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Great American Trailers.

HEARTLAND®
RECREATIONAL VEHICLES

DRV
Luxury Suites

BENEFIT GUIDE

2022

HEARTLAND®
RECREATIONAL VEHICLES

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DEAR EMPLOYEES:

This Guide goes over your employee benefits for the January 1 - December 31, 2022 plan year.

We recognize that benefits are a critical part of your total compensation package. This is why we are proud to provide great benefits for you and your dependents.

This document is not just an enrollment guide, it is a resource for you and your family to use throughout the year. Our benefits program is designed to allow you to choose what works best for your needs and your budget, allowing you to make informed decisions about the services and benefits provided to you.

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ELIGIBILITY

Employee Eligibility and Enrollment

All full time employees working an average of 30 hours per week are eligible to enroll in benefits.
For specific details, please refer to the plan documents.

New full time employees' benefits for all lines of coverage will begin on the 1st of the month following 60 days after the date of hire. **Benefits end on the last day worked.**

Dependent Verification of Eligibility

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:

- Spouse Verification Documentation: Marriage Certificate
- Child Verification Documentation: Birth Certificate, court document awarding custody or requiring coverage

Any misrepresentation in the benefits enrollment process of dependents will be considered falsification of documentation and will be sufficient cause of separation from employment with Heartland RV.

Dependent Eligibility – Medical Plans

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible dependents include:

- Spouse/Same Sex Spouse
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

ENROLLMENT

When You Can Enroll

You can enroll in benefits at the following times:

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

Please see below for examples of qualified life events.

Mid-Year Enrollment Changes–Section 125 Cafeteria Plan

Employees may take advantage of, at no cost to them, the tax benefits of a 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck. When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

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

Changes must be reported within 31 days of the actual event. Some common qualifying events may include:

- Marriage, Divorce or Death of Spouse
- Birth, Adoption or change in legal custody
- Loss of other coverage
- Enrollment in the Marketplace Exchange
- Change in Medicare or Medicaid entitlement
- Medical or Military Leave

To determine if any of these apply to you, please check with your Human Resources representative.

Please Note: the IRS does not consider financial hardship a qualifying event to drop coverage.

Sample of Saving Using Pre-Tax Deductions

	Pre-tax Contributions	Post-Tax Contributions
Employee Gross Pay	$35,000	$35,000
Pre-Tax Premium	$417	-
Taxable Income	$34,583	$35,000
Assumed Tax Rate[1]	25.65%	25.65%
Net Pay	$25,712	$26,023
After Tax Premium		$417
Take Home Pay	$25,712	$25,605

[1] Assumed Tax Rate of 18% Federal Income Tax and 7.65% FICA (Social Security and Medicare)

ENROLLMENT

Decisions You Will Need to Make

Choose the benefits, plans, and coverage levels that you need:

- Medical Insurance
- Dental & Vision Insurance
- Disability & Life Insurance
- Accident & Critical Illness

Newly Hired Employees

All new hires must enroll through the Employee Self-Service Portal in Thrive to make all benefit elections before benefit effective date.

How much do my benefits cost?

Your portion of benefits premiums are outlined throughout this guide.

Premiums will be deducted from your paycheck on a weekly basis. There are no charges during the 4 weeks of shut down. Specific weeks without premiums will be communicated by HR.

2022 Annual Enrollment
October 4th – 24th 2021

To make your benefit elections you must log into your Employee Self-Service Portal.

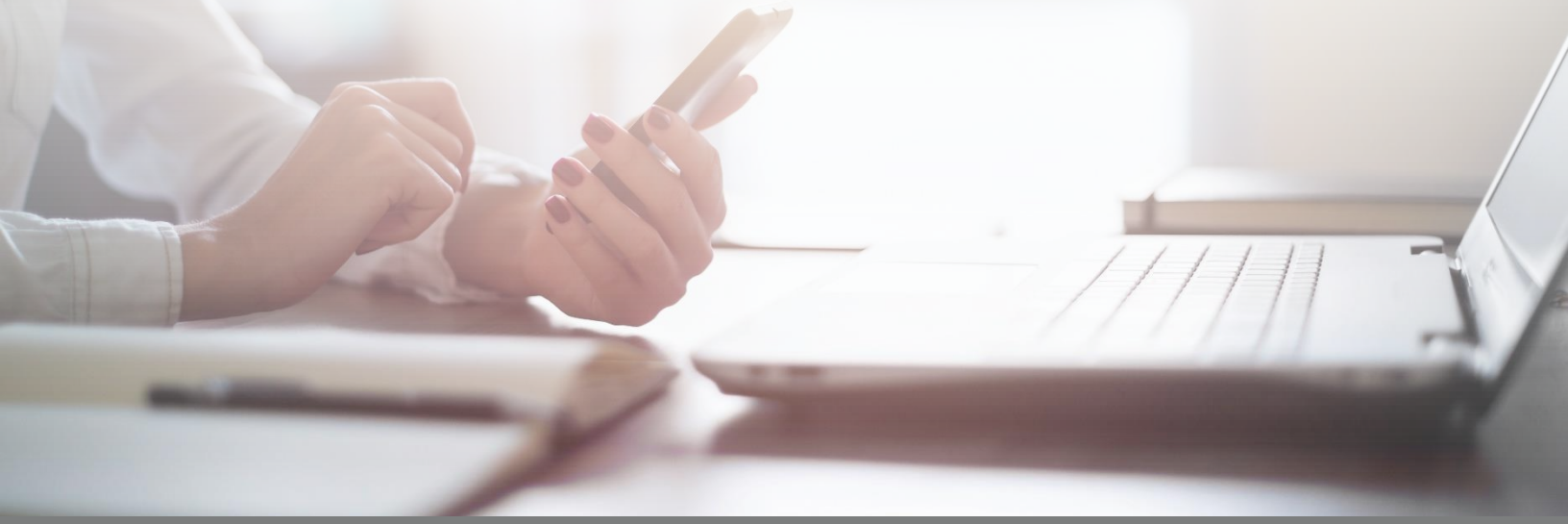
Once logged into your self-service portal, navigate to "My Benefits" and click on Open Enrollment. From there, follow the step by step instructions on how to complete your benefits enrollment.

