit.

Medical Insurance Opt-Out Program

Employees who provide proof of other medical coverage under a different plan are eligible to waive the GDI medical plan and be paid an opt-out in accordance with their labor agreement. Those not eligible for the full year of the opt-out will be paid on a pro-rated basis.

HRA Online Portal

EHIM has a member portal where you can log in for a personalized view of your benefits and claims.

Visit <https://med-member.ehimrx.com/#> for:

- Easy access to claims and plan information 24/7
- Review deductible and coinsurance responsibility
- View when a claim was process and paid

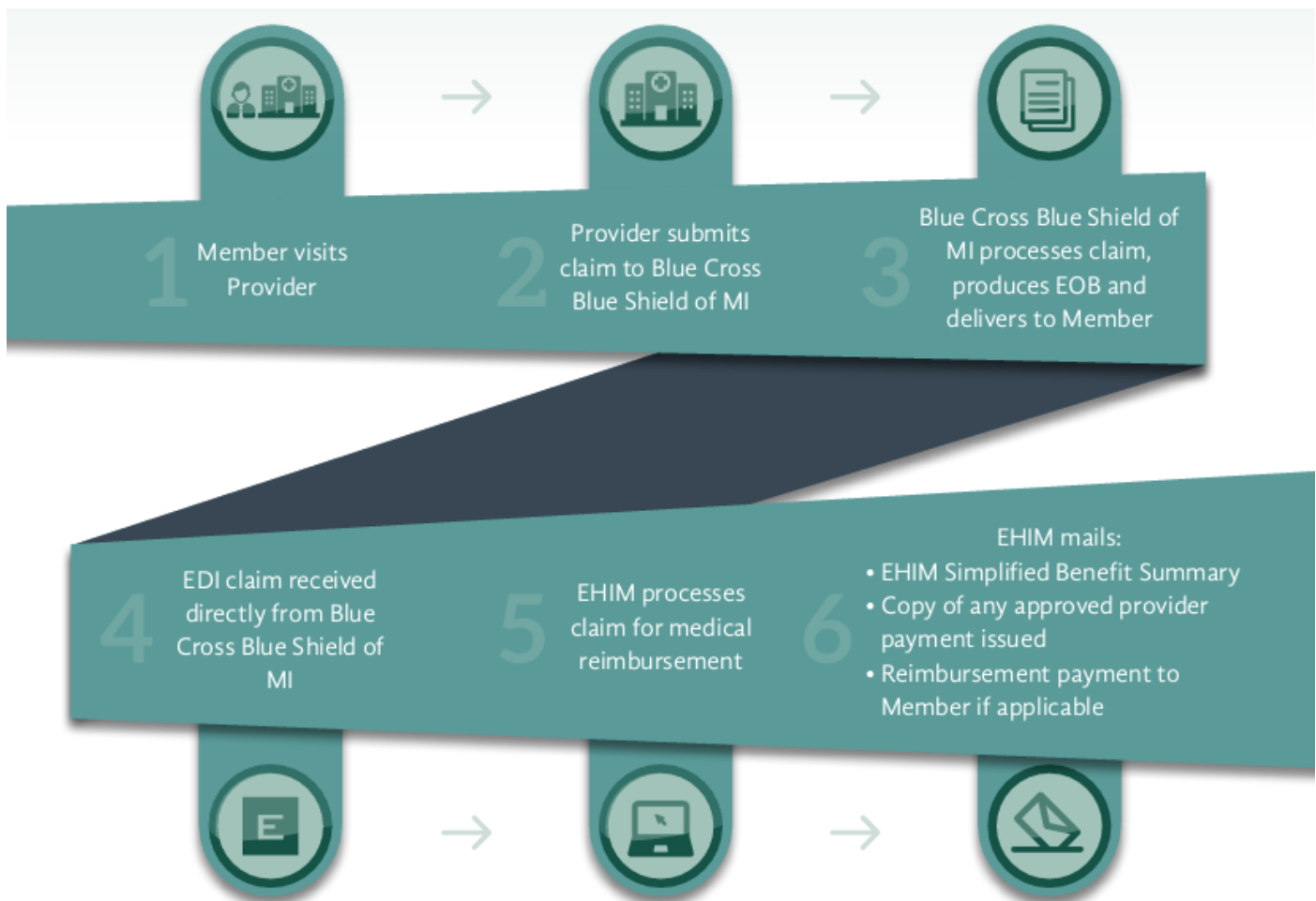
EHIM Customer Service

Customer service is at the core of EHIM. When you call, you talk to a person. The call center is available for all questions about your claims.

Call **800.311.3446** (8a.m. to 6p.m.(EST) or email medicalclaims@ehimrx.com. Please be prepared to verify your identity.

