THOR MOTOR COACH

2025 Employee Benefits Guide

Learn more about your benefits!

Inside

Welcome

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.

How to Enroll

- **Current Employees:** Open Enrollment, which occurs between **November 4th and November 15th** is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 60 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.

Enroll on ADP

Scan QR code or visit
www.workforcenow.adp.com

Need Help?

Schedule Your Enrollment Appointment with EOI

- **Call EOI:** 844-831-5969
- **Scan the QR Code OR Visit:** TMC.MyBenefitsAppointment.com

During your confidential, individual appointment, the counselor will answer your questions and enroll you in your benefits for 2025.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse.
- Birth, adoption, or death of a child.
- Change in child's dependent status.
- Change in residence.
- Change in employment status or a change in coverage under another employer-sponsored plan.

How to Enroll on ADP

1. Start Online or the Mobile App!

Scan the QR codes or visit www.workforcenow.adp.com and or download the **ADP Mobile Solution** app.

2. Enter your User ID and password, and then click **Sign In.**

Note: If this is your first time logging in, click **New? Get Started**. If you are unsure of your registration code, please contact your HR team.

3. Select **Benefits** and click **Start enrollment.**

Manage Dependents.

The **Manage Dependents** page is where you can add/view/edit your dependent and beneficiaries. Select "**Add dependent or beneficiary**" to add a new dependent/beneficiary. You would use the 3-dot action icon to view/edit an existing dependent/beneficiary.

Review and make changes to your benefits as needed.

When enrolling you need to designate **Covered Individu*al*** in this plan by clicking on the box next to the applicable dependents name. You may then choose to **Select plan** for desired enrollment.

You will then be presented a screen confirming your enrollment details.

Voluntary Life Elections and Beneficiaries:

When you elect **Voluntary Life**, you will also need to select your beneficiaries.

Start by clicking **View Available Plans**, and then choose the amount of coverage you want to elect from the drop down.

Next you will want to enter your beneficiary designation. Including **Primary** and **Secondary**, if applicable. All beneficiary delegation percentages combined must equal 100% for each category (Primary or Secondary). Click **Confirm details**. Then click **Confirm** to continue with your enrollment elections.

Note: At any time, you can click **Finish Later** to save your enrollment information. If you start the enrollment process on mobile, and then move to the self-service on your computer/desktop the information you saved on mobile will sync to desktop.

Continue through each step until all elections are complete and all tasks under the Action Required section are addressed. When ready to proceed to the **Review and Submit** step, click **Next**.

4. Review and Submit.

Note that your benefit elections will not be processed until you click **Submit** and receive confirmation. If you click **Finish Later** instead, these enrollments will not be submitted to your HR team but will be saved for a later time.

Please ensure you receive the **confirmation note** indicating your elections have been submitted.

New this Year!

Benefit Highlights

Benefit changes take effect on **01/01/2025**.

Protect Your **Health**

- **Medical:** Change in plan numbers but no changes to the PPO plan design. Slight increase to employee contributions.
- **Dental:** Offered through Delta Dental of Indiana. No plan changes, but rates will slightly increase due to rising cost of dental services.
- **Vision:** Offered through VSP. No changes to the plan. Rates are slightly decreasing.

Protect Your **Family**

- **Employer-Paid Life/AD&D:** Now offered through Sun Life! THOR Motor Coach provides Life and AD&D insurance for all full-time employees at no cost to you! Be sure to update your beneficiaries during this enrollment period.
- **Voluntary Life/NEW AD&D:** Now offered through Sun Life! Accidental Death and Dismemberment will be included with your Life election starting in 2025. This means the benefit will pay double if you pass away due to a covered accident. **THIS YEAR ONLY,** elect up to $250,000 of coverage through Sun Life without answering any health questions. Guaranteed issue coverage is also available for spouses ($50,000) and children ($10,000) (limits may apply).

Protect Your **Income**

- **Short-Term Disability and Long-Term Disability**: Now offered through Sun Life! This insurance provides income replacement in the event you are unable to work due to injury or sickness. Enroll at open enrollment with no health questions! Pre-existing condition limitations apply.

