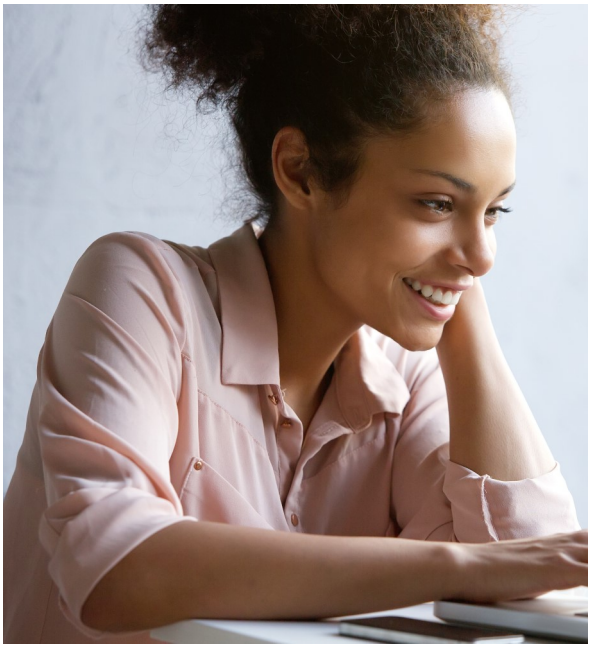
GPS SOLUTIONS

2023



Employee Benefits Guide

Table of Contents

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Benefits Overview

GPS Solutions is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours per week beginning the first of the month after initial hire date. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each plan.

Single, double (2-Person) and family premiums are set to offer equally distributed cost sharing per plan option for all employees. In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

A payroll deduction statement is required for all eligible employees, whether electing or declining coverage.
These should be

- emailed to: hr@gpssolutions.us
- **Must be received by: December 5, 2022**

Benefits Offered

- **Medical: BCBSM & BCN**
- **Voluntary Dental: Delta Dental (New Carrier)**
- **Voluntary Vision: Delta Dental (New Carrier)**
- **Employer Paid Life Insurance & AD&D: UNUM (New Carrier)**
- **Voluntary Life and AD&D: UNUM (New Carrier)**
- **Voluntary Short Term Disability: UNUM (New Carrier)**
- **Employer Paid Long Term Disability: UNUM (New Carrier)**

Qualifying events:

- ◊ Marriage
- ◊ Divorce, or legal separation
- ◊ Birth or adoption of a child, change in a child's dependent status
- ◊ Death of a spouse, child or other qualified dependent
- ◊ Change in residence due to an employment transfer for you
- ◊ Change in spouse benefits or employment status

Eligibility

You and your dependents are eligible for GPS Solutions benefits on the first of the month following initial hire date.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or GPS Solutions eligible dependents.

The coverage you elect will be effective January 1, 2023 through December 31, 2023. Under federal tax regulations, you may change your benefit elections ONLY when you have a qualified family status change and you must notify HR within 30 days of the event. Samples of qualified events are listed below. If you do not notify HR within 30 days of status change, you will not be able to make changes until the next open enrollment period.

It is your responsibility to notify HR within 30 days if you have a dependent who is no longer eligible under the terms of the plan (for example, a child's coverage is lost due to them reaching the end of the calendar month in which they turn age 26 and no longer meets the definition of a dependent, or you become divorced). Those dependents may have the continuation rights for medical, dental and vision coverage under the federal law known as COBRA.

How To Enroll

All benefit offerings will be effective January 1, 2023 through December 31, 2023. This year is an active enrollment and you must make new elections for all benefits. The new benefit offerings from UNUM, must be elected. Current policies with MetLife will terminate as of 12/31/2022. If you do not elect UNUM products for 1/1/2023, you will not have Voluntary Short Term Disability or Voluntary Life and/or Voluntary AD&D. Deductibles reset January 1st. You must act during the open enrollment window and make new 2023 elections, or you and your dependents will not have coverage!

NEXT STEPS

1. Review medical, dental and vision benefits and rates. Make your elections accordingly on the payroll deduction form. Even if you are waiving coverage, you must indicate as such.

2. If you are making changes, I.E., moving from one medical plan to another, you must also complete the BCN ECOS "Change form" in addition to the Payroll deduction form.

3. If you have elected the BCN/HMO/HSA plan, you **must** elect a new amount for the HSA account for the new calendar year. Place election amount on the payroll deduction form.

4. UNUM voluntary products are **NEW** for 2023. *You must make an election if you wish to continue these benefits*. The current MetLife polices will terminate 12/31/2022. You must enroll in new benefits on the payroll deduction form.

November

21

Open Enrollment window opens

December

5

Open Enrollment closes

January

01

Benefit elections effective

Medical Benefits

Blue Cross Blue Shield of Michigan and Blue Care Network

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

GPS Solutions is offering you a choice of three (3) medical plans.

BCBSM PPO, BCN HMO Gold and BCN HMO with HSA account.

With the Blue Cross Blue Shield, PPO, you may select where you receive your medical services. If you use in-network providers, your costs will be less. Blue Care Network, both HMO plans are in-network only and you must designate a primary care physician; referrals required for specialist visits.

New ID cards will be mailed directly to your home.

Please see Benefit at a Glance and/or SBC for full benefit details.

