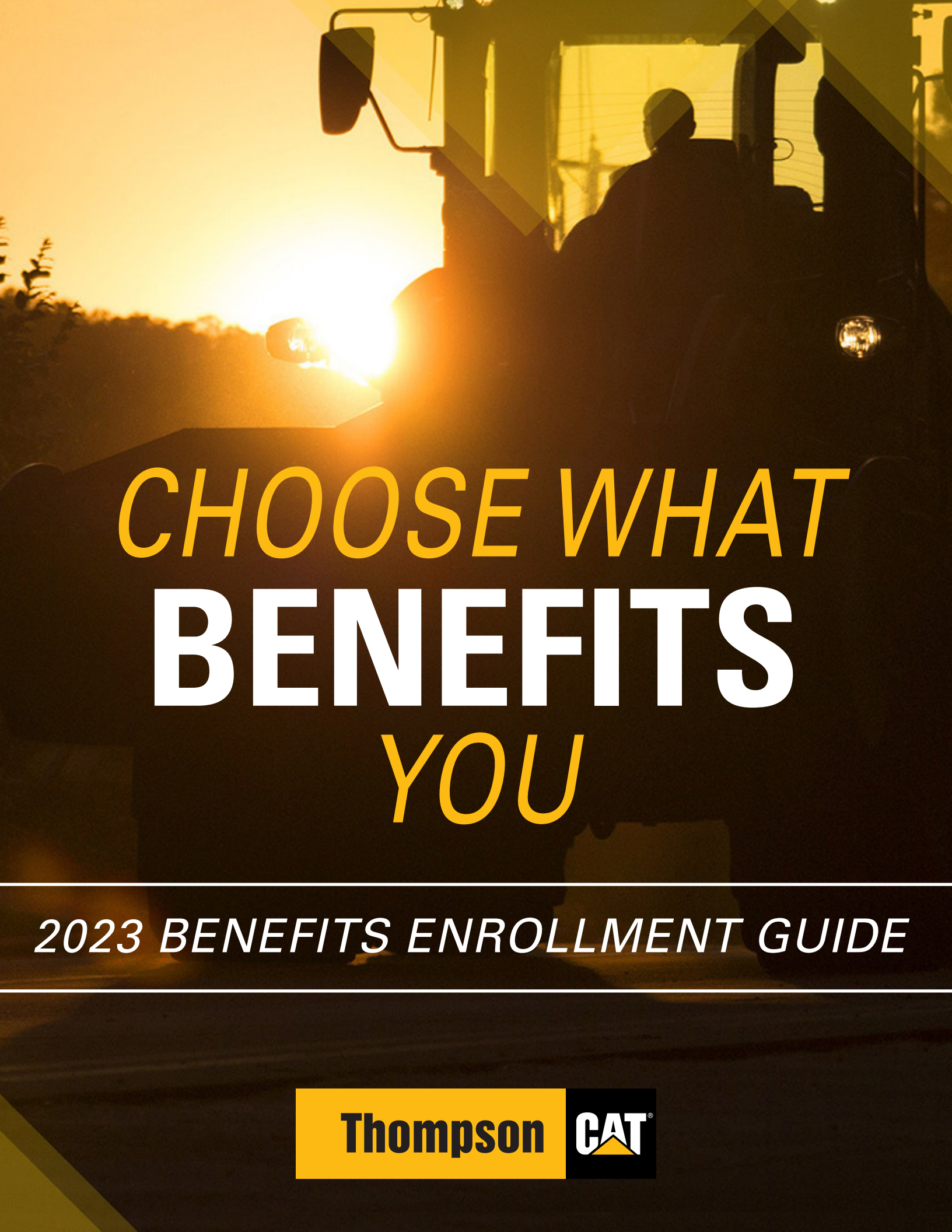


CHOOSE WHAT BENEFITS YOU

2023 BENEFITS ENROLLMENT GUIDE

Thompson CAT

Here's where to find...

WELCOME TO BENEFITS ENROLLMENT!

Thompson Tractor appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefits plans. We understand that you may have questions about enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Any time you have questions about benefits or the enrollment process, you can contact a member of our Benefits Team or email benefits@thompsontractor.com. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) by going to UKG >Myself>Employee Manual/ Company Info.

Dear Thompson Tractor Employee,

We are honored to have you as part of the Thompson team! *"Take care of the people who take care of Thompson"* is not just our vision statement, it represents our culture and purpose. This is especially true when it comes to the benefits we provide for you and your family.

In this 2023 benefits guide, you will find that we have put together a portfolio of benefits that offer a variety of coverage options, including three medical plan options from which to choose. Please use this benefits booklet as a resource when you make your elections during enrollment to familiarize yourself with the benefit plans we offer. It is also useful to keep around as a handy reference throughout the plan year for useful information about the carriers and partners we use to administer your benefits.

All employees must log in to UKG during open enrollment to make their 2023 benefit elections. Once logged in, navigate to **MYSELF > BENEFITS > MANAGE MY BENEFITS**. As you make your benefit elections, you will notice that the shopping cart in the top-right corner of the screen will update with your elections. Many of our benefits are offered under section 125 of the Internal Revenue code. Elections made may not be altered unless you have a qualifying life event. If you have any questions or would like assistance with making your open enrollment benefit elections, email benefits@thompsontractor.com and a member of the Human Resources team will be happy to assist you.

