



Employee Benefits Guide

2023 Plan Year

Integrated Design Solutions



Important Items to Remember

NEW HIRE WAITING PERIOD

New employees are eligible for company insurance benefits on the first of the month following date of hire.

TERMINATION OF BENEFITS

When your employment with the company is terminated, your benefits will be terminated at the end of the month following the termination date.

ELIGIBLE EMPLOYEES

To be eligible for company benefits, you must be a full time employee working an average of 30 hours per week throughout the year.

DEPENDENT CHILDREN

Children under the age of 26 are eligible to be covered under the benefits. They will be taken off of the plan at the end of the year in which they turn 26.

OPEN ENROLLMENT

Employees can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc.) during this time period each year. Open enrollment typically occurs 45 days prior to IDS plan renewal. All changes made during this time period will take effect on the renewal date, Jan 1st.

MAKING PLAN CHANGES DURING THE YEAR

If you've had a qualifying life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc.) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. Please turn in all paperwork within 30 days of your Qualifying Event. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it upon receipt.

COBRA

PLEASE NOTE: In the event your employment is terminated with the company, you will receive a letter in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 18 months. This is called COBRA coverage. Your employer DOES NOT contribute to this coverage.

MINI COBRA

PLEASE NOTE: In the event your employment is terminated with the company, you will receive a packet in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 12 months. This is called State Continuation, or Mini-COBRA. Your employer DOES NOT contribute to this coverage as they may when you are employed with them. You will be responsible for 102% of the actual cost of the insurance if you wish to continue with it.

STAY IN NETWORK

To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is in network BEFORE your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure EVERY doctor/nurse/radiologist/anesthesiologist/etc. is in your network.

EXPLANATION OF BENEFITS

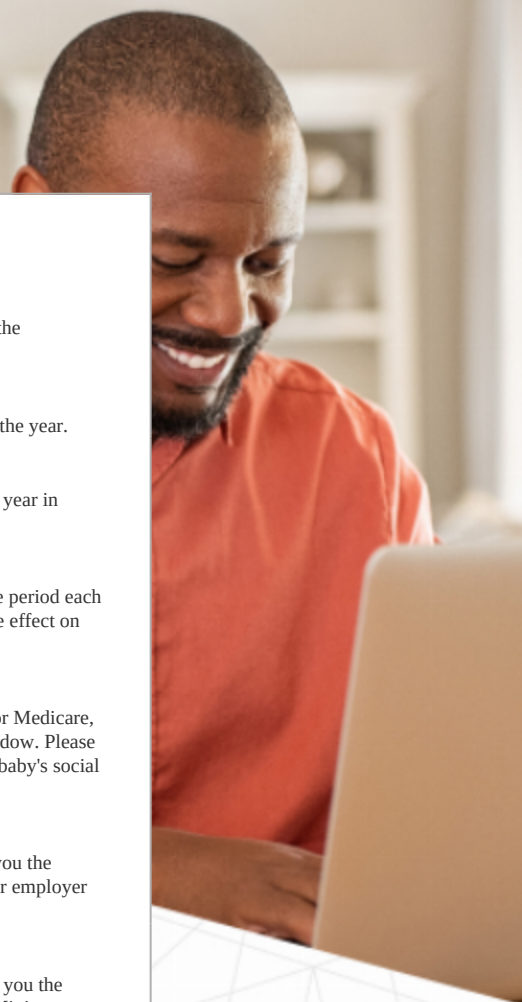
Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

NEED A NEW ID CARD OR ANOTHER ID CARD FOR A DEPENDENT?

You can register for the insurance carrier's website where you can print out temporary ID cards and order new cards, or you can contact insurance carrier from phone numbers listed on next page.

HAVE QUESTIONS ABOUT AN INSURANCE CLAIM?

PLEASE HAVE COPIES OF YOUR EXPLANATION OF BENEFITS ALONG WITH A COPY OF YOUR BILL(S) READY & CONTACT INSURANCE CARRIER.



Who to Contact if You Have Questions & Important Things to Know

Medical Plan Administrator- ASR Health Benefits

Address- P.O. Box 6392 Grand Rapids MI 49516-6392 Phone- (800) 968-2449 Business Hours: 8am - 4:30pm ESP Websites: P.O. Providers- www.physicianscare.com, www.hap.org, www.aetna.com Claims- www.physicianscare.com

Prescriptions- Navitus

Phone- (866) 333-2757 Website: www.Navitus.com

Health Savings Account- Further

Phone- (800) 859-2144, (651) 247-4695 Email- clientadvocate@hellofurther.com Reference Group #- 210007 Website: www.hellofurther.com, to access account online, sign in as a member.

Dental- Principal

Phone- (800) 247-4695 Website : www.principal.com

Life, AD&D, LTD, STD- UNUM

Phone- (877) 275-3539 Email- askunum@unum.com Website: www.unumprovident.com

Vision- NVA

Phone- (800) 672-7723 Website: www.e-nva.com

Waiving (Opting Out) of Coverage

You may opt out of coverage, however, you will be required to provide proof of health care coverage. If during the benefit year, you lose coverage involuntarily (e.g. your spouse loses a job, divorce, or you age out of your parent's plan), this is a Qualifying Life Event. See next section.

Qualifying Life Event

Types of qualifying life events that allow mid-year enrollment changes. (Not a complete list.) A change in marital status including marriage, divorce, legal separation, or annulment. A change in dependents, including a birth, death, adoption, and placement for adoption. A change in employment status of employee, spouse or dependents, including termination or commencement of employment. An employee's dependents satisfies or ceases to satisfy eligibility requirements for coverage due to attainment of age or change in student status. It is your responsibility to notify Human Resources within 30 days of the QLE.

Purchase Additional Vacation Option

Eligible IDS staff (all full-time, regular employees, and senior associates) have the opportunity to buy up to 40 hours of vacation time in 8 hour increments. This election has been incorporated into the Open Enrollment process through Employee Navigator. Time bought will be charged at the 2023 pay rate and withholding will begin with the first pay period of 2023 (January 13, 2023). This covers vacation taken between December 25, 2022 and December 22, 2023. This deduction would appear under the deductions section of your paystub with the code of VacW/H. Any unused vacation will be paid out on December 29, 2023.