There are two ways to access your self-service portal.

1. Company's URL - https://secure2.saashr.com/ta/PayServ172001.login
2. Mobile App – UKG Ready

* *You must log into your Self-service portal to review your benefit elections for 2022.*

** *If you do not make your elections before the end of open enrollment, you will not be enrolled in any benefit plans and will have to wait until the next Annual Enrollment (unless you experience a qualifying event).* ***Benefits will not roll over!!***



DELUXE HSA PLAN

Deluxe HSA Plan Overview

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

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

Benefits of the HSA

- A HSA is an individual account – you own and manage it.
- Funds accumulate each year in your HSA. There is no "use it or lose it" provision.
- HSAs are portable. You keep your account and all funds if you change jobs or retire.
- Contributions to your HSA are pre-tax or tax deductible, earnings are non-taxable, and qualified distributions are tax-free.

How is the High Deductible Plan Different?

You must first meet the annual deductible before the plan starts to pay. All expenses, including eligible prescription drugs, office visits, labs, and urgent care, are subject to the annual deductible. Once you meet your deductible, you and the plan share the cost of covered expenses. This is called coinsurance. Both the deductible and your coinsurance go toward the out-of-pocket maximum. If you meet your out-of-pocket maximum, all eligible expenses will be 100% covered for the rest of the plan year.

Plan 46 - HSA Weekly Payroll Deductitions	
Employee Only	$59.50
Employee + Spouse	$155.00
Employee + Child(ren)	$132.50
Employee + Family	$182.25

*To be eligible for the employer contributions, you must have elected the HSA 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.

Coverage Level	2022 IRS HSA Maximum	Heartland RV's Contribution	2022 Employee Maximum HSA Contribution
Single Coverage	$3,650	$750	$2,900
Employee + One or More Dependents	$7,300	$1,500	$5,800

Providers

Please visit www.anthem.com to seek participating providers. Although most physicians in this area participate, it is recommended that you verify with your doctor that they participate in the Anthem Blue Card network every time you make an appointment.

Contributions to a HSA can be made by an employee, employer, or both. Employee contributions are voluntary and can be made pre-tax through payroll deduction. Employer contributions will be made by Heartland to qualified individuals from January through October in 10% increments at the end of each month.

DELUXE HSA PLAN

Coverage through Anthem / IngenioRx

ANTHEM
Phone: 866-350-7596
Website: *www.anthem.com*

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible - Single	$2,800	$5,600
Deductible - Family	$5,600	$11,200
Is Deductible Calendar Year or Policy Year?	Calendar Year	
Out of Pocket Maximum – Single (including deductible)	$5,000	$10,000
Out of Pocket Maximum – Family (including deductible)	$10,000	$20,000
Coinsurance	80%	60%
PRESCRIPTION DRUGS - RETAIL OR MAIL ORDER		
Tier 1 - Many Generics	Deductible & Coinsurance Apply	Not Covered
Tier 2 - Mostly Preferred Brand Name Drugs		
Tier 3 - Non-Preferred Brand & Generic Drugs		
Tier 4 – Specialty Drugs		
PHYSICIAN OFFICE VISITS		
Primary Care Physician	Deductible & Coinsurance Apply	
Specialist		
PREVENTIVE CARE		
Routine Adult Physical Exams	100% - Deductible Does Not Apply *Claims must be coded as routine and preventive by your physician*	Deductible & Coinsurance Apply
Well Woman Exams		
Routine Mammograms and Colonoscopy		
Well Child		
OUTPATIENT SERVICES		
Outpatient Surgical Care (Hospital Facility)	Deductible & Coinsurance Apply	Deductible & Coinsurance Apply
Emergency Room		
Urgent Care		
PLAN FEATURES - LIMITS PER CALENDAR YEAR (Combined Network & Non-Network Allowance)*		
Physical/Occupational Therapy	30 Visits*	30 Visits*
Spinal Manipulation/Chiropractic	25 Visits*	25 Visits*
Speech Therapy	20 Visits*	20 Visits*
Home Health Care	100 Days*	100 Days*
Skilled Nursing Facility	100 Days *	100 Days*
Maternity Care	Same as Any Other Expense	Same as Any Other Expense

STANDARD PPO PLAN

Standard PPO Plan Overview

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

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**

Other Plan Highlights

- Utilizes the Anthem Blue Card network to ensure savings when you use in-network providers and in-network pharmacies.
- Covers Preventive Care at 100% with no deductible
- Has an unlimited maximum benefit

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

Plan 45 - PPO WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$76.00
Employee + Spouse	$170.25
Employee + Child(ren)	$151.00
Employee + Family	$217.50