Protect Your **Wallet**

- **Accident, Critical Illness, and Hospital Indemnity:** Offered through SunLife**!** Get cash benefits for non-work-related accidents, diagnoses such as cancer, stroke, or heart attack, or hospital stays including routine pregnancy. Each plan includes a $100 wellness benefit that pays you for completing a covered health screening (pays once per year per covered individual).

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 60 days from your initial start date to enroll in benefits.

- **Medical, Dental, Vision:** These coverages will take effect on the first of the month following 60 days of employment.
- **Other Coverages:** * All other coverages will take effect on the first of the month following 60 days of employment.
- **401K Retirement:** You must be continuously employed by TMC for more than 90 days to participate.
- **Flexible Spending Account (FSA):** You must be continuously employed by TMC for more than 365 days to participate.

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

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

Definition of "Eligible Dependents"

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26**. This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page 16 for additional definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a "spouse", and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.

Dependent Verification Requirement

Employees who wish to enroll a dependent in coverage are required to provide supporting documents to verify dependent eligibility. **If we do not have supporting documentation on file, your dependent's coverage will not be processed**. If you are unsure if you have the required documents on file, contact Human Resources.

Applicable documents include:

- Marriage certificate (for spouse)
- Birth certificate (for dependents)
- First page of most recent tax return listing covered dependents (for spouse or dependents)

Employee Contributions

If you elect coverage, you will only have benefit deductions taken from **48 pay periods.** This is so that double deductions will not be required for insurance premiums after regularly scheduled shutdown periods in July and December. Administrative employees that do not have scheduled shutdown periods will have those weeks off from premiums.

Medical	Anthem Plan 63- PPO	Anthem Plan 65- PPO
Employee Only	$89	$62
Employee + Spouse	$181	$153
Employee + Child(ren)	$171	$142
Employee + Family	$226	$185

Dental	
Employee Only	$6.21
Employee + Spouse	$12.43
Employee + Child(ren)	$18.11
Employee + Family	$26.83

Vision	
Employee Only	$1.26
Employee + Spouse	$2.52
Employee + Child(ren)	$2.69
Employee + Family	$4.31

Basic Life/AD&D	Employer-paid!

Voluntary Life/AD&D **Disability** **Accident** **Critical Illness** **Hospital Indemnity**	To view your personalized rates, log in to **ADP**.

Medical

Anthem | 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	Plan 63- PPO		Plan 65- PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$2,500	$5,000	$4,000	$8,000
Family	$5,000	$10,000	$8,000	$16,000
Coinsurance (after deductible)	You pay 20%	You pay 40%	You pay 20%	You pay 40%
Annual Out-of-Pocket Maximum				
Individual	$5,000	$10,000	$6,500	$13,000
Family	$10,000	$20,000	$13,000	$26,000
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	Covered 100%	You pay 40%	Covered 100%	You pay 40%
Office Visit	$40 Copay	You pay 40%	$40 Copay	You pay 40%
Urgent Care	$50 Copay	$50 Copay	$75 Copay	$75 Copay
Specialist	$60 Copay	You pay 40%	$60 Copay	You pay 40%
Diagnostic Scans / Imaging	You pay 20%		You pay 20%	
Emergency Room	$250 Copay		$250 Copay	
Hospitalization	You pay 20%	You pay 40%	You pay 20%	You pay 40%
Outpatient Surgery				
Prescription Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (30 days)	$15/$45/$75		$15/$45/$75	
Mail Order (90 days)	$30/$90/$150		$30/$90/$150	
Specialty Drugs	25% to $150 Max		25% to $200 Max	

Group Number: 212078

Locate an in-network provider near you at www.anthem.com, the Sydney Health app, or call **1-866-350-7596**.

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

Sydney Health App

Anthem's app is simple, smart and all about you!

Everything you need to know about your Anthem benefits – personalized and all in one place.