Bi-Weekly Employee Contributions For Medical and Dental

Integrated Design Solutions offers an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows your contributions toward medical and dental insurance to be made on pre-tax basis. Your taxable income is reduced by the amount of your contribution which reduces the income subject to federal and state income taxes as well as FICA taxes. The tax benefit amount that you receive will depend on your individual contribution and tax bracket. Medical Bi-weekly Contribution: Single- \$98.43 Family: \$246.42 Additional Contribution based on Salary: 0% to 2.25% Dental Bi-Weekly Contribution: Single- \$4.25 Family- \$11.75 Vision Bi-Weekly Contribution: Single- \$0 Family- \$0

IRS Annual Maximums

The annual inflation-adjusted limit on 2023 HSA contributions for self-only coverage will be \$3,850, the 2023 HSA contribution limit for family coverage will be \$7,750. The adjustments represent approximately a 5.5 percent increase over 2022 contribution limits.



Health Plan

ASR | Health Renewal

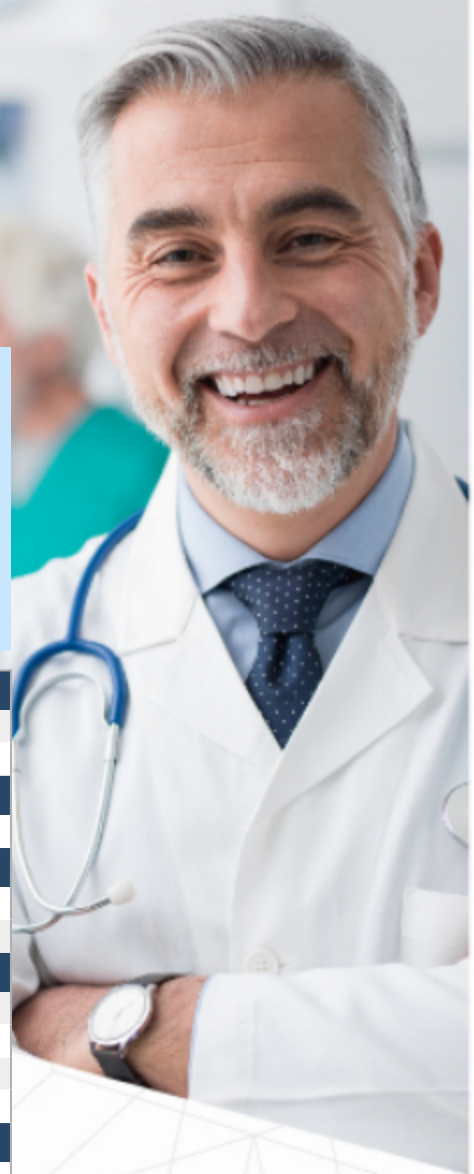
Plan Explanation

The plan is administered by ASR Administrators of Grand Rapids, Michigan. IDS' medical plan is a PPO HDHS Plan, which is a preferred provider organization (PPO) with a high deductible (HD) and health savings account (HSA). It was designed to provide employees with access to quality health care, comprehensive coverage, choice and the opportunity to save on taxes. The PPO portion of the plan is provided by PhysiciansCare. With a PPO plan, you have complete freedom to see any doctor of your choice. If you choose doctors and hospitals within the PPO network and have met your annual deductible, your out-of-pocket costs are covered. The pharmacy vendor is Navitus.

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	\$2,000	\$5,000
Family	\$4,000	\$10,000
COINSURANCE		
Member %	0%	50%
OUT OF POCKET MAXIMUM		
Single	\$6,900	\$10,000
Family	\$13,800	\$20,000
COMMONLY USED SERVICES		
Primary Care Physician Office Visit	No charge after Deductible	50% Coinsurance after Deductible
Specialist Office Visit	No charge after Deductible	50% Coinsurance after Deductible
Urgent Care	No charge after Deductible	50% Coinsurance after Deductible
Emergency Room	No charge after Deductible	No charge after in-network Deductible
PREVENTIVE CARE		
Preventive Services	No Charge	Not covered (except when required by law)
MAJOR MEDICAL EXPENSES		
Outpatient Surgery	No charge after Deductible	50% Coinsurance after Deductible
Inpatient Hospitalization / Surgery	No charge after Deductible	50% Coinsurance after Deductible
CT scan, PT scan, MRI	No charge after Deductible	50% Coinsurance after Deductible
Hospital Newborn Delivery	No charge after Deductible	50% Coinsurance after Deductible
PRESCRIPTION DRUG COVERAGE		
Generic (Tier 1)	25% of purchase price	50% of purchase price
Brand Name (Tier 2)	Lesser of 25% of purchase price or \$100	50% of purchase price
Non-Preferred (Tier 3)	Lesser of 25% of purchase price or \$150	50% of purchase price
Specialty (Tier 4)	25% of purchase price	N/A
Specialty (Tier 5)	25% of purchase price	N/A
Mail Order - 90 day Supply	Lesser of 25% of purchase price or \$200 for preferred brand name \$300 for non-preferred brand name	N/A
PLAN INFORMATION		
Plan Year	2023	
Deductible Period	1/1/2023- 12/31/2023	
Network Type	HSA PPO	
Network Name	Physicians Care/ Aetna	
Member Website	www.physicianscare.com	
Customer Service Phone Number	800-968-2449 is the number for ASR Health Benefits, this is who you should call with Medical Questions/ Concerns. When you call ID yourself as a participant under benefit plan group #895, ask to speak with a member of Claim Unit C. 866-333-2757 is the number for Navitus, this is who you should call when you have Prescription Questions/ Concerns.	

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.



ASR Healthcare Choices

ASR makes it easy to find quality, affordable care. When you shop for healthcare, you have the power to decide what meets your needs, from the doctors you see to the costs for your services.