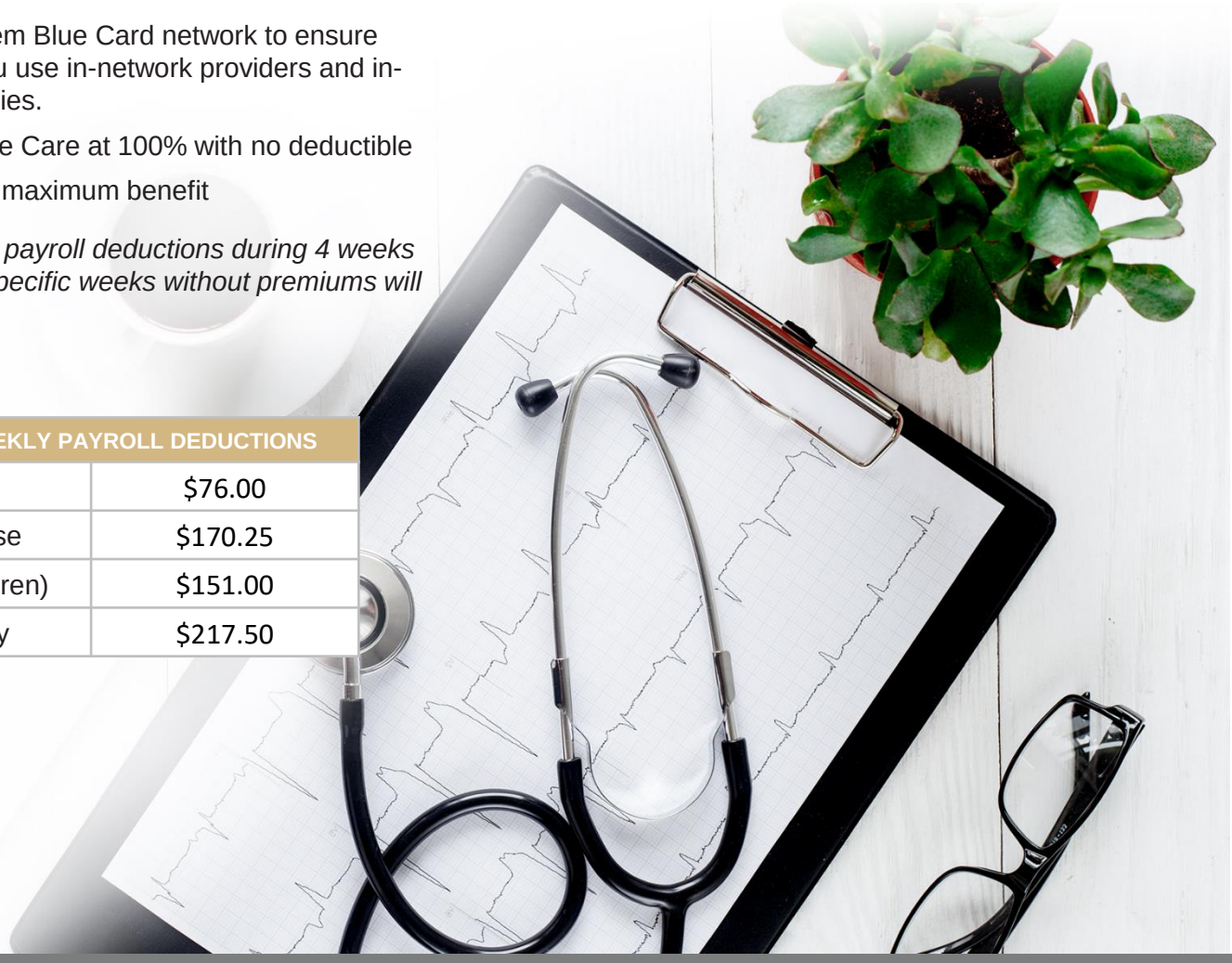
PPO Providers

Please visit www.anthem.com to seek participating providers. Although most physicians in this area participate, it is recommended that you verify with your doctor that they participate in the Anthem Blue Card network every time you make an appointment.

Anthem Website

Anthem's website, www.anthem.com, offers innovative tools to help you get the most out of your medical plan and manage your health:

- Check your claims & benefits
- Find a doctor
- Order an ID card
- Compare costs at medical facilities
- Research illnesses and treatments



STANDARD PPO PLAN

Coverage through Anthem / IngenioRx

ANTHEM
Phone: 866-350-7596
Website: *www.anthem.com*

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible - Single	$3,000	$6,000
Deductible - Family	$6,000	$12,000
Is Deductible Calendar Year or Policy Year?	Calendar Year	
Out of Pocket Maximum – Single (including deductible)	$6,000	$12,000
Out of Pocket Maximum – Family (including deductible)	$12,000	$24,000
Coinsurance	80%	60%
PRESCRIPTION DRUGS - RETAIL OR MAIL ORDER		
Tier 1 - Many Generics	$15	Not Covered
Tier 2 - Mostly Preferred Brand Name Drugs	$45	
Tier 3 - Non-Preferred Brand & Generic Drugs	$75	
Tier 4 – Specialty Drugs	$25% up to $200	
PHYSICIAN OFFICE VISITS		
Primary Care Physician	$40	Deductible & Coinsurance Apply
Specialist	$60	
PREVENTIVE CARE		
Routine Adult Physical Exams	100% - Deductible Does Not Apply *Claims must be coded as routine and preventive by your physician*	Deductible & Coinsurance Apply
Well Woman Exams		
Routine Mammograms and Colonoscopy		
Well Child		
OUTPATIENT SERVICES		
Outpatient Surgical Care (Hospital Facility)	Deductible & Coinsurance Apply	
Emergency Room	$250	$250
Urgent Care	$75	Deductible & Coinsurance Apply
PLAN FEATURES - LIMITS PER CALENDAR YEAR (Combined Network & Non-Network Allowance)*		
Physical/Occupational Therapy	30 Visits*	30 Visits*
Spinal Manipulation/Chiropractic	25 Visits*	25 Visits*
Speech Therapy	20 Visits*	20 Visits*
Home Health Care	100 Days*	100 Days*
Skilled Nursing Facility	100 Days *	100 Days*
Maternity Care	Same as Any Other Expense	Same as Any Other Expense

