2017

# BENEFITS

## GUIDE

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**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 27-30 for more details.**

# OPEN ENROLLMENT

This year's **benefits open enrollment** period has arrived! Open enrollment is your opportunity to evaluate your personal situation and decide how ZF's benefit package can help you meet your health and welfare needs. Based on your circumstances, you may choose to switch plans, add or remove dependents, or drop coverage all together.

We understand how important having a sound benefit package is, and that is why we are **committed** to providing you and your family with competitive benefits that meet your needs and keep you living well, while balancing our obligation to be financially responsible as a company. Your employee benefits are an important part of your total compensation.

This benefit guide includes important information describing your benefit plan offerings.

ZF invests a lot in your benefits—about **$46 million** annually. A key part of our health care strategy is to manage costs by improving overall health. That is why we place a priority on health plans that encourage you to get and stay healthy, and why we offer you the chance to save on your health premiums by living a healthy lifestyle.

Our medical and dental plans are **self-funded** which means that we are responsible for paying the actual cost of claims. This also means that our claims directly impact our costs, which is used to determine what employee contribution costs are for the following year—so it is in everyone's best interest to maintain a healthy lifestyle and to be a **wise consumer** of healthcare.

Once again this year, enrollments will be processed through our benefit administration system, **BenXpress**. A brochure was mailed to your home mid-October that contains information on 2017 changes (a copy is also posted on BenXpress). Please be sure to review the brochure and this Guide thoroughly, so you can make educated choices about your 2017 benefit elections.

**www.benxpress.com/zf**

**User name**: Z Number
**Password***: first initial + last name + last 6 digits of SSN

*Example Employee:* *John Doe-Smith / SSN 999-88-7777*
*Example Password:* *jdoesmith887777*

*do not use any punctuation in password, including "-" or " ' "

# COSTS & SPOUSAL SURCHARGE



## 2017 Employee Contributions (bi-weekly)

| | EE only | EE + SP | EE + Ch(ren) | Family |
|---|---|---|---|---|
| **Medical Plan 1** | $18.92 | $39.23 | $35.54 | $54.46 |
| **Medical Plan 2** | $4.62 | $9.69 | $8.77 | $13.38 |
| **PPO** | $31.38 | $66.00 | $60.00 | $91.38 |
| **Dental** | $7.38 | $15.23 | $16.15 | $23.08 |
| **Vision** | $3.15 | $5.98 | $6.30 | $9.25 |

*Rates for eligible part-time employees differ, and are shown in BenXpress. Or, see your local Human Resources department for more information.*

## Working Spouse Surcharge

If you are married and your spouse has medical coverage available through his/her employer, but declines it to be covered by one of ZF's medical plans, you will have a **surcharge of $76.92** added on to your bi-weekly paycheck.

The surcharge will not apply if:

- Your spouse does not work
- Your spouse is not eligible for coverage through his/her employer
- Your spouse is also employed by ZF
- Is covered only by Medicare or a private, individual plan
- Is covered on ZF's plan as secondary.

If, at any point, your working spouse ceases to be eligible for his/her employer's medical coverage, he/she may be enrolled under your medical plan coverage. You will have 30 days from the loss of eligibility for coverage to enroll your spouse under our plan.

If your spouse is covered under a ZF medical plan and it is later determined that your spouse was eligible for other group medical coverage, we may hold you financially responsible for providing inaccurate information. ZF may, at its discretion, take other disciplinary measures up to and including termination of employment. ZF reserves the right to contact your spouse's employer to verify eligibility for coverage.

# TOBACCO USER SURCHARGE

## Tobacco User Surcharge

Our employee's health is very important to us. Tobacco users are more likely to develop serious chronic medical conditions, visit the doctor more often, be absent from work with an illness, or have a short or long term disability—all of which are very costly for the employee and ZF's health plan, and impact productivity.

All employees enrolling in medical coverage must certify as a Tobacco or Non-tobacco user while enrolling on BenXpress. This declaration is an attestation of your tobacco usage, and all answers are subject to ZF review. If any statements are proven to be false, the surcharge will be applied and disciplinary action may be taken. ZF reserves the right to randomly test employee's for tobacco use.

If you are a tobacco user, you will pay a **bi-weekly surcharge of $30.77.**

### Who is a Tobacco User?

- You are considered a **non-tobacco user** if you have not used tobacco-based products (cigarettes, cigars, chewing tobacco, e-cigarettes, pipes, hookah, snuff, etc.) within six months of ZF's open enrollment period (or your benefits effective date, if newly eligible).
- You are considered a **tobacco user** if you are currently using tobacco-based products (cigarettes, cigars, chewing tobacco, e-cigarettes, pipes, hookah, snuff, etc.) in any amount, or, if you have used tobacco-based products (cigarettes, cigars, chewing tobacco, e-cigarettes, pipes, hookah, snuff, etc.) within six months of ZF's open enrollment period (or your benefits effective date, if newly eligible).

### Quit for Life

Quit for Life is the tobacco cessation program offered through Blue Cross Blue Shield of Alabama (BCBS AL). If you are a tobacco user and you complete this program, you can qualify to have the tobacco surcharge removed retroactively to January 1 (or your benefits effective date). This is a telephone-based program to support an individual's efforts to quit tobacco use. The program consists of an enrollment process and phone calls from a nurse counselor.

You must actively participate and complete the Quit for Life program by **September 30, 2017**, as reported by BCBS AL. **This is the only way to remove the tobacco user surcharge during the year**. Participation in other tobacco cessation programs will not be accepted for purposes of removing the tobacco user surcharge.