	BCBSM SB PPO $1,000		BCN / HMO GOLD $1,000	BCN / HMO / QHDHP with HSA
	In-Network	**Out-of-Network**	**In-Network Only**	**In-Network**
Annual Deductible	$1,000 Single / $2,000 Family	$2,000 Single / $4,000 Family	$1,000 Single / $2,000 Family	$1,500 Single / $3,000 Family
Annual Co-insurance Maximum (Excludes deductible)	$5,000 Single / $10,000 Family	$10,000 Single / $20,000 Family	$3,500 Single / $7,000 Family	N/A
Coinsurance	20% After Deduct	40% After Deduct	20% After Deduct	20% After Deduct
True Out of Pocket Max: (includes Deductible, Coinsurance and Copayments)	$8,150 Single / $16,300 Family	$16,300 Single / $32,600 Family	$8,150 Single / $16,300 Family	$4,000 Single / $8,000 Family
Doctor's Office (Deductible Waived)*				
Primary Care Office Visit	$30 Copay *	40% after OON Deductible	$20 Copay*	20% After Deductible
Urgent Care	$60 Copay*	40% after OON Deductible	$50 Copay *	20% After Deductible
Specialist	$50 Copay *	40% after OON Deductible	$40 Copay*	20% After Deductible
Chiropractic & Osteopathic manipulative therapy	$30 Copay *	40% after OON Deductible	$40 Copay*	20% After Deductible
Preventative Care: (routine exams, colonoscopy, immunizations, well baby care and mammograms)	100% Covered 1 per member per calendar; except well baby/child care	Not Covered	100% Covered 1 per member, per calendar; except well baby/child care.	100% Covered 1 per member, per calendar; except well baby/child care.
Prescription Drugs (Deductible Waived*)				
Retail—Generic Drug (30-day supply)	$20 Copay*	You pay $20 Copay Plus 25% of approved amount	$15 Copay Tier 1A* / $40 Copay Tier 1B*	Tier 1A $10 Copay / Tier 1B $30 Copay Both After Deductible
Retail—Preferred Drug (30-day supply)	$60 Copay *	You pay $60 Copay Plus 25% of approved amount	$80 Copay*	$60 Copay, After Deductible
Retail—Non-Preferred Drug (30-day supply)	$100 Copay*	You pay $100 Copay Plus 25% of approved amount	$100 Copay*	$80 Copay, After Deductible
Specialty Tier 4	20% of approved amount; Max $200	See benefit Summary	20% of approved, but no more than $200	20% of approved amount, but no more than $200, After Deductible
Specialty Tier 5	25% of approved amount; Max $300	See benefit Summary	20% of approved amount, but no more than $300	20% of approved amount, but no more than $300, After Deductible
Hospital Services				
Emergency Room	$250 Copay (Waived if Admitted)	$250 Copay (Waived if Admitted)	$250 Copay, after deductible, Copay Waived if admitted	20% Copay After Deductible

Pediatric Dental coverage with Medical

Included with the BCBSM & BCN medical plans, all covered minor dependents have pediatric dental coverage, which is required under ACA regulations. This is limited coverage and you may consider purchasing additional dental coverage for your minor dependents through Delta Dental for dual coverage. While dual coverage is not required, the Pediatric Dental coverage is limited services under the medical plan.

Note: Pediatric members are members who are 18 years of age or younger and enrolled under one of the offered medical plans. They will receive pediatric dental benefits through the end of the year in which they turn age 19. This does not cover adults over the age of 19.

Pediatric dental does not have orthodontia coverage. See the full benefit summary for full details.

Member's Responsibility (Deductible, Coinsurance and Dollar Maximums)	
Benefits	**Coverage**
Deductible: **Applies to Class II & Class II only**	$25 Per Member $50 For Two Members $75 Per Family per calendar year
Coinsurance: Approved amount **Class I Services** **Class II & III Services**	 20% 50%
Out-of-pocket Max:	$350 for one pediatric member or $700 for two or more pediatric members per calendar year **Note:** This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).
Network information: **Www.mibluedentist.com or call** **1-888-826-8152**	◊ Blue Dental PPO Network: In-network dentists / save more by visiting a PPO dentist ◊ Blue Par Select: Non-PPO (out of network)/they accept approved amount as full payment for covered services—members pay only applicable coinsurance and deductibles

Pediatric Vision coverage with Medical

Included with the BCBSM & BCN medical plans, all covered minor dependents have pediatric vision coverage, which is required under ACA regulations. This is limited coverage and you may consider purchasing additional vision coverage for your minor dependents through Delta Dental for dual coverage. While dual coverage is not required, the pediatric vision coverage is limited services under the medical plan.

Note: Pediatric members are members who are 18 years of age or younger and enrolled under one of the offered medical plans. They will receive pediatric vision benefits through the end of the year in which they turn age 19. This does not cover adults over the age of 19.

Member may choose between prescription glasses (lenses and frame) OR contact lenses, but not both. **See the full benefit summary for full details.**
Network: VSP. To find a provider, call 1-800-877-7195 or www.vsp.com

Member's Responsibility (Copays)		
Benefits	**In-Network**	**Out-of-Network**
Eye Exam, Prescription glasses (lenses and/or frames), Medically Necessary contact lenses	$0 Copay	$0 Copay
Eye Exam (One Eye exam per calendar year)		
By an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall health of the patient	100% of approved amount	Reimburses up to $34
Lenses & Frames (One pair of lenses, with or without frames per calendar year / One fram per calendar year)		
Standard Lenses (not to exceed 60 mm in diameter)	100% of approved amount	Reimbursed up to approved amount based on lens type
Standard frames from a "select" collection	100% of approved amount	Reimburses up to $38.25
Contact Lenses (Covered—Annual Supply)		
Medically necessary contact lenses (require PA from VSP & must meet criteria)	100% of approved amount	Reimburses up to $210
Standard: One Pair Annually Monthly: (Six month supply) Bi-Weekly: (Three month supply) Dailies: (Three-month supply)	100% of approved amount Covered According to quantities	$100 allowance applied towards contact lens exam and the contact lenses outlined in your certificate, per calendar yr.

How the HMO Plan Works

SELECTING A PRIMARY CARE PHYSICIAN:

If you don't select a primary care physician within the first 90 days of your plan, one will be selected for

WITH A BLUE CARE NETWORK PLAN, YOU'RE REQUIRED TO SELECT A PRIMARY CARE PHYSICIAN.

You want the best care. And with Michigan's largest HMO network of health care providers, we give you plenty of choices — as well as the capabilities to help you make informed decisions when selecting your primary care physician.

The primary care physician you select will coordinate your care, including wellness visits, routine screenings and nonemergency illnesses such as earaches and sore throats. He or she will also be the person who will arrange your care, including lab tests, specialty and hospital visits.

Your member account at bcbsm.com will let you easily:

- Compare doctors and facilities within your plan's network.
- Select your primary care physician.
- Evaluate quality reports.
- Check office hours, locations, specialties, the types of languages spoken and hospital affiliations.

YOUR BLUE CROSS MEMBER ACCOUNT WILL MAKE YOUR DOCTOR SELECTION EASY

- **Once you're enrolled and receive your ID card, you'll be able to register for your Blue Cross member account at bcbsm.com/register. Or, text REGISTER to 222764.***
- **Use your account to easily select or change your primary care physician.**
- **You'll also be able to select your doctor using the Blue Cross mobile app.**
- **It's available by searching BCBSM on the App Store® and Google Play™ or, text APP to 222764 to get the download link.***

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How the HMO Plan Works

Whether you're switching from a PPO plan or have been a Blue Care Network member for years, it's important to know how your HMO plan works so you can better manage your health care.