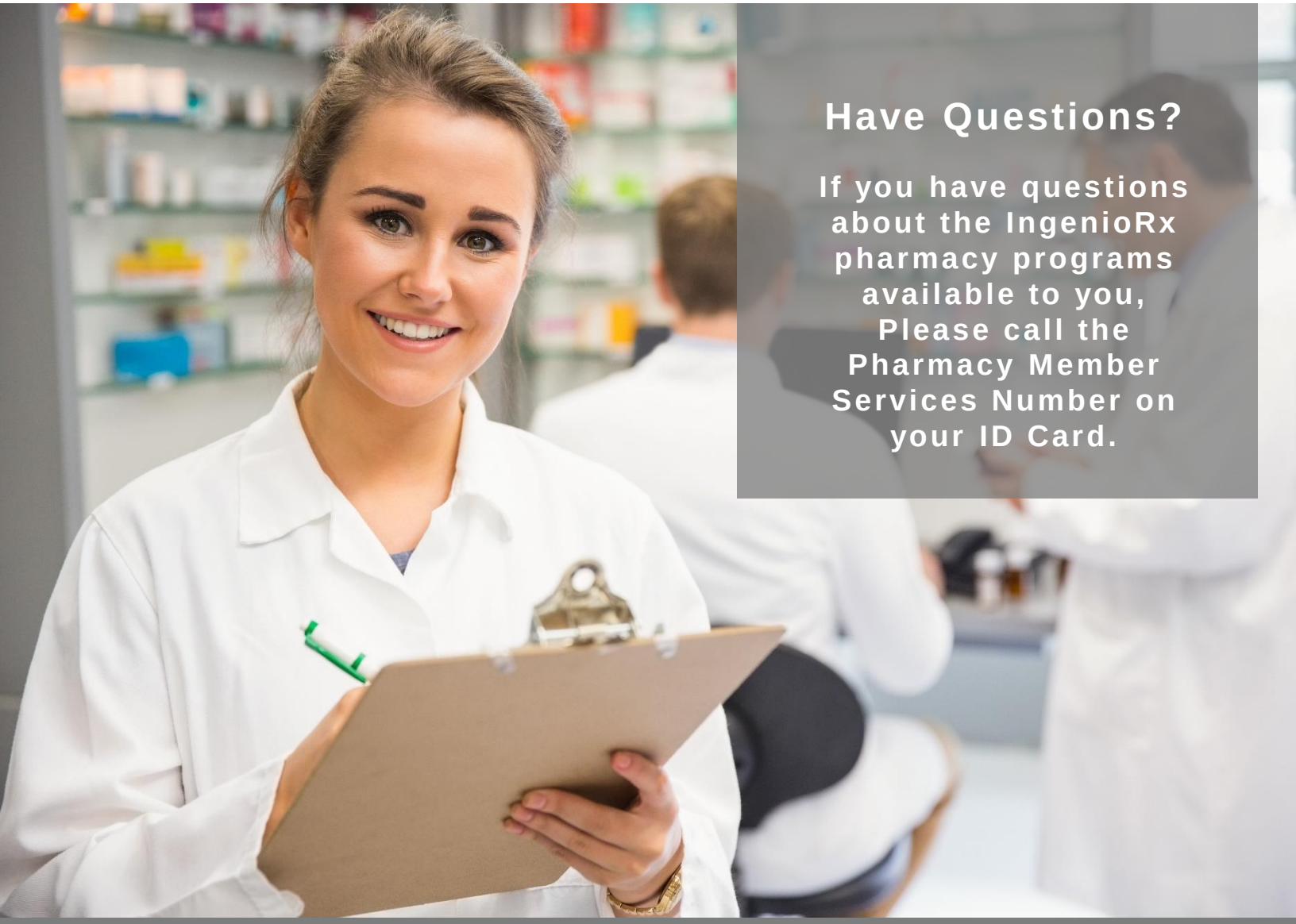
INGENIORX PHARMACY PROGRAMS

Retail 90 - 90 Day Prescriptions Available Through Retail Pharmacy

Through Retail90, you can choose to get a 90-day supply of any covered medication, instead of the usual 30 to 34 day supply from a participating local retail pharmacy. That includes prescriptions for maintenance medications, those taken on an ongoing basis for conditions like asthma, diabetes or high cholesterol.

Ninety-day prescriptions may help save you money and make it easier to keep on track with medication.

Do you prefer home delivery? - You don't have to use the Retail90 program, you can have prescriptions delivered to your door through the home delivery program. Home delivery is a safe, easy way to get medications when your employees need them. The home delivery program is offered at no extra cost.



Have Questions?

If you have questions about the IngenioRx pharmacy programs available to you, Please call the Pharmacy Member Services Number on your ID Card.

QUALIFIED MEDICAL EXPENSES FOR HSA ACCOUNTS

Qualified Medical Expenses

The Internal Revenue Service defines qualified medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

Under a rule that went into effect January 1, 2011, claims for over-the-counter medicine or drug expenses (other than insulin) cannot be reimbursed without a prescription. This rule does not apply to items for medical care that are not medicines or drugs.

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical examination
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment installed for a person with a disability
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Crutches
- Dental treatment
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction treatment
- Eye exam
- Eye glasses
- Eye surgery
- Fertility enhancement (in vitro fertilization or surgery)
- Guide dog or other service animal
- Health institute fees (if prescribed)
- Intellectually or developmentally disabled care, treatment or special home
- Laboratory fees
- Lactation expenses
- Lead-based paint removal (if a child in the home has lead poisoning)
- Learning disability care or treatment
- Legal fees associated with medical treatment
- Lifetime care, advance payments or “founder’s fee”
- Lodging at a hospital or similar institution
- Long-term care
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing home fees
- Nursing services
- Operations
- Osteopath
- Oxygen
- Physical examination
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychologist
- Special education
- Sterilization
- Stop-smoking programs
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Tuition for special education
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- Wig
- X-ray

Unfortunately, we cannot provide a definitive list of “qualified medical expenses” however the following list includes common qualified medical expenses. This list is subject to change in accordance with IRS regulations. To see a full list of current qualified medical expenses please visit: http://www.irs.gov/pub/irs-pdf/p502.pdf.

