RE:CAR, INC.
Benefits Enrollment Guide
2023

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A Message from HR at RE:CAR, INC.

At RE:CAR, INC. we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

You can also view overviews of our benefit plans by accessing our website below:

ReCar 2023 Open Enrollment - PES (pesenroll.com)

Military Leave

RE:CAR, INC. will now cover the full cost of the benefit premiums for regular employees when on a military leave of absence to serve our country. This new benefit goes above and beyond the unpaid job protected leave that is currently required by law.

Bonding Leave

RE:CAR, INC. has added a new Paid Parental Leave Benefit. This new plan will allow both full-time and part-time RE:CAR, INC. employees up to four weeks of supplemental paid parental leave for the birth or adoption of a child (or foster care placement). See your Human Resource department for details.

Eligibility

Eligible Employees:

You may enroll in the RE:CAR, INC. Employee Benefits Program if you are a full-time employee working at least 30 hours per week. Part-time employees working 20-29 hours per week are also eligible for benefits.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, domestic partner, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court- appointed legal guardianship, as well as children of same sex state-registered domestic partners.

When Coverage Begins:

The effective date for your benefits is August 1, 2023. All benefit eligible employees and dependents will be enrolled in RE:CAR, INC.'s benefits programs as of this date. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a family status event. If you are a newly hired employee of RE:CAR, INC., your benefits will begin the first of the month following your date of hire.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date, even if dropping coverage to enroll on a spouse's plan. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

Medical Insurance

RE:CAR, INC. offers medical coverage through Blue Cross Blue Shield of Michigan. The charts below are a brief outline of the plans offered. Please refer to the summary plan description for complete plan details.

	Platinum – Blue Cross Blue Shield of MI Simply Blue PPO $250 Deductible		Gold - Blue Cross Blue Shield of MI Simply Blue PPO $1,500 Deductible	
Benefits Coverage	**In-Network Benefits**	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
Annual Deductible				
Individual	$250	$500	$1,500	$3,000
Family	$500	$1,000	$3,000	$6,000
Maximum Out-of-Pocket				
Individual	$8,150	$16,300	$8,150	$16,300
Family	$16,300	$32,600	$16,300	$32,600
Physician Office Visit				
Primary Care	$20 copay	60% after deductible	$30 copay	60% after deductible
Specialty Care	$20 copay	60% after deductible	$50 copay	60% after deductible
Chiropractic	$20 copay	Not covered	$30 copay	Not covered
Preventive Care				
Adult Periodic Exams	100% covered	Not covered	100% covered	Not covered
Well-Child Care	100% covered	Not covered	100% covered	Not covered
Services				
Hearing Aids	Not covered	Not covered	Not covered	Not covered
X-ray and Lab Tests	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Complex Radiology	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Urgent Care Facility	$20 copay; deducible does not apply	60% after deductible	$60 copay; deducible does not apply	60% after deductible
Emergency Room Facility Charges* (*Per Visit Medical Deductible does not apply)	$150 copay; deductible does not apply	$150 copay; deductible does not apply	$250 copay; deductible does not apply	$250 copay; deductible does not apply
Mental Health and Substance Abuse				
Inpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Retail Pharmacy (30-Day Supply)				
Generic (Tier 1)	$10 copay	$10 copay plus 25% of approved amount	$15 copay	$10 copay plus 25% of approved amount
Preferred (Tier 2)	$40 copay	$40 copay plus 25% of approved amount	$50 copay	$40 copay plus 25% of approved amount
Non-Preferred (Tier 3)	$80 copay	$80 copay plus 25% of approved amount	$70 - $100 copay	$80 copay plus 25% of approved amount
Mail Order Pharmacy (90-Day Supply)				
Generic (Tier 1)	$20 copay	Not covered	$30 copay	Not covered
Preferred (Tier 2)	$80 copay	Not covered	$100 copay	Not covered