As an HMO, Blue Care Network contracts with physicians, hospitals and other medical professionals to provide a variety of health care services. Your coverage starts with preventive services that can keep minor problems from turning serious and includes special programs to help you reach your health and wellness goals. Coverage also includes the benefits you need when you're sick or injured, ranging from office visits and lab tests to hospitalization.

IT ALL STARTS WITH YOUR DOCTOR

As an HMO member, you're required to select a primary care physician who will be your partner in health care.

Sometimes, you'll need a routine checkup or an immunization. Other times, you might need treatment when you're sick. And, in some cases, you might have a more serious injury or illness and need to see a specialist.

No matter what your need, your starting point is your primary care physician. He or she is responsible for managing all the care you receive, from providing preventive health services to treating your illness to coordinating your care with specialists.

There are a few exceptions to the rule:

- Women can see any obstetrician/gynecologist, or OB-GYN, in their plan's network for routine services such as Pap tests, annual well-woman visits and obstetrical care without a referral from their primary care physician.
- If you have an accidental injury or medical emergency, we'll cover treatment no matter where you go.

KNOW YOUR PLAN'S NETWORK

Most BCN plans are built around a network, a group of providers (doctors, hospitals and other types of health care providers) that's contracted with us to provide health care services. Knowing your plan's network and how it works is important.

We have different HMO networks throughout the state. Some are broad and include doctors and hospitals in almost every county in Michigan. Others are small and based in a certain geographic area.

Most HMO plans don't cover care outside the network, except in an emergency, unless you're in one of the few

plans that allows members to pay more to see doctors outside the network.

Whichever plan you have, you need to make sure the doctor you've selected is part of your plan's network.

How the HMO Plan Works

SELECTING DOCTORS

You can select one primary care physician for everyone in your family, or you can select a different doctor for each person. For example, you may want the young child in your family cared for by a pediatrician, while other family members go to an internist.

We make it easy for you to find a primary care physician who's in your plan's network. Once you're enrolled in a BCN plan, log in to your account at **bcbsm.com** to find or change your primary care physician.

WHAT ARE REFERRALS AND AUTHORIZATIONS?

With most HMO plans, your primary care physician is providing or managing all your care.

However, you may also need special approval from us for certain services and to see specialists. If the service requires a referral and your primary care physician or OB-GYN doesn't refer you, you're responsible for the charges. Unless you receive special approval from BCN or you have a plan that allows you to pay more when you see a doctor outside your plan's network, visits to specialists who aren't part of your plan's network aren't covered.

EXAMPLE:

MEMBER

You get a skin rash and go to your primary care physician.

REFERAL FROM PCP

Your doctor can't treat it and sends you to a dermatologist in your network.

SPECIALIST

Your doctor gives you a referral to give the specialist, or sends it to the specialist electronically.

The referral process helps your primary care physician track the care you receive from other health care providers.

AT YOUR SERVICE

Our knowledgeable Customer Service representatives are available by phone from 8 a.m. to 5:30 p.m. Monday through Friday. You'll find the number on the back of your BCN ID card.

An automated telephone response system is also available 24/7 to answer many of your questions. If our automated system doesn't give you the answer you need, leave us a message. We'll return your call within two business days.

BLUE CROSS MOBILE APP

Once you're enrolled and receive your ID card, get the app by searching BCBSM at Apple® App Store® or Google Play™.

How the HMO Plan Works

NETWORK

A network is a list of physicians, hospitals and other health care providers that you can see for your health care needs. If you go to a network provider you will pay less than you will if you see a provider outside of your network.
Plans with larger networks give you more choices, but they can cost more.

Some things to think about are:

- Do I currently see a physician? If so, would they be in my network?
- How often do I travel?
- Do I have a second home and need access to doctors in multiple parts of the state?

COST

Nearly as important as network size is how costs of your plan will be shared. Before you choose any plan, consider how much you'll have to pay out of pocket. This will include monthly premium, deductible, copayments and coinsurance. The total you spend each year is limited to a maximum set by your plan. In general, the lower your monthly premium, the higher your out-of-pocket costs. It'll help to understand these common health insurance terms.

Premium – This is the amount that comes out of your paycheck every month to pay to your health care company to keep your coverage.

Copayment – This is a fixed amount that you pay for a covered service, usually at the time the service is rendered.

Deductible – This is the amount you pay for covered health care services before your plan starts to pay. With a $2,000 deductible, for example, you'll pay the first $2,000. After that, you usually pay only a copayment or coinsurance for covered services.

Allowed amount is the dollar amount Blue Cross has agreed to pay for health care services covered by your plan.

It's sometimes called the 'negotiated rate'.

You can find out if your doctor is in a Blue Cross network by going to bcbsm.com, logging in as a member and using our find a doctor tool. If you're not already a member, you can go to bcbsm.com/find-a-doctor

Coinsurance – This is your share of the costs of a covered health care service, usually a percentage of the allowed amount for the service that kicks in after you meet your deductible. For example, you may pay 20% while your plan covers 80%.

Out-of-pocket maximum – This is the most you'll pay in deductible, copayment and coinsurance combined during the year. (This doesn't include your monthly premium, which is a set amount.) Once you pay this specified amount, your plan covers costs at 100%.

COVERAGE

While most plans offer the same basic services, explore all options to see if one gives you better coverage for you and your family's individual needs. For example, one may have better prescription coverage and if you take a lot of medications, this could be the plan for you. Or maybe you need a plan with great maternity benefits because you're planning to start a family. If you travel a lot, check out plans with out-of-state coverage.

Note: Compare plans based on your health care needs. Ask questions about how much certain services, testing supplies, medications and surgeries, for example, will cost you out of pocket.

Health Savings Account (HSA)

WHAT IS A HEALTH SAVINGS ACCOUNT?

A health savings account that is tax-exempt for contributions, earnings and withdrawals for qualified medical expenses. An HSA is only offered in conjunction with a high deductible health plan and is used to save and pay for qualified medical expenses.

