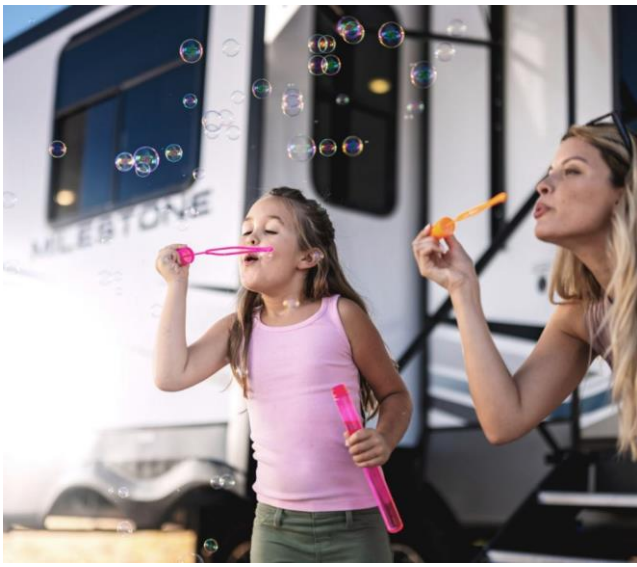

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2024 | All Employees

Benefits Guide

Your Health, Your Benefits

Launching Life's Journeys

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Important Notice:

The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department or to electronically access the SPDs, you may scan the QR code below with your phone.

SCAN ME

Welcome Valued Employees

This guide goes over your employee benefits for the January 1 – December 31, 2024 plan year.

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

This document is not just an enrollment guide; it is a resource for you and your family to use throughout the year!

To see the latest information regarding wellness, benefits, enrollment, programs, and announcements, please visit Heartland's Benefit Site.

Our online benefits library puts your benefit information right at your fingertips. This is your go-to, online resource for your benefit needs.

Visit the below URL or scan the QR code using your smartphone!

Heartland.MyBenefitsLibrary.com

SCAN ME

Eligibility

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have 30 days from your initial start date to enroll in benefits.

All lines of coverage will begin on the 1st of the month following 30 days of employment. Benefits end on the last day worked.

Plan contributions and premiums are calculated and deducted on a per week basis and are not prorated.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Examples of "Eligible Dependents"

- Legally Married Spouse
- Dependent Children: includes natural, step, foster, adopted, or other children in legal guardianship.

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26.

Qualifying Event Documentation

When you first enroll and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list: Marriage Cert., Birth Cert, Court document/Custody arrangement.

Protect your health, family, income, and wallet!

- Medical: Anthem Blue Cross Blue Shield
- Dental: Delta Dental
- Vision: VSP
- Short/Long Term Disability: MetLife
- Basic Life / AD&D / Voluntary Life: MetLife
- Accident/Critical Illness: Aflac

Enrollment

When can I apply for my benefits?

- During initial new hire eligibility period
- During the annual open enrollment period
- Within 31 days of a qualifying life event

How To Enroll

To make your benefit elections you must log into your Employee Self-Service Portal either from the company's URL or via the mobile app in your app store. Once logged into your self-service portal, navigate to "My Benefits" and click on New Employee Enrollment. From there, follow the step-by-step instructions on how to complete your benefits enrollment.

For assistance logging in, please contact your HR department or visit the Benefit Site (details on pg. 2).

Please review all benefit materials. All full-time employees must complete their online enrollment even if you choose to waive coverage. All full-time employees receive free life insurance and must designate a beneficiary in the enrollment portal.

If you do not make your elections before the end of your new hire enrollment period (1st of the month after 30 days of employment), you will have to wait until the Annual Enrollment period held in the fall (unless you experience a qualifying event) to elect benefits.

IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event.

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

Qualifying Life Event

If you experience any of the following life events; **birth, adoption, loss of other coverage, change in coverage marriage, divorce, or death**, you may make changes to your benefit elections within 31 days of the event date with documentation. If you fail to submit your changes, along with supporting documentation, within the 31-day window, your request to make changes will be denied.