Non-Preferred (Tier 3)	$160 copay	Not covered	$140 - $200 copay	Not covered
	Silver - Blue Cross Blue Shield of MI Simply Blue HSA PPO $3,000 Deductible		**Bronze - Blue Cross Blue Shield of MI Simply Blue HSA PPO $6,350 Deductible *No Employee Contributions – 100% RE:CAR, INC. Paid***	
Benefits Coverage	**In-Network Benefits**	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
Annual Deductible				
Individual	$3,000	$6,000	$6,350	$12,700
Family	$6,000	$12,000	$12,700	$25,400
Maximum Out-of-Pocket				
Individual	$6,900	$13,800	$6,350	$15,000
Family	$13,800	$27,600	$12,700	$30,000
Physician Office Visit				
Primary Care	100% covered after deductible	80% after deductible	100% covered after ded	80% after deductible
Specialty Care	100% covered after deductible	80% after deductible	100% covered after ded	80% after deductible
Chiropractic	100% covered after deductible	80% after deductible	100% covered after ded	80% after deductible
Preventive Care				
Adult Periodic Exams	100% covered	Not covered	100% covered	Not covered
Well-Child Care	100% covered	Not covered	100% covered	Not covered
Services				
Hearing Aids	Not covered	Not covered	Not covered	Not covered
X-ray and Lab Tests	100% covered after deductible	80% after deductible	100% covered after ded	80% after deductible
Complex Radiology	100% covered after deductible	80% after deductible	100% covered after ded	80% after deductible
Urgent Care Facility	100% covered after deductible	80% after deductible	100% covered after ded	80% after deductible
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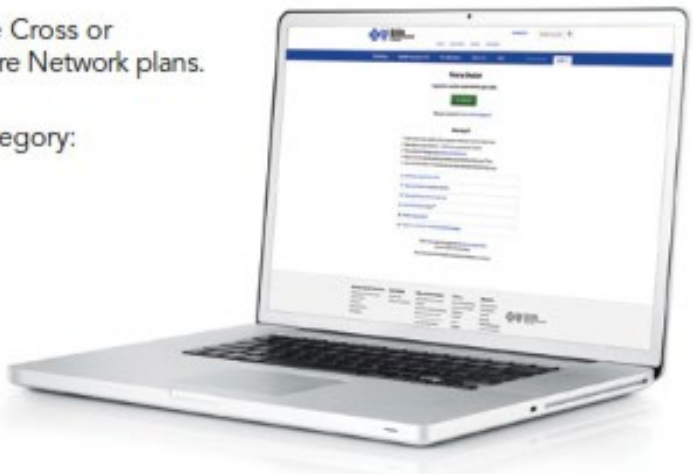
Mental Health and Substance Abuse				
Inpatient	100% covered after deductible	80% covered after ded	100% covered after ded	80% covered after ded
Outpatient	100% covered after deductible	80% covered after ded	100% covered after ded	80% covered after ded
Retail Pharmacy (30-Day Supply)				
Generic (Tier 1)	$10 copay after deductible	$10 copay plus 20% of approved amount after ded	100% covered after ded	80% covered after ded
Preferred (Tier 2)	$40 copay after deductible	$40 copay plus 20% of approved amount after ded	100% covered after ded	80% covered after ded
Non-Preferred (Tier 3)	$80 copay after deductible	$80 copay plus 20% of approved amount after ded	100% covered after ded	80% covered after ded
Generic (Tier 1)	$20 copay after deductible	Not covered	100% covered after ded	Not covered
Preferred (Tier 2)	$80 copay after deductible	Not covered	100% covered after ded	Not covered
Non-Preferred (Tier 3)	$160 copay after deductible	Not covered	100% covered after ded	Not covered

Find a doctor at **bcbsm.com**.

When you're with Blue Cross Blue Shield of Michigan, you can easily search for network doctors and hospitals at **bcbsm.com**.

To find a doctor, other health care provider or hospital, follow these steps:

1. Go to **bcbsm.com/find-a-doctor**.
2. Under the *Get Started* box, click *Search without logging in*.
3. Set your location and then click *All Plans* at the upper right side of the screen.
4. Click *Find a different plan*.
5. Click *PPO Plans* for Blue Cross or *HMO* or *POS* for Blue Care Network plans.



Then you can search by category:

- All categories
- Doctors by name
- Doctors by specialty
- Places by name
- Places by type

Finding a doctor has never been easier with bcbsm.com.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

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know. compare. choose.

Understanding your health care plan

Your online **Blue Cross member account** can help you understand how your plan works — and how to get the most from it.

Here's an example: Lisa strains her knee while running. Her primary care provider recommends physical therapy twice a week for roughly two months to strengthen the ligaments surrounding her knee.* Lisa asks herself:

"Does my plan include physical therapy?"

Lisa checks her account to see if physical therapy is a benefit under her health plan. She's allowed up to 20 visits each year.

"But how close am I to reaching my deductible?"

Lisa has a deductible of $2,600. Her account shows she needs to pay $1,000 to meet the deductible before her health plan will pick up most of the remaining cost.*

"Can I pay for my portion out of my health spending account?"

Lisa's account shows she has enough to pay her portion of physical therapy. Because she's had few health expenses during the year, she also has enough to pay for the deductible and qualified medical expenses her plan doesn't cover.

"Who do I see?"

Lisa's doctor recommends a physical therapist who's close to Lisa's home. Before making an appointment, Lisa checks her account for more details. She sees he's accepting new patients and takes her plan. Lisa schedules an appointment.