Things to keep in mind—

- You are only eligible for the HSA when you enroll in the Blue Care Network, HSA HMO $1,500/20% High Deductible Health Plan, are not covered under any other plan, including Medicare and cannot be claimed as a dependent on anyone's tax return. If your spouse contributes to a health care FSA, you are not eligible to contribute to an HSA.

- If you elect the HDHP, there are limits on how much you can contribute to the HSA Account. For 2023, the IRS has set the maximum limits to:

  Single: $3,850.00
  Family, $7,750.00

- If your adult child is not a tax dependent, HSA funds used to reimburse medical expenses incurred by that child may be taxable.

- For the reimbursement of a domestic partner's expenses to be tax-free, he or she must qualify as a tax dependent under IRS Code- Section 152.

Advantages of an HSA

Portability

You can take 100% of the deposited funds with you when you retire or change employers. You are the account owner.

Flexibility

You can choose whether to spend the money on current medical expenses, or you can save your money for future use. Unused funds remain in the account from year to year and there is no "use it or lose it" provision.

Tax Savings

Contributions are tax free (pre-tax through payroll deductions or tax deductible). Earnings are tax free. Funds withdrawn for eligible medical expenses are tax free.

Premium Savings

An HSA-qualified insurance plan tends to be less expensive than a traditional insurance plan.

Frequently Asked Questions HSA

What are the benefits of a health savings account (HSA)?

HSAs are tax advantaged accounts that help people save and pay for qualified medical expenses. Benefits include:

- Contributions are pre-tax or tax deductible.
- Earnings are income tax-free.
- You can make tax-free withdrawals for qualified medical expenses.
- You can carry over unused funds from year to year.
- The HSA is yours to keep even if you change jobs, change health plans or retire.
-

Note: Contributions are tax deductible on your federal tax return. Some states do not recognize HSA contributions as a deduction, and some states tax interest earned on your HSA. Your own HSA contributions are either tax deductible or pre-tax (if made by payroll deduction). See IRS Publication 969, or consult a qualified tax advisor to see how your state treats HSA contributions.

Who qualifies for an HSA?

To open an HSA, you must have a qualifying high-deductible health plan (HDHP) and meet other IRS eligibility requirements. Unless an exception applies.

- You cannot be covered by any other health plan that is not an HDHP.
- You cannot be currently enrolled in Medicare or TRICARE.
- You cannot be claimed as a dependent on another individual's tax return.

What is a qualifying HDHP?

This is a health plan that satisfies certain IRS requirements with respect to deductibles and out-of-pocket expenses.

What happens to my remaining account balance at the end of the year?

Any remaining balance automatically rolls over year after year.

What can I use my HSA for?

You can use the funds in your HSA:

- To pay for qualified medical, dental, vision and prescription drug expenses, including over-the-counter drugs, as defined in IRS Publication 502.
- As supplemental income after age 65. Once you are 65, you can withdraw funds for any reason without paying a penalty, but they will be subject to ordinary income tax. If you are under age 65 and use your HSA funds for nonqualified expenses, you will need to pay taxes on the money you withdraw, as well as an additional 20 percent penalty.

Can I use my HSA to pay for qualified medical expenses for a spouse or tax dependent?

Yes, even if your spouse or tax dependent is covered under another health plan. To get personalized details, consult a qualified tax advisor.

Are health insurance premiums considered qualified medical expenses?

In general, no, but exceptions include qualified long-term - care insurance, COBRA health care continuation coverage, any health plan maintained while receiving unemployment compensation under federal or state law and, for those 65 and over (whether or not they are entitled to Medicare), any employer-sponsored retiree medical coverage premiums for Medicare Part A or B or Medicare HMO. Conversely, premiums for Medigap policies are not qualified medical expenses.

Can I invest my HSA dollars?

Yes, you can choose to invest your HSA dollars in mutual funds once you reach your investment threshold.

What happens to my HSA if I no longer am covered by a qualifying high deductible plan (HDHP).

While you can no longer contribute to your HSA, you can still use the remaining funds to pay or be reimbursed for future qualified medical expenses.

How can I make contributions?

- Payroll deductions through your employer, if available.

Frequently Asked Questions HSA

When can contributions be made?

Contributions for a taxable year can be made any time within that year and up until the tax filing deadline for the following year, which is typically April 15.

If I change employers, what happens to my HSA?

Since you are the owner of the HSA, you may continue to maintain the account if you change employers. The funds are yours to keep.

Can I reimburse myself with HSA funds for qualified medical expenses incurred prior to my enrollment in an HSA?

No, qualified medical expenses may be reimbursed only if the expenses are incurred after the date your HSA was established.

Is there a time limit for reimbursing myself?

You can reimburse yourself at any time for expenses you paid for out-of-pocket. There is no time limit, but the expenses must have been incurred since you opened your HSA.

How can I use my HSA to pay for medical services?

You can use your HSA debit card upon receiving an invoice from your provider and/or an EOB from BCN.

Can I use my HSA to pay for non-health related expenses?

Yes. However, any amount of a distribution not used exclusively to pay for qualified medical expenses for you, your spouse or your tax dependents is includable in your gross income. These distributions could be subject to taxes and an additional 20 percent IRS tax penalty, except in the case of distributions made after your death, disability or reaching age 65.

How much can I contribute to my HSA?

The IRS 2023 allowable amounts for an individual is $3,850 and for a family, $7,750. At age 55, an additional $1,000 is allowed annually.

Note: The primary account holder must be 55 or older (even if the spouse is of that age).

What happens if my HSA balance exceeds the annual contribution limit?

If you contribute more than the IRS annual contribution limit, you have until the tax-filing deadline to withdraw excess contributions. If excess contributions are not withdrawn by the tax-filing deadline, an annually assessed excise tax of 6 percent will be imposed on any excess contributions.

Is tax reporting required for an HSA?

Yes, you must complete IRS form 8889 each year with your tax return to report total deposits and withdrawals from your account. You do not need to itemize. For more information about tax rules including distribution information, consult a qualified tax advisor.

What happens to my HSA when I die?

If you are married, your spouse will become the owner of the account and assume it as their own HSA. If you are unmarried, your account will cease to be an HSA. The money in your account will pass to your beneficiaries or become a part of your estate, and it will be subject to applicable taxes.