INELIGIBLE MEDICAL EXPENSES HSA ACCOUNTS

Ineligible Medical Expenses

The following list includes examples of products and services that are NOT eligible for reimbursement according to the IRS. Please note that this list is not all-inclusive, and is subject to change.

- Babysitting, childcare and nursing services for a normal, healthy baby
- Controlled substances or illegal drugs
- Cosmetic surgery
- Dancing lessons
- Diapers or diaper service
- Electrolysis or hair removal
- Funeral expenses
- Future medical care (except advance payments for lifetime care, or long- term care)
- Hair transplant
- Health coverage tax credit
- Household help
- Illegal operations or treatments
- Insurance premiums (with a few exceptions)
- Maternity clothes
- Medication from other countries
- Nonprescription drugs and medicine, except insulin (over-the-counter medicine is eligible for reimbursement with a prescription)
- Nutritional supplements, unless recommended by a physician
- Personal use items (e.g., toothbrush, toothpaste, dental floss)
- Swimming lessons
- Teeth whitening
- Veterinary fees
- Weight-loss program (unless for a specific disease diagnosed by a physician)

Unfortunately, we cannot provide a definitive list of “ineligible medical expenses” however the list includes common ineligible medical expenses. This list is subject to change in accordance with IRS regulations. To see a full list of current ineligible medical expenses please visit: http://www.irs.gov/pub/irs-pdf/p502.pdf.

KNOW YOUR OPTIONS

5 HEALTHCARE OPTIONS

to help you make the best decision for your medical needs

Virtual Visits $

24/7/365 access to a doctor through the convenience of phone or video consults.

Where you can receive care for:

Cough, Cold & Flu • Allergies • Skin Problems • Sinus Problems • Minor Fevers

Convenience Care Clinic $

Your condition is not urgent or an emergency. Conveniently located in Walgreen's, Walmart and Target

Where you can receive care for:

Cough, Cold & Flu • Pink Eye • Urinary Tract Infections
Ear Infections • Head Lice • Insect Bites
Minor Burns, Cuts, and Scrapes • Sprains and Strains

Doctor's Office $$

Routine care or treatment for a current health issue.

Where you can receive care for:

Routine Checkups • Immunizations • Preventive Services
Manage Medications • Receive a Referral to a Specialist

Urgent Care Center $$$

You need medical care fast for a non-emergent medical issue.

Where you can receive care for:

Migraines • Severe Back Pain • Vomiting and Diarrhea
Minor Broken Bones • Asthma Attacks • Severe Cough
Animal Bites • Wounds Requiring Stitches

Emergency Room $$$$

For a true medical emergency that results in serious jeopardy to your health, impairment of bodily functions or organs

Where you can receive care for:

Head Trauma or Loss of Consciousness • Chest Pain
Numbness or Difficulty Speaking • Severe Abdominal Pain
Coughing or Vomiting Blood • Severe Bleeding and Burns

Sign up for LiveHealth Online

Sign up today — so you're ready for a video visit when you need it

Using LiveHealth Online, you can have a private and secure video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer with a webcam. It's an easy way to get the care you need at home or on the go.

When your own doctor isn't available, use LiveHealth Online 24/7 if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or other common health condition. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if it's needed.[1]

If you're feeling anxious or having trouble coping on your own and need some support, you can have a video visit with a therapist using LiveHealth Online. Make an appointment in four days or less at **livehealthonline.com** or on the phone at **1-888-548-3432** from 7 a.m. to 7 p.m., seven days a week.[2] Evening and weekend appointments are available. You can get help for anxiety, depression, grief, panic attacks and more.

How to get started

Rather than waiting to sign up when you're not feeling well, register today so you're ready for a visit when you need one. To sign up, visit **livehealthonline.com** or download the free LiveHealth Online app to your mobile device. 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.

Anthem. LiveHealth ONLINE

SurgeryPlus™

Quality Care Surgeons of Excellence

With the SurgeryPlus™ benefit, you'll have access to our network of quality surgeons who have all met our rigorous screening standards.

All of our surgeons meet our standards for:

Board Certification	Speciality Training Requirements	Procedure Volume Requirements	Sanctions and Malpractice Review	Ongoing Recredentialing
✓	✓	✓	✓	✓

Financial Incentives

Waived deductible and/or coinsurance

Because Heartland cares about the quality of your care, your deductible and/or coinsurance could be waived.

Commonly Covered Procedure Categories Include:

- Cardiac
- Pain Management
- Orthopedic
- Bariatric
- ENT
- Gastroenterology
- Spine
- General Surgery

Call: 833.907.2005

Email: Thor@SurgeryPlus.com

Great Experience

Commonly Covered Procedure Categories Include:

After your first call in, your dedicated Care Advocate takes care of the rest, including:

1. Providing you with a selection of surgeons best suited for your specific needs
2. Scheduling your consultations, operative and post-operative appointments
3. Arranging for the transfer of your medical records to your surgeon
4. Coordinating any travel (if required) for the procedure
5. Following up with you after your surgery

DENTAL INSURANCE

Delta Dental

DELTA DENTAL

Phone: 800-524-0149

Website: *www.deltadentalin.com*

Dental Option 1 - Low Plan
The Low Plan provides $1,000 per person per calendar year on Diagnostic, Preventive, and Basic services. It does not cover Major services such as Periodontics, Major Restorative, and Orthodontic services.

Dental Option 2 - High Plan
The High Plan provides $1,250 per person per calendar year on Diagnostic, Preventive, Basic, and Major services. In addition, the High Plan offers Orthodontic services to dependents up to age 26 at a lifetime maximum of $1,000.