Lisa saves money and has the peace of mind that she'll receive great care. You can, too.

*Illustrative example, not actual medical advice. Check your plan for cost and coverage details.

Register today:
bcbsm.com/register

Or, text REGISTER to 222764.

Get the app.

Download on the App Store

GET IT ON Google Play

Search BCBSM.

Message and data rates may apply. Visit **bcbsm.com** for our *Terms and Conditions of Use* and *Privacy Practices*.

Learn the terms and how your plan works

Before and throughout your plan year

- To receive health coverage, you or your employer must pay a monthly **premium**.

Beginning of your plan year

- Depending on your plan, we pay for certain preventive care and wellness costs throughout the year at no cost to you.
- You may pay **copayments** for certain services under your plan, such as primary care provider office visits and urgent care.
- You pay for other medical costs until you meet your **deductible**, if your plan includes one.

Once you've met your deductible (if applicable)

- You continue to pay **copayments** and **coinsurance** until the total you've paid for copayments, coinsurance and deductible meets your **out-of-pocket maximum**.
- If there's more than one person on your plan, you may have to meet a family, as well as an individual, **out-of-pocket maximum**.

Once you've reached the out-of-pocket maximum(s)

- Your plan pays for all other services under your plan. You don't owe a thing. (Please note your plan may not have an **out-of-pocket maximum**.)

At the end of the plan year

- Your **deductible** and **out-of-pocket maximum** reset for the next year.

Premium
A fixed monthly payment for your health coverage. This payment doesn't include any subsidy for which you may be eligible.

Copayment (copay)
A fixed dollar amount (for example, $25) you pay at the time health care is provided, such as a doctor's visit.

Deductible
The dollar amount you or your family pays for medical services before your health plan starts to pay.

Coinsurance
The percentage or portion you owe after you've paid your deductible, if you have one. Your health plan pays the remaining percentage.

Out-of-pocket maximum
The maximum dollar amount you pay in deductible, copayments and coinsurance during the year.

Ask MIBlue Virtual Assistant℠ to help you find answers fast to questions about your plan.

Log in to your member account at **bcbsm.com** or use the **Blue Cross mobile app**.

For details about our app, go to bcbsm.com/app.

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Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; your balance carries over year to year.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone is able to enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse’s PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person’s tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse’s FSA. (Enrollment in a limited purpose health care FSA is allowed).

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes.

2023 HSA Contributions

You are able to contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

- FOR THE 2023 TAX YEAR:
  - Individual $3,850
  - Family $7,750
  - If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

Membership has its benefits

Blue Cross Blue Shield of Michigan and Blue Care Network members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States.

We've got plenty of deals to keep you and your family healthy.

Member discounts with Blue365 offers exclusive deals on things like:

- **Fitness and wellness:** Health magazines, fitness gear and gym memberships
- **Healthy eating:** Cookbooks, cooking classes and weight-loss programs
- **Lifestyle:** Travel and recreation
- **Personal care:** Lasik and eye care services, dental care and hearing aids

Cash in on discounts

Start saving today! Show your Blue Cross or Blue Care Network ID card at participating local retailers or use an offer code online to take advantage of these savings. For a full list of discount offers, log in or register at **bcbsm.com** and click *Member Discounts with Blue365®* on your home page. You can also conveniently access discounts on the go with the Blue Cross mobile app. Search **BCBSM** in Google Play™ or the App Store® to download our mobile app.

Blue Cross Blue Shield Blue Care Network of Michigan | Blue365®
Because health is a big deal™

Member discounts with Blue365

Take advantage of discounts from the businesses listed below and many more.

SEA LIFE Michigan · LEGOLAND DISCOVERY CENTER MICHIGAN · METROPARKS · fitbit

Bicycling RUNNER'S · Men's Health Women's Health · BetterHealth · GARMIN. · Dunham's

LasikPlus · Reebok · jenny · Fairmont HOTELS & RESORTS · Simple Organics

TruHearing · fitness your way · dentalsolutions · WeightWatchers

You can conveniently access discounts from any device — anytime, anywhere.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Program information valid as of August 2018.

The Blue365 program is brought to you by the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield plans. Blue365 offers access to savings on items that members may purchase directly from independent vendors, which are different from items that are covered under health care plan policies with Blue Cross Blue Shield of Michigan or Blue Care Network, its contracts with Medicare or any other applicable federal health care program. Neither Blue Cross Blue Shield of Michigan, Blue Care Network nor the Blue Cross and Blue Shield Association recommends, endorses, warrants or guarantees any specific vendor or item.