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Qualified Medical Expenses: HSA

Once you've contributed money to your health savings account (HSA), you can use it to pay for qualified medical expenses for yourself, your spouse and your eligible dependents. The amount you spend will be federal income tax-free.

EXAMPLES OF QUALIFIED MEDICAL EXPENSES

The following list includes common examples of HSA qualified medical expenses. For a complete list, visit irs.gov and search for Publication 502, Medical and Dental Expenses.

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Artificial teeth
- Breast reconstruction surgery (mastectomy-related)
- Chiropractic services
- Cosmetic surgery (only if due to trauma or disease)
- Dental treatment (X-rays, fillings, braces, extractions, etc.)
- Diagnostic devices (such as blood sugar test kits for diabetics)
- Doctor's office visits and procedures
- Eyeglasses, contact lenses and eye exams
- Eye surgery (such as laser eye surgery or radial keratotomy)
- Fertility enhancements
- Hearing aids (and batteries for use)
- Hospital services
- Laboratory fees
- Long-term care (for medical expenses and premiums)
- Nursing home
- Nursing services
- Operations/surgery (excluding unnecessary cosmetic surgery)
- Over-the-counter medications no longer require a doctor's prescription
- Physical therapy
- Prescription medicines or drugs
- Psychiatric care
- Speech therapy
- Stop-smoking programs
- Weight-loss programs (must be to treat a specific disease diagnosed by a physician)
- Wheelchairs
- X-rays

EXAMPLES THAT DON'T QUALIFY

- Advance payment for future medical care
- Amounts reimbursed from any other source (such as other health coverage or a flexible spending account)
- Babysitting, child care and nursing services for a normal, healthy baby
- Cosmetic surgery (unless due to trauma or disease)
- Diaper services
- Electrolysis or hair removal
- Funeral expenses
- Gasoline expenses to doctor visits
- Health club dues
- Household help
- Massage (unless a prescription is presented)
- Maternity clothes
- Meals
- Nutritional supplements
- Personal-use items (such as toothbrush, toothpaste)
- Swimming lessons
- Teeth whitening
- Weight-loss programs (unless prescribed to treat a specific disease)

The examples listed here are not all-inclusive, and the IRS may modify its list from time to time. Consult your tax advisor for specific tax advice.

What happens if I use my HSA for a non-qualified expense?

If you pay for anything other than qualified expenses with your HSA, the amount will be taxable. If you are 64 or younger, you will also pay an additional 20 percent tax penalty. If you are 65 or older, the tax penalty does not apply, but the amount must be reported as taxable income.

How do I pay with my HSA?

To pay for qualified medical expenses, choose the option that's most convenient for you:

- Use your HSA debit card.
- Pay out-of-pocket and then distribute funds from your HSA to reimburse yourself.

Voluntary Dental

New Carrier for 2023

DELTA DENTAL	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	NON-PARTICIPATING DENTIST*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontics Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, implants, and dentures	50%	50%	50%
Orthodontics			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit	19	19	19

DEDUCTIBLE – $50 deductible per person total per calendar year limited to a maximum deductible of $150 per family per calendar year. The deductible does not apply to Diagnostic & Preventive and Orthodontics.

MAXIMUM PAYMENT – $1,000 per person total per calendar year on Diagnostic & Preventive, Basic Services and Major Services. $1,000 per person total per lifetime on Orthodontics.

Welcome to Michigan's largest dental benefits family!

Quality Dental Program With our quick and accurate claims processing, we pay more than 90% of claims in 10 days or less. Delta Dental also offers world-class customer service from our Benchmark Portal Certified Center of Excellence call center.

Online Access Our online Member Portal lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more -- all at your own convenience.

A Healthy Smile Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions? If you have questions, please call our Customer Service team at 800-524-0149 TTY users call 711 or look online at www. DeltaDentalMI.com

This is a brief summary of your dental premiums and benefits. Please refer to the full Delta Dental summary for a comprehensive list of covered services and limitations.

***There is a participation requirement of 50% in order to offer the Voluntary Dental plan. If this requirement is not met, employees will be notified.**

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

Voluntary Vision: Provided by Delta Dental

New Carrier for 2023

Get quality coverage on the vision services you need:

- Thousands of eye doctors nationwide
- Covers in & out of network
- Eyeglasses, contact lenses and more

***There is participation requirement in order to offer the Voluntary Vision. If this requirement is not met, employees will be notified.**

Out-of-network allowances

Exam	Up to $45
Single vision lenses	Up to $30
Bifocal lenses	Up to $50
Trifocal lenses	Up to $65
Progressive lenses	Up to $50
Lenticular lenses	Up to $100
Frames	Up to $70
Elective contact lenses	Up to $105
Necessary contact lenses	Up to $210

Delta Dental uses VSP Network

DeltaVision®
130 **Enhanced**

Benefits overview

Exam/lens/frame frequency (months)	12/12/12
Contacts (instead of glasses) frequency (months)	12

In-network coverage

Exam copay	$10
Materials copay	$25
Frames allowance	$130
Elective contact lenses allowance	$130
Necessary contact lenses	Covered in full after copay
Contact lens fit evaluation copay	Up to $60

Lens enhancements (member cost)[3]

Anti-glaring coating	$41 single/$41 multifocal
Impact-resistant lenses (adult)	$31 single/$35 multifocal (covered for children)
Progressive lenses	Standard progressive lenses are covered
Light-reactive lenses	$75 single/$75 multifocal
Scratch-resistant coating	$17 single/$17 multifocal

Additional savings[2]

Frames discount over allowance	An extra $20 allowance on featured designer brands for frames. 20% savings on any amount above the retail allowance.
Additional pair	20% savings on unlimited additional pairs of prescription glasses and/or nonprescription sunglasses from any VSP network provider within 12 months of exam.
LASIK	Average 15% off the regular price, or 5% off the promotional price; discounts only available from contracted facilities.
Retinal imaging	Routine retinal screening covered for a maximum fee of $39.
Lens coverage	Glass or plastic single vision, lined bifocal, lined trifocal or lenticular lenses are covered in full.[3]
VSP Diabetic EyeCare Plus Program℠	Retinal screening for members with diabetes, $0 copay. Additional exams and services for members with diabetic eye disease, glaucoma or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP network doctor for details. $20 copay per exam.
Low vision	Pre-approved low-vision supplemental testing covered every two years. 75% coverage for approved low-vision aids, up to $1,000 (less any amount paid for supplemental testing) every two years.
Eyeconic®	Go to eyeconic.com® for an easy-to-use, convenient online eyewear option.
TruHearing®	Save up to 60% on hearing aids and batteries. Visit truhearing.com/vsp or call 877-396-7194 for more information.[4]