If you are making any benefit elections due to a qualifying life event or change in status, this booklet will be helpful to you. Please follow the same enrollment process in UKG to make your benefit elections. Any elections made due to a life event or status change will have only a 30-day eligibility period, meaning you have only 30 days from the effective date of your change (i.e., new hire, life event, status change, etc.) to make your elections. Again, if you have any questions or need assistance, please reach out to Human Resources by emailing benefits@thompsontractor.com.

We hope that this benefits guide serves as a helpful resource for you and that the benefits being offered to you enhance your employee experience at Thompson!

Take care & serve well,

Jason Long

Jason Long
Director, Human Resources

This booklet is a summary of benefits available under the Thompson Tractor Co., Inc. employee health and welfare benefit plans (the "Plans"). It is only a general description of the Plans and is not intended to amend or modify any provision of the Plans. If there is any discrepancy between this summary and the formal legal documents for the Plans, the Plan documents prevail. Group health plans sponsored by Thompson Tractor Co., Inc. maintain a Notice of Privacy Practices that provides information to individuals whose protected health information will be used or maintained by the plans. If you would like a copy of the plans' Notice of Privacy Practices, please contact benefits@thompsontractor.com.

WHO IS ELIGIBLE?

Benefits are available to all full-time employees working a minimum of 30 hours per week and their eligible dependents.

Eligible dependents include:

Your legal spouse*

Your children from birth to age 26

(Including your natural/legally adopted/stepchildren, and/or your unmarried dependent children of any age who are mentally or physically disabled and who are dependent on you for support)

**Spouses of Thompson employees who have access to health insurance through their own employer must receive primary insurance through their employer's plan. If the spouse's employer offers health insurance but does not pay at least 50% of the cost, the spouse will be allowed to purchase primary health insurance from Thompson. Spouses who purchase primary insurance through their own employer may elect to purchase secondary health insurance through Thompson at the same rate paid if the spouse was purchasing primary insurance.*

HOW TO ENROLL

To sign up for benefits, visit n12.ultipro.com before the end of your enrollment period.

QUALIFYING LIFE EVENTS

You may only make changes to your elections during open enrollment each year or during the year if you experience a qualifying event. Qualifying life events include, but are not limited to:

- Birth, legal adoption, or placement for adoption.
- Marital status.
- Dependent child reaches age 26.
- Spouse gains or loses employment or eligibility with current employer.
- Death of a covered dependent.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or SCHIP.
- Change in residence that changes eligibility for coverage.
- Court-ordered change.

Changes to your coverage due to a qualifying life event must be made within 30 days of that life event. Proof of the qualifying life event is required (marriage certificate, divorce decree, birth certificate, or loss of coverage letter).

Note: Any change you make to your coverage must be consistent with the change in status.

ENROLLMENT DEADLINES

Type of Employee/Dependent	Enrollment opportunity	Coverage effective date
Current Employee	Annually during the enrollment period	Start of plan year
Qualified Life Event	Changes must be made within 30 days of life event	Date of life event

EMPLOYEE PAYROLL CONTRIBUTIONS

Medical/Rx

	Hourly Employees (Bi-Weekly)			Salary Employees (Semi-Monthly)		
	Co-Pay Plan	Co-Insurance Plan	$2,800 HDHP	Co-Pay Plan	Co-Insurance Plan	$2,800 HDHP
Employee	$79.13	$70.05	$56.52	$85.73	$75.89	$61.24
Employee + spouse	$203.78	$181.11	$145.56	$220.77	$196.20	$157.69
Employee + child(ren)	$164.14	$146.02	$117.24	$177.82	$158.19	$127.02
Family	$231.73	$206.17	$165.52	$251.04	$223.35	$179.32

Dental

	Hourly Employees (Bi-Weekly)	Salary Employees (Semi-Monthly)
	Delta Dental PPO	Delta Dental PPO
Employee	$6.76	$7.33
Family	$16.90	$18.31

Vision

	Hourly Employees (Bi-Weekly)	Salary Employees (Semi-Monthly)
	VSP	VSP
Employee	$4.30	$4.66
Family	$9.50	$10.29

Note: Additional rate information can be found in UKG.

BlueCross BlueShield of Alabama

bcbsal.com

800.321.5319

MEDICAL

You medical benefits are provided by BlueCross BlueShield of Alabama and provides coverage for both in-network and out-of-network providers. You will always have stronger benefits when visiting in-network providers.

Medical	Co-Pay Plan		Co-Insurance Plan		$2,800 HDHP	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Annual deductible (Individual/Family)	$400/$800	$800/$1,600	$1,000/$2,000	$2,000/$4,000	$2,800/$5,600	$5,600/$11,200
Out-of-pocket maximum (Individual/Family)	$2,000/$4,000	$4,000/$8,000	$2,500/$5,000	$5,000/$10,000	$5,600/$11,200	$11,200/$22,400
Preventive care	100%	Not covered	100%	Not covered	100%	Not covered
Primary physician office visit	$25 copay	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible
Specialist office visit	$50 copay	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible
Inpatient hospital services	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible
Outpatient hospital services (lab, x-ray, diagnostic)	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible
Advanced diagnostics	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible
Urgent care	$50 copay	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible	80% subject to the calendar year deductible	60% subject to the calendar year deductible
Emergency room care	$200 copay	$200 copay	80% subject to the calendar year deductible	80% subject to the calendar year deductible	80% subject to the calendar year deductible	80% subject to the calendar year deductible
Prescription drugs	Deductible does not apply		Deductible does not apply		Patient Pays (after deductible)	
Retail (30-day supply)						
Generic	$10	Not covered	$10	Not covered	$10	Not covered
Brand preferred	$30	Not covered	$30	Not covered	$30	Not covered
Brand non-preferred	$75	Not covered	$75	Not covered	$75	Not covered
Specialty	80% ($150 max)	Not covered	80% ($150 max)	Not covered	80% ($150 max)	Not covered
Mail order (90-day supply)						
Generic	$20	Not covered	$20	Not covered	$20	Not covered
Brand preferred	$60	Not covered	$60	Not covered	$60	Not covered
Brand non-preferred	$150	Not covered	$150	Not covered	$150	Not covered
Specialty	80% ($150 max)	Not covered	80% ($150 max)	Not covered	80% ($150 max)	Not covered