HRA Process

Below is a flowchart of the HRA process that happens behind the scenes. You should only pay for services once you receive an Explanation of Benefits (EOB) from EHIM.



Prescription Drugs-EHIM

EHIM has a national pharmacy network, allowing you to get medications from any local retail pharmacy. If your chosen pharmacy is out of network, contact the Pharmacy Help Desk to enroll it. You will receive an ID card with the employee's name for use at the pharmacy. All family members over 18 will receive a card, and the care can be used by all family members. For additional care, contact your HR Director or call the Pharmacy Help Desk.

Our toll-free number is printed on your ID card. If you are experiencing a problem filling a retail or mail order prescription, please contact the Pharmacy Help Desk. For your convenience, the help desk has representatives available **24 hours a day, 7 days a week, 365 days a year. 800.311.3446**

Summary of Copayments

Copayments are the dollar amount which will be collected at the pharmacy every time you receive a prescription. Generally, your copayment will be lowest for generic prescriptions and highest for medications that are considered Non-Preferred under your plan design. Below highlights your plan's copay levels:

\$10	Copayment on any generic medication
\$20	Copayment on any Preferred Brand Medication
\$40	Copayment on any Non-Preferred Brand Medication
\$40	Copayment on any Multi-Source Brand Medication (Brand Name Drugs that are dispensed when an exact generic is available). The <i>physician</i> will indicate "DAW" or "Dispense as Written" on the prescription.
\$40	Copayment plus the difference in cost between the brand & generic on any Multi-Source Brand Prescription (Brand Name Drugs that are dispensed when an exact generic is available) The <i>patient</i> indicates the brand to be dispensed. DAW penalty does not count towards the OOP Max
\$0	Copayment on any medication covered under the EHIM OTC program
Generic \$20 Brand \$40 NP Brand \$80	Standard Copayment for all eligible maintenance medication filled in a three month supply. Brand & Generic eligible maintenance medications can be filled through the Local Retail Pharmacy or through Mail Order in order to obtain them in a 3 month supply.
Single \$5,100 Family \$8,700	Out of Pocket Maximum: Once a member/contract meets the amount in pharmacy copays and medical spend combined that member/contract will have a \$0 copay on all eligible medications for the rest of the plan year. Out of Pocket Maximum: Once a member/contract spends the maximum in pharmacy copays that member/contract will have a \$0 copay on all covered medications for the rest of the plan year. One person in a 2-person/Family contract will be capped at the single amount and the rest of the members under that contract will have to meet the other single max combined.

Quantity Limits for Certain Medications - certain medications under your program may be subject to quantity limits to ensure that these medications are utilized appropriately and that maximum dosages are not exceeded. EHIM's quantity limitations are based on FDA approved dosing recommendations, pharmaceutical guidelines, and have been reviewed and approved by our licensed clinical staff.

Non-Preferred Drug List - some medications under this program are classified as "non-preferred". This means there are alternative medications which are therapeutically equivalent. If your physician writes for a medication that is part of our non-preferred list, you may want to discuss alternative medications that are just as effective.

Dental Benefits

The GDI Dental plan is with Blue Cross Blue Shield of Michigan. This plan allows you to choose between a participating dentist, or a dentist outside of the network. Choosing a participating dentist allows you lower out-of-pocket expenses, since the fees are negotiated. For a list of participating network dentists, log in to your member account at www.bcbsm.com. You may also call **888.826.8152**. You may, however, choose a non-participating dentist with potentially higher out-of-pocket costs.

BCBSM Dental Summary	
Deductible	
Single	\$0
Family	\$0
Coinsurance	
Preventive/Diagnostic	100%
Basic	80%
Major	50%
Orthodontia	50%
Annual Maximum	\$1,000
Lifetime Orthodontia Max	\$1,500

Vision Coverage

You may elect comprehensive vision coverage with Blue Vision provided by VSP. Benefits for in-network providers include:

- An examination, every 24 months, subject to a \$0 copay
- Standard glass or plastic lenses are also covered every 24 months
- Frames every 24 months, up to a \$150 retail allowance, with a 20% discount off any balance over \$150
- Elective contact lenses are also covered up to a \$150 retail allowance, with discounts for amounts over \$150
- There are additional benefits, including fixed fees and discounts for additional lens options and services

Extra discounts and savings from a VSP doctor call **800.877.7195** for information. You can also access information at www.vsp.com.



Disability

Short Term Disability (STD)

If you become disabled and are unable to work, this plan provides financial security on a short-term basis until you are able to return to work. The basic features of the plan are outlined below.

Who is eligible for STD?

The plan, administered by Guardian is available to all active full-time employees after the first day of the month following 90 days of employment.

Waiting Period

Benefits begin on the 8th day of total disability in the event of an accident or illness.