**For free, confidential help,**

**call 1-888-768-7848 or visit www.quitnow.net**

*ZF is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact the ZF Benefits department at (734) 416-6200 and we will work with you (and if you wish, your doctor) to find a program with the same reward that is right for you in light of your health status.*

# Wellness Incentive Program

ZF is focused on supporting employees and their dependents in achieving and maintaining life-long health, and is proud to offer our Wellness Incentive Program. The program is available to employees and spouses enrolled in a ZF medical plan. You can earn incentive dollars simply by making wise lifestyle choices and actively participating in your health! Here are the requirements:

## By February 28, 2017 you must:

1. Complete a **health screening** (annual physical or onsite biometric screening). ZF will acknowledge physicals received from your doctor, back to February 28, 2016.
2. Complete the **Health Quotient** (HQ), which is an online health assessment offered through the BCBS AL member portal.

If you (and your spouse, if enrolled in a ZF medical plan) do not complete steps 1 and 2 above by February 28, 2017, you will pay an annual surcharge of $100 per employee and $50 per spouse.

Employees hired after February 28, 2017 will automatically receive the HSA funding tied to the Health Screening and HQ completion, but do not have to complete these activities in the year they are hired.

## Wellness Activities

You will also have the opportunity to earn additional dollars by participating in ZF-coordinated wellness activities. Activities will be offered at each facility.

## Incentive Amounts

The below chart details the funds that can be earned, by employee enrollment tier and plan.

| | Medical Plan 1 | Medical Plan 2 | PPO |
|---|---|---|---|
| **Health Screening & Health Quotient** (complete by | $250/EE<br>$250/SP | $250/EE<br>$250/SP | $200/EE<br>$100/SP |
| **ZF-coordinated Wellness Activities** | $50 per activity<br>(up to $150/EE & $150/SP) | $50 per activity<br>(up to $150/EE & $150/SP) | $50 per activity<br>(up to $150/EE & $150/SP) |
| **Payment Method** (timing varies) | Pre-tax contribution into Health Savings Account (HSA) | Pre-tax contribution into Health Savings Account (HSA) | Lump sum amount into paycheck |
| **Total Possible Wellness Incentive by Tier** | **$400 EE only**<br>**$650 EE+Ch(ren)**<br>**$800 EE+SP, Family** | **$400 EE only**<br>**$650 EE+Ch(ren)**<br>**$800 EE+SP, Family** | **$350 EE only**<br>**$350 EE+Ch(ren)**<br>**$600 EE+SP, Family** |

# ELIGIBILITY

## Dependent Eligibility Rules and Documentation Requirements

### New Hires or Newly Eligible Employees

It is required that you provide proof of eligibility for each dependent you are enrolling in benefits. This documentation must be provided to Human Resources within **30 days** of your hire date, or the dependent(s) will not be enrolled.

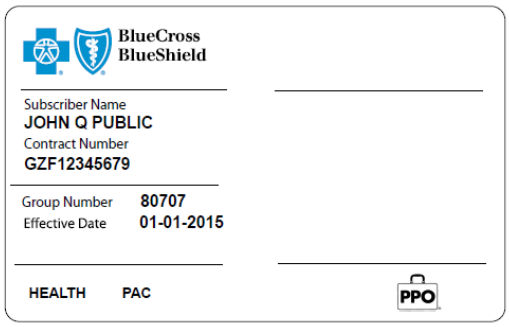
### Qualified Change in Status (life event)

If you experience a qualified change in status (life event) you will need to provide proof of the qualifying event. If a dependent needs to be added to your coverage, you will need to provide proof of eligibility. All documentation is due within **30 days** of the event date.

Any dependent not verified as eligible within 30 days will not be enrolled for coverage(s).

| | Eligibility Requirements | Documentation to Submit |
|---|---|---|
| **Spouse** | Legal spouse of the employee<br><br>"Spouse" means the individual to whom you are legally married as determined under Federal law<br><br><u>Ineligible Dependents</u><br>• Domestic partners<br>• Common law spouses (unless covered prior to 1/1/2017)<br>• Ex-spouses, even if you are obligated by the Court to maintain health coverage | <u>Both</u> of the following:<br>• Marriage certificate - must be presently valid and issued by a State, County or other applicable foreign government agency<br>• The first page of the employee's filed Federal income tax return Form 1040 (or equivalent) from the most recent tax year. Financial information may be blacked out.<br><br>***NOTE***: In the event employee/spouse file taxes separately or are newly married during the year, a copy of the spouse's valid driver's license may be submitted showing proof of same residency as employee. For a newly married employee, the spouse's valid driver's license must be submitted when acquired, but no later than 60 days from the marriage date. |
| **Children** | Under age 26:<br>• Natural child<br>• Stepchild<br>• Legally adopted child or child placed with the employee for adoption<br>• Foster child (must be placed with the employee by an authorized placement agency or court order)<br>• Child for whom the employee has permanent legal custody<br>• Child covered under a Qualified Medical Child Support Order (QMCSO)<br>• An unmarried grandchild who lives with the employee in a parent-child relationship and for whom the employee provides more than one-half the child's support<br><br>Over age 26:<br>**Unmarried**, incapacitated child (as defined above) who is not able to support him/herself and depends on the employee for support. Child must be incapacitated prior to age 26. | One of the following:<br>• Birth certificate which identities the employee as the parent, or which identifies the spouse of the employee as the parent (if the spouse was not previously verified as eligible for coverage according to the above criteria, the spousal relationship must be verified as stated above)<br>• Adoption paperwork<br>• The first page of the employee's filed Federal income tax return Form 1040 (or equivalent) from the most recent tax year, listing the child's name. Financial information may be blacked out.<br>• A QMCSO listing the employee as responsible for providing benefit coverage to the child<br>• Court paperwork documenting legal guardianship or foster child relationship<br>• For a grandparent-grandchild relationship, contact HR<br><br>Over age 26:<br>Must supply one the above AND one of the following:<br>• Documentation from a physician verifying a permanent disability occurring prior to the child attaining age 26<br>• Disability paperwork from the Social Security Administration |

Medical coverage is one of the most significant parts of your overall benefits package with ZF North America, Inc., and it is important that you take the time to understand the details of the medical plan in which you are enrolled.