The IRS does not consider financial hardship a qualifying event to drop the coverage.

All changes are to be made on the employee self-service portal.

IMPORTANT INFORMATION REGARDING THE 2024 BENEFITS ENROLLMENT

All employees need to make an election for the 2024 calendar year.

- Whether you are enrolling for the first time
- Keeping everything the same
- Making changes to your benefit elections
- Waiving all benefits offered

BENEFITS WILL NOT ROLL OVER!!

If you do not take action, you will not be enrolled in any benefit plans for 2024 and will have to wait until the next Annual Enrollment. (Unless you experience a qualifying life event) **NO EXCEPTIONS**.

Get prepared and review all 2024 benefit details in this benefit guide. For helpful resources, visit the Benefit Site (pg. 2).

DECISIONS YOU WILL NEED TO MAKE!

Choose the benefits, plans, and coverage levels that you need. Social security numbers, gender, and birthdates are required for all dependents.

Your portion of benefit premiums are outlined throughout this guide. Premiums will be deducted from your paycheck on a weekly basis.

There are two ways to enroll:

❶ Employee Self-Service

- Log into your employee self-service portal to complete your enrollment online.
- **Website:** https://secure2.saashr.com/ta/PayServ172001.login

Mobile App: UKG Ready

❷ Call Center

- Call the enrollment center at **866-824-6117** to schedule your call with a counselor.
- Schedule your call online here: https://heartlandrv.mybenefitsappointment.com

Medical Plans

ANTHEM

Locate an in-network provider near you at www.anthem.com or call 866-350-7596.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	Deluxe HSA – Plan 46		Standard PPO – Plan 45	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$3,200	$6,400	$3,000	$6,000
Family	$6,400	$12,800	$6,000	$12,000
Coinsurance	80%	60%	80%	60%
Annual Out-of-Pocket Maximum				
Individual	$6,400	$12,800	$6,000	$12,000
Family	$12,800	$25,600	$12,000	$24,000
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	Covered 100%; deductible waived	Deductible & Coinsurance Apply	Covered 100%; deductible waived	Deductible & Coinsurance Apply
Telemedicine Visit	$59 Copay		$59 Copay	
Primary Care Office Visit	80% after deductible		$40 Copay	
Specialist Office Visit	80% after deductible		$60 Copay	
Urgent Care	80% after deductible		$75 Copay	
Emergency Room	80% after deductible		$250 Copay	
Hospitalization	80% after deductible		80% after deductible	
Prescription Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Tier 1 – Many Generics	80% after deductible	Not Covered	$15 Copay	Not Covered
Tier 2 – Preferred Brand Names			$45 Copay	
Tier 3 – Non-Preferred Brand Names			$75 Copay	
Tier 4 – Specialty Drugs			25% coinsurance (Max up to $200)	
Plan Features	***Combined network & non-network allowance**		***Combined network & non-network allowance**	
Physical/Occupation Therapy	30 Visits*		30 Visits*	
Spinal Manipulation/Chiropractic	25 Visits*		25 Visits*	
Speech Therapy	20 Visits*		20 Visits*	
Home Health Care/Skilled Nursing	100 Days*		100 Days*	

Deluxe HSA

Plan 46

Overview

The Deluxe Plan is a qualified high deductible plan with a Health Savings Account (HSA) to help cover the health care expenses that apply to the annual deductible and coinsurance. All eligible covered expenses (except preventative care) apply towards meeting the annual deductible under the plan.

You must first meet the annual deductible before the plan starts to pay. In return, you will generally pay less in premiums than in other medical plans and preventative care services are fully covered. Once the deductible is met, coinsurance kicks in, sharing the cost of covered expenses between you and the plan.

HSA Benefits

- An HSA is a tax-advantaged way to pay for qualified medical expenses. Contributions are pre-taxed.
- This account is yours. You own, manage it, and decide how much to contribute through payroll deduction.
- This account is flexible. Spend your funds today or save for tomorrow. Your balance will carry over from year to year and you keep your account and funds if you change jobs or retire.