How much does the plan pay?

The benefit is equal to 66⅔% of your weekly earnings or \$400 (whichever is less).

How long can I stay on STD?

You may receive Short Term Disability benefits for up to 26 weeks if your disability was caused by an accident or illness.

How do I receive benefits?

Fastest and recommended method: Go to guardianlife.com and select "Log in" to start the claims submission process. Or, if you have a Guardian Anytime account, please log in to Guardian Anytime to file your claim.

Phone - You can also call our Claims Service Center to submit your claim at **800.268.2525**, Monday-Friday, 8:00 am - 8:00 pm ET.

Long Term Disability (LTD)

You may elect Long Term Disability coverage administered by Guardian.

- This plan is designed to help provide financial security if an injury or illness keeps you away from work for a prolonged period of time.
- The plan provides benefits of up to % of your salary. The maximum monthly benefit you can receive under the plan is \$5,000.
- Benefits begin after you have been disabled by injury or illness for 180 consecutive days.
- LTD benefits can continue as long as your disability continues, up to the Social Security Normal Retirement Age. If you are age 62 or above when the disability begins, your disability benefits continue on a sliding scale based on your age.
- Please see the Summary Plan Description for more details on this plan.



Life and Accidental Death & Dismemberment (AD&D)

Life Insurance is one of those things that nobody really likes to think about, but everyone knows they need. Think of it as buying some peace of mind for yourself and your family. With GDI's Life and AD&D plans with Guardian, you have the ability to take care of your loved ones and provide your family with an extra level of safety and security.

Employee Life

GDI provides \$50,000 of Basic Life Insurance at no cost to you. This plan can also be converted into a personal policy if your employment ends.

AD&D

GDI provides \$50,000 of Basic AD&D Insurance at no cost to you. AD&D coverage provides benefits in the case of death or severe injury due to an accident. AD&D benefits can vary depending on the extent of the injury.

Please refer to the Summary Plan Description for more information about the Life Insurance and AD&D plans.



Voluntary Life and Dependent Life with Accidental Death & Dismemberment

You also have the option to purchase additional voluntary life insurance coverage with Accidental Death and Dismemberment insurance for yourself and your dependents. The cost of coverage depends on your age and the amount of coverage you wish to purchase. These plans are administered by Guardian.

For Yourself

You may purchase voluntary life insurance for yourself in increments of \$10,000. The maximum amount of insurance you may buy for yourself is \$500,000.

New hires can elect up to a guarantee issue amount of \$200,000 when they are first eligible. If you elect to purchase more insurance than this amount, you will be required to submit evidence of insurability (EOI).

For Your Spouse

You may purchase voluntary life insurance for your spouse in \$5,000 increments. The maximum amount of insurance you may purchase for your spouse is \$100,000, not to exceed 100% of your Voluntary Life coverage

New hires can elect coverage for his/her spouse up to a guarantee issue amount of \$25,000. If you elect to purchase more insurance than this amount, your spouse will be required to submit evidence of insurability (EOI). You must enroll yourself in the plan in order to cover your spouse.

For Your Dependents

You may purchase voluntary life insurance for your dependent children (up to age 25) in increments of \$1,000 to a maximum of \$10,000. You must enroll yourself in the plan in order to provide coverage for your dependents.



Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current lifestyle.