DENTAL PLAN OPTIONS	DENTAL OPTION 1 - LOW PLAN	DENTAL OPTION 2 - HIGH PLAN
	In-Network Benefits	In-Network Benefits
Annual Deductible	None	None
Annual Maximum Benefit	$1,000	$1,250
Preventive Services	100%	100%
Basic Services	50%	50%
Major Services	Not Covered	50%
Orthodontia	Not Covered	50%
Orthodontia Lifetime Maximum	N/A	$1,000
Network of Providers	Delta Dental PPO & Premier	Delta Dental PPO & Premier
Dependent Child Age Limit	To Age 26	To Age 26 26 for Orthodontia
Out of Network Benefits	When you receive services from a Nonparticipating Dentist, you may be responsible for fees in excess of Delta Dental's allowable amount.	
EMPLOYEES WEEKLY PAYROLL DEDUCTIONS: There are no payroll deductions during 4 weeks of shutdown	Low Plan	High Plan
Employee Only	$3.37	$5.93
Employee + Spouse	$6.88	$11.44
Employee + Child(ren)	$11.87	$17.48
Employee + Family	$15.24	$23.14

VISION INSURANCE

VSP

VSP
Phone: 800-877-7195
Website: *www.vsp.com*

The vision plan is offered through VSP. This plan offers one eye examination per year, new lenses or contact lenses each year, and frames every two years.

You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, the plan is designed to be easy to use and to save you money.

VISION PLAN	IN-NETWORK	OUT-OF-NETWORK
Exam (Once every 12 months)	$10 Copay	$45 Allowance
Frame (Once every 24 months)	$140 Allowance	$55 Allowance
Single Vision Lenses	$0 After Copay	$30 Allowance
Bifocal Lenses	$0 After Copay	$50 Allowance
Trifocal Lenses	$0 After Copay	$60 Allowance
Retinal Imaging	$39 Max (No Copay)	Applied to Allowance For Eye Exam
Standard Contact Lens Fitting	$60 Maximum Copay	Applied to The Allowance for Contact Lenses
Disposable Contacts - Elective (Once every 12 months)	$120 Allowance	$100 Allowance

EMPLOYEES WEEKLY PAYROLL DEDUCTIONS There are no payroll deductions during 4 weeks of shutdown	
Employee Only	$1.26
Employee + Spouse	$2.53
Employee + Child(ren)	$2.71
Employee + Family	$4.33

BASIC TERM LIFE AND AD&D INSURANCE

MetLife - 100% Employer Paid

Heartland RV provides each eligible full-time active employee with $20,000 in term life and accidental death and dismemberment insurance at no cost to you. This coverage is administered through MetLife. Keep in mind that there is no cash value in this benefit. Benefits will only be paid to your beneficiaries in the event of your death.

VOLUNTARY TERM LIFE INSURANCE

MetLife

Below is a summary of the voluntary life benefits that are available to all full-time employees.

Please note that while you can enroll during the annual open enrollment period, if you are not a new hire in your initial enrollment period, you will have to complete a medical questionnaire and possibly a physical exam to be approved for voluntary life coverage.

Because rates are based on your age, the cost of your insurance may change each calendar year.

General Plan Information	Schedule of Benefits
Voluntary Life Benefit Amount	
Employee	$10,000 Increments Maximum Lesser of 5x Salary or 300,000
Spouse	$5,000 Increments Maximum Lesser of 50% of EE Election or $150,000
Dependent Child(ren)	$10,000 No EOI required
Guarantee Issue Amount*	
Employee	$200,000
Spouse	$25,000
Child(ren)	$10,000 each of Your Children

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

There is no guarantee you will be approved for benefits.

SHORT TERM DISABILITY INSURANCE

MetLife

BENEFIT SUMMARY	
Elimination Period	Benefits Begin: 15 days after non-work related illness or injury
Weekly Benefit	Up to 60% of weekly salary up to maximum amount
Maximum Benefit Period	24 weeks

Premium is based on age and estimated gross annual income.

Claims for Short Term Disability benefits should be submitted through the Human Resource Department. Claims are reviewed by MetLife.

LONG TERM DISABILITY INSURANCE

BENEFIT SUMMARY	
Elimination Period	Benefits Begin: 180 days after non-work related illness or injury
Weekly Benefit	Up to 60% of monthly pre-disability earnings up to maximum amount
Maximum Benefit Period	Up to age 65

Premium is based on age and estimated gross annual income. Claims are reviewed by MetLife.

UNIVERSAL LIFE / LIFE EVENTS

Trustmark

Trustmark Universal Life/LifeEvents® is permanent life insurance. It provides a death benefit to your beneficiaries if you pass away, but also builds cash value and features living benefits for long-term care services. Your price won't increase due to age, and your policy builds cash value over time. You may choose between the Universal Life and Universal LifeEvents plans.

The standard Universal Life plan features a consistent level of death and living benefits throughout life. The LifeEvents® option gives you a higher death benefit during your working years for the same price, and a higher long-term care benefit that never reduces. The LifeEvents death benefit reduces one-third at the latter of age 70 or the 15th policy anniversary; issue age for LifeEvents is 18-65.

FEATURES YOU'LL APPRECIATE:

- **Lifelong protection** – Provides coverage that will last your lifetime.
- **Fully portable** – Keep your coverage at the same rate and benefits if you change jobs or retire.
- **Family coverage** – Apply for your spouse and family. Dependent children and grandchildren can be covered under a Universal Life policy.
- **Terminal Illness Benefit** – Accelerates up to 75 percent of your death benefit if your doctor determines your life expectancy is 24 months or less.
- **Guaranteed Renewable** – Guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all policies in your class changes.
- **Children's Term Life** – Covers newborns to age 22 and is convertible to Universal Life insurance without evidence of insurability (separately priced).