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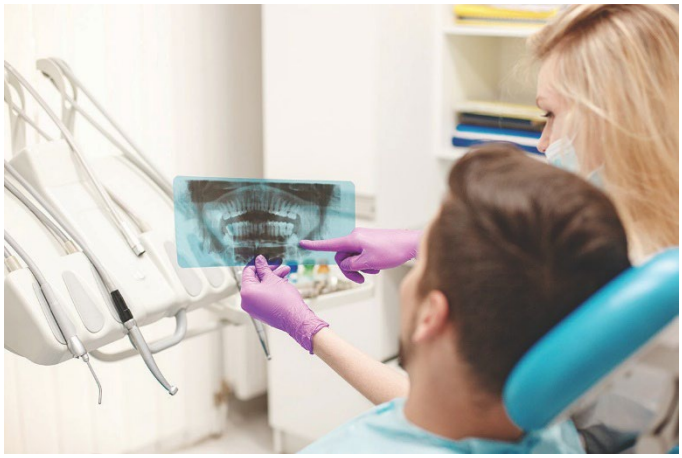
Dental Insurance



Dental Benefits

RE:CAR, INC. offers a dental program through Blue Cross Blue Shield of MI. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

	Blue Dental PPO Plus	
	In-Network Benefits	**Out-of-Network Benefits**
Annual Deductible		
Per Insured Person	None	$50
Family	None	$150
Waived for Diagnostic/Preventive Care?	Yes	Yes
Waiting Period	None	None
Annual Benefit Maximum		
Per Insured Person	$1,500	$1,500
Dental Services		
Diagnostic & Preventive Services	100%	80%
Basic (Restorative) Services	80%	60%
Major (Restorative) Services	60%	40%
Orthodontia		
Orthodontia	50%	50%
Adults	Not covered	Not covered
Dependent Child(ren)	Covered up to 18 years of age	Covered up to 18 years of age
Lifetime Benefit Maximum	$1,500	$1,500

Vision Insurance

Vision Benefits

RE:CAR, INC. now provides Vision Insurance through Blue Cross Blue Shield of MI through the VSP Choice network. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

	Blue Vision		
	In-Network	**Out-of-Network**	**Frequency**
Routine Eye Exam			
Comprehensive eye exam	$10 copay	Reimbursed up to $42	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 Allowance, less $25 copay	Reimbursed up to $70, less $25 copay	Once every other calendar year
Eyeglass Lenses (instead of contact lenses)			
One pair of standard plastic prescription lenses • Single vision lenses • Bifocal lenses Trifocal lenses	 $25 copay $25 copay $25 copay	Reimbursed up to approved amount based on lens type, less $25 copay	Once every calendar year
NOTE:	Eyeglass lens upgrades are available		
Contact Lenses (instead of eyeglass lenses)			
• Elective (non-disposable)	$130 Allowance	Reimbursed up to $105	Once every calendar year
• Elective Disposable	$130 Allowance	Reimbursed up to $105	
• Medically Necessary	$25 copay	Reimbursed up to $210, less $25 copay	

Group Term Life Insurance and AD&D

RE:CAR, INC. provides Basic Life and Accidental Death and Dismemberment benefits to eligible employees at no cost to you. The chart below provides a brief outline of the plan. Please refer to the summary plan description for complete plan details.

BCBSMI Life Group Term Life/AD&D	
You	
Benefit Maximum	1 x base annual earnings to a maximum of $250,000
Guaranteed Issue	$250,000

Supplemental Group Term Life and AD&D

In addition to the employer paid Group Term Life and Accidental Death and Dismemberment coverage, you have the option to purchase additional supplemental life/AD&D insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability. The chart below provides a brief outline of the plan. Please refer to the summary plan description for complete plan details.

BCBSMI Life Supplemental Life/AD&D			
	You	**Your Spouse**	**Your Child(ren)**
Benefit Maximum	Increments of $10,000 to a maximum of $500,000	Increments of $5,000 up to a maximum of $250,000	Increments of $10,000 up to a maximum of $10,000
Guaranteed Issue	$100,000	$30,000	$10,000

You may purchase additional Life insurance with Blue Cross Blue Shield of Michigan. if you want more coverage for yourself, your spouse, and dependent child(ren). Your contributions will depend on your age and your spouse's age and the amount of coverage elected.

Short-Term Disability Insurance

RE:CAR, INC. offers a short-term disability option through Blue Cross Blue Shield of MI. This benefit covers 60% of your weekly base salary up to $2,000/week. The benefit begins after 8 days of injury or illness and lasts up to 25 weeks. Please see the summary plan description for complete plan details.

Long-Term Disability Insurance

RE:CAR, INC. offers long-term income protection through Blue Cross Blue Shield of MI in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 60% of your monthly base salary up to $10,000/month. Benefit payments begin after 180 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details.