1 Prices shown reflect the standard plastic price for each respective category. Premium lens enhancement prices may vary. Prices are valid only through VSP Choice network providers and are subject to change without notice. **2** In-network only. **3** Covered in full materials and services are less any applicable copay. Based on applicable laws, benefits and savings may vary by location. Benefits may also vary at participating retail chains. Promotions like rebates are continually evaluated and subject to change without notice. In the state of Washington, VSP Vison Care, Inc., is the legal name of the corporation through which VSP does business. Promotions and Featured Frame Brands do not apply at Costco® Optical. Walmart/Sam's Club and Costco® Optical allowance of $80 is equivalent to the frame allowance at VSP doctor locations and participating retail chains. The following items are excuded under this plan: plano lenses (lenses with refractive correction of less than ± .50 diopter), two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics; vision training or supplemental testing. **4** VSP is providing information to its members, but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations, or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly. TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain health care groups for hearing aid sales and services; TruHearing provides fitting, programming and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those health care providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California.

The amount of benefits provided depends upon the plan selected. The premium will vary with the amount of benefits selected. This policy has exclusions, reduction of benefits or terms under which the policy may be continued in force or discontinued.

DeltaVision plans are sold only in combination with Delta Dental plans. DeltaVision plans are underwritten by Renaissance Life & Health Insurance Company of America, PO Box 1596, Indianapolis, IN 46206. DeltaVision plans are administered by VSP Vision Care, that performs certain services, including claims processing, customer service and provider network administration for DeltaVision products.

Life AD&D Insurance

LIFE INSURANCE: EMPLOYER PAID

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by GPS Solutions. The company provides **basic life insurance of $25,000 at no cost to you.**

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE : EMPLOYER PAID

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. GPS SOLUTIONS provides **AD&D coverage of $25,000 at no cost to you**. This coverage is in addition to your company-paid life insurance described above.

Voluntary Life & AD&D

Enrollment is available to **all employees working 30 hours or more per week**. If you are a new hire, and elect Voluntary Life Insurance within 31 days of eligibility, there is no Evidence of Insurability "EOI" required. Any purchase or increase in benefits that occur after eligibility period is subject to EOI. **There is a total of 20% participation required** in order to offer this benefit. If this in not met, employees will be notified. *This is 100% employee paid.*

Election Parameters: Employee must elect coverage for self in order to elect coverage for spouse and/or children. Benefits terminate the last day you are actively employed. A reduction of benefits will reduce to 65% of the original amount when you reach age 65, and will reduce to 50% of the original amount when you reach age 70.

- The Voluntary Life policy has a guaranteed issue limit, which means medical underwriting is not required.
- The guaranteed issue limit is up to $110,000.
- The maximum is 5 times your annual earnings to a maximum of $500,000.
- Any amount between $111,000 through $500,000, will require EOI (Evidence of Insurability). EOI is handle directly through UNUM, not the employer and kept in confidence. It may require medical exam, and possible blood test.

This is just a snapshot view of Benefit Plan information. Please refer to the full Benefit Highlight Summary Sheet for a more detailed information.

During this Open Enrollment period, there is guaranteed issue without the Evidence of Insurability (EOI). Take advantage of this offer now and receive up to the GI amount without medical underwriting. At next year's open enrollment, if you wish to purchase an additional amount, or elect for the first time, medical underwriting may apply.

- FOR 2023: If you currently have over the guarantee issue amount of Voluntary Life & AD&D with MetLife, you have been grandfathered by UNUM to elect up to the same amount you currently have without EOI. You **MUST** make a new election with UNUM, your current policy does not carry over to UNUM.
- Example: I currently have $200,000 in Voluntary Life insurance for myself with MetLife which was previously approved. I can elect up to $200,000 of Voluntary Life insurance for myself with UNUM. Anything over $200,000 will require EOI (Evidence of insurability). You will have to pay the new UNUM rate, but will not be required to go through medical underwriting. Please check with HR if you are not sure of your current election amount.

Voluntary Life AD&D Insurance Continued

HOW DOES IT WORK?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is bundled with voluntary life, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

WHY IS THIS COVERAGE SO VALUABLE?

If you buy a minimum of $10,000 of coverage now, you can increase your coverage in the future up to $110,000 to meet your growing needs. There would be no medical underwriting to qualify for coverage.

WHAT ELSE IS INCLUDED?

A 'Living' Benefit — If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to $250,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable. These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and may be taxable.

Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium — Your cost may be waived if you are totally disabled for a period of time.

Portability — You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

See full benefit summary for exclusions

WHO CAN GET TERM LIFE COVERAGE?

If you are actively at work at least 30 hours per week, you may apply for coverage for:

You:	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. You can get up to $110,000. This is the amount of coverage you can qualify for with no medical underwriting.
Your spouse:	Get up to $500,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. Your spouse can get up to $15,000 with no medical underwriting, if eligible (see delayed effective date).
Your children:	Get up to $10,000 of coverage in $2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 19th birthday – or until their 26th birthday if they are full-time students. The maximum benefit for children live birth to 6 months is $1,000.

WHO CAN GET ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) COVERAGE?

You:	Get up to $500,000 of AD&D coverage for yourself in $10,000 increments to a maximum of 5 times your earnings.
Your spouse:	Get up to $500,000 of AD&D coverage for your spouse in $5,000 increments, if eligible (see delayed effective date).
Your children:	Get up to $10,000 of coverage for your children in $2,000 increments if eligible (see delayed effective date).

No medical underwriting is required for AD&D coverage.

Voluntary Life AD&D Insurance Continued

How Much Can I Get?