Policy Election Amount		Monthly premiums displayed. Cost of AD&D is included.							
Employee		Policy Election Cost Per Age Bracket							
	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
\$10,000	\$.65	\$.65	\$.72	\$.87	\$ 1.17	\$ 1.67	\$ 2.47	\$ 4.17	\$ 5.97
\$20,000	\$ 1.30	\$ 1.30	\$ 1.44	\$ 1.74	\$ 2.34	\$ 3.34	\$ 4.94	\$ 8.34	\$ 11.94
\$30,000	\$ 1.95	\$ 1.95	\$ 2.16	\$ 2.61	\$ 3.51	\$ 5.01	\$ 7.41	\$ 12.51	\$ 17.91
\$40,000	\$ 2.60	\$ 2.60	\$ 2.88	\$ 3.48	\$ 4.68	\$ 6.68	\$ 9.88	\$ 16.68	\$ 23.88
\$50,000	\$ 3.25	\$ 3.25	\$ 3.60	\$ 4.35	\$ 5.85	\$ 8.35	\$ 12.35	\$ 20.85	\$ 29.85
\$60,000	\$ 3.90	\$ 3.90	\$ 4.32	\$ 5.22	\$ 7.02	\$ 10.02	\$ 14.82	\$ 25.02	\$ 35.82
\$70,000	\$ 4.55	\$ 4.55	\$ 5.04	\$ 6.09	\$ 8.19	\$ 11.69	\$ 17.29	\$ 29.19	\$ 41.79
\$80,000	\$ 5.20	\$ 5.20	\$ 5.76	\$ 6.96	\$ 9.36	\$ 13.36	\$ 19.76	\$ 33.36	\$ 47.76
\$90,000	\$ 5.85	\$ 5.85	\$ 6.48	\$ 7.83	\$ 10.53	\$ 15.03	\$ 22.23	\$ 37.53	\$ 53.73
\$100,000	\$ 6.50	\$ 6.50	\$ 7.20	\$ 8.70	\$ 11.70	\$ 16.70	\$ 24.70	\$ 41.70	\$ 59.70
\$110,000	\$ 7.15	\$ 7.15	\$ 7.92	\$ 9.57	\$ 12.87	\$ 18.37	\$ 27.17	\$ 45.87	\$ 65.67
\$120,000	\$ 7.80	\$ 7.80	\$ 8.64	\$ 10.44	\$ 14.04	\$ 20.04	\$ 29.64	\$ 50.04	\$ 71.64
\$130,000	\$ 8.45	\$ 8.45	\$ 9.36	\$ 11.31	\$ 15.21	\$ 21.71	\$ 32.11	\$ 54.21	\$ 77.61
\$140,000	\$ 9.10	\$ 9.10	\$ 10.08	\$ 12.18	\$ 16.38	\$ 23.38	\$ 34.58	\$ 58.38	\$ 83.58
\$150,000	\$ 9.75	\$ 9.75	\$ 10.80	\$ 13.05	\$ 17.55	\$ 25.05	\$ 37.05	\$ 62.55	\$ 89.55
\$160,000	\$ 10.40	\$ 10.40	\$ 11.52	\$ 13.92	\$ 18.72	\$ 26.72	\$ 39.52	\$ 66.72	\$ 95.52
\$170,000	\$ 11.05	\$ 11.05	\$ 12.24	\$ 14.79	\$ 19.89	\$ 28.39	\$ 41.99	\$ 70.89	\$ 101.49
\$180,000	\$ 11.70	\$ 11.70	\$ 12.96	\$ 15.66	\$ 21.06	\$ 30.06	\$ 44.46	\$ 75.06	\$ 107.46
\$190,000	\$ 12.35	\$ 12.35	\$ 13.68	\$ 16.53	\$ 22.23	\$ 31.73	\$ 46.93	\$ 79.23	\$ 113.43
\$200,000	\$ 13.00	\$ 13.00	\$ 14.40	\$ 17.40	\$ 23.40	\$ 33.40	\$ 49.40	\$ 83.40	\$ 119.40
\$210,000	\$ 13.65	\$ 13.65	\$ 15.12	\$ 18.27	\$ 24.57	\$ 35.07	\$ 51.87	\$ 87.57	\$ 125.37
\$220,000	\$ 14.30	\$ 14.30	\$ 15.84	\$ 19.14	\$ 25.74	\$ 36.74	\$ 54.34	\$ 91.74	\$ 131.34
\$230,000	\$ 14.95	\$ 14.95	\$ 16.56	\$ 20.01	\$ 26.91	\$ 38.41	\$ 56.81	\$ 95.91	\$ 137.31
\$240,000	\$ 15.60	\$ 15.60	\$ 17.28	\$ 20.88	\$ 28.08	\$ 40.08	\$ 59.28	\$ 100.08	\$ 143.28
\$250,000	\$ 16.25	\$ 16.25	\$ 18.00	\$ 21.75	\$ 29.25	\$ 41.75	\$ 61.75	\$ 104.25	\$ 149.25
\$260,000	\$ 16.90	\$ 16.90	\$ 18.72	\$ 22.62	\$ 30.42	\$ 43.42	\$ 64.22	\$ 108.42	\$ 155.22
\$270,000	\$ 17.55	\$ 17.55	\$ 19.44	\$ 23.49	\$ 31.59	\$ 45.09	\$ 66.69	\$ 112.59	\$ 161.19
\$280,000	\$ 18.20	\$ 18.20	\$ 20.16	\$ 24.36	\$ 32.76	\$ 46.76	\$ 69.16	\$ 116.76	\$ 167.16
\$290,000	\$ 18.85	\$ 18.85	\$ 20.88	\$ 25.23	\$ 33.93	\$ 48.43	\$ 71.63	\$ 120.93	\$ 173.13