The Flexible Spending Account (FSA) plan with Infinisource allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

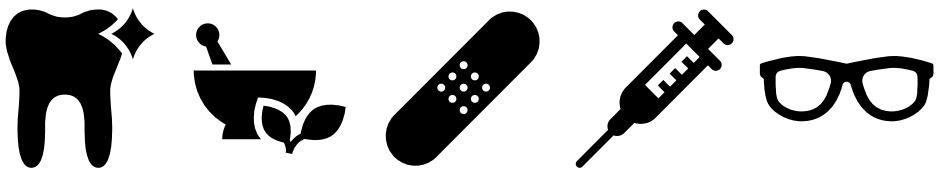
- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Important rules to keep in mind:

- The IRS increased the carry over amount for 2023 to $610 per year
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event
- You cannot transfer funds from one FSA to another
- **If you enroll in a High Deductible Health Plan (Silver or Bronze) you will only be eligible for a Limited Purpose Flexible Spending Account (LPFSA) which is a pre-tax benefit used to pay for eligible dental and vision care expenses for participants enrolled.**

Please plan your health care FSA contributions carefully, as any funds over $610 not used by the end of the calendar year will be forfeited. Re-enrollment is required each year.

2023 MAXIMUM ANNUAL ELECTION	
Health Care FSA	$3,050
Dependent Care FSA	$2,500 - $5,000 (Based on tax filing status)



Retirement Plans

The 401(k) plan is an employer sponsored retirement plan through Vanguard. Eligible employees can elect to make contributions through payroll withholdings. Employees can enroll once their first payroll check is processed. Both Traditional & Roth 401(k)s are available. See below for details:

Traditional 401(k):

Employee contributions reduce income taxes for the year, but withdrawals are taxed.

Roth 401(k):

Employee contributions are post-tax income contributions and withdrawals are tax-free.

RE:CAR, INC. offers a Basic Safe Harbor Match. The formula is a dollar-for-dollar match on the first 3% of pay that the eligible employee defers and a 50% match on the next 2% of pay that the eligible employee defers for a total maximum of up to 4% of compensation. Safe Harbor Contributions are always 100% vested and will be deposited each pay period.

2023 Contribution Limits: $22,500

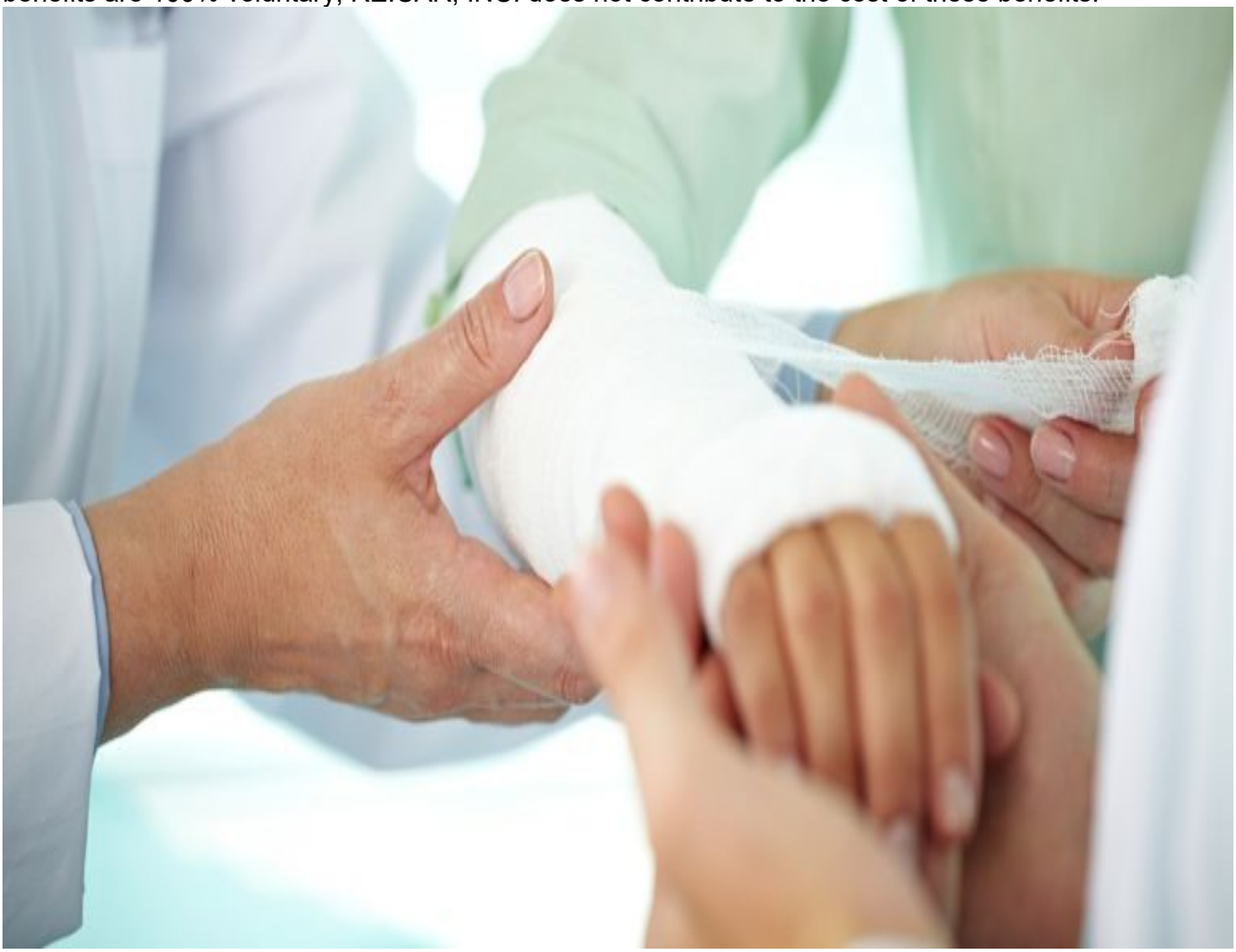
Catch-up contributions for employees over 50 years of age - $7,500