Medical - Deluxe HSA Plan 46	Weekly Premiums
Employee Only	$64.75
Employee + Spouse	$183.00
Employee + Child(ren)	$148.00
Family	$200.75

** NOTE: There are no payroll deductions during 4 weeks of shutdown. The specific weeks without premiums will be communicated.

To see a full list of current eligible and ineligible medical expenses visit the Benefit Site (details on pg. 2).

Contributions

Contributions to an HSA can be made by an employee, employer, or both. Employee contributions are voluntary and can be made pre-tax through payroll deduction. (See HR for form). Employer contributions will be made by Heartland RV to qualified employees from January through October in 10% increments on the last payroll of each month. See amounts below. To be eligible for the employer contributions, you must have elected the HSA medical plan, been employed with Heartland for 12 consecutive months (eligibility begins on the 1st of the month after 12 consecutive months of service), and have an open, active HSA. Please provide proof of account numbers to HR.

Coverage Level	2024 IRS HSA Maximums	Heartland RV's Contribution	2024 Employee Maximum HSA Contribution
Employee Only	$4,150	$750	$3,400
Employee + 1 or more dependents	$8,300	$1,500	$6,800

Standard PPO

Plan 45

Overview

This plan is a traditional PPO plan that includes copayments for office visits and prescription drugs.

Preventative Care is covered at 100% with no deductible.

Prescription drugs are covered with a copayment.

There are 4 Tiers of drug types and prescriptions can be purchased at a local pharmacy or through mail order.

- Tier 1 prescriptions: $15 copay
- Tier 2 prescriptions: $45 copay
- Tier 3 prescriptions: $75 copay
- Tier 4 prescriptions: 25% up to a $200 maximum

** NOTE: There are no payroll deductions during 4 weeks of shutdown. The specific weeks without premiums will be communicated.

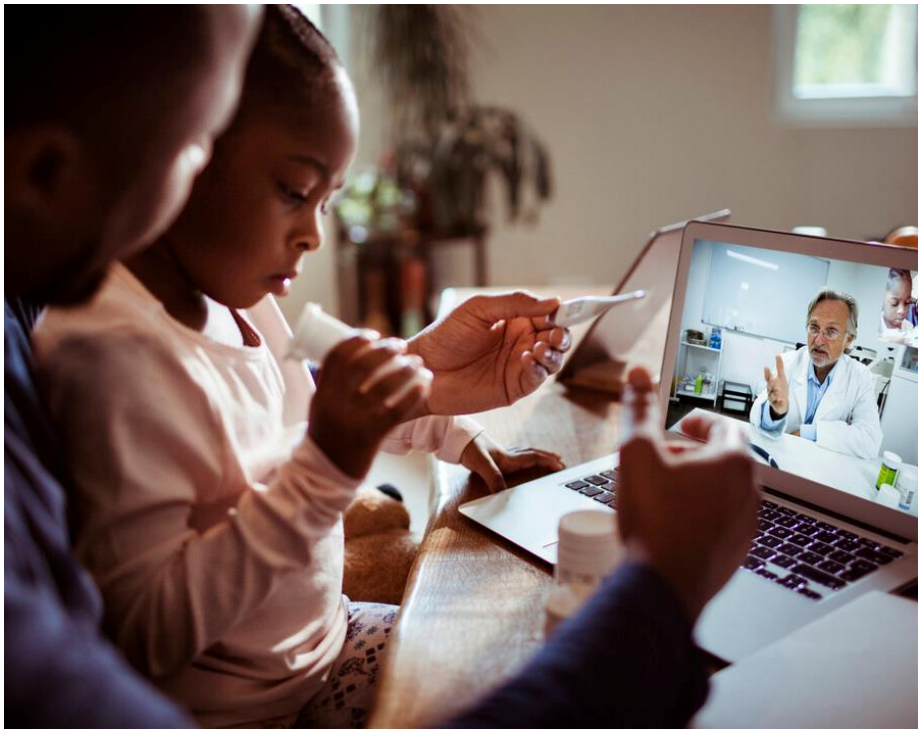
Medical – PPO Plan 45	Weekly Premiums
Employee Only	$94.75
Employee + Spouse	$200.75
Employee + Child(ren)	$168.75
Family	$238.50