This is a summary of coverage; please refer to your summary plan description for the full scope of coverage. In-network services are based on negotiated charges; Out-of-network services are based on a percentage of Medicare charges.

MEDICAL PLANS

You can choose from three medical plan options. Each plan offers comprehensive health care benefits, including free in-network preventive care services and coverage for prescription drugs. As you consider which medical plan is right for you, it's important to understand how the Co-Insurance and Co-Pay plans compare to the HDHP plan.

Medical Plan Comparison

HDHP

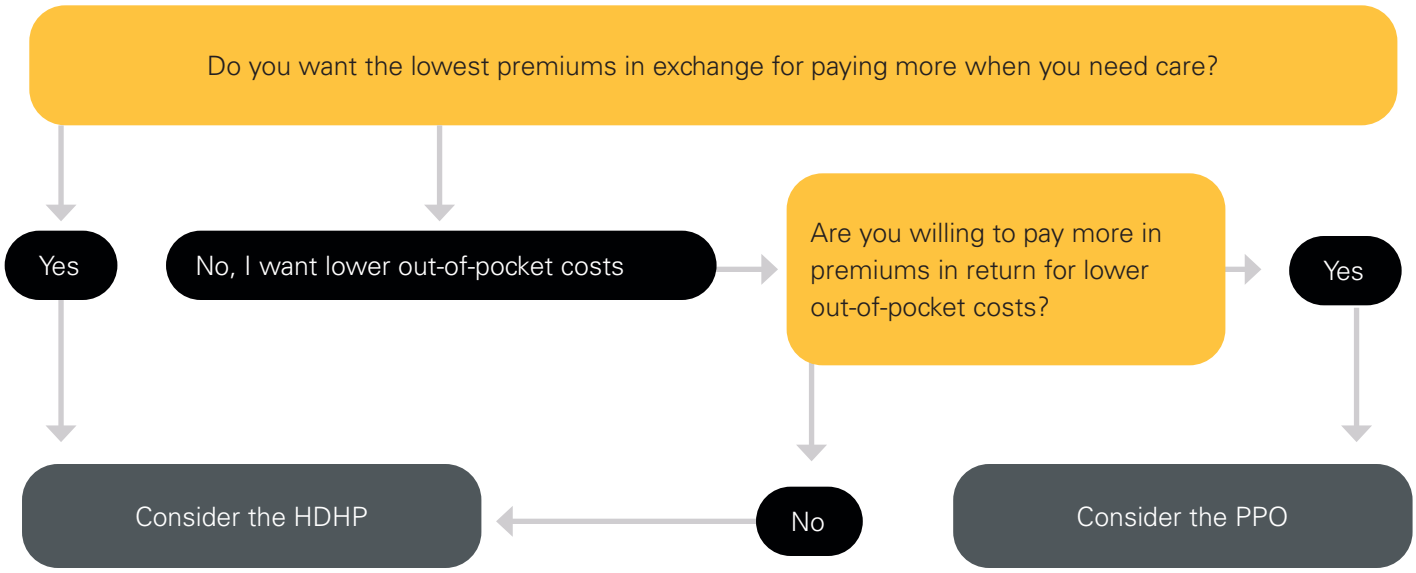
1. Offers eligibility to contribute to a health savings account (HSA), see page 16.
2. Higher deductibles
3. Lower monthly premiums
4. Out-of-pocket limits: $5,600/individual and $11,200/Family

VS.

Co-Insurance & Co-Pay Plans

1. Offers eligibility to contribute to a medical flexible spending account (FSA), see page 14.
2. Lower deductibles
3. Higher monthly premiums
4. Out-of-pocket limits: $2,000/Individual and $4,000/Family for the Co-Pay Plan and $2,500/Individual and $5,000/Family for the Co-Insurance Plan

Which Plan is Right for Me?



HOW TO BE A SMART CONSUMER

Pharmacy

- Your pharmacy benefit information is included on your BCBS medical ID card.
- Find an in-network pharmacy or use the drug cost estimator tool by visiting express-scripts.com/NATPLSNATPREF14.
- Ask if a generic/mail order is available.
- Generic contraceptives and diaphragms are covered and available at no cost.
- See if your drug has a Patient Assistance Program.

EXPRESS SCRIPTS®

express-scripts.com/NATPLSNATPREF14

855.723.6090.

Bluecare Advocacy

You have questions, and Blue Cross has the answers. We are here to save you time and help you navigate a complex healthcare system.

Health Advisors are standing by to address your immediate needs when you call the customer service number on the back of your Blue Cross ID card – things like coverage or claims questions. But, we take customer service a step further by offering clinical support to help you better understand your health.