ZF offers three **comprehensive** medical plan options:

- Medical Plan 1 , with a Health Savings Account (HSA)
- Medical Plan 2, with a Health Savings Account (HSA)
- PPO

## About Your Plans

- All three options use the same "PPO" network through Blue Cross Blue Shield of Alabama—so there is no difference in the provider network across all three plans. PPO stands for Preferred Provider Organization, which is a group of doctors and hospitals who join together provide medical services at a discount to its membership. Since PPO providers agree to offer services at a discounted fee, each of the three ZF plans provide a higher benefit level if you use an in-network provider.
- You can see out-of-network, or non-participating, providers but your benefits will be reduced and you'll pay more out-of-pocket. A participating provider must accept the BCBS Allowed Amount as payment in full—they can't balance bill you for more than your deductible and coinsurance. A non-participating provider can balance bill you for the difference between their charge and the BCBS Allowed Amount—plus your deductible and coinsurance. There's no limit to what you can be charged by a non-participating provider.
- Although we encourage you to choose a primary care physician and establish a regular relationship with that doctor, you can see any provider you want, even a specialist. To search for in-network providers, visit www.alabamablue.org.

### Deductible
The amount of expenses you pay each calendar year before the plan begins to pay for benefits that have a coinsurance.

### Copay
This is a set fee for a service in the PPO—for example, $30 for a primary care office visit. Copays do not apply towards your deductible, but they count towards your out-of-pocket maximum.

### Coinsurance
After you've met the deductible, the plan pays a major portion of the covered expenses, and you pay the remaining portion. This sharing of expenses is called "coinsurance." For example, if the plan pays 80% for a particular service, your coinsurance is 20%.

### Out-of-Pocket Maximum
The out-of-pocket maximum provides you with financial protection by limiting the total amount you pay for covered expenses in a calendar year. If your out-of-pocket costs reach the out-of-pocket maximum for an individual or family, the plan will start to pay 100% of your remaining expenses for that individual or family for the remainder of the year. The out-of-pocket dollar maximum includes all medical and prescription drug out-of-pocket expenses, including the deductible, coinsurance and copays.

# HEALTH SAVINGS ACCOUNT

When you enroll in Medical Plan 1 or 2, you have the option to open a **Health Savings Account** through Fidelity. A HSA is a tax-advantaged medical savings account. Similar to a Health Care Flexible Spending Account (FSA), you pay no federal taxes on your contributions (and, in most states, contributions are also tax-exempt).

You can use funds in your HSA to pay for **eligible expenses** incurred after the date the HSA is established (opened). It is possible for this date to be later than your effective date if you delay opening your HSA. Unused funds roll over in your account year over year, so there is no "use it or lose it" requirement with a HSA.

**Important!**
If your enrollment tier is employee + spouse, employee + child(ren) or family, then you are responsible for satisfying the full family deductible amount *before* you will begin to pay coinsurance. Unlike in the PPO plan, there is not an "individual" deductible in these plans.

You decide when to withdraw money from your HSA to reimburse yourself for qualified medical expenses. You can either request a disbursement from your account, transfer funds into a personal bank account, or use the **debit card** that is provided to HSA participants to receive immediate access to funds at the point of service. Or, you can choose to pay for your care out-of-pocket until you reach your deductible and/or out-of-pocket maximum—this approach will let your HSA balance grow and earn interest toward future qualified expenses.

There does not need to be a qualifying event in order to make a change to your **HSA contribution**. To change your election amount during the year, simply submit the request through BenXpress. This can be done once every 30 days.

## 2017 HSA Contribution Limits

Your total maximum, including the company contribution and any wellness incentives paid by the company on your behalf, cannot exceed the IRS indexed statutory maximums below.

| | Employee Only | | All Other Tiers | |
|---|---|---|---|---|
| | **Medical Plan 1** | **Medical Plan 2** | **Medical Plan 1** | **Medical Plan 2** |
| **Employee Maximum Annual Contribution** (minimum $100) | $3,400 | $3,400 | $6,750 | $6,750 |
| **ZF's Core Contribution** | $350 | For employees earning < $36,000 per year: $100 | $700 | For employees earning < $36,000 per year: $200 |
| **Catch-up** (55 or older) | $1,000 | | | |

## Health Savings Account Q & A

***Can everyone participate in the HSA?***
No, not everyone. The Internal Revenue Code says that to participate in a HSA, individuals must be enrolled in a "**qualified**" High Deductible Health Plan (Medical Plans 1 & 2 are qualified), they cannot be a dependent on another person's tax return, and they cannot be covered by another non-qualified medical plan. Individuals are not eligible to contribute to both the HSA and a Full Scope Health Care FSA, or a spouse's Health Care FSA. Additionally, you cannot contribute to a HSA if you have received VA medical benefits in the previous three months, or if you are enrolled in Medicare.

***How do I contribute to a HSA?***
You can choose to **contribute** via pre-tax payroll deduction, or you can deposit lump sum amounts (post-tax) into your HSA then take the tax deduction at the end of the year when you file your income tax return.

***What kind of health expenses can be paid for with HSA funds?***
Eligible or "**qualified**" expenses are defined by Section 213(d) of the IRS Tax Code. They are the same expenses that are eligible for reimbursement under a Health FSA (see IRS Publication 502).

***What if I start a HSA now, but lose eligibility later because I enroll in a non-qualified plan?***
You need to be covered by a qualified plan in order to contribute to your HSA. So if you gain coverage under another plan that **doesn't qualify**, you'll need to stop making contributions to your HSA. You can still use the funds in your HSA for qualified expenses, even if you may not be eligible to contribute to one.

***Can I use the money in my HSA to pay for qualified expenses for my spouse or child?***
Yes, you can spend your HSA dollars on qualified expenses for yourself, or **anyone you claim** as a spouse or dependent on your personal income tax—even if that person is not enrolled on your medical plan.