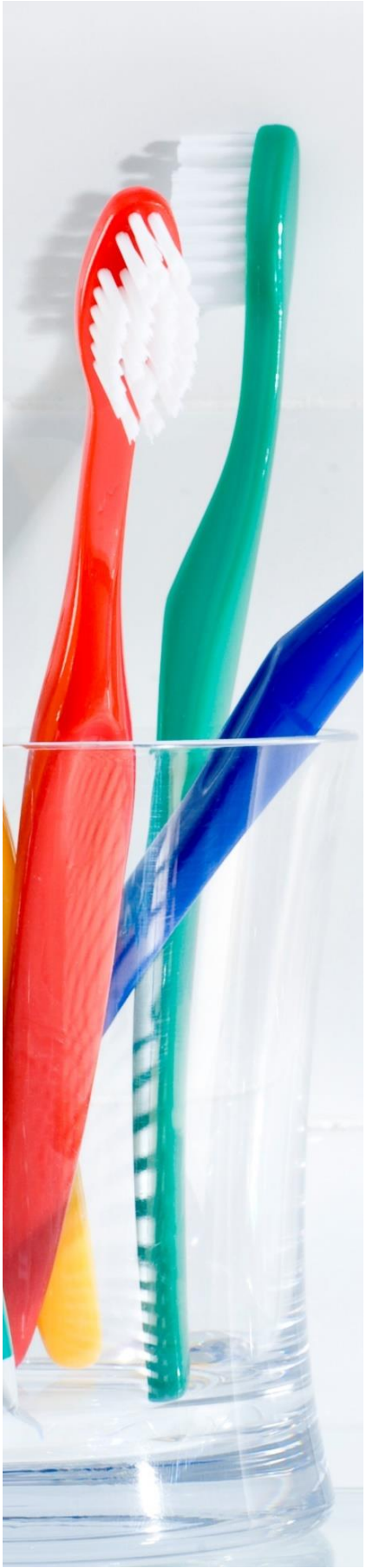
CarelonRx Pharmacy

90-day prescriptions are available through retail pharmacy. If you have questions about pharmacy programs available to you, please call the Pharmacy Member Services number on your ID card.

Sydney Health App

Anthem offers a digital platform that offers mobile healthcare options to its members. The Sydney Health app offers live chat and virtual visits. It can connect you to in-network doctors, the closest Urgent Care centers, and you can look up Pharmacies and medications. The app also allows you to view your medical claims and ID cards all from your phone. Make informed healthcare decisions and download the Sydney Health app today! For more information, visit anthem.com.





Dental

Delta Dental

Locate an in-network provider near you at www.deltadentalin.com or call 800-524-0149.

Dental	In-Network
Annual Deductible	$50 per individual $150 per family
Annual Benefit Maximum	$1,500 (Preventative services NOT included in annual maximum)
Sealants	Covered up to age 16
Plan Pays	In-Network
Preventive Care (Deductible waived) - Exams, cleanings, fluoride, sealants, space maintainers, brush biopsy, radiographs	100% Covered
Basic - Minor restorative services, endodontic services, oral surgery services (extractions & dental surgery) and other basic services	80%
Major - Relines and repairs (to prosthetics), major restorative services (crowns), and prosthodontic services (bridges, implants & dentures)	50%
Orthodontia - Up to Age 26	50%

** NOTE: There are no payroll deductions during 4 weeks of shutdown. The specific weeks without premiums will be communicated.

Dental	Weekly Premiums
Employee Only	$5.55
Employee + Spouse	$11.10
Employee + Child(ren)	$16.17
Family	$23.96

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Vision

VSP

Locate an in-network provider near you at www.vsp.com or all 800-877-7195.