A Health Advisor can help you:

- Get answers to common customer service questions
- Understand your benefits, claims and coverages
- Research and resolve hospital and doctor billing issues
- Locate a doctor or specialist and schedule appointments
- Know which preventive screenings are recommended
- Enroll in available health and wellness programs
- Connect with support groups and community services

BlueCross BlueShield of Alabama

bcbsal.com

Call the customer service number on the back of your Blue Cross ID card.

TELEMEDICINE

teladoc.com/alabama

855.477.4549

Thompson Tractor provides access to telemedicine through Teladoc.

If you are covered on one of the three Thompson Tractor medical plans, you and your covered dependents have access to telemedicine through Teladoc. If you are covered on the Co-Pay or Co-Insurance plan, you will pay $5 per visit. If you are covered on Thompson's HDHP plan, you will be charged $55 until your deductible is met.

If you are not covered on a Thompson Tractor medical plan, you and dependents can still use Teladoc for $75 per visit.

By scheduling a visit with a U.S. board-certified and licensed medical doctor, the program lets you get the care you need — including most prescriptions — for everyday non-emergency healthcare issues, including sinus problems, allergies, flu symptoms, and much more. The service can be accessed by app, web, or phone, and visits are available by phone or video.

To get started download the Teladoc app, visit Teladoc.com/Alabama, or call **855.477.4549** to set up your account. Get well, sooner. Care by phone or video 24/7.

VISION

vsp vision care

vsp.com

800.877.7195

Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around the VSP providers, who have higher benefits at a lower cost to you. When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. To locate an in-network provider, visit vsp.com.

NEW! Do you need safety glasses?

Did you know that each year, about 20,000 U.S. workers sustain a job-related eye injury that requires medical treatment? 90% of these injuries are preventable with proper eyewear protection. Thompson Tractor has added a ProTec Safety Plan to help promote a safe workplace, with no additional premium. Pay a $10 copay and choose a safety frame for the Protec Eyewear collection. (See ProTec Safety chart below.)

Your Coverage with a VSP Provider			
Benefit	**Description**	**Copay**	**Frequency**
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Essential Medical Eye Care	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 screening $20 per exam	Available as needed
Prescription Glasses		$25	
Frame*	• $200 featured frame brands allowance • $180 frame allowance • 20% savings on the amount over your allowance • $100 Walmart®/Sam's Club®/Costco® frame allowance	Included in Presciption Glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Presciption Glasses	Every calendar year
Lens Enhancements	• Scratch Resistant Coating • Anti-Reflective Coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $25 $0 $0 $0	Every calendar year
Contacts (in stead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $25	Every calendar year
ProTec Safety® (for Thompson employees only)			
Frame*	• Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$10	Every calendar year
Lenses	• Prescription single vision, lined bifocal, and lined trifocal, light-reactive lenses • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$10	Every calendar year

*Coverage with a retail chain may be different or not apply.

Your Coverage with a VSP Provider	
Benefit	**Description**
Extra Savings	
Glasses & Sunglasses	• Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam
Routine Retinal Screening	• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

Your Coverage Goes Further In-Network

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam	up to $46	Single Vision Lenses	up to $47	Lined Triifocal Lenses	up to $85
Frame	up to $45	Lined Bifocal Lenses	up to $66	Progressive Lenses	up to $66
Contacts	up to $105				

DENTAL

DELTA DENTAL®

deltadentalins.com

800.521.2651

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less. If you choose an out-of-network provider, you may be billed the difference between what Delta Dental pays, and what your out-of-network provider charges for the services. To locate an in-network provider, please visit deltadentalins.com.

Dental	Delta Dental PPO	
	In-network	Out-of-network
Annual deductible (Individual/Family)	$50/$150	$50/$150
Annual maximum (per person)	$2,000	$2,000
Diagnostic and preventive care Includes cleanings, fluoride treatments, sealants and x-rays	100%	100%
Basic services Includes fillings, periodontics, scaling and root planning, and oral surgery	80%	80%
Major services Includes crowns, implants, bridges, and full and partial dentures	50%	50%
Orthodontia	50%	50%
Lifetime orthodontia maximum	$1,000 per person	$1,000 per person

Plan includes out-of-network benefits, see plan summary for additional details.

uprisehealth

members.uprisehealth.com/thompson

Access code: Thompson

800.925.5327

EMPLOYEE ASSISTANCE PROGRAM (EAP)

EAP benefits are free for all Thompson employees, their dependents, and their household members. The EAP offers confidential advice, support, and practical solutions to real-life issues and is a short-term solution to help you navigate a variety of life's challenges. Uprise provides short-term counseling via phone, or in-person counseling sessions. You can access these confidential services by calling 800.925.5327, or visiting members.uprisehealth.com/thompson. You will be asked to provide your employer's name and basic contact information in case a call back is needed. Services include up to six face-to-face sessions. Please contact Uprise before scheduling your appointment. Please note this benefit is carved out of the medical plan to offer all of our employees care when they need it most.

Virtual Or In-Person Counseling

- Access short-term counseling via phone, or in-person counseling sessions.
- You will be asked about your needs and preferences for counseling and be matched with a short list of counselors that are available virtually or near your home or work.
- Typical calls take 5 to 10 minutes. Depending on your issue, you may be asked for more information. This is normal and helps ensure you get the appropriate level of care.
- When you call Uprise Health, a real person answers the phone. You will be asked to provide your employer's name and basic contact information in case a call back is needed.
- You can call to make your own appointment or ask for help. If you call a counselor that is on the list and they don't call you back, please contact the EAP and let us know so that we can provide you with an additional list of counselors.
- If you are in a crisis, you will be connected with a counselor during the call for immediate help.