Download the app today!

www.sydneyhealth.com/

Enjoy a simpler, more connected health experience:

- Find care and check costs
- See claims
- Check all benefits
- View and use digital ID cards
- Use the interactive chat feature and get answers quickly

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Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning

Where Should I Go for Care?
http://www.cottinghambutler.com/KnowWhereToGo/

Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

Virtual Care: LiveHealth Online

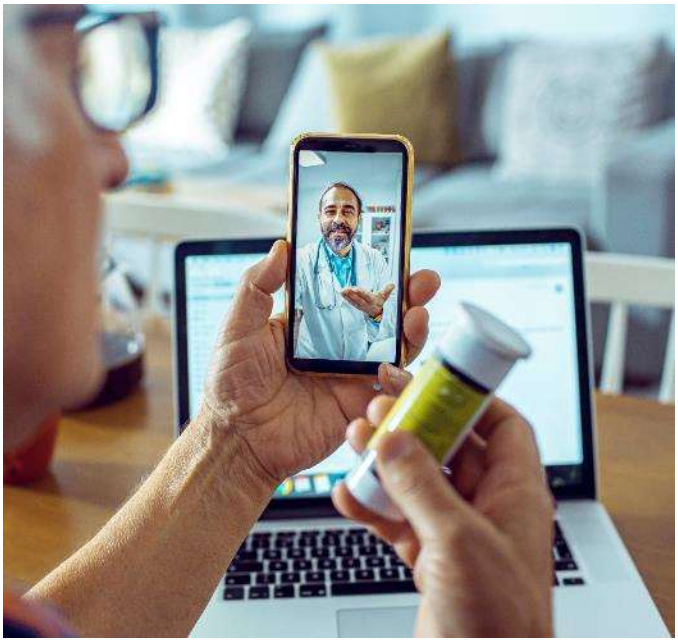
Medical & Mental Health

When you're not feeling well you can get the support you need easily using **LiveHealth Online**.

Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. You can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet, or computer from home or anywhere.

Get help with common health issues, such as:

- Allergies
- Cold & Flu
- Fever
- Rashes
- Pinkeye
- Sinus infections



You may also schedule a visit with a licensed therapist online or consult with a board-certified psychiatrist for mental health concerns.

Depending on which medical plan you enroll in, your cost for LiveHealth will not exceed **$59**.

Sign up today!

Register today so you're ready for a visit when you need one. To sign up, visit www.LiveHealthOnline.com or download the LiveHealth Online mobile app. Next, you:

1. Choose **Sign Up** to create your LiveHealth Online account. Then enter information like your name, email address, date of birth and create a secure password.
2. Read the **Terms of Use** and check the box to agree.
3. Choose your location in the drop-down box of states.
4. Enter your birth date and choose your gender.
5. For the question "Do you have insurance?", select **Yes**. Be sure to have your Anthem member ID card handy to complete your insurance information. If you choose **No**, you can still enter your insurance information later.
6. For **Health Plan**, in the drop-down box, select **Anthem**.
7. For **Subscriber ID**, enter your identification number, which is found on your Anthem member ID card. Select **Yes** if you are the primary subscriber or **No** if you are not the primary subscriber.
8. Insert a service key if you have one. If you don't have a service key that's OK, this is optional and not required to register.
9. Select the green **Finish** button.

Get started today!

www.LiveHealthOnline.com
LiveHealth Online mobile app

Questions? Call 1-888-548-3432 or email help@livehealthonline.com.

Ways to Save on Medical Costs

Find A Provider, Check Quality & Compare Costs

Did you know different doctors and hospitals may charge different amounts for the same service?

Find in-network providers and shop around using Anthem's cost estimator tool to see costs based on your own medical benefits before you get care. You can also compare the quality of different procedures.

To learn more, visit www.anthem.com.

Keep Drug Costs Down

Be a wise health care consumer and possibly cut your prescription drug costs by up to 90%. Strategies to help you save money include:

- Shop around at local pharmacies to find the best price
- Ask your doctor about generic or over-the-counter alternatives
- Check discount prescription drug programs like GoodRx www.GoodRx.com or BlinkHealth www.blinkhealth.com

Practice Prevention

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health.

Most health plans cover a set of preventive services at no cost to you, such as:

- Annual checkups
- Health screenings
- Immunizations

Flexible Spending Account

Anthem

Available to employees once you have been employed with TMC for over 365 days.