VOLUNTARY SUPPLEMENTAL BENEFITS

AFLAC

Heartland RV is making it easy for you to increase your supplemental insurance coverage with Accident and Critical Illness through AFLAC.

BENEFIT SUMMARY	
Accident Insurance 	**Accident Insurance** provides a lump sum payment based on the accident or injuries sustained; it's paid directly to you, and you decide the best way to spend it. It's that simple. Whether it's to pay medical expenses, the mortgage, car payments or even utility bills, you decide. Other advantages of accident insurance are: • Cash benefits for expenses that may not be covered under your medical insurance • Employees can keep coverage even if they leave their current employer • There are no health questions to answer • You can cover your spouse and children • There is no limit to the amount of accidents you can claim under the policy (with the exception to policy rules) **Why do I need accident insurance?** Ride bikes or drive a car? Jog or play sports? Accidents can happen when you least expect it. Are you prepared financially to pay the expenses that can occur as a result? What about day to day activities that can lead to accidental injuries: cooking, walking down the stairs, or driving to work? Accident insurance is a way to ensure you can stay ahead of the out-of-pocket expenses associated with medical treatments. Your medical plan's copays, coinsurance, and deductibles add up so quickly after a sudden or unexpected injury. While you can't predict when an accident will happen, you can be prepared financially.
Critical Illness Insurance 	**Critical Illness** coverage provides a way for you to stay ahead of the medical and out-of-pocket expenses that can accompany certain covered medical events. Consider the following advantages of this critical illness coverage offering: • A set amount of money is paid directly to you to be used however you choose • You can keep the policy even if you leave Heartland RV or retire, as long as you pay the premium • Order an ID card • Convenience of payroll deduction • You can insure your spouse and children **Why do you need critical illness coverage?** Most medical plans provide coverage for hospital and medical expenses associated with critical illnesses such as stroke, heart attack, kidney failure, major organ transplant, coma, and paralysis. Even so, there are many uncovered expenses that can be financially devastating. With critical illness coverage, you can be prepared financially for costs like: • Copays, deductibles, and coinsurance • Possible transportation and lodging needs • Childcare and other domestic help expenses • Possible loss of income

401K RETIREMENT PLAN

Eligibility

- Must be 18 years of age
- Complete three months of service

When can I enroll?

- First day of each month. Contact your Human Resources Department for enrollment details

How much can I contribute?

- 1% to 80% of eligible compensation

Easy today.
Get started in 60 seconds with **EasyEnroll.**

Smart going forward.
Choose a savings approach that suits you today—and adjust it any time to fit your changing needs.

*** You can also enroll by visiting www.401K.com or by calling 1-800-835-5097**

Heartland RV will match 25% per dollar of your weekly deferrals up to an annual max of $600.

- You must be enrolled with Fidelity in order to receive the match.
- Roth 401K plan excluded from the match

Enroll now:
NetBenefits.com/Easy

Get a reminder to enroll later*: Text START to 343898

Fidelity INVESTMENTS

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.

EMPLOYEE ASSISTANCE PROGRAM

MetLife

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward. We can help you and your family to get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.

The program's experienced counselors provided through LifeWorks; one of the nation's premier providers of Employee Assistance Program services can talk to you about anything going on in your life, including: Family, work, money, health, legal services, and everyday life.

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. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.
When you call, just select "Employee Assistance Program" when prompted. You'll immediately be connected to a counselor. If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app.

When you need some support, we're here to help.

Phone
1-888-319-7819

Web
metlifeeap.lifeworks.com
user name: metlifeeap
and password: eap

Mobile App
user name: metlifeeap
and password: eap

Your EAP may be used to address a broad range of issues including:

- Marriage, Relationship and Family Problems
- Problems at Work
- Legal and Financial Issues
- Stress and Anxiety
- Alcohol and Drug Dependency
- Identity Theft
- Health and Wellness Concerns

MetLife

GRACE AGENCY – MEDICARE COUNSELORS

Heartland RV has partnered with the Grace Agency to help our team members and loved ones who may have questions about Medicare.

Medicare is confusing, and we want to make sure that we assist with understanding the options available to ensure you, a family member or friend make the best decisions possible.

Most Americans become eligible for Medicare at age 65. Sadly, they don't have a true understanding of what that means for them or what to do about it. Those who are still working and already passed age 65 typically just keep their work insurance without consulting with a Licensed Medicare expert for counsel.

The associates of Grace Agency are experts in Medicare insurance option and also understand the specifics of our current Group Insurance plan. Many Medicare plans have low or in some cases no premiums or deductibles and also come with Dental, Vision and other extras like Gym Memberships.

If you would like to contact them to evaluate your specific situation or to help a loved one, please call them at 800-791-4840. You can also email them at info@graceagency.org.

Our Services

Plan Selection Consulting
We want you to find the Medicare insurance plan that perfectly suits your nees, which is why we offer comprehensive consulting services at no charge to Help you make an informed decisión. This starts with helping you understand how and when to apply for Medicare and other government programs you may qualify for. Then, we help you find a plan that Works with your doctors, covers your medications and best fits your Budget.

Customer Service
Once we have helped you with the process of selecting a plan, we want to make sure that you completely understand how to use benefits of the plan you have selected. We want you to be fully satisfied with the products we present and the service we offer. That's why we not only provide profesional advice before you make a decision, but we are also there to Help you afterwards. We provide reliable support when you have questions about how to use your benefits, so you won't have to rely on an automated system for help.

Our Commitment

Quality
Everything we do centers on providing services of the highest level of quality. We want you to be 100% satisfied.

Efficiency
We pride ourselves on our efficient procedures and solutions and we continually strive for improvement in order to deliver results more effectively.