24-Hour Crisis Support

- If you call during business hours (6 a.m. to 5 pm. PT), the Uprise Health care team will immediately connect you with a clinician.
- During a crisis call, the counselor will work with you to stabilize your situation or arrange for immediate support.
- You can call for crisis support whenever needed, 24/365.
- After hours or weekend calls are always answered directly by behavioral health professionals. You will not have to leave a message.
- Actions during the call may include ensuring that you have immediate supports available, contacting emergency services, or planning to schedule local counseling.

Tips to Help You with Your First Session

- Make notes about the problem you are having, how it's affecting you, and what you would like to be different.
- Once the counselor understands your overall situation, they will work with you to develop a plan of action.
- If for some reason you aren't comfortable with your counselor after the first session, please call the EAP to change counselors.

FLEXIBLE SPENDING ACCOUNT (FSA)

AVAILABLE TO PARTICIPANTS IN THE CO-PAY OR CO-INSURANCE PLAN

What is a Flexible Spending Account?

A flexible spending account (FSA) is an account that can reimburse you for qualified healthcare or dependent care expenses. You can fund qualified expenses with pre-tax dollars deducted from your paychecks.

When electing an FSA, you will set an annual contribution amount. FSAs do not rollover year to year, but any funds left in your account at the end of the plan year can be rolled over to the next plan year (up to $570). Think of it like a safety net for your FSA. If you end up spending less than you anticipate, you can tap into those funds next year.

You can choose to participate in one or both accounts, and it's not necessary to "sign up" specific family members for these accounts.

Healthcare FSA

A healthcare FSA reimburses employees for eligible medical expenses, up to the amount contributed for the plan year. Eligible healthcare expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. Visit irs.gov for a full list of eligible expenses.

You may contribute up to $2,850 annually (funds will be available as of the election effective date).

Dependent Care FSA

You may use pre-tax dollars from your Dependent Care FSA to pay expenses for the care of a dependent child, spouse, or elderly parent inside your home (from a qualified provider), and expenses outside your home, such as baby-sitters, nursery schools, or day care centers.

You may contribute up to $5,000 annually (or $2,500 if you are married and file a separate tax return). You can only be reimbursed up to the amount that you have contributed.

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA)

AVAILABLE TO PARTICIPANTS IN THE $2,800 HDHP INSURANCE PLAN

What is a Limited Purpose Flexible Spending Account?

A limited purpose flexible spending account (LPFSA) is an account that allows you to choose how much of your paycheck you would like to set aside, before taxes are taken out, for qualified dental and vision expenses. It pairs well with a Health Savings Account (HSA). Pairing these plans allows you to spend your limited FSA dollars on eligible expenses while saving or investing your HSA dollars. A LPFSA cannot be paired with a FSA.

LPFSA

Employees enrolled in an HDHP accompanied by an HSA may enroll in a Limited Purpose FSA, which reimburses **dental and vision expenses**. The maximum yearly contribution is currently $2,850.

You will have access to your full Limited Purpose FSA contribution on the first day of the plan year. Medical expenses are not eligible for reimbursement under the Limited Purpose FSA plan. Your Limited Purpose FSA funds do not roll over year to year.

HEALTH SAVINGS ACCOUNT (HSA)

AVAILABLE TO PARTICIPANTS IN THE $2,800 HDHP INSURANCE PLAN

What is a Health Savings Account?

A health savings account (HSA) is a tax-advantaged savings account that can be used for your qualified healthcare expenses, if you enroll in the High Deductible Health Plan. You own your HSA and can contribute to the account with pre-tax payroll deductions based on your needs.

Did you know an HSA provides triple tax benefits? The money you contribute is pre-tax, and the interest that accumulates in the account is tax-free. In addition, money withdrawn from an HSA isn't taxed, provided you use it for qualified healthcare expenses. Like a savings account, you will only be able to withdraw funds that are in the account.

As an added benefit, Thompson Tractor will seed your HSA annually with a one-time employer deposit. If you elect individual medical coverage, Thompson will deposit $400 in your HSA. If you elect any medical tier other than individual, Thompson will deposit $800 in your HSA. New hires will receive a deposit no later than the first of the month following 30 days of employment. In order to receive the employer deposit, your HSA must be activated.

How Much Can Be Deposited into an HSA in 2023?

<55*

- Up to $3,850 for individual
- Up to $7,750 for family

*Not enrolled in Medicare

- The maximum contribution increases by $1,000

*Not enrolled in Medicare

55+*

Please keep in mind the amounts reflected above include deposits from Thompson Tractor. Therefore, the maximum amount you can elect is $3,450 (individual) and $6,950 (family).

OTHER HSA ADVANTAGES

- You can use the account to pay for qualified healthcare expenses.
- Unspent dollars roll over each year and are yours to keep if you retire or leave the company.
- If you have at least $1,000, you can invest your HSA funds, so your available healthcare dollars can grow over time.

You are eligible if:

- You are enrolled in the HDHP
- You are not covered by a spouse's plan
- No one else can claim you as a dependent
- You are not enrolled in Medicare, TRICARE or TRICARE for Life
- You have not received VA benefits in the past 3 months

NEW!

WELLNESS

gopivot.

AVAILABLE TO EMPLOYEES ENROLLED IN ONE OF THE TRHEE THOMPSON TRACTOR MEDICAL PLANS ONLY

Thompson cares about your overall wellbeing. As part of our continued commitment to taking care of the people who take care of Thompson, we are excited to offer a new holistic wellness program for 2023!