***Does the HSA earn interest?***
Yes! This is one of the best features of a HSA. Deposits are held in an **interest-bearing** checking account. Individuals can also choose to **invest** the funds. The earnings accumulate tax free, and as long as the money in the account is used to pay for qualified expenses, account holders will never pay taxes on the money deposited or the interest or earnings gained. ZF pays the HSA administrative fee on your behalf while you are an active employee.

***What happens after I turn 65, or enroll in Medicare?***
You will not be able to contribute to a HSA once you enroll in **Medicare**; however, you will be able to continue to use the money in your account to pay for eligible medical expenses as well as Medicare or long term care insurance premiums. Generally, this means that at age 65 you are no longer able to contribute, since most individuals enroll in Medicare Part A (hospital) at no cost upon turning 65.

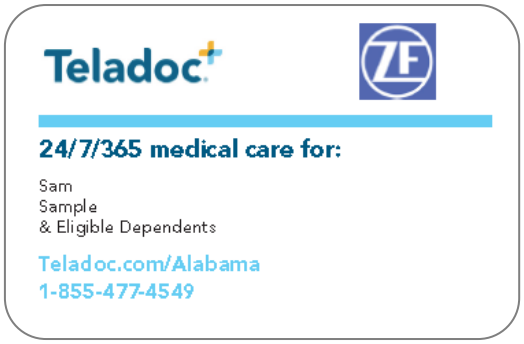
***Do I have to keep records about my HSA?***
Yes, you need to keep **complete records** so you can show the IRS that you've used the money in your account to pay for qualified expenses in the event of an audit. You should keep a record of all deposits and expenditures, and save all receipts. These records are subject to IRS audit, so keep everything in a safe place. ZF nor the bank housing your HSA will have information regarding distributions from your HSA.

***What happens if I use the money in my HSA for a non-qualified expense?***
Money in your HSA is not taxed when used for qualified health expenses. If you use your funds for **non-qualified** expenses, a 20% penalty plus regular taxes apply. Once you reach age 65, withdrawals for non-qualified expenses are taxable, but no penalty applies.

Keep in mind that you are eligible to contribute to the **Limited Purpose Health Care Flexible Spending Account,** even if you are contributing to a HSA. This is another great way to save the funds in your HSA for future expenses.

# TELADOC

As part of the ZF medical plans, you will have access to U.S. board-certified doctors via **phone or online video consultations** 24 hours per day and 7 days per week through Teladoc. This is not a separate insurance policy; rather, it has been added to the ZF medical plans as an affordable alternative to more costly emergency room or urgent care visits. And of course, it is much more **convenient**—when you are up in the middle of the night with a young child, or traveling for work or pleasure. You can contact Teladoc for a variety of medical conditions.




Costs for Teladoc visits are below. Any out-of-pocket expenses you pay will accumulate towards your total out-of-pocket maximum on the ZF medical plans.

- **Medical Plan 1:** $40 until deductible is met, then $8 (this is 20% after deductible)
- **Medical Plan 2:** $40 until deductible is met, then $12 (this is 30% after deductible)
- **PPO:** $30 copay

With your permission, Teladoc can send information about your consultation to your primary care physician. Visit the Teladoc website (www.teladoc.com/alabama) or call them at 1-855-477-4549 for more information.

## When should I call Teladoc?

Common conditions include sinus problems, respiratory infection, allergies, urinary tract infection, cold or flu symptoms and other non-emergency illnesses.

## Do I talk to "real" doctors?

Yes. Teladoc doctors are U.S. board-certified internists, state-licensed family practitioners, and pediatricians licensed to practice medicine in the U.S. and living in the U.S. When you request a consultation, Teladoc will connect you with a doctor licensed in your state.

## Can I request a particular doctor?

No, you cannot request a particular doctor. Teladoc is designed to support your relationship with your existing doctor. It is not a means of establishing an exclusive relationship with a Teladoc doctor.

## What if I need a prescription?

It is up to the doctor to recommend the best treatment. Teladoc doctors are able to write some prescriptions, but do not issue them for substances controlled by the DEA and/or certain other drugs which may be harmful because of their potential for abuse. Also, non-therapeutic drugs such as Viagra and Cialis are not prescribed by Teladoc doctors.

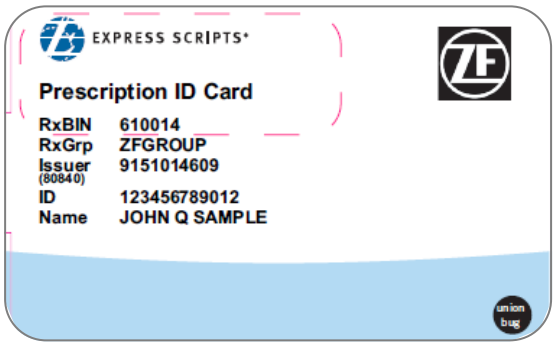
## Can Teladoc handle an emergency?

No. Teladoc is designed to handle non-emergent medical problems. You should NOT use it if you are experiencing a medical emergency.

# PRESCRIPTION DRUGS



If you are enrolled in one of our medical plan options, you also receive prescription drug coverage through **Express Scripts**. Coverage is included for both retail pharmacy and mail order prescriptions, and differs depending if a prescription is a "generic" or "brand name" medication.




- **Generic:** a drug whose formula is equivalent to that of a brand name drug
- **Brand:** an original formula with no generic equivalent

Contact Express Scripts for a complete list of affected medications for the below programs.

**Step therapy** requires you to try one or more specified drugs to treat a particular condition, before the plan will cover another (usually more expensive) drug. Step therapy is intended to reduce costs to you and the plan by encouraging use of drugs that are less expensive but can still treat your condition effectively. If you are taking a medication that requires step therapy, you'll receive a letter explaining that your plan will not cover it unless the alternative drug(s) is tried first.