Calculate your costs

1.Enter the coverage amount you want

2.Divide by the amount shown

3.Multiple by the rate. Use the table below to find the rate based on age as of 1/1/2023. **Your spouse rate is determined by the employee age, also as of 1/1/2023**

4. Enter your costs

5. Line 4 provides you with the *monthly cost*. To calculate per pay: Take the monthly amount in number 4, multiply by 12 then divided by either 20 or 24 pays

6. Enter your per pay amount on the payroll deduction form

	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $_____	= $_____
			Total cost	

Age	Employee monthly rate Per $10,000 of coverage Cost	Spouse monthly rate Per $5,000 of coverage Cost	Child monthly rate $0.938 per $2,000 of coverage
15-24	$0.760	$0.395	
25-29	$0.760	$0.395	
30-34	$0.960	$0.495	
35-39	$1.060	$0.545	
40-44	$1.160	$0.595	
45-49	$1.560	$0.795	
50-54	$2.260	$1.145	
55-59	$3.960	$1.995	
60-64	$5.860	$2.945	
65-69	$9.960	$4.995	
70-74	$14.160	$7.095	
75+	$14.160	$7.095	

Voluntary Life example:

Employee, age 45 purchasing $40,000 in life insurance, 24 payroll
$40,000 ÷ 10,000 = 4 X $1.560 = $6.24 per month X 12 ÷ 24 = $3.12 per pay for $40,000 in Vol. Life Insurance AND $40,000 in Vol AD&D

Employee, age 45 purchasing $40,000 in life insurance, 20 payroll
$40,000 ÷ 10,000 = 4 x $1.560 = $6.24 per month X 12 ÷ 20 = $3.74 per pay for $40,000 in Vol. Life Insurance AND $40,000 in Vol AD&D

The Voluntary Life and Accidental Death & Dismemberment must be purchased together. They cannot be purchased separately.

Billed amount may vary slightly. If you apply for coverage above the guaranteed issue amount, you may be subject to medical underwriting which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.

Disability Insurance

Long Term Disability Income Benefits

Long Term Disability (LTD) helps replace a portion of your income for an extended period of time. This is provided to you at ***no cost*** through your employer and is available to **all employees working 30 hours or more per week.**

How it works

Following the Own Occupation period, you are considered disabled if, due to sickness, pregnancy or accidental injury, your are receiving appropriate care and treatment and complying with the requirements of the treatment and you are unable to earn 80% of your pre-disability earning at any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.

There is no wait period, and the benefit amount is 60% of your pre-disability earnings, with a maximum of $6,000 per month. Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. Your elimination period is 90 days.

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of the time you must wait, while disabled, before you are eligible to receive a benefit. The elimination period is as follows:

For Injury: 14 days

For Sickness (including pregnancy): 14 days

Benefits continue for as long as you are disabled up to a maximum of duration of 11 weeks of disability.

See Benefit summary for detailed information and pricing.

*exclusions for pre-existing conditions may apply.

Voluntary Short-Term Disability Income Benefits

Short Term Disability

Voluntary Short Term Disability can help by protecting your income if a sickness or accidental injury kept you from working. The plan is being made available to you through your employer and with the convenience of payroll deduction. This voluntary benefit is available to **all employees working 30 hours or more per week.**

How it works

Generally, you are considered disabled and eligible for benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment and you are unable to earn more than 80% of your pre-disability earnings at your own occupation.

Employee Worksheet

During this Open Enrollment period, all eligible full time employees (working 30 or more hours per week) may elect Short-Term Disability. The coverage is outlined in the UNUM Benefit Guide. This benefit is 100% employee paid and only to our employees. **There is a total 20% participation requirement** in order to offer the Voluntary Short Term Disability. If this requirement is not met, employees will be notified.

Monthly Premium Calculation Spreadsheet per $10 of covered weekly benefit

Your Age as of 1/1/2023	Rate Per $10
Under 25	$0.430
25-29	$1.200
30-34	$1.490
35-39	$0.980
40-44	$0.370
45-49	$0.250

Your Age as of 1/1/2023	Rate Per $10
50-54	$0.310
55-59	$0.390
60-64	$0.520
65-69	$0.630
70– 74	$0.630
75+	$0.630

Based on 24 Pays per year:

EXAMPLE: VOLUNTARY SHORT TERM DISABILITY						
Employee Annual Gross Earnings	**Divide by 52**	**Multiply by 60%**	**Equals max. weekly benefit (if exceeds $1500, enter $1500)**	**Your weekly benefit amount divided by 10, times your age rate from above**	**Your Monthly Cost times 12 equals your annual cost**	**Your Annual cost, divided by 24 payroll deductions, equals per pay amount**
$45,000	$45000 ÷ 52 = $865.38	$865.38 X 60% = $519.23	$519.23	$519.23 ÷ 10 = $51.92 X 0.980 = **$50.88**	$50.88 x 12 = $610.61	$610.61 ÷ 24 = **$25.44**

Based on 20 Pays per year:

EXAMPLE: VOLUNTARY SHORT TERM DISABILITY						
Employee Annual Gross Earnings	**Divide by 52**	**Multiply by 60%**	**Equals max. weekly benefit (if exceeds $1500, enter $1500)**	**Your weekly benefit amount divided by 10, times your age rate from above**	**Your Monthly Cost times 12 equals your annual cost**	**Your Annual cost, divided by 20 payroll deductions, equals per pay amount**
$45,000	$45000 ÷ 52 = $865.38	$865.38 X 60% = $519.23	$519.23	$519.23 ÷ 10 = $51.92 X 0.980 = **$50.88**	$50.88 x 12 = $610.61	$610.61 ÷ 20 = **$30.53**

IMPORTANT NOTICES REGARDING YOUR BENEFITS UNDER THE GPS SOLUTIONS ("Plan")

To: All Employees

From: GPS SOLUTIONS

Date: November 1, 2022

Federal law requires that employers provide specific disclosures to employees about their group health plans and enrollment rights that may be available. Please carefully review the following information.

If you have questions about any of these notices, please contact the Plan Administrator at:

GPS Solutions
Human Resources Department
29777 Telegraph Rd., Ste 2120
Southfield, MI 48034

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).

Women's Health & Cancer Rights Act

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; 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.

Special Enrollment Notice & HIPAA Notice

Special Enrollment Notice: If you decline enrollment for yourself or an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. Further, if you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact the HR Manager.

HIPAA Privacy Notice
Reminder of Privacy Notice

The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact GPS Solutions, HR Department, 29777 Telegraph Rd., Ste 2120, Southfield MI 48034.

Full Privacy Notice This notice describes how the Plan may use and disclose your protected health information (PHI) and how you can get access to this information. **Please review it carefully.** If you have any questions about this Notice, please contact the Privacy Officer at GPS SOLUTIONS, HR Department.