GoPivot offers fun and impactful ways to elevate all areas of your health. Earn points FAST and redeem them for just about anything you want!

Download the GoPivot mobile app

support@gopivotsolutions.com

888.949.1001

Quick Start User Guide

Register For An Account:

1. Download the GoPivot mobile app and click on “Register”
2. Enter your Promo Code: TTS
3. Enter your USER ID, which is the first letter of your first name and your entire last name. For example, John Smith would be “jsmith”.
4. Enter your PASSWORD, which is your eight-digit date of birth (MMDDYYYY).
5. Create your own username and password to use moving forward and toggle on notifications to stay up to date.

Sync Your Device:

Sync your activity tracker tapping on the three lines in the top left-hand corner of your app and selecting ‘Connect Tracker’. Follow the easy instructions to add your activity tracker and automate your steps activity.

PRO TIP:
If you do not have an activity tracker you can use a health app on your smartphone, such as Apple Health Kit or GoogleFit. As long as you carry your phone with you, it will count your steps and activity!

Available on the App Store

GET IT ON Google play

Download the GoPivot mobile app

support@gopivotsolutions.com

888.949.1001

Build Your Exercise Plan:

Build a custom exercise plan that meets you where you are and guides you on a path to better fittness. Start by selecting your preferences with our easily exercise plan builder to help created a personalized exercise plan just for you! Take a FitIn and receive your own FitScore! A FitScore is a fitness measurement rating that evaluates you on a variety of exercise and compare you to other of the same age and gender in America. The FitScore is designed specifically to offer every participant an ongoing goal.

PRO TIPS:

- Update your exercise preferences to change the difficult of your plan or to change the days you are scheduled to work out!
- Want to try something new? Browse the exercise programs where you will find a variety of workout videos ranging from a beginner to advanced level.

Build Your Nutritional Plan:

Build a recommended recipe plan derived from your wellness goals, allergies, preferred cuisines, desired weight and exercise plan.

Your Calorie Goal below is specific to you and based on a number of factors including your current activity level and the exercise goal you specied in the Exercise Preferences of your prole. Your calories and macronutrients are only 60% of your total recommended amounts, taking into account that side items and healthy snacks will make up the remaining 40%.

PRO TIP:
Selecting fewer cuisines will reduce the number of recipes available to create your meal plan.

Complete Activities + Challenges:

Check out the designated point-earning activities that can be completed throughout the year. Activities are grouped based on the frequency and type of activity. (For example: There areactivities that you can complete every day or only once a year.)

Join your co-workers in a company-wide challenge to help your organization reach its health and wellness goals. Log your results and see how you stack up against your colleagues by tracking progress on the Leaderboard.

PRO TIP:
Make sure you complete all of your Quick Point Activities so that you're set up to earn maximum points fast.

Explore The Rewards Mall:

Choose your own rewards from the most comprehensive shopping mall boasting thousands of merchandise choices and hundreds of gift card options, or save your points to redeem for a larger reward such as a weekend getaway or sporting event. The options are endless!

LIFE AND DISABILITY INSURANCE

mutualofomaha.com
800.775.8805

Life Insurance and Accidental Death & Dismemberment (AD&D)

We provide Basic Life and AD&D insurance at no cost to you!

Insurance coverage	Benefit
Basic Employee Life	An amount equal to 1.5 times your annual salary plus $5,000, but in no event less than $20,000 or more than $205,000
Dependent Life	$5,000; Live birth to less than 14 days - $1,500
Basic Employee AD&D	The Principal Sum amount is equal to 2 times your annual salary, but in no event more than $200,000

If you would like additional coverage, Voluntary Life and AD&D insurance is available to you, your spouse and your dependent children. You must enroll in coverage for yourself in order to cover your spouse or children. If you don't enroll in Voluntary Life when it's first available to you, or elect an amount over the Guaranteed Issue, you may be required to complete an Evidence of Insurability (EOI) form.

Voluntary Life Insurance

Eligibility Requirement: You must be actively working a minimum of 30 hours per week to be eligible for coverage. Coverage is effective after 30 days of conitnuous and active employment.

Dependent Eligibility Requirements: To be eligible for coverage, your dependents must be able to peform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and children to be eligible for coverage, you must elect coverage for yourself.

Premium Payment: The premiums for this insurance are paid in full by you.

Coverage Guidelines	Minimum	Guarantee Issue	Maximum
For You	$10,000	10 times annual salary, up to $250,000	$250,000 in increments of $10,000, but no more than 10 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $50,000	100% of employee's benefit, up to $100,000
Children	$2,000	100% of employee's benefit, up to $10,000	100% of employee's benefit, up to $10,000

Voluntary AD&D Insurance*

Employee Eligibility Requirement: You must be an active full-time (working 30 hours or more per week) employee of the Policyholder domiciled in the United States. Employee means a citizen or permanent resident of the United States or a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.

Dependent Eligibility Requirements: You must elect insurance for your dependent(s) to be eligible. Eligible dependent(s) include your spouse and any unmarried dependent child(ren) or foster child(ren) under the age of 26.

Premium Payment: You pay 100% of the premium for this insurance.

Benefit Guidelines	Employee	Family Plans	
		+ Spouse Only	+ Child(ren) Only
Minimum Benefit	$10,000	$10,000	$10,000
Maximum Benefit	$500,000	$250,000 Spouse's Principal Sum cannot exceed the Employee's selected amount	$50,000 Child's Principal Sum cannot exceed the Employee's selected amount
Increment(s)	$10,000	$10,000	$10,000

*For all employees, excluding pilots.