Voluntary Benefits

No employee's situation is alike. That's why we offer voluntary benefits to assist in easing the financial burden an accident or illness may cause. Employees with children may find themselves visiting urgent care or emergency rooms more due to accidents sustained during sports or play. Older adults may find themselves seeking treatment for chronic conditions which may lead to hospital stays. By selecting a voluntary critical illness or accident plan, you can receive cash back for each accident or episode of critical illness. This is paid to you directly in a lump sum, tax free payment. Additionally, some voluntary plans will also reward you with getting a yearly physical-cash back in your pocket that does not have to be applied to health care expenses.

For additional details and pricing, please go to ReCar 2023 Open Enrollment - PES (pesenroll.com) and select RE:CAR, INC. Accident and Critical Illness. For rates, please select RE:CAR, INC. | Your Guide to Specialty Benefits.

Please note, these products do not replace medical insurance nor are they ACA compliant. These benefits are 100% voluntary; RE:CAR, INC. does not contribute to the cost of these benefits.



Changes in Benefit Elections

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefit plans. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts. To continue your FSA benefits, you must re-enroll each plan year.

If you do not make your 2023 benefit elections, you will not be able to enroll in benefits until a Qualified Life Event occurs.

Note: Some states (currently California, Massachusetts, New Jersey, Rhode Island, Washington D.C., and Vermont) may impose a tax on residents who do not have health insurance coverage, subject to limited exceptions.

Contact Information

Benefit Resource Center (BRC)

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution

Call the Benefit Resource Center (“BRC”)
We’re Here To Help!

Benefit Resource Center

BRCEast@usi.com | Toll Free: 855-874-6699

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

Carrier Customer Service

CARRIER	PHONE NUMBER	WEBSITE
BCBS of Michigan	1-877-469-2583	https://www.bcbsm.com/

Medical/Rx – Contributions (Full time EEs)

Platinum Plan ($250/$500 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$803.75	$560.11	$243.64	$112.45	$56.22
Employee +Spouse	$1,928.98	$1,393.47	$535.51	$247.16	$123.58
Employee+ Child(ren)	$2,411.24	$1,999.98	$411.26	$189.81	$94.91
Family	$2,411.24	$1,659.13	$752.11	$347.13	$173.56

Gold Plan ($1,500/$3,000 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$672.13	$499.69	$172.44	$79.59	$39.79
Employee+ Spouse	$1,613.13	$1,234.11	$379.02	$174.93	$87.47
Employee+ Child(ren)	$2,016.41	$1,725.33	$291.08	$134.34	$67.17
Family	$2,016.41	$1,484.08	$532.33	$245.69	$122.85

Silver Plan ($3,000/$6,000 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$584.28	$521.89	$62.39	$28.80	$14.40
Employee+ Spouse	$1,402.27	$1,265.13	$137.14	$63.29	$31.65
Employee+ Child(ren)	$1,752.83	$1,647.51	$105.32	$48.61	$24.30
Family	$1,752.83	$1,560.22	$192.61	$88.90	$44.45

Bronze Plan ($6,350/$12,700 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly **No Cost to Employees**	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$483.31	$483.31	$0	$0	$0
Employee+ Spouse	$1,159.94	$1,159.94	$0	$0	$0
Employee+ Child(ren)	$1,449.92	$1,449.92	$0	$0	$0
Family	$1,449.92	$1,449.92	$0	$0	$0

*All deductions are done on a pre-tax basis unless requested otherwise.