ESTIMATE COSTS

Get cost estimates for treatments and procedures like MRIs or flu shots

Estimate your costs

Type a medical service name to compare provider costs



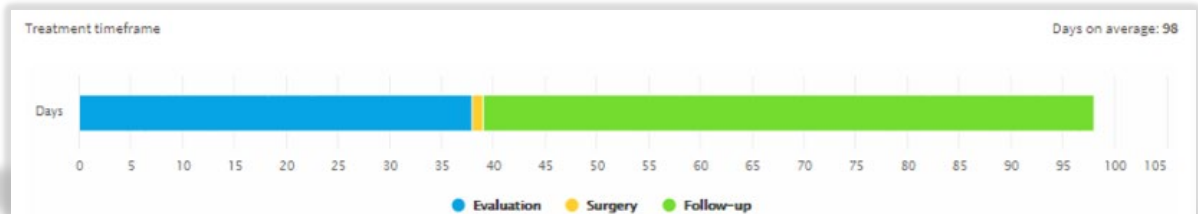
Shoulder Repair (Arthroscopic)

Shoulder Repair (Arthroscopic), Rotator Cuff

Shoulder Repair, Rotator Cuff

TREATMENT TIMELINES

Find treatment timelines for surgeries and long-term health problems



CONDITION INFORMATION

Learn about treatments and conditions and find doctors who offer them



Coronary Artery Disease (Atherosclerosis/Arteriosclerosis)

Coronary artery disease (CAD) is the most common type of heart disease. This disease causes narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart.



VISIT THE ASR MEMBER PORTAL TO START SAVING!

- Visit www.asrhealthbenefits.com or call (800) 968-2449 for assistance
- Get help activating your account
- Find the best priced, highest-quality healthcare
- Choose a doctor or specialist who meets your needs

Here's how to get started with ASR Healthcare Choices

Register at asrhealthbenefits.com.

Get access to your personalized account in a few simple steps.



Member Log-in

Username

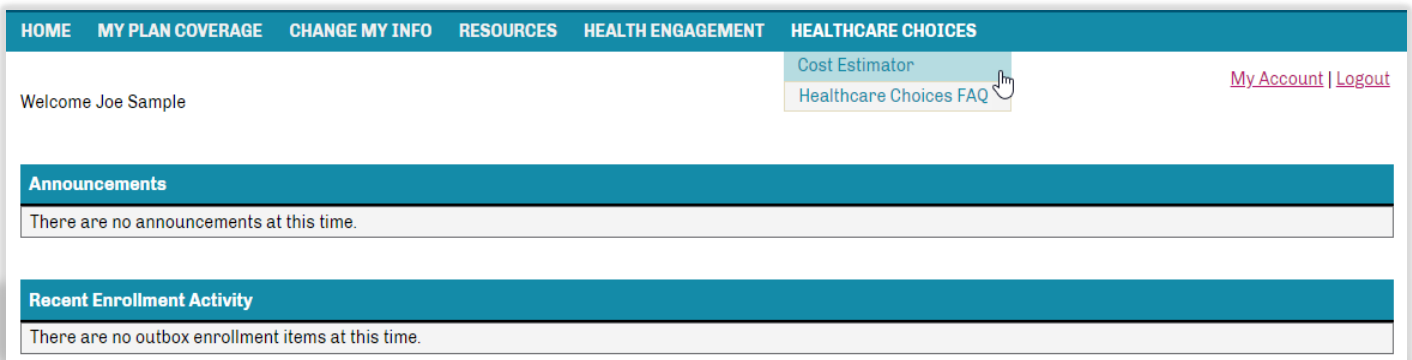
Password

LOG-IN

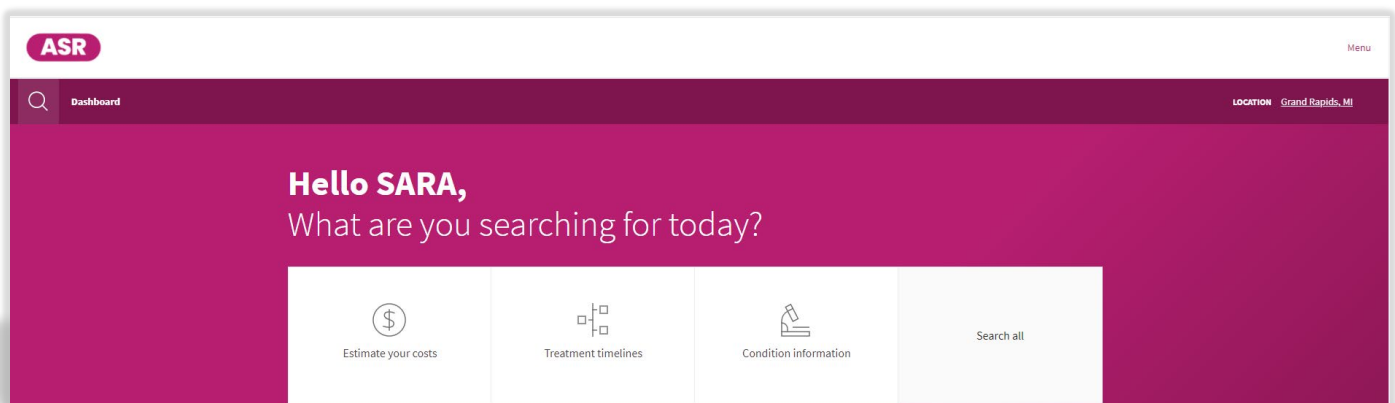
If you have forgotten your password
click our [Password Reminder](#).

Need a Log-in?
If you have not yet completed a log-in
form, please take a moment to do so.
[SIGN UP FOR A LOG-IN](#) ▶

Locate the **HEALTHCARE CHOICES** tab, and select **Cost Estimator** from the drop-down menu.



Begin estimating procedure costs, exploring treatment timelines, and more!