Vision	In-Network	Out-of-Network
Exam	$10 copay	$45 Allowance
Lenses – Single Vision	$0 after copay	$30 Allowance
- **Bifocal**	$0 after copay	$50 Allowance
- **Trifocal**	$0 after copay	$60 Allowance
Retinal Imaging	$39 Max (no copay)	Applied to Allowance for Eye Exam
Frames	$140 allowance	$55 Allowance
Contact Lenses – Standard	$60 copay max	$100 Allowance
- **Disposable Contacts (elective)**	$120 Allowance	$100 Allowance
Frequencies		
Exams	1 per 12 months	
Lenses	1 per 24 months	
Contacts	1 per 12 months	
Frames	1 per 24 months	

Vision	Weekly Premiums
Employee Only	$1.26
Employee + Spouse	$2.53
Employee + Child(ren)	$2.71
Family	$4.33

**NOTE: There are no payroll deductions during 4 weeks of shutdown. The specific weeks without premiums will be communicated.

VSP offers more than just your basic eye exams, lenses, and frames; it also offers exclusive member extras on health, wellness, lifestyle products, and services. VSP SimpleValues provides discounts and everyday savings to VSP Vision covered members. Visit **vsp.com/simplevalues**

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Life/AD&D

MetLife

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D	
Benefit Amount	**Employee:** $20,000*
Age Reduction	**After age 65, the benefit amount begins to decrease:** Age 65: $13,000 (65% of benefit) Age 70: $10,000 (50% of benefit) Age 75: $7,000 (35% of benefit)
Benefit Cost	Employer-paid – No cost to you!

Voluntary Term Life/AD&D	
Benefit Amount	**Employee:** Up to $300,000 or 5x of Salary ($10,000 increments). **THIS YEAR ONLY**, elect up to $150,000 of coverage for yourself without answering any health questions. **Spouse:** Up to $150,000 or up to 50% of EE Election (increments of $5000) ^ **Child(ren):** Up to $10,000^
Guaranteed Issue Amount[1]	**Employee:** $200,000 **Spouse:** $25,000 **Child(ren):** $10,000 per child
Benefit Cost	Personalized rates are based on age and income.

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Definition of "Eligible Dependents"
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

^ Dependent elections require employee enrollment and may be limited by employee volume.

[1] If you enroll when first offered, you may receive up to the listed amount without having to answer medical questions.

Guarantee issue only applies during the initial period. If you do not enroll when you are initially eligible or as a new hire, you will have to complete a medical questionnaire/statement of health form and possibly a physical exam to be approved for benefits.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Disability

MetLife

For more information, please visit www.Metlife.com or all 800-275-4638.

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Short-Term Disability	Benefit Summary
Benefit Amount	Replaces 60% of earnings up to a maximum amount per week
Benefit Begins	Injury: after 15 days Illness: after 15 days
Benefit Duration	Up to 24 weeks
Pre-Existing Condition Limitations	3-month look back period. 12-month exclusion period.
Benefit Cost	Personalized rates are based on age and income.

THIS YEAR ONLY: Elect coverage with NO health questions -- guaranteed issue. Pre-existing condition limitations apply.

Short-term disability excludes work-related injury or illness.

Long-Term Disability	Benefit Summary
Benefit Amount	Replaces 60% of earnings up to a maximum amount per month
Benefit Begins	After a period of 180 days
Benefit Duration	Up to Social Security normal retirement age (SSNRA)
Pre-Existing Condition Limitations	3-month look back period. 12-month exclusion period.
Benefit Cost	Personalized rates are based on age and income.

THIS YEAR ONLY: Elect coverage with NO health questions -- guaranteed issue. Pre-existing condition limitations apply.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Pre-Existing Condition Limitations:
If you file a claim within the 3-month exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the 12-month look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Guarantee issue only applies during the initial period. If you do not enroll when you are initially eligible or as a new hire, you will have to complete a medical questionnaire/statement of health form and possibly a physical exam to be approved for benefits.

Supplemental Health

AFLAC

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Wellness Benefit	$50	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging	Accidental death and dismemberment

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Benefit Amount	**During enrollment you will be able to choose the coverage amount that is needed.**	
Wellness Benefit	$50	
Pre-Existing Condition Limitations	None	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders

Get paid for taking care of your health!