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Medical/Rx – Contributions (Part time EEs)

(working 20-29 hours per week)

Platinum Plan ($250/$500 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$803.75	$511.38	$292.37	$134.94	$67.47
Employee + Spouse	$1,928.98	$1,286.37	$642.61	$296.59	$148.30
Employee + Child(ren)	$2,060.66	$1,566.48	$493.52	$227.78	$113.89
Family	$2,060.66	$1,508.70	$902.54	$416.55	$208.28

Gold Plan ($1,500/$3,000 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$672.13	$465.20	$206.93	$95.51	$47.75
Employee + Spouse	$1,613.13	$1,158.30	$454.83	$209.92	$104.96
Employee + Child(ren)	$2,016.41	$1,667.12	$349.29	$161.21	$80.61
Family	$2,016.41	$1,377.61	$638.80	$294.83	$147.41

Silver Plan ($3,000/$6,000 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$584.28	$509.41	$74.87	$34.56	$17.28
Employee + Spouse	$1,402.27	$1,237.70	$164.57	$75.95	$37.98
Employee + Child(ren)	$1,752.83	$1,626.45	$126.38	$58.33	$29.16
Family	$1752.83	$1,521.70	$231.13	$106.68	$53.34

Bronze Plan ($6,350/$12,700 Deductible)	Monthly Rate	Re:Car Contribution Monthly	Employee Contribution Monthly **No Cost to Employees**	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$483.31	$483.31	$0	$0	$0
Employee + Spouse	$1,159.94	$1,159.94	$0	$0	$0
Employee + Child(ren)	$1,449.92	$1,449.92	$0	$0	$0
Family	$1,449.92	$1,449.92	$0	$0	$0

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*All deductions are done on a pretax basis unless requested otherwise.

Vision – Contributions

Full-time Employees

Coverage	Monthly Cost	Re:Car Contribution	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$5.02	$3.90	$1.12	$0.52	$0.26
Employee + Spouse	$10.03	$7.79	$2.24	$1.03	$0.52
Employee + Child(ren)	$16.65	$14.14	$2.51	$1.16	$0.58
Family	$16.65	$12.70	$3.95	$1.82	$0.91

Part-time Employees

Coverage	Monthly Cost	Re:Car Contribution	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$5.02	$3.68	$1.34	$0.62	$0.31
Employee + Spouse	$10.03	$7.34	$2.69	$1.24	$0.62
Employee + Child(ren)	$16.65	$13.64	$3.01	$1.39	$0.70
Family	$16.65	$11.91	$4.74	$2.19	$1.09

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Dental – Contributions

Full-Time Employees

Coverage	Monthly Cost	Re:Car Contribution	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$28.43	$22.10	$6.33	$2.92	$1.46
Employee + Spouse	$56.85	$43.94	$12.91	$5.96	$2.98
Employee + Child(ren)	$99.49	$83.35	$16.14	$7.45	$3.73
Family	$99.49	$75.53	$23.96	$11.06	$5.53

Part-Time Employees

Coverage	Monthly Cost	Re:Car Contribution	Employee Contribution Monthly	Employee Contribution Bi-Weekly	Employee Contribution Weekly
Employee Only	$28.43	$20.83	$7.60	$3.51	$1.75
Employee + Spouse	$56.85	$41.36	$15.49	$7.15	$3.58
Employee + Child(ren)	$99.49	$80.12	$19.37	$8.94	$4.47
Family	$99.49	$70.74	$28.75	$13.27	$6.64

*All deductions are done on a pre-tax basis unless requested otherwise.

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Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. Deductibles, copays, or coinsurance may apply. If you would like more information on WHCRA benefits, call your Plan Administrator.

NEWBORNS ACT DISCLOSURE - FEDERAL

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 DISCLOSURE

The Anthem Blue Cross Blue Shield plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Note: If you do not designate a primary care provider for yourself and any family members covered under the HMO plan, certain claims may be denied. You do not need prior authorization from Anthem Blue Cross Blue Shield 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 information on how to select primary care provider and for a list of the participating primary care providers, including those who specialize in obstetrics or gynecology, contact Anthem Blue Cross Blue Shield customer service at 888-333-4742 or online at www.guardiananytime.com.

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 (or after the employer stops contributing toward the other coverage).

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

You are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who you may be covering under this group health plan.

Important Notice About Your Prescription Drug Coverage 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 with RE:CAR, INC. and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. **RE:CAR, INC. has determined that the prescription drug coverage offered by BC BS of MI 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. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with RE:CAR, INC. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary

premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through RE:CAR, INC. 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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment–based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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. 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% 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.1

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.