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69 [†]
\$300,000	\$19.50	\$19.50	\$21.60	\$26.10	\$35.10	\$50.10	\$74.10	\$125.10	\$179.10
\$310,000	\$20.15	\$20.15	\$22.32	\$26.97	\$36.27	\$51.77	\$76.57	\$129.27	\$185.07
\$320,000	\$20.80	\$20.80	\$23.04	\$27.84	\$37.44	\$53.44	\$79.04	\$133.44	\$191.04
\$330,000	\$21.45	\$21.45	\$23.76	\$28.71	\$38.61	\$55.11	\$81.51	\$137.61	\$197.01
\$340,000	\$22.10	\$22.10	\$24.48	\$29.58	\$39.78	\$56.78	\$83.98	\$141.78	\$202.98
\$350,000	\$22.75	\$22.75	\$25.20	\$30.45	\$40.95	\$58.45	\$86.45	\$145.95	\$208.95
\$360,000	\$23.40	\$23.40	\$25.92	\$31.32	\$42.12	\$60.12	\$88.92	\$150.12	\$214.92
\$370,000	\$24.05	\$24.05	\$26.64	\$32.19	\$43.29	\$61.79	\$91.39	\$154.29	\$220.89
\$380,000	\$24.70	\$24.70	\$27.36	\$33.06	\$44.46	\$63.46	\$93.86	\$158.46	\$226.86
\$390,000	\$25.35	\$25.35	\$28.08	\$33.93	\$45.63	\$65.13	\$96.33	\$162.63	\$232.83
\$400,000	\$26.00	\$26.00	\$28.80	\$34.80	\$46.80	\$66.80	\$98.80	\$166.80	\$238.80
\$410,000	\$26.65	\$26.65	\$29.52	\$35.67	\$47.97	\$68.47	\$101.27	\$170.97	\$244.77
\$420,000	\$27.30	\$27.30	\$30.24	\$36.54	\$49.14	\$70.14	\$103.74	\$175.14	\$250.74
\$430,000	\$27.95	\$27.95	\$30.96	\$37.41	\$50.31	\$71.81	\$106.21	\$179.31	\$256.71
\$440,000	\$28.60	\$28.60	\$31.68	\$38.28	\$51.48	\$73.48	\$108.68	\$183.48	\$262.68
\$450,000	\$29.25	\$29.25	\$32.40	\$39.15	\$52.65	\$75.15	\$111.15	\$187.65	\$268.65
\$460,000	\$29.90	\$29.90	\$33.12	\$40.02	\$53.82	\$76.82	\$113.62	\$191.82	\$274.62
\$470,000	\$30.55	\$30.55	\$33.84	\$40.89	\$54.99	\$78.49	\$116.09	\$195.99	\$280.59
\$480,000	\$31.20	\$31.20	\$34.56	\$41.76	\$56.16	\$80.16	\$118.56	\$200.16	\$286.56
\$490,000	\$31.85	\$31.85	\$35.28	\$42.63	\$57.33	\$81.83	\$121.03	\$204.33	\$292.53
\$500,000	\$32.50	\$32.50	\$36.00	\$43.50	\$58.50	\$83.50	\$123.50	\$208.50	\$298.50

Policy Election Amount**Spouse/DP**

\$5,000	\$33	\$33	\$36	\$44	\$59	\$84	\$1.24	\$2.09	\$2.99
\$10,000	\$65	\$65	\$72	\$87	\$1.17	\$1.67	\$2.47	\$4.17	\$5.97
\$15,000	\$98	\$98	\$1.08	\$1.31	\$1.76	\$2.51	\$3.71	\$6.26	\$8.96
\$20,000	\$1.30	\$1.30	\$1.44	\$1.74	\$2.34	\$3.34	\$4.94	\$8.34	\$11.94
\$25,000	\$1.63	\$1.63	\$1.80	\$2.18	\$2.93	\$4.18	\$6.18	\$10.43	\$14.93
\$30,000	\$1.95	\$1.95	\$2.16	\$2.61	\$3.51	\$5.01	\$7.41	\$12.51	\$17.91
\$35,000	\$2.28	\$2.28	\$2.52	\$3.05	\$4.10	\$5.85	\$8.65	\$14.60	\$20.90
\$40,000	\$2.60	\$2.60	\$2.88	\$3.48	\$4.68	\$6.68	\$9.88	\$16.68	\$23.88
\$45,000	\$2.93	\$2.93	\$3.24	\$3.92	\$5.27	\$7.52	\$11.12	\$18.77	\$26.87
\$50,000	\$3.25	\$3.25	\$3.60	\$4.35	\$5.85	\$8.35	\$12.35	\$20.85	\$29.85