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Use It or Lose It Reminder: Unused FSA funds are forfeited if you do not used them before the end of the year.

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

Annual contribution limit	$3,300

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

The weekly administration fee to enroll in the FSA is $1.37/week

Is a Health FSA Right for You?
www.cottinghambutler.com/HealthFSA/

Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) to learn more about eligible expenses.

Dental

Delta Dental

Reminder: ID cards are not provided. Please supply your provider with your Social Security Number to verify benefits and coverage.

Dental	In-Network
Annual Deductible	$50 per individual $150 per family
Annual Benefit Maximum	$1,500
Lifetime Orthodontia Maximum	$1,500
Services	In-Network
Preventive Care (Deductible waived) Exams, cleanings, fluoride, and space maintainers; sealants to prevent decay of permanent teeth; brush biopsy to detect oral cancer; x-rays.	Covered 100%
Basic Emergency palliative treatment to temporarily relieve pain; minor restorative services - fillings and crown repair; oral surgery - extractions and dental surgery, relines and repairs to bridges, implants, and dentures.	Plan pays 80%
Major Endodontic services - root canals; periodontic services to treat gum disease; major restorative services - crowns; prosthodontic services - bridges, implants, and dentures.	Plan pays 50%
Orthodontia Braces	Plan pays 50% up to age 26

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.

Group Number: 1013

Locate a **Delta Dental PPO** dentist near you for maximum savings at www.deltadentalin.com or call **1-800-524-0149**.

Vision

VSP |

Reminder: ID cards are not provided. Please supply your provider with your Social Security Number to verify benefits and coverage.

Vision	In-Network		
Exam Services	• $10 Co-pay / Covered Every 12 months	• Comprehensive WellVision Exam® covered in full*	• Routine retinal screening covered after a no more than $39 copay
Lenses	• $10 Co-pay / Covered Every 12 months • Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses are covered in full*		
Lens Enhancements	Lens Enhancement Anti-reflective coating Polycarbonate - Adult Polycarbonate - Children Progressive Photochromic Scratch-resistant coating	Single Vision • $41 • $31 • Covered • N/A • $75 • $17	Multifocal • $41 • $35 • Covered • Covered • $75 • $17
Frame	• $10 Co-pay / Covered every 24 months • Frames covered up to the retail allowance of $140. • Members who select a featured frame brand, including Anne Klein, bebe®, Calvin Klein, Flexon, Lacoste, Nike, Nine West and more, will receive an extra $20 toward their frame allowance. (Featured frame brands subject to change). • Walmart® or Costco® Optical allowance of $65 is equivalent to the frame allowance at VSP doctor locations and participating retail chains • 20% off any amount above the retail allowance		
Additional Pairs of Glasses	Within 12 months of exam: 20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses from any VSP doctor		
Elective Contact Lenses (in lieu of frames & lenses)	• $10 Co-pay / Covered every 12 months • Contact lens exam (fitting and evaluation): Standard and Premium fits are covered in full after copay. Member receives 15% off of contact lens exam services and member's copay will never exceed $60. • Prescription contact lens materials are covered in full up to the retail allowance of $140 (in lieu of frame & lenses)		
KidsCare Plan	The VSP KidsCare Plan provides children two comprehensive eye exams, up to two pairs of lenses (with prescription change), and a frame every year, even when the subscribing member's plan only provides coverage for glasses every other year. The VSP KidsCare Plan also provides coverage for contact lenses in lieu of glasses		
Laser VisionCare Program	Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, Custom LASIK, and IntraLase		

Group Number: 30100875

Locate a **VSP Advantage** network provider near you at www.vsp.com/eye-doctor or call **1-800-877-7195**.

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.

Hearing Aid Discounts

TruHearing through VSP's Exclusive Member Program

Available to all VSP® Vision Care members.

Save Up to 60% on Brand-Name Hearing Aids

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,0001, and few people have hearing aid insurance coverage.

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too.