GLOSSARY

Commonly Used Terms

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have

a PPO plan, there is usually a separate higher deductible for using out of network providers.

EVIDENCE OF INSURABILITY (EOI):

This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Used

for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out- of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of- network, but will pay higher out-of-pocket costs.

PARTICIPATING PROVIDER: Individual

physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN):

A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

CONTACT INFORMATION

	Web Address	Phone Number
Medical		
Anthem Blue Cross Blue Shield	www.anthem.com	866-350-7596
24/7 Nurse Help Line	www.anthem.com	888-596-9473
Mental Health/Substance Abuse (Pre-Certification)	www.anthem.com	866-776-4793
LiveHealth Online Medical: Visit a Doctor 24/7	Livehealthonline.com	888-548-3432
Prescription Drug		
IngenioRx	www.anthem.com	833-284-7515
Prior Authorization	www.anthem.com	833-293-0659
Home Delivery Pharmacy	www.anthem.com	833-203-1742
Specialty Pharmacy	www.anthem.com	833-255-0645
Dental		
Delta Dental	www.deltadentalin.com	800-524-0149
Vision		
VSP	www.vsp.com	800-877-7195
Voluntary Life, Spouse/Child Life, Voluntary AD&D, & LTD		
MetLife	www.metlife.com	800-243-8786
Accident & Critical Illness		
AFLAC	www.aflacgroupinsurance.com	800-433-3036
Universal Life		
Trustmark	www.trustmarksolutions.com	877-201-9373
401K		
Fidelity	www.401k.com	800-835-5097
Medicare Counselors		
Grace Agency	info@graceagency.org	800-791-4840
Employee Assistance Program (EAP)		
LifeWorks	Metlifeeap.lifeworks.com	888-319-7819
Human Resources		
Benefits Department	human.resources@heartlandrvs.com	574-266-8726

MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your Legal Counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

IF you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 27-28 for more details.

IMPORTANT NOTICE: MEDICARE D CREDITABLE COVERAGE DISCLOSURE

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 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 has determined that the prescription drug coverage offered by the Anthem 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 group plan coverage as an employee, or dependent or spouse of an active employee

Group plans with < 20 lives will not be affected. There is coordination of benefits and Medicare will be your primary coverage and the group plan will become your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

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 under the group plan 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.

MANDATORY NOTICES

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

Contact your Human Resources 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 the group plan coverage changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- 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).

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Human Resources.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RIGHTS

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

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

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

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

MANDATORY NOTICES

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

MANDATORY NOTICES

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

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

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit: www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Plan and COBRA continuation coverage can be obtained on request:
Human Resources Benefits Department
Human.resources@heartlandrvs.com

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

STATE CONTINUATION OF COVERAGE

Due to size, your group plan does not fall under Federal COBRA guidelines. However, you may have a state continuation option available to you. Contact your insurance carrier or Human Resources for more information. Additional information can be found on your state's department of insurance website.

WELLNESS PLAN NOTICE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. We will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Contact Human Resources for more information.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

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

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

MANDATORY NOTICES

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

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 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

PATIENT PROTECTION NOTICE

The Anthem plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Anthem may designate one for you. For information on how to select a primary care provider, contact the plan administrator.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider: You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

MANDATORY NOTICES

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: http://myalhipp.com/ | Phone: 1-855-692-5447

ALASKA – Medicaid

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

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
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+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurancebuy-program
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

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

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

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.maine.gov/dhhs/ofi/applications-forms
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:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programsand-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

MANDATORY NOTICES

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (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/oii/hipp.htm 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
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
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: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

MANDATORY NOTICES

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.
OMB Control Number 1210-0123 (expires 1/31/2023)

NOTICE REGARDING CHANGES TO THE THOR INDUSTRIES, INC. WELFARE BENEFIT PLAN

In an effort to lower premiums, Michigan recently enacted significant changes to no-fault motor vehicle insurance.

Michigan Law will allow residents who are also health plan members to maintain unlimited coverage or select from Personal Injury Protection (PIP) coverage tiers of $250,000 or $500,000.

As a Michigan resident you will also have an option to opt out of medical, no-fault coverage entirely if you have 'qualified health coverage', which is a health plan that (1) has an annual deductible of $6,000 or less per individual and (2) does not exclude coverage for auto accident injuries

You should understand that regardless of medical coverage coordination, health plans do not cover certain items that PIP would cover, including but not limited to, attendant care, lost wages, survivor benefits, and vehicle or housing modifications. In addition, PIP benefits last indefinitely whereas health plan coverage may be finite and may end because of changes in eligibility, termination, or other unanticipated circumstances.

In response to the changes, the Thor Industries, Inc. Welfare Benefit Plan ("Plan") will become "secondary" to your Personal Injury Protection (PIP) under your no-fault insurance. In general terms, the changes mean that if you (or a covered dependent) are a Michigan resident and become injured in a motor vehicle accident:

1. The Plan will not pay the first $250,000.00 of medical expenses.
2. You will want to have at least $250,000.00 in PIP coverage under your Michigan no-fault policy. (Under the prior Michigan law, you were required to have unlimited PIP coverage).
3. For expenses above $250,000.00, the Plan will consider any remaining charges that are not paid by your PIP coverage and pay secondary with a coordination of benefits.

The Plan document will be amended to provide for these new requirements. While most Michigan drivers will be required to have at least $250,000.00 in PIP coverage that becomes effective on or after July 1, 2020, some may qualify for $50,000.00 or opt-out options.

You will want to think very carefully before electing PIP coverage below $250,000.00 under your motor vehicle insurance – and may even want to consider electing PIP coverage greater than $250,000.00.

For more information about changes to Michigan no-fault motor vehicle insurance, consult with your auto insurance provider or contact the Plan Administrator, Thor Industries, Inc., at (574) 970-7460.

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