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69 [†]
\$55,000	\$3.58	\$3.58	\$3.96	\$4.79	\$6.44	\$9.19	\$13.59	\$22.94	\$32.84
\$60,000	\$3.90	\$3.90	\$4.32	\$5.22	\$7.02	\$10.02	\$14.82	\$25.02	\$35.82
\$65,000	\$4.23	\$4.23	\$4.68	\$5.66	\$7.61	\$10.86	\$16.06	\$27.11	\$38.81
\$70,000	\$4.55	\$4.55	\$5.04	\$6.09	\$8.19	\$11.69	\$17.29	\$29.19	\$41.79
\$75,000	\$4.88	\$4.88	\$5.40	\$6.53	\$8.78	\$12.53	\$18.53	\$31.28	\$44.78
\$80,000	\$5.20	\$5.20	\$5.76	\$6.96	\$9.36	\$13.36	\$19.76	\$33.36	\$47.76
\$85,000	\$5.53	\$5.53	\$6.12	\$7.40	\$9.95	\$14.20	\$21.00	\$35.45	\$50.75
\$90,000	\$5.85	\$5.85	\$6.48	\$7.83	\$10.53	\$15.03	\$22.23	\$37.53	\$53.73
\$95,000	\$6.18	\$6.18	\$6.84	\$8.27	\$11.12	\$15.87	\$23.47	\$39.62	\$56.72
\$100,000	\$6.50	\$6.50	\$7.20	\$8.70	\$11.70	\$16.70	\$24.70	\$41.70	\$59.70

Policy Election Amount

Child(ren)									
\$1,000	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17
\$2,000	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33
\$3,000	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50
\$4,000	\$0.66	\$0.66	\$0.66	\$0.66	\$0.66	\$0.66	\$0.66	\$0.66	\$0.66
\$5,000	\$0.83	\$0.83	\$0.83	\$0.83	\$0.83	\$0.83	\$0.83	\$0.83	\$0.83
\$6,000	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00
\$7,000	\$1.16	\$1.16	\$1.16	\$1.16	\$1.16	\$1.16	\$1.16	\$1.16	\$1.16
\$8,000	\$1.33	\$1.33	\$1.33	\$1.33	\$1.33	\$1.33	\$1.33	\$1.33	\$1.33
\$9,000	\$1.49	\$1.49	\$1.49	\$1.49	\$1.49	\$1.49	\$1.49	\$1.49	\$1.49
\$10,000	\$1.66	\$1.66	\$1.66	\$1.66	\$1.66	\$1.66	\$1.66	\$1.66	\$1.66

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts. Premiums for Voluntary Life Increase in five-year increments

Infant coverage is limited for the first two weeks of infant's life.

Spouse/DP coverage premium is based on Employee age.

[†]Benefit reductions apply.

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

Your Employee Assistance Program

Maintaining a balance between work and family life can be difficult sometimes. Having someone to help you through the rough times can be a big relief. That's where GDI's Employee Assistance Program (EAP) can help. The EAP is administered by ComPsych.

The EAP is designed to help you and members of your family with difficult problems that affect you at home and on the job. The EAP provides confidential, professional counseling services from trained counselors with master level degrees and solid clinical experience. You can reach a counselor at **888.628.4844**.

They offer assistance 24 hours a day, 365 days a year for the following:

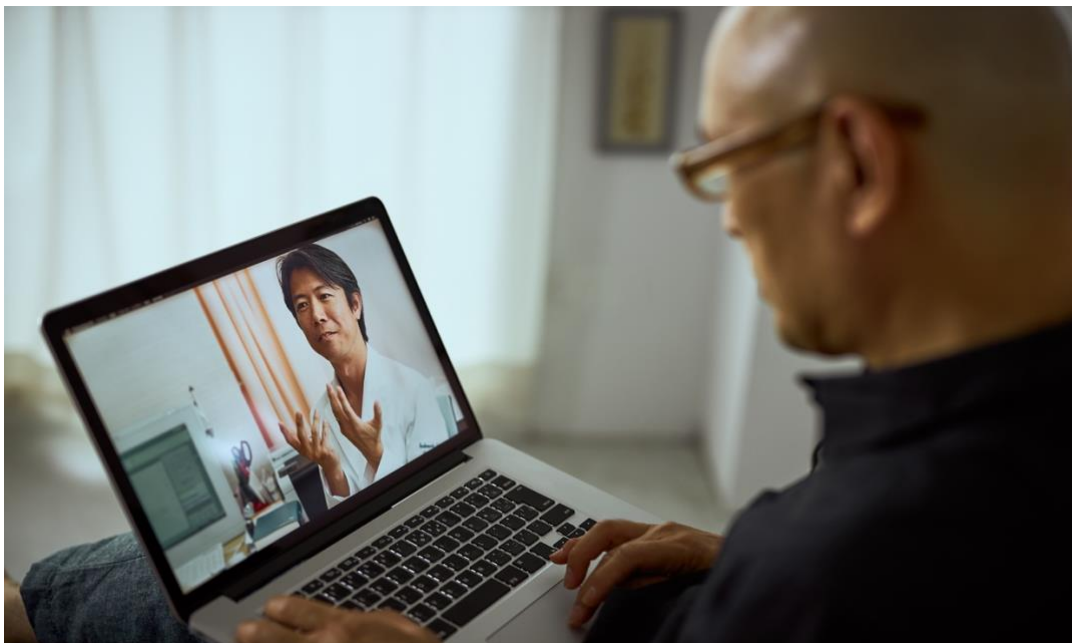
- Confidential Emotional Support - Stress, anxiety, depression, grief, loss, life adjustments, relationship/marital conflicts
- Work-Life Solutions – finding child and elder care, hiring movers or home repair contractors, planning events, locating pet care
- Legal Guidance – divorce, adoption, family law, wills, trusts and more.
- Financial Resources – retirement planning, taxes, relocation, mortgages, insurance, budgeting, debt, bankruptcy and more
- Online Support – GuidanceResources Online is your 24/7 link to vital information, tools and support. Log in for articles, podcasts, videos, slideshows, on-demand trainings, “ask the expert” personal responses to your questions