ASR Healthcare Choices

Rewardable Services

IMAGING SERVICES	REWARD
Bone and joint scan of whole body	\$50
Bone density study of spine or pelvis	\$50
Breast Tomosynthesis	\$50
Chest X-Ray	\$25
CT abdomen & pelvis w/o & w/ contrast	\$50
CT Angiography, Abdomen w/o & w/ contrast	\$50
CT Angiography, Head w/o & w/ contrast	\$50
CAT Scan, Lower Limb (without Contrast)	\$50
CT scan abdomen w/o & w/ contrast	\$50
CT scan chest w/o & w/ contrast	\$50
CAT Scan, Needle Imaging Guidance	\$50
CT scan head/brain w/o & w/ contrast	\$50
CT scan of lumbar lower spine w/o & w contrast	\$50
CT scan of mouth, jaw, and neck w/o contrast	\$50
CT Soft Tissue Neck w/ Dye	\$50
Doppler Echo for Carotid Artery Evaluation	\$50
Duplex Ultrasound Scan of Blood Flow, Complete & Limited, At	\$50
Echo Exam of Abdomen	\$50
Echocardiogram - Trans-thoracic with Doppler (Complete)	\$50
Echocardiogram - Trans-thoracic with Rest & Stress Test	\$50
Echocardiogram - Trans-thoracic with Rest & Stress Test (Co	\$50
Extremity Arterial Studies	\$50
Heart Muscle Image Spect Mult	\$50
Hepatobiliary Nuclear Medicine Imaging	\$50
Mammogram	\$50
MR Angiography Head w/o Dye	\$50
MRI Abdomen w/o & w/ contrast	\$50
MRI brain w/o & w/ contrast	\$50
MRI Breast	\$50
MRI lower limb with joint w/o & w/ contrast	\$50
MRI lower limb w/o & w/ contrast	\$50
MRI lumbar spine w/o & w/ contrast	\$50
MRI neck spine w/o & w/ contrast	\$50
MRI orbit/face/neck w/o & w/ contrast	\$50
MRI Pelvis w/o & w/ contrast	\$50
MRI spine w/o & w/ contrast	\$50
MRI Upper Limb Joint w/o & w/ contrast	\$50
MRI upper limb (other than joint) w/o contrast	\$50
Pet scan image from skull base to mid-thigh	\$50
Single Fetus Ultrasound After 14 Weeks	\$50
Single Fetus Ultrasound Before 14 Weeks	\$50
Single Fetus Ultrasound Detailed Fetal Exam	\$50
Transthoracic Echocardiogram for Congenital Heart Defects	\$50
Transvaginal Ultrasound (Obstetrical & Non-Obstetrical)	\$50
Ultrasound Exam Scrotum	\$50
Ultrasound of abdomen, breast(s) or pelvis	\$50
Ultrasound of Abdomen & Back (Retroperitoneal)	\$50
Ultrasound of head and neck (e.g. thyroid, parathyroid, paroti	\$50
Bone Age Studies	\$50
X-Ray Exam of Abdomen, Ankle, Finger(s), Foot, Hand, Hip, Kne	\$25
(3 views), Lower Spine, Neck Spine, Pelvis, Shoulder or Wrist	

INPATIENT SURGERIES	REWARD
Spinal fusion (lumbar)	\$100
Combined anterior/posterior spinal fusion	\$100
Coronary bypass with cardiac catheterization	\$100
Delivery (C-section or vaginal)	\$100
Hip or knee replacement	\$100
Hysterectomy	\$100
Major small & large bowel procedures	\$100
Removal of plaque build-up in the major neck (carotid) arterie	\$100
Removal of prostate gland and surrounding tissue	\$100
Revision of total hip or total knee replacement	\$100

OUTPATIENT SURGERIES	REWARD
ACL repair by arthroscopy	\$75
Appendix Removal (Laparoscopic)	\$75
Benign Breast Tumor Removal	\$75
Bladder repair for incontinence (sling)	\$75
Bladder Scope with stent or with Lithotripsy (Kidney Stone fragm	\$75
Breast biopsy percutaneous w/imaging or breast lumpectomy	\$75
Bronchoscopy	\$75
Bunionectomy	\$75
Carpal tunnel w/o or w/ Scope	\$75
Cataract removal	\$75
Cervical Biopsy w/ Scope	\$75
Colonoscopy with biopsy or removal of lesion(s)	\$75
Drainage of Bursa or Abscess	\$75
Dysrhythmia Focus Ablation	\$75
Esophagoscopy	\$75
Eyelid Revision	\$75
Fine Needle Aspiration for Biopsy w/Imaging	\$75
Hammertoe correction	\$75
Hysteroscopy with removal of lesion(s) or uterine lining (e.g. end	\$75
Kidney Stone Removal by Bladder Scope	\$75
Knee arthroscopy with cartilage repair	\$75
Laparoscopic removal of gallbladder, ovaries and/or fallopian tu	\$75
Left heart catheterization	\$75
Minor or Moderate Wound Repair	\$75
Mohs Surgery for Tumor Removal	\$75
Nasal/sinus - corrective surgery - septoplasty	\$75
Pre-malignant Skin Lesion Destruction	\$75
Reduction Mammoplasty	\$75
Repair Detached Retina	\$75
Repair Finger Tendon	\$75
Repair of blepharoptosis	\$75
Repair of umbilical or inguinal hernia (age 5+) or ventral hernia	\$75
Retinal Lesion Treatment - Photocoagulation	\$75
Screening colonoscopy	\$75
Shock wave treatment for kidney stones	\$75
Shoulder arthroscopy w/o & w rotator cuff repair	\$75
Sigmoidoscopy	\$75
Simple Biopsy of Uterus Lining	\$75
Skin Lesion Biopsy	\$75
Sleep Study with or without CPAP	\$75
Spinal fusion of neck - front	\$75
Spinal Injection for Pain Management	\$75
Steroid Injection into Tendon	\$75
Tonsillectomy and adenoidectomy	\$75
Total Hysterectomy (Laparoscopic)	\$75
Tympanostomy and myringotomy	\$75
Upper GI endoscopy w/o & w/ biopsy	\$75
Urethra and bladder scope	\$75
Uterine tissue sample (biopsy)	\$75
Varicose Vein Ablation or Treatment via Injection	\$75
Vasectomy	\$75

FURTHERSM
by HealthEquity

HSA

Health Savings Account

Welcome to your health savings account (HSA) from Further. As one of the largest, most experienced and trusted HSA administration partners in the nation, we're making these accounts intuitive, accessible and pain-free. Everything you need is just a tap, click, call or swipe away.

If you have questions or need more information about your HSA, our expert customer service team is ready to help.



**Save money
tax-free**

**Earn interest
tax-free**

**Pay for health
care expenses
tax-free**



Introducing the HSA

A health savings account (HSA) is a tax-advantaged member-owned account that lets you save pretax dollars for future qualified medical expenses. It belongs to you and the money is yours to keep, even if you change jobs or retire. You don't pay any taxes on the money you put in or take out, as long as you use it for medical expenses as defined by the IRS.



Watch the ["What is a Health Savings Account \(HSA\)?"](#) video.

Is an HSA right for you?

You're enrolled in an
HSA-qualified health plan.

You can't be claimed as a dependent
on someone else's taxes.