Disability

You have the opportunity to purchase Short-Term and Long-Term Disability. These plans give you income protection in the event you are ill or injured in a non-work related injury, and can't come to work. If you don't enroll in Disability coverage when it's first available, you may be required to complete an Evidence of Insurability (EOI) form.

Short-term disability benefits		Long-term disability benefits	
Elimination period	8 days	Elimination period	90 days
Weekly benefit	66 2/3% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources	Monthly benefit	60% of monthly earnings
Maximum weekly benefit	$1,000	Maximum monthly benefit	Dependent upon class
Maximum benefit period	Up to 12 weeks	Maximum benefit period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.

SUPPLEMENTAL HEALTH BENEFITS

Aflac

Our medical plans provide great coverage for you and your family's healthcare needs. Still, everyone's needs are slightly different. That's where supplemental health options come in! These benefits are designed to protect your family's finances in case of an unforeseen injury or illness.

Accident Insurance

Accident plans pay cash benefits directly to you to help pick up some of the costs remaining after your health insurance plan kicks in following a covered accident.

Critical Illness Insurance

Critical illness insurance helps protect your income and personal assets when out-of-pocket expenses increase as a result of a specified illness. This plan covers conditions like: heart attack, stroke, end stage renal failure, invasive cancer, and more.

Hospital Indemnity Insurance

An unexpected or even planned stay in the hospital can be expensive as you meet your deductible and out-of-pocket obligations under the medical plan. The Hospital Indemnity plan is designed to provide financial protection by paying you a direct benefit to meet out-of-pocket expenses and extra bills that can occur. Lump sum benefits are paid directly to you based on the type of facility and number of days of confinement.

Details for each of the Supplemental Health Benefits can be found on the following pages.

AFLAC GROUP ACCIDENT INSURANCE

Just because an accident can change your health, doesn't mean it should change your lifestyle too.

Accidents can happen in an instant affecting you or a loved one. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

Protection for the unexpected, that's the benefit of the Aflac Group Accident Plan.

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you in your time of need to help cover expenses such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Major Diagnostic Testing
- Burns

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid regardless of any other medical insurance.

How It Works

Aflac Group Accident coverage is selected.	The Aflac Group plan pays: **$6,500**
You are injured in a car accident and transported to an emergency room by ambulance.	
You have X-Rays and CT Scan.	
You are diagnosed with a fractured femur and wrist and a concussion.	

Amount payable was generated based on benefit amounts for: Initial Treatment with X-Ray ($400), Ambulance ($500), Major Diagnostic Testing ($500), Concussion ($500), Appliances -Crutches ($200), Fracture-Leg ($2,400) and Fracture-Wrist ($2,000).

Aflac

AFLAC GROUP CRITICAL ILLNESS

Aflac can help ease the financial stress of surviving a critical illness.

Chances are you may know someone who's been diagnosed with a critical illness. You can't help notice the difference in the person's life-both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-ofpocket expenses is the last thing anyone needs.

That's the benefit of an Aflac Group Critical Illness plan.

It can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

But it doesn't stop there. Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

Features

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.

How It Works

Aflac Group Critical Illness coverage is selected.	Aflac Group Critical Illness pays an Initial Diagnosis Benefit of: **$10,000**
You experience chest pains and numbness in the left arm.	
You visit the emergency room.	
A physician determines that you have suffered a heart attack.	

Amount payable based on $10,000 Initial Diagnosis Benefit.

AFLAC GROUP HOSPITAL INDEMNITY

The plan that can help with expenses and protect your savings.

Does your major medical insurance cover all of your bills?

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay.

That's how the Aflac Group Hospital Indemnity plan can help.

It provides financial assistance to enhance your current coverage. It may help avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time away from work, for instance.

The Aflac Group Hospital Indemnity plan benefits include the following:

- **Hospital Confinement Benefit**
- **Hospital Admission Benefit**
- **Hospital Intensive Care Benefit and more**

How It Works

Aflac Group Hospital Indemnity coverage is selected.	Aflac Group Hospital Indemnity plan pays: **$1,200**
The insured has a high fever and goes to the emergency room.	
The physician admits the insured into the hospital.	
The insured is released after two days.	

Amount payable was generated based on benefit amounts for: Hospital Admission ($1,000) and Hospital Confinement ($100 per day).

ADDITIONAL BENEFITS

Benefit	Description	Contact information	Who pays?
Identify Theft Protection	Protect what matters most with ID theft protection, credit monitoring, and restoration services. Every online transaction leaves a trace behind, taking on a life of its own, which can put your credit and identity at risk. IdentityForce can help monitor your credit and protect your identity.	IdentityForce A TransUnion® Brand IdentityForce mybenefits.identityforce.com Member Services: 855.441.0270	Employee paid monthly premiums: Employee - $8.99 Family - $16.99
Retirement	Thompson Tractor encourages you to make your retirement work by participating in the Thompson Tractor Co., Inc. Profit Sharing Plan ("the Plan"). When you participate, you take an important step toward reaching your financial goals. Schwab Retirement Plan Services, our retirement plan service provider, is available to help you make choices that fit you and your life. You can find helpful information, resources, and tools online at **workplace.schwab.com** to help you plan for retirement. Visit **workplace.schwab.com** to take advantage of the tools and resources available through your plan that can help you with planning for retirement.	charles SCHWAB Schwab Retirement Plan Services workplace.schwab.com Participant Services: 800.724.7526	Employee elected payroll deferrals

GLOSSARY OF TERMS

COPAYMENT: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

DEDUCTIBLE: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,000 deductible. After that, you share the cost with your plan by paying coinsurance.