Contact the Employee Assistance Program at **888.628.4844**.

Online: guidanceresources.com

App: GuidanceResources Now

Web ID: DLEAP



Benefit Providers & Contacts

General Questions/Service/Claim issues - Comprehensive Benefits **248.221.1602** or service@cbi4benefits.com

Medical - Blue Cross Blue Shield of Michigan (BCBSM) plus EHIM HRA

Use BCBSM card to access medical services, the HRA reimbursement is behind the scenes

- **BCBSM Customer Service 877.790.2583**
- **EHIM HRA Customer Service Number: 800.311.3446 or Email: medicalclaims@ehimrx.com**
- EHIM Website: <https://med-member.ehimrx.com/#>

To register your BCBSM account online (your adult family members can register for their accounts, too)

Go online:

1. Go to bcbsm.com/register
2. Select Register Now

Use the app:

1. Download the app from the App Store® or Google Play™ (search BCBSM)
2. Tap the MICHIGAN app and then Register

Text us:

Text REGISTER to 222764 to start setting up your account

Prescription Drugs - EHIM

Use EHIM Rx card

EHIM RX Help Desk: **800.311.3446** or visit <https://ehim.procarerx.com/>

Dental - Blue PPO Dental

Use BCBSM card

To find a dentist, visit mibluedentist.com or call **888.826.8152**

Vision - VSP

Use BCBSM card

To find a VSP doctor, visit vsp.com/eyedoctor or call **800.877.7195**

Short Term Disability – Guardian

Call **800.268.2525** or visit guardianlife.com

Long Term Disability – Guardian

Call **800.538.4583** or visit guardianlife.com

Life/AD&D – Guardian

Call **800.525.4542** or visit guardianlife.com

EAP – Compsych

Call **888.628.4844** or visit guidanceresources.com

Required Notices

GDI Services

24300 Southfield Road, Suite 300, Southfield, MI, 48075
Mary Redman, Plan Administrator, (864) 297-5793

Effective Date: November 21, 2024

Employee & Eligible Beneficiaries,

As an employee of GDI Services and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact Mary Redman, Director of Benefits, GDI Services at: (864) 297-5793

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

IMPORTANT INFORMATION

MEDICARE PART D NOTICE - Medical Plan: BCBS Michigan with EHIM RX

About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. We have determined the prescription drug coverage offered by BCBS Michigan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore **considered Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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 be affected. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. Visit <http://www.cms.hhs.gov/CreditableCoverage/> which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know 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 the person listed in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage 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 or 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 (800) 772-1213 (TTY 1-800-325-0778).

Remember to 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).

NOTIFICATIONS

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

HIPAA regulations will be followed in administrative activities undertaken by assigned personnel when they involve protected health information (PHI) and e-PHI.

The company has adopted a policy that protects the privacy and confidentiality of PHI whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs.

PHI refers to individually identifiable health information received by the company's group health plans and/or received by a health care provider, health plan or health care clearinghouse, and includes information regarding medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

All information related to enrollment, changes in enrollment and payroll deductions, aiding in claims problem resolution and explanation of benefits issues, and assistance in coordination of benefits with other providers will be maintained in confidence. Employees shall not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by Human Resources.

The Company will consider any breaches in the privacy and confidentiality of handling of PHI to be serious, and disciplinary action will be taken in accordance with our code of conduct.

Company records that are governed by this policy will be maintained for a period of no less than six years.

Questions or issues regarding PHI should be addressed with Human Resources.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. **As Required by Law.** We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

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 (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at <http://www.dol.gov/vets>**. An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra/>. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

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

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

QMCSO (Qualified Medical Child Support Order)

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an “alternate recipient’s” right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An “alternate recipient” is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

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). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhp_a_factsheet.html.