You have no other health coverage.

You can contribute some money to save or
pay for health care expenses.

You aren't enrolled in Medicare.

You want to be ready when you
have unexpected health care needs.

How an HSA works with your eligible health plan

Medical
premium
(your payment
for health
insurance)

Premiums often cost less
for HSA-qualified plans.

Out-of-pocket
costs you pay
for health care
(up to deductible
and coinsurance)

Consider how much
you'll spend on health
care next year. Put that
money into an HSA pretax
from your paycheck.

HSA
contributions

Putting money into an
HSA helps you prepare
and pay for these costs
tax-free. If you don't
need the money, save
it for future needs.

Out-of-pocket
maximum

Once you reach your
out-of-pocket max,
everything is 100%
covered. This protects
you from a major financial
crisis should unexpected
health care needs arise.



Use [this worksheet](#) to determine
your eligibility and decide how
much to contribute.

Five ways an HSA can help you save for your future

- 1 Money is not taxed.** Money goes into your HSA pretax. That reduces your taxable income saving you money on your medical expenses.¹
- 2 No “use it or lose it” rule.** Money in your HSA belongs to you, even if you change jobs or health plans, or retire.
- 3 Invest and grow your money.** Your money earns interest tax-free, from day one. When your Base Balance reaches \$1,000, you can open a basic investment account with access to 30+ mutual funds. When your basic investment account assets exceed \$10,000, you can choose to invest funds with a self-directed brokerage account through Charles Schwab.
- 4 More flexibility and choice.** You can use your HSA dollars for certain health care expenses² beyond what your plan covers, allowing you to purchase these services tax-free even if they aren’t covered.
- 5 Even out medical expense highs and lows.** Since you manage your funds, you can save HSA money when you’re healthy so it’s ready when you need it.

¹ Please consult your tax advisor with questions

² Refer to the [hellofurther.com](https://www.hellofurther.com) HSA page for a list of HSA-eligible services and products

All systems go!

Use your HSA for these:

- Medical expenses that your plan doesn’t cover
- Over-the-counter medications, supplies, and some feminine hygiene products
- Copayments, coinsurance and prescription drugs
- Dental and vision care expenses
- Some long term care premiums

NOTE: It’s important to save all your receipts to validate expenses, as required by the IRS.

Heads up!

You can’t use your HSA for these:

- Health insurance premiums
- Costs that aren’t considered qualified medical expenses as defined by the IRS



Use our **eligible expenses search** to see what else you can pay for with an HSA.

The total amount you can put in an HSA tax-free:

	2022 limits	2023 limits
Single	\$3,650	\$3,850
Family	\$7,300	\$7,750
Catch Up (age 55+)	\$1,000	\$1,000



Meet Jim¹



His annual salary: \$58,000

His annual HSA contribution: \$2,600

His taxable income after HSA contribution: \$55,400

His estimated tax rate²: 25%

His estimated tax savings: \$650

When Jim incurs a \$650 health care bill, it actually costs him nothing when factoring in the tax savings.*

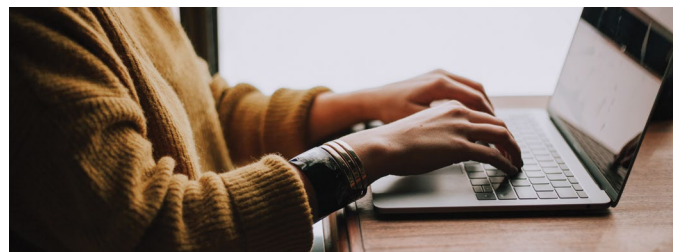


Calculate your potential savings with an HSA.

¹ Hypothetical example for illustration purposes only.

² Assumes Jim is subject to a 25% income tax rate.

³ The Further Visa Debit Card is issued by The Bancorp Bank, pursuant to a license from Visa U.S.A. Inc. and can be used for qualified expenses wherever Visa debit cards are accepted.



Select an HSA eligible health plan at enrollment*

- Further will send your Further Visa[®] Debit Card and Spending Account I.D. number by mail.³
- Use your SA I.D. number to set up your online access.
- Download the Further app or use the website to view and manage your account.

* Member must open a Further HSA account if not automatically enrolled by their employer based on eligible health plan choice. Please consult your plan documents.

We're here for you

If you can't find the answers you're looking for online, give us a call. You can talk with one of our specially trained HSA customer service representatives.



1-800-859-2144

7 a.m. to 8 p.m. CST, Monday-Friday



hellofurther.com

Health Savings Account

An HSA lets you put money away for future healthcare costs while saving on taxes. How? HSAs are never taxed at a federal income tax level when used for qualified medical expenses. Contributions can come straight out of your paycheck, and your HSA can grow tax-free too.

- ✓ No 'use-it-or-lose-it,' keep your HSA forever
- ✓ Create a healthcare emergency safety net
- ✓ Invest¹ your HSA tax-free, like a 401(k)



Annual tax saving potential²

\$1,550

Family plan

\$770

Individual plan

2023 IRS Contribution Limits

\$7,750

Family plan

\$3,850

Individual plan

Members 55+ can contribute an extra \$1,000

Common qualified medical expenses:

- Pain relievers
- Doctor visits
- Dental cleaning
- Sleep aids
- Eyeglasses/contacts
- Cold/cough medicine
- Chiropractic care
- Insulin testing supplies



**See how much
you can save**

learn.hellofurther.com

¹Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by Further by HealthEquity, Inc. | ²Estimated savings are based on an assumed combined federal and state income tax rate of 20%. Actual savings will depend on your taxable income and tax status. | Further by HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

Dental Plan

Principal | Dental Renewal

Plan Explanation

Comprehensive coverage is provided for eligible employees and their families which includes eligible dependent children up to the age of 26. Your HSA account can be used to cover co-pays. The plan has a maximum annual amount of coverage of \$1,000 per covered person. It also has an accumulation plan which may allow members to carry forward a portion of unused balance. A member must have submitted a claim during the year to qualify. If no claims were submitted, the entire balance is forfeited. If less than \$500 of benefits were used during the plan year, \$250 will be carried forward to the next plan year. The maximum balance that can be accumulated is \$1,000.