In addition to great pricing, TruHearing provides you with:

- Three provider visits for fitting and adjustments
- 45-day trial
- Three-year manufacturer warranty for repairs and one-time
- loss and damage replacement
- 48 free batteries per hearing aid for non-rechargeable models

Plus, with TruHearing you'll get:

- Access to a national network of more than 6,000 hearing healthcare providers
- Discounted pricing on a wide selection of the latest brand name hearing aids
- High-quality, low-cost batteries delivered to your door

Best of all, if you already have a hearing aid allowance from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

Here's how it works.

Contact TruHearing.

Call 877.396.7194. You and your family members must mention VSP.

Schedule exam.

TruHearing will answer your questions and schedule a hearing exam with a local provider.

Attend appointment.

The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at www.truhearing.com/vsp or call 877.396.7194 with questions.

Life/AD&D

SunLife

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:** $15,000*
Benefit Cost	Employer-paid – No cost to you!

Voluntary Term Life	
Benefit Amount	**Employee:** Up to $500,000 or 5 times your salary, whichever is less. In $10,000 increments. **Spouse:** Up to 100% of Employee amount up to $150,000 in $10,000 increments. **Child:** Flat $10,000
Guaranteed Issue Amount[1]	**Employee:** Up to $250,000 **Spouse:** Up to $50,000 **Child**: Up to $10,000
Benefit Cost	To view your personalized rates, log in to **ADP**.

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.

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.

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.

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

- **Spouse:** Person to whom You are legally married; eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates first of the month following turning 26. 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.

^ 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.

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.

Policy #963553
www.sunlife.com/us/en/
1-800-247-6875

Disability

SunLife

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		Salaried & Sales Employees	Hourly Employees
Benefit Amount		Replaces 60% of weekly earnings, up to $1,000 per week	
Benefit Begins	Injury	After 7 consecutive days of disability	After 14 consecutive days of disability
	Illness		
Benefit Duration		Up to 12 weeks	Up to 11 weeks
Pre-Existing Condition Limitations		3-month look back period. 12-month exclusion period.	

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

Long-Term Disability	Salaried & Sales Employees	Hourly Employees
Benefit Amount	Replaces 60% of earnings, up to $5,000 per month	Replaces 60% of earnings, up to $2,000 per month
Benefit Begins	After a period of 90 days or end of Short-Term Disability period	
Benefit Duration	Reduced Benefit Duration to Social Security normal retirement age (SSNRA)	
Pre-Existing Condition Limitations	3-month look back period. 12-month exclusion period.	

Policy #963553
www.sunlife.com/us/en/
1-800-247-6875

Disability Employee Cost

To view your personalized rates, log in to **ADP**.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the 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.

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.

IMPORTANT:
This is a Fixed Indemnity Policy, NOT Health Insurance

Hospital Indemnity Notice

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Supplemental Health

SunLife

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	$100	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Emergency room visits Hospital admission	Surgical benefits Follow-up treatments Ambulance
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	**Employee:** Up to $40,000 ($10,000 increments) **Spouse:** Up to 100% of employee amount ($10,000 increments) **Child:** Up to 50% of employee amount ($5,000 increments)	
Wellness Benefit	$100	
Pre-Existing Condition Limitations	None	
Common Covered Conditions	Cancer Heart attack	Major organ failure Stroke

Policy #963553

www.sunlife.com/us/en/

1-866-806-3619

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.

Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

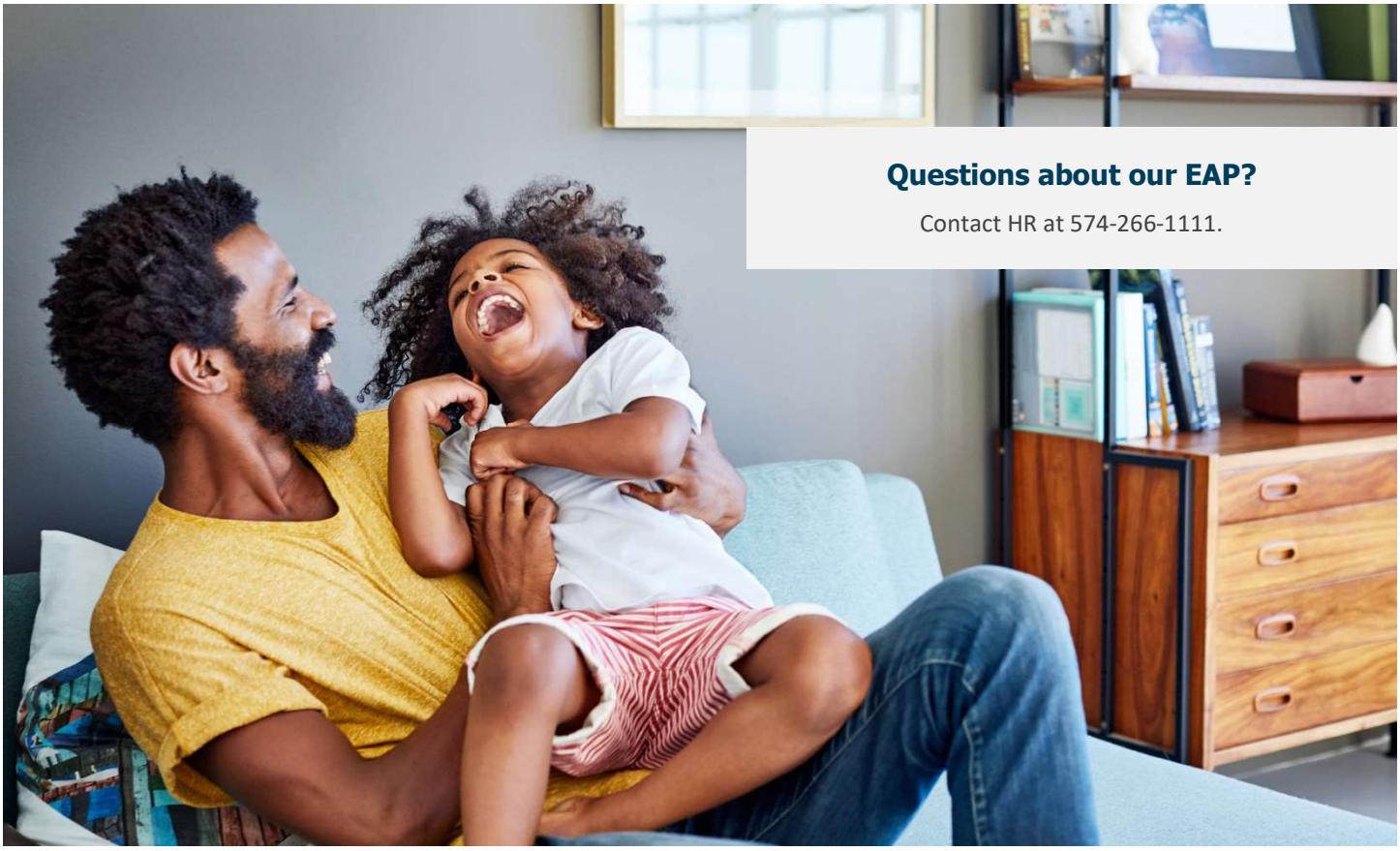
Benefit Amount	$1,000 hospital admission benefit **Daily Confinement Benefit:** - Hospital: $100/day up to 30 days - ICU: $100/day up to 30 days
Wellness Benefit	$100
Pre-Existing Condition Limitations	None
Other Covered Benefits	Newborn Nursery Confinement ($100/day for up to 2 days) Rehabilitation Unit ($50/day for up to 30 days) Observation Unit ($100 for 1 day)

Supplemental Health Employee Cost	To view your personalized rates, log in to **ADP**.

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.

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.



Questions about our EAP?

Contact HR at 574-266-1111.

Employee Assistance Program

SunLife- ComPsych

Available to full-time employees and their immediate family members; including the spouse, and dependent children (unmarried and under 26) who reside with the employee.

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 and your family find solutions and peace of mind.

Receive up to 5 FREE consultations per individual each calendar year!

If you need additional support, the EAP team will try to refer you to resources that are affordable or covered by your medical insurance.

Confidential Support

- Marriage, relationship, and family problems
- Anxiety, depression, stress
- Grief and loss
- Financial sources
- Legal guidance
- Health and wellness concerns
- Online Will prep
- Digital support

Connect with a counselor 24/7

Request support by phone or online form.