If you are enrolled in coverage, you can receive a wellness benefit payment each year when you have a qualifying screening or test.

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

[Include only if benefit has Dependent Coverage]

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Employee Assistance Program

MetLife

Available to all full-time employees.

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you find solutions and peace of mind.

Your program includes up to 5 in person, phone, or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year.

Confidential Support

- Alcohol or substance abuse
- Child care
- Eldercare
- Financial problems
- Gambling addiction
- Grief and loss
- Job pressures
- Mental health
- Legal concerns
- Relationships

Connect with a counselor.

1-888-319-7819

www.metlifeeap.lifeworks.com
Username: metlifeeap
Password: eap

Also contact the LifeWorks team on their mobile app!

Download the mobile app in your app store and use the same username and password above to log-in.

401(k) Retirement Plan

Fidelity

Your retirement plan is a 401(k) plan that gives you a way to save for retirement through before or after-tax contributions*. We offer a 401(k) plan with a company match for eligible employees. Heartland RV will match 25% per dollar of your weekly deferrals up to an annual max of $600. Employees are eligible to enroll in the 401(k) after 90 days of employment and can do so by going to www.401k.com or by calling Fidelity at 1-800-835-5097.

Roth 401K plan excluded from company match.

Certain highly compensated employees are not eligible for the 401(k) plan or the match. The IRS sets the income levels annually as far as who can participate in the 401(k). If you aren't eligible to participate due to your income level, you will be offered the **THOR Industries Deferred Compensation Plan** and provided information on that program.

Make the most of your future and start saving today!

If you have questions or need help getting started call Fidelity at 1-800-835-5097.

Establish Your Beneficiaries

It's important to name and regularly review and update beneficiaries for your 401(k) retirement plan benefits to prevent benefits being paid according to Plan rules, which might be different from the designation you would choose.

Please take a few moments today to name your beneficiaries (https://netbenefits.fidelity.com/NBLogin/?option=Beneficiary) to ensure that your benefits will be distributed according to your wishes.

Medicare Information

What are my options once I turn 65?

If you continue to work full-time, you may remain on the company medical plan as long as you meet the eligibility requirements. However, you may also be eligible for Medicare A & B, a Medicare Supplement and Medicare D. Please read the summary below and explore your options to determine what is best in your situation.

Working Beyond Age 65: If you are purchasing medical insurance through your employer, a Medicare plan could help you save money on your health care expenses. It may make sense for you to sign up for Medicare in addition to OR instead of the coverage you have today. If you enroll in Medicare and remain on the company health plan be sure to check the coordination rules to determine which coverage is primary.

Medicare Options: Many people who choose to work past age 65 enroll in Part A (Hospital Insurance) because there is no monthly premium. You may choose to enroll in Medicare Part B, a Medicare Supplement, and/or Medicare Part D (these options will be subject to a monthly premium cost).

- Medicare Part B – Physician Insurance
- Medicare Part D – Drug Coverage
- Supplemental Coverage – This can include Medigap coverages, employer plans or Medicaid.

It is recommended that you explore all options to determine what is best for you. You may also shop for and change plans each year based on your specific needs.

Understanding Your Options: Employees who choose to remain on the group health plan can sign up for premium-free Part A (if eligible) during or after their Initial Enrollment Period begins. You can only sign up for Part B (or Part A if you have to buy it) during certain enrollment periods as dictated by Medicare. For additional information on Medicare enrollment opportunities visit www.medicare.gov or reach out to your local SHIP office (see Medicare Resources for contact information).

Making Changes to Your Medicare Plans: Health care needs can change from year to year. Be sure to review your needs annually (upcoming surgeries, current prescription drugs, new wellness goals) so you can find a plan to best meet them.

Medicare Open Enrollment Period: You can enroll in or change your plan once a year during the Open Enrollment Period (OEP) even if you do not have a qualifying event. The OEP is a seven-week period from October 15 through December 7.