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	\$0	\$25
Family	\$0	\$25
MAXIMUM THE CARRIER WILL PAY		
Annual Maximum	\$1,000	\$1,000
FREQUENCIES		
Cleaning	2x per Year	
Exam	2x per Year	
DENTAL COVERAGE		
Cleanings	100%	100%
Exams	100%	100%
X-Rays	100%	100%
Sealants	100%	100%
Fillings	100%	100%
Simple Extractions	100%	100%
Root Canal	60%	60%
Oral Surgery	60%	60%
Crowns	60%	60%
Dentures	60%	60%
Bridges	60%	60%
Orthodontia	50%	50%
OUT OF NETWORK EXPLANATION		
	Out of network dentists are NOT contracted with your dental insurance carrier. After you pay for the service based on your benefit plan, the insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist. In most cases, the out of network dentist does not consider this as payment in full (like an in-network dentist would) and may "Balance bill" you. That is, they may ask you to pay the difference.	
PLAN INFORMATION		
Plan Year	2023	
Network Type	PPO HSA	
Network Name	Principal Plan Dental Network	
Member Website	https://www.principal.com	
Customer Service Phone Number	800-247-4695	

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.



Vision Plan

NVA | Vision Renewal

Plan Explanation

Eligible members and dependents are entitled to receive a vision examination and one pair of lenses once every calendar year, and a frame once every two calendar years. Or contact lenses and a contact lens fitting/ evaluation once every calendar year. At the time of your appointment simply present your NVA identification card or indicate that your benefit is administered by NVA.

VISION COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	\$10	\$35
Single Vision Lens	\$0	\$25
Lined Bi-Focal Lens	\$0	\$45
Lined Tri-Focal Lens	\$0	\$75
Lenticular Lens	\$0	\$75
Contact Lens Allowance	\$0	\$25
Frame Allowance	\$0	\$45
FREQUENCIES		
Exam Frequency	Once every Year	
Lens Frequency	Once every Year	
Frame Frequency	Once every 2 Years	
OUT OF NETWORK EXPLANATION		
	While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you. You may have to file the claim yourself.	
PLAN INFORMATION		
Plan Year	2023	
Network Name	National Vision Administrators	
Member Website	www.e-nva.com	
Customer Service Phone Number	800-672-7723	

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.



Bi-Weekly Employee Contributions for Medical and Dental

Integrated Design Solutions offers an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows your contributions toward medical and dental insurance to be made on pre-tax basis. Your taxable income is reduced by the amount of your contribution which reduces the income subject to federal and state income taxes as well as FICA taxes. The tax benefit amount that you receive will depend on your individual contribution and tax bracket.

Plan	Single Bi-Weekly Deduction	Family Bi-Weekly Deduction
Medical Base + Adjustments		
Contribution based on Salary	0% to 2.25%	0% to 2.25%
Medical Base	\$98.43	\$246.42
Dental	\$4.25	\$11.75
Vision	\$0	\$0

*These deductions will appear on your paystub as deductions. The code for medical is ASR, the code for Dental is Dental.

Life Plan

UNUM | Life Coverage

Plan Explanation

IDS offers eligible employees Basic Life, Long Term Disability and Accidental Death and Disability (AD&D) coverage through UNUM Provident. Your basic life benefit is equal to the lesser of your base annual earnings (rounded to the next highest \$1,000) or \$50,000. AD&D benefits are also provided. If your death is determined to be an accident, the Accidental Death & Dismemberment (AD&D) portion of the policy will pay an additional benefit equal to the lesser of your base annual earnings (rounded to the next highest \$1,000) or \$50,000 to your beneficiary.

LIFE INSURANCE BENEFITS	
Life Insurance Coverage	1x annual salary, maximum benefit of \$50,000
Accidental Death & Dismemberment	1x annual salary, maximum benefit of \$50,000
Age Reduction Schedule	Life insurance is reduced by 65% after age 70, and reduced by 50% after age 75.
Taxation of Benefit	Pre-tax means that you elect to pay taxes on the imputed value of the premium now, in the current tax year. This occurs through payroll. If you elect this option, your paystub will reflect the bi-weekly amount under earnings and deductions. Post-tax means that you are electing to pay taxes on any LTD benefits that you may receive as a result of an event occurring during the plan year resulting in LTD benefits. No taxes will be withheld if no LTD benefits are paid.
PLAN INFORMATION	
Plan Year	2023
Member Website	www.unumprovident.com or email: askunum@unum.com
Customer Service Phone Number	877-275-3539



Disclaimer

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Voluntary Life

UNUM | Voluntary Life Coverage

Plan Explanation

You can elect to purchase Supplemental Life coverage in increments of \$10,000 up to the lesser of five times your base annual earnings or \$500,000. You may elect to purchase Supplemental Life coverage for your spouse in \$5,000 increments. The maximum benefit is the lesser of 100% of your (the employee's) Supplemental Life coverage or \$500,000. You may elect to purchase Supplemental Life coverage for your eligible dependent children aged 14 days to 19 years of age (or to age 26 if a full-time student) in \$2,000 increments. The premium amount provides life coverage for all of your eligible dependent children. In other words, your monthly rate is the same regardless of the number of eligible children that you have. The maximum amount of Life coverage on your dependent children is \$10,000.

LIFE INSURANCE BENEFITS

Employee Life Insurance Coverage	Amounts in \$10,000 benefit units as applied for by you, and approved by UNUM. Evidence for Insurability is required for an amount over \$50,000. Maximum Benefit is the lesser of 5 times your annual earnings, or \$500,000.
Spouse Life Insurance Coverage	Amounts in \$5,000 benefit units as applied for by you and approved by UNUM. Evidence for Insurability is required for an amount over \$25,000. Maximum Benefit is the lesser of 100% of your insurance, or \$500,000.
Child(ren) Life Insurance Coverage	Amounts in \$2,000 benefit units as applied for by you and approved by UNUM. Maximum Benefit for children: Birth to 6 months: \$1,000 6 months to age 19, or 26 if a full time student: The lesser of 100% of your insurance, or \$10,000
Age Reduction Schedule	Insurance amount reduces by 65% at age 70, and then by 50%
Guaranteed Insurability	You will be required to submit an Evidence of Insurability statement if: 1) in previous years you were eligible for Supplemental Life benefits but have never elected to enroll OR 2) you are enrolled and chose to increase the amount of coverage such that the new supplemental life policy exceeds \$50,000.