How Can I Get More Information?

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

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

1 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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name RE:CAR, INC.	4. Employer Identification Number (EIN) 88-2384023	
5. Employer address 2600 Bellingham Road Suite 300	6. Employer phone number 248-330-9857	
7. City Troy	8. State MI	9. ZIP code 48083
10. Who can we contact about employee health coverage at this job? Albert De Veer		
11. Phone number (if different from above)	12. Email address Albert.deveer@rebuildmanufacturing.com	

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

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Full Time Employees working 30 or more hours per week
    Part Time Employees working 20 to 29 hours per week

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [xx] We do offer coverage. Eligible dependents are:

    Legal Spouse, Domestic Partners & Dependent Child(ren) to age 26.

  - [ ]

We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

• 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 (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

• 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 (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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 January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	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)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

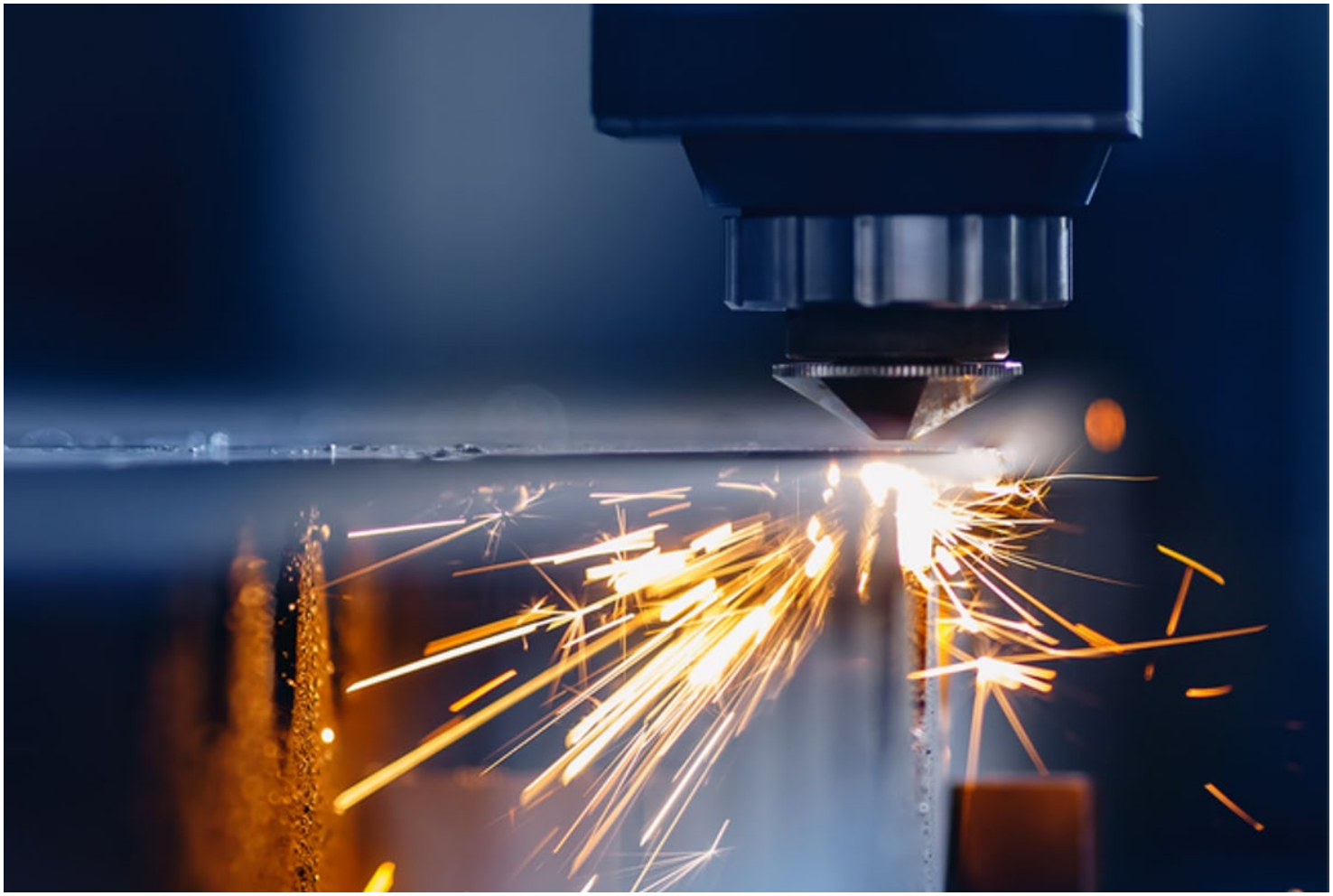
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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



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