Retiring At or After Age 65: Whether you retire or decide to work part-time, once you turn age 65 you will be eligible for Medicare (Parts A and B) and other Medicare Supplement Plans. If you don't have employer-sponsored coverage, you should consider enrolling during your Initial Enrollment Period. You can enroll any time within the 3 months before your 65th birthday month, your birthday month or 3 months after.

Medicare Resources Available

Next Level Planning and Wealth Management

- Get advice from Licensed insurance agents at no cost or obligation to enroll.
- Explore plans from numerous health insurance companies.
- Learn more about Medicare and be guided through the process.
- 1 on 1 assistance with benefit and financial planning
- Call (414) 369-6628 or visit www.NLPWM.com.

Our Medicare library is available 24/7 online. Here you can browse videos, download guides/presentations, listen to an agent and access information at your convenience.

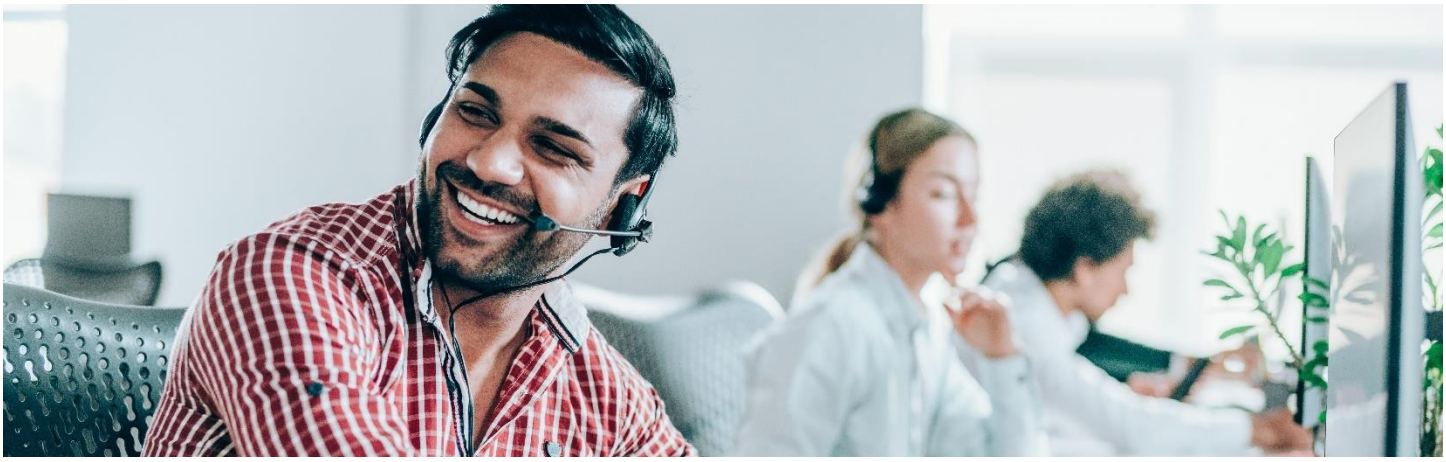
Visit: www.employeenavigator.com/benefits/Account/Login
Login using the following credentials:

- USERNAME: Medicare
- PASSWORD: Benefits65

You may also complete the Permission to Contact Form to speak to an agent and receive assistance with questions related to Medicare as well as explore affordable options available based on your specific needs.

It is important to note that **Medicare resources and options vary by state**. Each state has a **SHIP** (Senior Health Insurance Information Program) that offers free education and assistance specific to their state. To find your state resource and get the number to speak to a licensed counselor, you may either visit www.shiptacenter.org, call 877-839-2675 or email info@shiptacenter.org.

Additional Information (Government resources):
Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.Medicare.gov.