PLAN INFORMATION

Plan Year	2023
Member Website	www.unumprovident.com or email askunum@unum.com
Customer Service Phone Number	877-275-3539

Disclaimer

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Short Term Disability

UNUM | Short Term Disability Coverage

Plan Explanation

Short term disability insurance is available to all eligible employees on an elective basis. This plan, through UnumProvident, is designed to provide a benefit to replace a portion of your lost income should you be unable to work due to a non-occupational illness or injury.

STD INSURANCE BENEFITS

Weekly Benefit	60% of weekly earnings up to \$750 per week. Up to 13 weeks.
When do benefits start? (Elimination period)	0 days due to an injury. 7 days due to sickness or illness.
How long do my benefits pay out?	13 weeks

PLAN INFORMATION

Plan Year	2023
Member Website	www.unumprovident.com or email askunum@unum.com
Customer Service Phone Number	877-275-3539

Disclaimer

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Long Term Disability

UNUM | Long Term Disability Coverage

Plan Explanation

IDS offers Long Term Disability insurance provides you with 60% of monthly (maximum \$6,000) income if you are totally disabled. Disability income benefits begin on the 91st day of disability and may be paid while you are disabled until you attain 65 years of age, or later, depending upon your age when the disability starts.

LTD INSURANCE BENEFITS

Monthly Benefit	60% of monthly earnings with a maximum of \$10,000 per month for partners and \$6,000 per month for employees.
When do benefits start? (Elimination period)	90 days.
How long do my benefits pay out?	Age at Disability Maximum Period of Payment: Less than age 60 to age 65, but not less than 5 years Age 60, 60 months Age 61, 48 months Age 62, 42 months Age 63, 36 months Age 64, 30 months Age 65, 24 months Age 66, 21 months Age 67, 18 months Age 68, 15 months Age 69 and over, 12 months
Taxation of Benefit	Pre-tax means that you elect to pay taxes on the imputed value of the premium now, in the current tax year. This occurs through payroll. If you elect this option, your paystub will reflect the bi-weekly amount under earnings and deductions. Post-tax means that you are electing to pay taxes on any LTD benefits that you may receive as a result of an event occurring during the plan year resulting in LTD benefits. No taxes will be withheld if no LTD benefits are paid.

PLAN INFORMATION

Plan Year	2023
Member Website	www.unumprovident.com or email, askunum@unum.com
Customer Service Phone Number	877-275-3539

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Accident

All State | Accident Plan

Plan Explanation

Accident Insurance Coverage can help pick up where your Health Insurance plan leaves off. Accident Coverage can be used to pay deductibles, coinsurance or copays. The Accident plan also can be used for Emergent situations such as bone fractures or ambulance services.

INJURY	SCHEDULED BENEFIT
Burn - 2nd Degree	\$300
Burn - 3rd degree	\$300
Coma	\$30,000
Dental Injury	\$300
Dislocation - Hip	\$6,000
Dislocation - Knee	\$2,400
Dislocation - Shoulder	\$1,200
Fracture - Hip	\$6,000
Fracture - Skull	\$5,700
Fracture - Arm	\$3,300
Fracture - Hand	\$2,100
Quadriplegia	\$60,000
Paraplegia	\$60,000
Loss of Speech	\$60,000
Loss of Hearing	\$60,000
PLAN INFORMATION	
Plan Year	2023
Member Website	https://www.allstate.com/
Customer Service Phone Number	1-800-669-1552

Disclaimer

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Critical Illness

All State | Critical Illness Plan

Plan Explanation

Critical Illness coverage will help provide financial support if you are diagnosed with one of the listed critical illnesses. When a diagnosis occurs you can focus on getting better, and not on the financial burden.

CRITICAL ILLNESS BENEFIT	
Minimum Benefit	N/A
Maximum Benefit	N/A
ILLNESS	% OF SCHEDULE BENEFIT
Cancer	\$15,000
Cancer - Carcinoma in situ	\$3,750
Heart Attack	\$15,000
Major Organ Failure	\$15,000
Stroke	\$15,000
PLAN INFORMATION	
Plan Year	2023
Member Website	https://www.allstate.com/
Customer Service Phone Number	1-800-669-1552

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AllstateSM Identity Protection Select



Strong protection
for your employees'
identity and finances



Identity theft impacts
10 million¹
consumers a year

When fraud occurs, unraveling it
can be overwhelming and costly.
In 2020 alone, identity theft victims
experienced nearly

\$13.3 billion¹
in total fraud losses.

Introducing...

Allstate Identity Protection *Select*, a new product that provides comprehensive financial and identity monitoring to help employees protect themselves against the impact of identity theft. **Allstate Identity Protection Select** is available to employers who offer it with at least one Allstate Benefits Voluntary Benefit product. And as part of this special offer, employees gain access to exclusive pricing for Allstate Identity Protection *Select*.

Protecting your employees also protects your business

Identity theft affects employees and employers

- 85% of identity theft victims feel worried, angry and frustrated²
- Distraction and stress increase the potential for absenteeism, threatening overall productivity²
- With 73% of passwords duplicated, often across work and personal accounts, stolen employee PII could be used to access an employer's sensitive client or customer information³

More **SECURE** Employees = More **SECURE** Employers

Sources - ¹Javelin Strategy & Research, "2021 Identity Fraud Study: Shifting Angles," March 2021. ²The Identity Theft Resource Center, "Identity Theft: The Aftermath Report," 2019. ³Microsoft, "One simple action you can take to prevent 99.9 percent of attacks on your accounts," August 2019

We make it simple



Enrollment integration

Sign up for all products in one simple process



Consolidating billing

Allstate Benefits products and Allstate Identity Protection **Select** all on one bill



Seamless customer care

Just one support number for employers to call for help with all products

Allstate Identity Protection Select provides everything employees need to gain more peace of mind:



Detect

View and manage alerts in real time to help identify threats



Resolve

Identity Specialists are on call 24/7 to help members recover from identity theft – even if the fraud occurred before members were a customer



Reimburse

If identity theft occurs, we'll cover out-of-pocket expenses, lost wages, legal fees and stolen funds

Allstate Identity Protection Select



Individual Premiums

Monthly	\$5.95
Semi-Monthly	\$2.98
Bi-Weekly	\$2.75
Weekly	\$1.37



Family Premiums

Monthly	\$11.95
Semi-Monthly	\$5.98
Bi-Weekly	\$5.52
Weekly	\$2.76

9thly, 10thly, Quarterly, Semi-Annual and Annual rates are also available

With Allstate Identity Protection **Select**, members are able to¹

- Check their identity health score
- Get comprehensive identity and financial monitoring
- View and manage alerts in real time
- Receive high-risk financial transaction alerts
- Depend on in-house customer care specialists 24/7
- Rely on \$1 million identity theft expense coverage**
- Protect themselves and their family (everyone that's "under the member's roof and wallet")***
- And much more!