RESCISSIONS

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

PREVENTIVE CARE

Health plans through BCBS Michigan will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit:

<https://www.healthcare.gov/coverage/preventive-care-benefits/>

Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.

WOMEN'S PREVENTIVE HEALTH SERVICES

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network through BCBS Michigan:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Please check component plan documents for specific list of possible preventative coverage with no-cost sharing.

FMLA

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor [FMLA page](#).

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

MHPA/MHPAEA

Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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 coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., \$2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

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

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

For all other qualifying events (divorce, or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), employees must notify the Plan Administrator within 60 days after the qualifying event occurs.

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 employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two 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 the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. 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.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

MICHIGAN COMPREHENSIVE PROTECTIONS AVAILABLE:

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities; and (2) non-emergency services provided by out-of-network professionals at in-network facilities*
 - Provided by all or most classes of out-of-network health care professionals
- State provides a payment standard**

- State provides a dispute resolution process***
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services****
 - enrollees in self-funded plans

* With respect to non-emergency services provided by out-of-network providers at in-network facilities, protections are contingent on either a) enrollee not having the ability to choose a participating provider b) health care services provided without enrollee disclosure, or c) health care services provided by a non-participating provider at a participating facility to a enrollee admitted after receiving emergency services.

** Payment standard is defined as the greater of 1) the median amount negotiated by the enrollee's carrier for the region and provider specialty (as determined by the enrollee's carrier) or 2) 150% of the Medicare fee-for-service fee schedule for the health care service provided. In both cases, in-network coinsurance, copayments, and deductibles are excluded.

***In cases where an enrollee has received emergency services, a non-participating provider can request an additional payment that is 25% of the payment standard amount if a complicating factor is identified. If the carrier rejects the request, a non-participating provider can initiate binding arbitration specific to whether there was a complicating factor.

**** Protections do not apply to non-emergency services when enrollee consents in writing. But when the enrollee does not have the ability to choose a participating provider or is admitted through the emergency room, protections do apply. To establish consent, documents need to be provided and signed by non-emergency enrollee at the earliest of the following:

1. At least 14 days before the scheduled procedure, or within 14 days if service will be provided within 14 days, for services not provided in physician's office or similar outenrollee setting
2. At the time of first contact with the non-emergency enrollee, for services provided in a physician's office or similar outenrollee setting.
3. During pre-surgical consultation, scheduling/intake call, pre-operative review, or any other similar event occurring before a service
4. Any other contact occurring before a health care service that is similar to the above.

Disclosure cannot be provided at the time of the non-emergency enrollee's admittance to a facility, or at the time of preparation for surgery or other medical procedure.

Referenced from <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059 the federal phone number for information and complaints.

Visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

Visit https://www.michigan.gov/som/0,4669,7-192-29943_34759-561696—rss,00.html for more information about your rights under Michigan.

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 July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: 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/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

With the key parts of the health care law that took effect in 2014, there is a new 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 and employment-based health coverage offered by GDI Services.

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.

The Open Enrollment period each year is usually between the beginning of November to mid-January; this can sometimes vary by state. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See [Special Enrollment Period](#) and [Qualifying Life Event](#)).

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 may not be eligible for a tax credit through the Marketplace depending on the below factors and your household income. You may want 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 8.39% of your household income for the 2024 year, 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. Beginning in 2021 with the American Rescue Plan Act (ARPA), and extended for tax years 2023-2026 by the Inflation Reduction Act of 2022, the federal poverty ceiling is no longer capped at 100%-400%, and the applicable percentage of household income to qualify for a tax credit through the marketplace has been lowered to 8.5 %.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, you may lose the employer contribution (if any) to the employer-offered coverage. Additionally, the employer contribution, as well as your employee contribution to employer-offered coverage, are 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 your employer.

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. Residents of the following states must use the state-run health exchange, and more information about the state-specific sites can be found at <https://www.healthcare.gov/marketplace-in-your-state/>

CA, CO, CT, DC, ID, KY, MA, MD, ME, MN, NJ, NM, NV, NY, PA, RI, VT, WA

Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name: GDI Services
2. Employer Identification Number (EIN):
3. Employer Address: 24300 Southfield Road, Suite 300
4. Employer phone number: (864) 297-3748
5. City: Southfield
6. State: MI
7. ZIP code: 48075
8. Who can we contact about employee health coverage at this job: Mary Redman
9. Phone number for contact: (864) 297-3748
10. Email address: mary.redman@gdi.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to: All Employees.
- With respect to dependents: We do offer coverage to all eligible dependents.
Eligible dependents are: spouse and dependent children.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

* 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.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

2025 BENEFITS GUIDE

GDI  **Services Inc.**