Phone support available in more than 120 languages!

877-595-5284

www.guidanceresources.com

App: GuidanceNow

Web ID: EAPComplete

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. Eligible employees will receive .30 on every dollar up to $1,000 match each year. 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.

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.

Easy Enroll

Choose a savings approach that suits you today – and adjust it any time to fit your changing needs. You can update your contributions online at Netbenefits.com/easy.

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.

To navigate to your beneficiary designations online:

1. Log into your account at www.netbenefits.com.
2. Click the Your Profile link.
3. Select Beneficiaries and follow the online instructions.

Once you have completed your beneficiary designations, you will be able to view them on NetBenefits®. Please be sure to review your choices regularly and update them after certain life events, such as a marriage, divorce, birth of a child, or a death in the family.

* Certain individuals who earn over a specific threshold annually (the amount varies each year and is set by the IRS) are not eligible to participate in the 401K plan, but are eligible for our Deferred Compensation Plan. If this applies to you we will let you know so that you can make your enrollment decision.

www.netbenefits.com.

1-800-835-5097

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.

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 are able to 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.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **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.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Contacts

Benefits Contact		
HR Department	574-266-1111	humanresources@tmcrv.com

Coverage	Carrier	Phone	Website
Medical & Pharmacy			
Member Services	Anthem	1-866-350-7596	www.anthem.com
24/7 Nurse Line	Anthem	1-888-596-9476	www.anthem.com
Mental Health/Substance Abuse (Pre-Certification)	Anthem	1-866-766-4793	www.anthem.com
Coverage While traveling	Anthem	1-800-810-2583	www.anthem.com
Dental	Delta Dental	1-800-524-0149	www.deltadentalin.com
Vision	VSP	1-800-877-7195	www.vsp.com
Flexible Spending Account	Anthem	1-866-350-7596	www.anthem.com
Basic & Voluntary Life/AD&D	SunLife	1-800-247-6875	www.sunlife.com/us/en/
Disability	SunLife	1-800-247-6875	www.sunlife.com/us/en/
Hospital Indemnity Insurance, Accident & Critical Illness	Sun Life	1-866-806-3619	www.sunlife.com/us/en/
Employee Assistance Program (EAP)	SunLife	1-877-595-5284	www.sunlife.com/us/en/

Thor Motor Coach Group Health 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 July 31, 2024. V 0.4.0. 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
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
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)

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: https://www.hhs.nd.gov/healthcare
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
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

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

VIRGINIA – Medicaid and CHIP
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
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 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 ❖

Patient Protection Notice

If the Thor Motor Coach Group Health 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 8.39% 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 Thor Motor Coach Group Medical Plan (the "Plan"), which includes medical and dental coverages offered under the Thor Motor Coach 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 Thor Motor Coach 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
Thor Motor Coach 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 Thor Motor Coach, 701 County Road 15, Elkhart, Indiana 46516, (574) 584-2133.

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 Thor Motor Coach, 701 County Road 15, Elkhart, Indiana 46516, (574) 584-2133. 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 Thor Motor Coach, 701 County Road 15, Elkhart, Indiana 46516, (574) 584-2133. 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 Thor Motor Coach, 701 County Road 15, Elkhart, Indiana 46516, (574) 584-2133. 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 Thor Motor Coach, 701 County Road 15, Elkhart, Indiana 46516, (574) 584-2133. 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 Thor Motor Coach, 701 County Road 15, Elkhart, Indiana 46516, (574) 584-2133 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 Thor Motor Coach, 701 County Road 15, Elkhart, Indiana 46516, (574) 584-2133. 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 Motor Coach Group Health 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 Thor Motor Coach 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. Thor Motor Coach has determined that the prescription drug coverage offered by the Thor Motor Coach 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 Thor Motor Coach coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Thor Motor Coach 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 Thor Motor Coach 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 Thor Motor Coach 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: 1/1/2025
Name of Entity/Sender: Thor Motor Coach
Contact--Position/Office: Human Resources
Address: 701 County Road 15, Elkhart, Indiana 46516
Phone Number: (574) 584-2133 ❖