**Prior Authorization** means that certain drugs under the plan will require prior approval. If you need one of these drugs, your physician will need to call Express Scripts to request authorization. If you or your doctor does not obtain authorization for one of these drugs, the drugs will not be covered by the plan and you will be responsible for the full cost.

**Specialty drugs** treat complex conditions, such as cancer, hemophilia, hepatitis C, multiple sclerosis and rheumatoid arthritis. The ZF plan requires that certain specialty drugs be accessed through Accredo Health Group, Inc., Express Scripts' specialty pharmacy. If you purchase your specialty medication from a pharmacy other than Accredo, you may be responsible for the full cost. To confirm whether the drug you take is part of the specialty drug program, contact Express Scripts or access the Accredo website, www.accredo.com.

## Exclusive Home Delivery (mandatory mail order)

The mail order pharmacy through Express Scripts is for members who are on a **maintenance medication**. If you fill your maintenance medication through mail order, you will save since you only pay for 2.5 months, but you'll receive a three-month supply. You should continue to use retail pharmacies for short-term prescriptions, or for medications such as controlled substances, which are prohibited from being dispensed through a mail order pharmacy.

Filling your maintenance medication prescription through mail order is **mandatory** after three fills within a 270-day period. If you do not switch to mail order on the fourth fill (or subsequent fills), you will be responsible for the full cost of the medication.

If you (or your spouse) are enrolled in **Medical Plan 2** and are **Medicare eligible,** it is important to know that the prescription coverage for Medical Plan 2 is **non-creditable**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage through this plan. This also is important because it may mean that you may pay a higher premium (**a penalty**) if you do not join a Medicare drug plan when you first become eligible.

# PRESCRIPTION DRUGS

## Exclusions

Certain medications, or classes of medications, are not covered under your prescription drug plan. Express Scripts will be able to tell you if the ZF plans cover your specific medication(s). For example, there is no coverage under the ZF prescription drug plans for weight loss, erectile dysfunction, Proton Pump Inhibitor (PPI), and non-sedating antihistamine (NSA) medications. This is not a complete list of exclusions.

## Dispense as Written (DAW) Guidelines

You will pay the difference in cost between a generic and brand (plus a copay, if applicable) if a brand name medication is dispensed in place of an available generic. This will apply even if your doctor indicates to DAW on your prescription. Exceptions are allowed for medical necessity—your doctor will need to work with Express Scripts to receive authorization before the brand name medication will be covered by the plan.

## Preventive Medications

In addition to a healthy lifestyle, preventive medications can help people avoid many illnesses and conditions. If you are enrolled in **Medical Plan 1 or 2**, certain generic preventive drugs will be available at **no cost**—without having to satisfy the deductible first!

Contact Human Resources or Express Scripts to inquire if a certain medication is on the list. Specified medications in the following categories are included:

- Pregnancy prevention
- Tobacco cessation
- Cholesterol
- Asthma
- Ulcer agents
- Obesity
- Heart disease
- Stroke

If you are enrolled in any of the three medical plans, certain preventive medications as required by the Affordable Care Act are also covered at 100%. This includes generic medications, such as contraceptives, pre-natal vitamins, folic acid or aspirin therapy. Express Scripts can provide more information on which medications are on this list.

| Item/Service | Medical Plan 1 | | Medical Plan 2 | | PPO | |
|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network[1] | In-Network | Out-of-Network[1] | In-Network | Out-of-Network[1] |
| Annual deductible | $1,500/EE only<br>$3,000/all other tiers | $3,000/EE only<br>$6,000/all other tiers | $2,750/EE only<br>$5,500/all other tiers | $5,500/EE only<br>$11,000/all other tiers | $650/individual<br>$1,300/family | $1,300/individual<br>$2,600/family |
| Coinsurance | Plan pays 80%<br>You pay 20% | Plan pays 60%<br>You pay 40% | Plan pays 70%<br>You pay 30% | Plan pays 50%<br>You pay 50% | Plan pays 80%<br>You pay 20% | Plan pays 60%<br>You pay 40% |
| Annual out-of-pocket maximum (includes medical and Rx deductible, copays and coinsurance) | $3,500/EE only<br>$7,000/all other tiers | $7,000/EE only<br>$14,000/all other tiers | $5,500/EE only<br>$11,000/all other tiers<br>*Maximum of $7,150 per individual* | $11,000/EE only<br>$22,000/all other tiers<br>*Maximum of $14,300 per individual* | $3,600/individual<br>$7,200/family | $7,200/individual<br>$14,400/family |
| **Preventive Care** | | | | | | |
| Routine preventive services (one physical exam per calendar year and screenings for blood pressure, cholesterol, diabetes and more.) See *www.bcbsal.org/preventiveservices* | Covered 100% | 60% after deductible | Covered 100% | 50% after deductible | Covered 100% | 60% after deductible |
| Routine immunizations, see *www.bcbsal.org/immunizations* | Covered 100% | 60% after deductible | Covered 100% | 50% after deductible | Covered 100% | 60% after deductible |
| **Physician Services (including mental health and substance abuse)** | | | | | | |
| Office visits and outpatient consultations - primary care | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | $30 copay | 60% after deductible |
| Office visits and outpatient consultations - specialists | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | $40 copay | 60% after deductible |
| Teladoc—phone/video consultations | $40 before deductible<br>$8 after deductible | Not covered | $40 before deductible<br>$12 after deductible | Not covered | $30 copay | Not covered |
| Allergy testing and treatment | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | 100% after copay | 60% after deductible |
| **Maternity** | | | | | | |
| Initial visit | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | $30 copay | 60% after deductible |
| Delivery, pre-natal and post-natal visits | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | 80% after deductible | 60% after deductible |
| **Emergency Care (including mental health and substance abuse)** | | | | | | |
| Urgent care | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | $40 copay | $40 copay |
| Emergency Room (facility charges) | 80% after deductible | 80% after in-network deductible[2] | 70% after deductible | 70% after in-network deductible[2] | $150 copay (waived if admitted) | $150 copay[2] (waived if admitted) |
| Emergency Room (physician services) | 80% after deductible | 80% after in-network deductible[2] | 70% after deductible | 70% after in-network deductible[2] | Covered 100% | Covered 100%[2] |
| Ambulance | 80% after in-network deductible | | 70% after in-network deductible | | 80% after in-network deductible | |