FORMULARY: A list of prescription drugs covered by the plan. Also called a drug list.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): This is a type of medical plan that requires the member to reach a deductible prior to having services covered by coinsurance. All expenses paid by the member count toward the deductible and out-of-pocket maximum.

CONTACTS

Benefit	Carrier	Phone	Website
Medical Plan	BlueCross BlueShield of Alabama	800.321.5319	bcbsal.com
Prescription Services	Express Scripts, Inc.	855.723.6090	express-scripts.com/NATPLSNATPREF14
Telemedicine	Teladoc	855.477.4549	teladoc.com/alabama
Dental	Delta Dental	800.521.2651	deltadentalins.com
Vision	VSP	800.877.7195	vsp.com
Health Savings Account (HSA), Flexible Spending Account (FSA), and Limited Purpose Flexible Spending Account (LPFSA)	WEX	866.451.3399	wexinc.com
Life & Disability	Mutual of Omaha	800.775.8805	mutualofomaha.com
Accident, Critical Illness, and Hospital Indemnity	Aflac	800.433.3036	aflac.com
Employee Assistance Program (EAP), Mental Health Benefits, and Substance Abuse Benefits	Uprise Health	800.925.5327	members.uprisehealth.com/thompson Access Code: Thompson
Identity Theft Protection	IdentityForce	855.441.0270	mybenefits.identityforce.com
Retirement	Schwab Retirement Plan Services	800.724.7526	workplace.schwab.com

THOMPSON TRACTOR HEALTH PLAN NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
Medicare Part D Creditable Coverage Notice
Notice of Special Enrollment Rights
General COBRA Notice
Women's Health and Cancer Rights Notice
ADA Wellness Program Notice

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is entitled, "Important Notice From Thompson Tractor Co., Inc. About Your Prescription Drug Coverage and Medicare."

If you have any questions regarding any of these notices, please contact:

General Contact:	Jessica Parrish
Phone:	205-849-4279
Email:	jessicaparrish@thompsontractor.com
Mailing Address:	2401 Pinson Highway, Birmingham, AL 35217

Distribution Date: 10/14/2022

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

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

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

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

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

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
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	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 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
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
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	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)	**MONTANA – 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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: Email: HHSHIPPProgram@mt.gov
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Websitehttps://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
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp 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: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhhr.wv.gov/bms/ https://www.mywvhipp.com/ Medicaid Phone: 304-558-1700 Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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 1/31/2023)

IMPORTANT NOTICE FROM THOMPSON TRACTOR CO., INC. 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 Thompson Tractor Co., 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents. However, you should keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Thompson Tractor Co., Inc. has determined that the prescription drug coverage offered by the Thompson Tractor Co., Inc. Employees Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Thompson Tractor Co., Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Thompson Tractor Co., Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Thompson Tractor Co., Inc. Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Thompson Tractor Co., Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the Benefit Department for further information or call 1-800-245-8824. **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 Thompson Tractor Co., Inc. changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

NOTICE OF SPECIAL ENROLLMENT RIGHTS
THOMPSON TRACTOR CO., INC. EMPLOYEES HEALTH CARE PLAN

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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.

To request special enrollment or obtain more information, contact:

Jessica Parrish
205-849-4279

GENERAL COBRA NOTICE

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Jessica Parrish
205-849-4279
2401 Pinson Highway
Birmingham, AL 35217

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

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

The Thompson Tractor Co., Inc. Employees Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Thompson Tractor Co., Inc. Employees Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

High PPO Plan	In-Network	Out-of-Network
Individual Deductible	$400	$800
Family Deductible	$800	$1,600
Coinsurance	80%	60%
Low PPO Plan	In-Network	Out-of-Network
Individual Deductible	$1,000	$2,000
Family Deductible	$2,000	$4,000
Coinsurance	80%	60%

2800 HSA Plan	In-Network	Out-of-Network
Individual Deductible	$2,800	$5,600
Family Deductible	$5,600	$11,200
Coinsurance	80%	60%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Jessica Parrish
205-849-4279

Thompson Tractor Wellness Program

Notice Regarding Wellness Program

Thompson Tractor offers a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you will be asked to complete an annual wellness screening, which will include tests determined by your health care provider to constitute an annual wellness screening. You are not required to participate in the screening. However, employees who choose to participate in the wellness program will receive an incentive through our wellness vendor GoPivot with the completion of an annual wellness screening. There will be other incentives available through the new vendor as well for completion of things such as a Health Risk Assessment, surveys, and challenges announced through the plan year.

The results from your annual wellness screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to discuss your results or concerns with your own doctor. Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all active employees of Thompson Tractor Co., Inc.. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at the number below and we will work with you (and, if you wish, with your doctor) to find a wellness program component with the same reward that is right for you in light of your health status. You may incur a cost for other such reasonable alternatives.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Thompson Tractor Company, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, the Thompson Tractor Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information under the wellness program are the individuals who conduct and assess the screenings.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

GINA Warning for wellness program materials requesting information

In answering these questions, do not include any genetic information. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which an individual may be at risk.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Jessica Parrish at 205-849-4279 or jessicaparrish@thompsontractor.com.

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The information in this guide should in no way be construed as a promise or guarantee of employment or benefit coverage. Pricing, underwriting, plan specifics and all other product features are solely that of the Insurance Company. If there is a conflict between the information in this guide and the actual plan document or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from the Benefits Department.

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