Protect your employees and their families

Families are more likely to experience identity theft than individuals. And when they do experience fraud, it takes families two times longer to resolve. Plus, the costs families incur as a result of fraud are three times higher.⁴ Our Family Plan provides coverage for kids and teens of all ages, so employees can help protect their future and give them a safe head start. If they are dependent on your employee financially or live under their roof, they're covered.^{***}

Contact your Allstate Benefits representative today to learn more about **Allstate Identity Protection Select**.

Good hands working together can do great things.SM

Sources - ⁴Javelin Strategy & Research, "Identity Fraud and Families — Impacts of a Digitally Connected Life," 2020.

^{*}Certain features require additional activation. ^{**}Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Product may be updated or modified prior to availability. ^{***}For family plans only.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation. Allstate Identity Protection offers its products and services subject to its own terms, limitations and exclusions. Allstate Benefits makes no representations or warranties regarding the Allstate Identity Protection Select program, and is not responsible



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www.allstate.com or allstatebenefits.com

IMPORTANT DISCLOSURES

NOTE TO ALL EMPLOYEES

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

Integrated Design Solutions

Nicole Kolhagen – Human Resources Manager

Address: 1441 West Long Lake Rd. Suite 200, Troy, MI 48098

Phone: 248-823-2100

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within 30 days of the loss of that coverage. For this purpose, “loss of coverage” will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer’s Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within 30 days of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within 60 days after either:

(1.) You or your Eligible Dependent’s Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

NOTICE REGARDING WOMEN’S HEALTH AND CANCER RIGHTS ACT

(JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

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

If you would like more information on WHCRA benefits, please call your plan administrator.

NEWBORNS AND MOTHERS NOTICE

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury. The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage. Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

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NOTICE REGARDING PATIENT PROTECTION RIGHTS

Integrated Design Solutions group health plan allows members to designate a Primary Care Provider. The following paragraphs outline certain protections under the Patient Protection and Affordable Care Act (Affordable Care Act) and only apply when the Plan requires or allows the designation of a Primary Care Provider.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. 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 or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

MEDICARE NOTICE

You must notify Integrated Design Solutions when you or your dependents become Medicare eligible. Integrated Design Solutions is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice below.

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MEDICARE PART D COVERAGE NOTICE – IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

If you are covered by 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 Integrated Design Solutions 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:

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.

Integrated Design Solutions has determined that the prescription drug coverage offered by your company plan, 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. If 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 15 through December 7. 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.

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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. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 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 19 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 your HR Representative. You will receive this notice each year and again, if this coverage through your company 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, visit U.S. Social Security Administration’s at www.socialsecurity.gov or call 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 (penalty).

Integrated Design Solutions

Nicole Kolhagen – Human Resources Manager

Address: 1441 West Long Lake Rd. Suite 200, Troy, MI 48098

Phone: 248-823-2100

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

There is an additional way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

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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 9.83 percent of your household income for 2021 (9.61 percent for 2022), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

(An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

HOW CAN I GET MORE INFORMATION?

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

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

THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information.

Builds on HIPAA's protections. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Before the Affordable Care Act, HIPAA prevented a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information. Under the Affordable Care Act, plans are prohibited from excluding coverage or benefits due to any preexisting condition. HIPAA continues to prohibit discrimination in eligibility, benefits, or premiums based on a health factor (including genetic information).

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Additional underwriting protections. GINA provides that group health plans cannot adjust premiums or contribution amounts for a plan, or a group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

Prohibits requiring genetic testing. GINA generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer under certain conditions to request (but not require) that a participant or beneficiary undergo a genetic test.

Restricts collection of genetic information. GINA prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with enrollment in the plan, or at any time for underwriting purposes. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA).

GINA includes an exception for incidental collection of genetic information, provided the information is not used for underwriting purposes. However, the GINA regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

Other protections. GINA also contains individual insurance market provisions, administered by the Department of Health and Human Services' Centers for Medicare & Medicaid Services, privacy and confidentiality provisions, administered by the Department of Health and Human Services' Office for Civil Rights, and employment-related provisions, administered by the Equal Employment Opportunity Commission (EEOC).

For more information, see the **Frequently Asked Questions Regarding the Genetic Information Nondiscrimination Act** on the EBSA Website.

NO SURPRISES ACT

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

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YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Michigan Department of Insurance and Financial Services PO Box 30220 Lansing, MI 48909. Call toll free Monday – Friday 8:00 am – 5:00 pm (800) 999-6442.

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,

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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, 2018. Contact your State for more information:

ALABAMA – MEDICAID Website: http://myalhipp.com/ Phone: 1-855-692-5447	FLORIDA – MEDICAID Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – MEDICAID The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	GEORGIA – MEDICAID Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – MEDICAID Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	INDIANA – MEDICAID Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	IOWA – MEDICAID Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

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KANSAS – MEDICAID	NEW HAMPSHIRE – MEDICAID
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhcpp/ Phone: 603-271-5218
KENTUCKY – MEDICAID	NEW JERSEY – MEDICAID AND CHIP
Website: http://chfs.ky.gov/dms/default.htm 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/ n/331	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://dma.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: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – MEDICAID	OREGON – MEDICAID
Website: https://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
NEBRASKA – MEDICAID	RHODE ISLAND – MEDICAID
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
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: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473

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TEXAS – MEDICAID Website: http://gethipptexas.com/ Phone: 1-800-440-0493	WEST VIRGINIA – MEDICAID Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – MEDICAID AND CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	WISCONSIN – MEDICAID AND CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
VERMONT– MEDICAID Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	WYOMING – MEDICAID 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 January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. DEPARTMENT OF LABOR SECURITY ADMINISTRATION www.cms.hhs.gov 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
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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.

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