| Item/Service | Medical Plan 1 | | Medical Plan 2 | | PPO | |
|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network[1] | In-Network | Out-of-Network[1] | In-Network | Out-of-Network[1] |
| **Hospital Care[3], Diagnostic and Surgical Services (including mental health and substance abuse)** | | | | | | |
| Inpatient facility coverage and pre-admission testing | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | 80% after deductible | 60% after deductible |
| Surgery | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | 80% after deductible | 60% after deductible |
| Diagnostic lab, x-ray and pathology | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | 80% after deductible | 60% after deductible |
| Hemodialysis, IV therapy, chemotherapy and radiation | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | 80% after deductible | 60% after deductible |
| **Other Services** | | | | | | |
| Chiropractic services[4] | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | $30 copay | 60% after deductible |
| Physical, speech or occupational therapy[4] | 80% after deductible | 60% after deductible | 70% after deductible | 50% after deductible | $30 copay | 60% after deductible |
| Durable medical equipment | 80% after in-network deductible | | 70% after in-network deductible | | 80% after in-network deductible | |
| **Prescription Drugs** | | | | | | |
| Retail[5] | Generic & Brand: 80% after deductible | Generic & Brand: 60% after deductible | Generic & Brand: 70% after deductible | Generic & Brand: 50% after deductible | Generic: $15 copay<br>Brand: You pay 40% ($30 min/$100 max per prescription) | Generic & Brand: 60% after deductible |
| Mail Order (90-day supply) *Mandatory for maintenance medications on the 4th fill in a 270-day period* | Generic & Brand: 80% after deductible | Not covered | Generic & Brand: 70% after deductible | Not covered | Generic: $40 copay<br>Brand: You pay 40% ($75 min/$250 max per prescription) | Not covered |

[1]Out-of-network services are paid based on the BCBS Allowed Amount, not the provider's charge. There is the potential to be balance billed when receiving services from a non-participating provider.

[2]For life-threatening medical emergencies or accidental injuries within 72 hours of the emergency or accident. Thereafter, services are covered subject to the applicable deductible and coinsurance.

[3]All hospital admissions require preadmission certification, except emergency admissions and maternity. Notification must be made to BCBS within 48 hours for emergencies. Call 1-800-248-2342. If preadmission certification is not obtained, benefits will be paid at 50% after deductible. PPO physicians will obtain approval on the patient's behalf; patient is responsible for obtaining approval prior to admission to a non-PPO facility.

[4]Limited to a combined total of 60 sessions (visits) per person per calendar year. The 60 visit limitation includes sessions for physical, speech and occupational therapy, as well as chiropractic services.

[5]Certain preventive medications will be available at no cost in Medical Plans 1 and 2, and specified preventive medications as mandated by the ACA are available at no cost in all three medical plans.

## Accident

ZF offers voluntary Accident coverage through Lincoln Financial. A **lump-sum benefit** is paid directly to you, and you can use that money in any way you like. For example, imagine you fall at home and break a limb. You will need to visit the emergency room, and may require surgery and physical therapy. You can use the accident benefit to pay your medical bills, or you could use it to pay other expenses.

You can still contribute to a HSA if you enroll in Accident coverage. In addition, the accident benefit will not be used to offset (or reduce) any disability payments you may receive.

A few examples of benefit payments are listed below. Benefits are only payable once per covered accident. Remember, the covered treatment/service must occur as a result of an accident.

- Admission to a hospital: $1,000
- Emergency Room treatment: $150
- Ambulance/air ambulance: $150/$600
- Surgical fracture: $200—$5,600
- Occupational, physical or speech therapy: $50 (up to 6 visits)
- Medical imaging test (MRI, MR, CT, CAT, EEG): $200
- Hospital confinement daily benefit: $200
- Concussion: $100

## Critical Illness

You also have the option to purchase a voluntary Critical Illness policy through Lincoln Financial. Critical Illness insurance can help protect your finances from the expense of a serious health problem. This plan pays a **lump sum benefit** directly to you—not to a doctor or health care provider—at the first diagnosis of a covered condition.

Read the policy details on BenXpress regarding covered illnesses and diagnoses information to ensure you understand the plan prior to electing.

Included with the Critical Illness coverage are **health advocate** services, which means that you can work with a dedicated advocate who will offer personalized help and guidance to assist you with care coordination, understanding medical information, arranging home care equipment or insurance appeals for any service, not just services related to your critical illness.

The plan also awards healthy lifestyles by paying a **$75 wellness benefit**, just for getting a covered test (such as a blood test for triglycerides, colonoscopy, EKG, mammogram, fasting blood glucose test, pap smear, PSA, stress test, etc.). This payment is in addition to the wellness incentive offered by ZF.

A few of the covered conditions are:

- Heart attack or transplant
- Stroke
- Invasive cancer/cancer in situ
- Benign brain tumor
- Bone marrow transplant
- End stage renal failure
- Major organ transplant
- ALS/Lou Gehrig's disease
- Advanced Alzheimer's
- Advance Parkinson's disease
- Advanced MS
- Loss of sight, hearing or speech

If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. Each condition is payable once per lifetime.

*Rates are displayed online through the enrollment process in BenXpress. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.*

# DENTAL

ZF provides dental benefits to help you and your family maintain **good dental health**. The highest level of coverage is for preventive care, because having routine preventive dental services has proven effective in helping adults and children avoid the cost of more extensive dental work.