Our Policy Regarding PHI. We understand that health information about you obtained in connection with the Plan is personal, and we are committed to protecting your health information. For Plan administration purposes, we may maintain information related to your coverage under the Plan that identifies you and relates to your physical or mental health, related health care services, and payment for health care. This information is called Protected Health Information, or PHI.

This Notice tells you the ways in which we may use and disclose your PHI. It also describes our obligations and your rights regarding the use and disclosure of PHI.

We are required by law to:

- Keep PHI obtained and created by the Plan private;
- Provide you with certain rights with respect to your PHI;
- Give you this Notice of our legal duties and privacy practices with respect to PHI;
- Follow the terms of the Notice of Privacy Practices that is currently in effect; and
- Notify affected individuals if a breach occurs that may have compromised the privacy or security of PHI.

How We May Use and Disclose PHI. The following categories describe how we may use and disclose PHI without your written authorization. We may use and disclose PHI:

For treatment. To facilitate health treatment or services by providers.

For payment. To determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your PHI with a utilization review or precertification service provider. Likewise, we may share your PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For health care operations. For operations necessary to run the Plan. For example, we may use PHI for underwriting, premium rating, and other activities relating to Plan coverage, to submit claims for stop-loss coverage; conduct or arrange for health review, legal services, audit services, and fraud and abuse detection; business planning and developing such as cost management; and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

To communicate with business associates. Some services are provided to the Plan through contracts with "business associate." We may disclose PHI to our business associates so that they can perform a service for the Plan. To protect your PHI, we require business associates to agree in writing to appropriately safeguard your information.

Disclosure to health plan sponsor. Information may be disclosed to your employer's personnel solely for purposes of administering benefits under the Plan. However, those employees are permitted to use or disclose your information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Other. For other reasons permitted under HIPAA, such as when required to do so by law, for workers' compensation or similar programs, or in response to a court or administrative order.

Your Rights. You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You may inspect and copy certain PHI that may be used to make decisions about your Plan benefits.

Right to Amend. You may amend incorrect or incomplete PHI if you provide a reason that supports your request.

Right to an Accounting of Disclosures. You may request a list (an "accounting") of the times we have shared your protected health information with others. The accounting will not include disclosures for purposes of treatment, payment, or health care operations; disclosures made to you; disclosures made pursuant to your authorization; or disclosures made for certain governmental functions.

Right to Request Restrictions. You may request a restriction or limitation on the disclosure of your PHI for treatment, payment, or health care operations, or to someone who is involved in your care or the payment for your care, such as a family member or friend.

Right to Request Confidential Communications. You may request that we communicate with you about your PHI in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to a Paper Copy of This Notice. You may ask for a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this Notice.

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact GPS Solutions, HR Manager, 29777 Telegraph Rd., Ste 2120, Southfield MI 48034. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

Changes to this Notice. We may revise this Notice and reserve the right to make the revised Notice effective for PHI we possess as of the date of the revision as well as any information we receive after the change. The new Notice will be available, upon request, and we will distribute a paper copy.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ **Phone: 1-855-692-5447**	**Website: http://flmedicaidtplrecovery.com/hipp/** **Phone: 1-877-357-3268**
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program **Website: http://myakhipp.com/** **Phone: 1-866-251-4861** **Email: CustomerService@MyAKHIPP.com** **Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	**Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** **Phone: 678-564-1162 ext 2131**
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ **Phone: 1-855-MyARHIPP (855-692-7447)**	**Healthy Indiana Plan for low-income adults 19-64** **Website: http://www.in.gov/fssa/hip/** **Phone: 1-877-438-4479** **All other Medicaid** **Website: http://www.indianamedicaid.com** **Phone 1-800-403-0864**
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
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**	**Website:http://dhs.iowa.gov/Hawki** **Phone: 1-800-257-8563**

CHIP Continued

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	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
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

CHIP Continued

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov **Medicaid Phone: 1-800-992-0900**	**Website: https://www.scdhhs.gov** **Phone: 1-888-549-0820**
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov **Phone: 1-888-828-0059**	**Website: https://www.hca.wa.gov/** **Phone: 1-800-562-3022 ext. 15473**
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ **Phone: 1-800-440-0493**	**Website: http://mywvhipp.com/** **Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)**
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ **CHIP Website: http://health.utah.gov/chip** **Phone: 1-877-543-7669**	**Website:** **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** **Phone: 1-800-362-3002**
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ **Phone: 1-800-250-8427**	**Website: https://wyequalitycare.acs-inc.com/** **Phone: 307-777-7531**
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm **Medicaid Phone: 1-800-432-5924** **CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm** **CHIP Phone: 1-855-242-8282**	

To see if any other states have added a premium assistance program since July 31, 2019, 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

Medicare Part D

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.

Medicare Part D – Prescription Drug Coverage

Important Notice About Your Prescription Drug Coverage Under the Plan and Medicare. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. We have determined that the prescription drug coverage offered by the 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 coverage will not be affected.

See pages 7 - 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at: http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/ options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop you current Employer coverage, be aware that you and your dependents will not be able to get this coverage back except for re-enrollment during a designated open enrollment period.

Medicare Part D. Continued

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 under this 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.

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact GPS SOLUTIONS, Human Resources, 29777 Telegraph Rd., Ste 2120, Southfield MI 48034 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 your Employer 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).

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical & Pediatric Dental & Pediatric Vision	Blue Cross Blue Shield of Michigan	877-354-2583	www.bcbsm.com
Medical & Pediatric Dental & Pediatric Vision	Blue Care Network	800-637-2227	www.bcbsm.com
Voluntary Dental	Delta Dental New Carrier	800-524-0149	Www.deltadentalmi.com
Voluntary Vision	Delta Dental New Carrier	800-524-0149	Www.deltadentalmi.com
Life, AD&D, LTD	UNUM New Carrier	For EOI only: 800-421-0344 option 2 Other than EOI, please see HR	For EOI only: Employee only customerservices@unum.com
Voluntary Life, AD&D	UNUM New Carrier	For EOI only: 800-421-0344 option 2 Other than EOI, please see HR	For EOI only: Employee only customerservices@unum.com
Voluntary STD	UNUM New Carrier	Please see HR	

Notes

Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.