Contacts

Heartland RV Benefits Contact		
Human Resources	574-266-8726	Human.resources@heartlandrvs.com

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	Anthem Blue Cross Blue Shield	1-866-350-7596	www.anthem.com
24/7 Nurse Help Line	Anthem Blue Cross Blue Shield	1-888-596-9476	www.anthem.com
Mental Health/ Substance Abuse	Anthem Blue Cross Blue Shield	1-866-766-4793	www.anthem.com
LiveHealth Online Doctor Visits	Anthem Blue Cross Blue Shield	1-888-548-3432	www.livehealthonline.com
Prescription Drug	CarelonRx	1-833-284-7515	www.anthem.com
Dental Insurance	Delta Dental	1-800-524-0149	www.deltadentalin.com
Vision Insurance	VSP	1-800-877-7195	www.VSP.com
Basic Life, Voluntary Life, Spouse/Child Life, Voluntary AD&D, and Disability	MetLife	1-800-243-8796	www.metlife.com
Accident & Critical Illness	AFLAC	1-800-433-3036	www.aflacgroupinsurance.com
401K	Fidelity	1-800-835-5097	www.401k.com
Employee Assistance Program (EAP)	LifeWorks	1-888-319-7819	www.Metlifeeap.lifeworks.com
Medicare Counselors	Next Level Planning	414-369-6628	www.NLPWM.com

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you can make sense of the terminology.

Definitions

Annual limit—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.

Claim—A bill for medical services rendered.

Cost-sharing—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.

Coinsurance—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.

Copayment (copay)—A fixed amount you pay for a covered health care service, usually when you receive the service.

Deductible—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.

Dependent Coverage—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.

Explanation of Benefits (EOB)—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.

Group Health Plan—A health insurance plan that provides benefits for employees of a business.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

Inpatient Care—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.

Insurer (carrier)—The insurance company providing coverage.

Insured—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.

Open Enrollment Period—Time period during which eligible persons may opt to sign up for coverage under a group health plan.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Out-of-pocket Maximum (OOPM)—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.

Outpatient Care—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.

Policyholder—The individual or entity that has entered into a contractual relationship with the insurance carrier.

Premium—Amount of money charged by an insurance company for coverage.

Preventive Care—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.

Provider—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.

Qualifying Life Event—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.

Qualified Medical Expense—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.

Acronyms

ACA—Affordable Care Act

CPT Code—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.

FPL—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.

FSA—Flexible spending account. An employer-sponsored savings account for health care expenses.

HDHP—High deductible health plan

HMO—Health maintenance organization

HRA—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.

HSA—Health savings account. A tax-advantaged savings account that accompanies HDHPs.

OOP—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.

PCE—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.

PPO—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.

Thor Industries, Inc. Welfare Benefit Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of January 31, 2023. V 0.1.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991 / State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or
www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
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. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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 ❖

Patient Protection Notice

If the Thor Industries, Inc. Welfare Benefit Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

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

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.12% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in the area.

* 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% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:
1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or

2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
The Heartland RV Group Medical Plan (the "Plan"), which includes medical and dental coverages offered under the Heartland RV Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Heartland RV has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
Heartland RV is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to

take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Heartland RV, 2831 Dexter Drive Elkhart, IN 46514, 574-266-8726.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Heartland RV, 2831 Dexter Drive Elkhart, IN 46514, 574-266-8726. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Heartland RV, 2831 Dexter Drive Elkhart, IN 46514, 574-266-8726. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Heartland RV, 2831 Dexter Drive Elkhart, IN 46514, 574-266-8726. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Heartland RV, 2831 Dexter Drive Elkhart, IN 46514, 574-266-8726. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Heartland RV, 2831 Dexter Drive Elkhart, IN 46514, 574-266-8726 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Heartland RV, 2831 Dexter Drive Elkhart, IN 46514, 574-266-8726. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Thor Industries, Inc. Welfare Benefit Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Heartland RV 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. Heartland RV has determined that the prescription drug coverage offered by the Heartland RV Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Heartland RV coverage will not be affected.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Heartland RV and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information about this Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Heartland RV changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: 01/01/2024
Name of Entity/Sender: Heartland RV
Contact--Position/Office: Human Resources
Address: 2831 Dexter Drive Elkhart, IN 46514
Phone Number: 574-266-8726 ❖

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