Your dental selection is completely separate from your medical plan selection. You can elect dental coverage even if you have waived medical coverage, and vice versa.


DELTA DENTAL

REFERENCE CARD

For **inquiries** about your dental benefits, or to find a participating dentist:

www.deltadentalmi.com

(800) 524-0149

| SEND WRITTEN INQUIRIES TO: | MAIL CLAIMS ONLY TO: |
|---|---|
| P.O. BOX 9089<br>FARMINGTON HILLS, MI<br>48333-9089 | P.O. BOX 9085<br>FARMINGTON HILLS, MI<br>48333-9085 |

THIS CARD IS FOR REFERENCE PURPOSES ONLY AND IS NOT A GUARANTEE THAT COVERAGE IS IN FORCE.

Employees selecting dental coverage and working in all locations except Alabama will be covered on the **Delta Dental of Michigan** plan (no ID cards are issued by Delta). Employees selecting dental coverage and working in **Alabama** will be covered on the BCBS AL dental plan.

You can see the dentist of your choice, but you will have **less out-of-pocket costs** if you select a dentist who is in-network. Dental services by out-of-network providers are subject to set reimbursement rates, which means that after you pay the annual deductible and applicable coinsurance, you may be billed by your dentist for charges exceeding the plan's reimbursement. In-network providers are contractually prohibited from billing patients for fees exceeding negotiated rates.

If you have coverage under Delta Dental, keep in mind that they classify providers into **three networks**:

**Delta PPO**
- Claim paid based on the Delta approved amount, plus a PPO Provider discount is applied
- Provider cannot balance bill the patient

**Delta Premier**
- Claim paid based on the Delta approved amount
- Provider cannot balance bill the patient

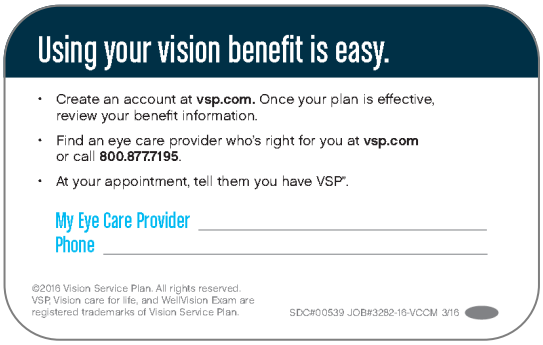
**Non-participating**
- Claim paid based on the Delta approved amount
- Provider can balance bill the patient for the difference between their fees and Delta's approved amount

| Item/Service | Coverage | |
|---|---|---|
| Deductible (waived for Tier 1 and Tier 4) | $50 per person | $150 max per family |
| Annual Maximum Benefit (does not apply to Tier 1) | $1,500 per person | |
| Orthodontia Lifetime Maximum | $1,500 per person | |
| **Tier 1: Diagnostic & Preventive Services** | | |
| Includes: exams, cleanings, fluoride (up to age 19) , x-rays, sealants and periodontal maintenance | Plan pays 100% | You pay $0 |
| **Tier 2: Basic Services** | | |
| Includes: fillings (including composite), crown repair, root canals, periodontic services, extractions, relines and repairs to bridges, implants and dentures | Plan pays 80% | You pay 20% |
| **Tier 3: Major Services** | | |
| Includes: crowns, bridges, implants and dentures | Plan pays 50% | You pay 50% |
| **Tier 4: Orthodontic Services** | | |
| Braces (no age limit) | Plan pays 50% | You pay 50% |

## Vision Discount Program

When you elect medical coverage, you and your dependents are automatically enrolled in the Vision Discount Program. The plan consists of:

- $10 copay for an exam with a VSP provider (up to a $45 reimbursement for a non-VSP provider)
- 20% discount on glasses (frames, lenses and lens enhancements)
- 15% discount on contact lens fitting and evaluation (materials not included)




If you are enrolled in medical coverage with ZF, your medical and vision enrollment tiers must match. If you waive medical coverage through ZF, you are only eligible to enroll in the Voluntary Vision plan, not the Vision Discount Program (you may choose your tier of coverage based on your needs).

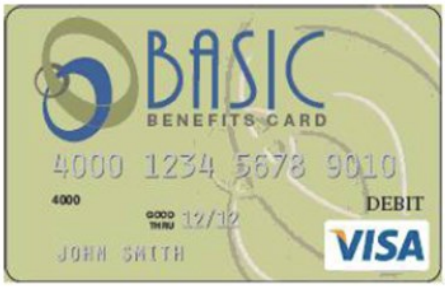
## Voluntary Vision

If you'd like additional vision coverage, you have the option to enroll in the Voluntary Vision plan, which includes comprehensive vision coverage for exams, glasses and contacts. Services are covered both in-network and out-of-network, but you will have less out-of-pocket expenses when you see an in-network provider.

Coverage details for the Voluntary Vision plan can be found below.

| **Item/Service** | **Coverage** | |
|---|---|---|
| | *In-network* | *Out-of-network* |
| **Exam** (every calendar year) | $10 copay | Reimbursed up to $45 |
| **Glasses** (every calendar year) | $25 copay | Reimbursed up to $70 |
| Frame | $150 allowance<br>$200 allowance for featured brands<br>$80 allowance at Costco/Walmart<br>20% discount on remaining balance | |
| Lenses | Single vision, lined bifocal/trifocal<br>Polycarbonate lenses for children | Reimbursement varies by lens type |
| Lens Enhancements | Standard progressive - $55<br>Premium progressive - $95 to $105<br>Custom progressive - $150 to $175<br>Scratch resistant coating - $0<br>Average savings of 20-25% on others | N/A |
| **Contacts** (instead of glasses; every calendar year) | Up to $60 copay (fitting and evaluation)<br>$130 allowance | Reimbursed up to $105 |

# FLEXIBLE SPENDING ACCOUNTS




A Flexible Spending Account (FSA) lets you pay for health and/or daycare expenses with **tax-free** dollars. You save money because you pay for those expenses with pre-tax money—how much you save depends on how much you pay in income tax.

You must make an active enrollment election each year to contribute to a FSA, even if you participated the prior year. You decide before the start of the year how much to contribute. Your contributions are withheld, in equal amounts, from your paychecks throughout the year. As you incur expenses you can file a claim to be **reimbursed** from your account.

If you enroll in a FSA, you will also receive a **debit card** that you can use at the point of service so you have immediate access to your funds. You may still have to substantiate your expenses by providing proof that they are eligible, though, so be sure to keep all documentation.

BASIC administers ZF's FSAs.

## Health Care FSAs

There are two Health Care (HC) FSA options:

- **Full Scope**: use this FSA to pay for eligible medical, dental or vision expenses. You cannot enroll in this option if you are covered by Medical Plan 1 or 2, or a qualified High Deductible Health Plan through another source (for example, your spouse's employer).
- **Limited Purpose**: this FSA can be used to pay for eligible dental or vision expenses, and medical expenses *after* you have met your deductible. You are eligible to enroll in this option if you are covered by Medical Plan 1 or 2, and are not eligible to enroll in this option if you are covered by the PPO.

For a complete list of expenses eligible for reimbursement, review **IRS Publication 502**.

| | Minimum | Maximum |
|---|---|---|
| **2017 Contribution Limits** | $100 | $2,550 |

### Full Scope FSA: Use it or Lose it

If you are actively enrolled on December 31, your eligible health care expenses must be incurred by March 15 (this is the 2.5 month grace period) of the following year, and submitted by March 31.

If you terminate employment during the year, your eligible expenses must be incurred prior to your termination date and submitted for reimbursement within 90 days of your termination.

### Limited Purpose FSA: $500 Carryover

If you are actively enrolled on December 31, unused funds (up to $500) will carryover to the following plan year.

If you terminate employment during the year, your eligible expenses must be incurred prior to your termination date and submitted for reimbursement within 90 days of your termination.

## Dependent Care FSA

The Dependent Care (DC) FSA lets you pay eligible **dependent care** expenses with pre-tax dollars. Most childcare, eldercare and companion services are eligible expenses. Your dependents must be:

- Under age 13 or mentally or physically unable to care for themselves
- Spending at least 8 hours per day in your home
- Eligible to be claimed as a dependent on your federal income tax return
- Receiving care when you are at work and your spouse (if married) is at work, searching for work, is in school full-time or is mentally or physically disabled and unable to provide the care.

| | Minimum | Maximum |
|---|---|---|
| **2017 Contribution Limits** | $100 | $5,000 per household (or less, see below) |

If both you and your spouse work, the IRS limits your contribution to a DC FSA:

- If you file separate income tax returns, the annual contribution limit is $2,500 each for you and your spouse
- If you file a joint tax return and your spouse also contributes to a DC FSA, your combined limit is $5,000
- If your spouse is disabled or a full-time student, special limits apply
- If you or your spouse earn less than $5,000, the maximum is limited to earnings under $5,000.

With a DC FSA, you can be **reimbursed** up to the amount that you have in your account. If you file a claim for more than your balance, you will be reimbursed as new deposits are made.

Eligible dependent care expenses can either be reimbursed through the DC FSA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually, the DC FSA will save you more money than the tax credit, but to find out what is best for you and your family, talk to your tax advisor or take a look at IRS Publication 503.

If you contribute to a DC FSA, you must file an **IRS Form 2441** with your federal income tax return. Form 2441 is simply an informational form on which you report the amount you paid and who you paid for day care.

**DC FSA: Use it or Lose it**

For active and terminated employees, eligible dependent care expenses must be incurred by March 15 (this is the 2.5 month grace period) of the following year, and submitted for reimbursement by March 31.

# LIFE/AD&D

## Basic Life/AD&D

Life and Accidental Death and Dismemberment (AD&D) insurance offers financial protection in the event of your death. ZF provides Basic Life/AD&D coverage for eligible employees at **no cost** through The Hartford.

The below items are part of your Basic Life/AD&D benefit.

- **Survivor Support:** a financial counseling service that offers objective, face-to-face financial planning and advice to beneficiaries and to terminally ill employees. The counseling includes a full financial plan reviewed with the employee in an objective manner.
- **Accelerated Benefits:** if you are diagnosed with a terminal illness (12 months or less to live), you may receive up to 50% of your benefit amount to help you with medical and other expenses.
- **AD&D Repatriation:** Hartford will pay up to $5,000 to help defray the cost of transporting the body if an accidental death occurs at least 75 miles from your primary residence.
- **AD&D Seat Belt and Air Bag Benefit:** Hartford will pay an additional 10% of your life insurance coverage amount, to a maximum of $10,000, if an employee dies as the result of an accident in a private passenger vehicle while wearing a seat belt. Hartford will pay and additional 5% of your life insurance coverage amount, to a maximum of $5,000, if an employee dies as the result of an accident in a private passenger vehicle where the air bag deployed. For example, an employee with a $50,000 life benefit would receive an additional $5,000 seat belt benefit and $2,500 air bag benefit, as applicable.

## Supplemental Life and Supplemental AD&D

You have the opportunity to purchase **additional life and/or AD&D** insurance to supplement the Basic Life/AD&D provided to you by ZF. As a new hire or newly eligible employee you will have an opportunity to newly enroll or increase your amounts. Depending on the amount of coverage requested and when you request it, you may have to answer some health questions which is known as the Evidence of Insurability (EOI) process. Hartford will either approve or deny your request for coverage based on your responses. This will occur during your enrollment on BenXpress.

If additional information is required by The Hartford, you will be contacted directly by them. If you do not respond or turn in the required information during the required timeframe, your application will be closed and you will be welcome to reapply during the next open enrollment period.

At the beginning of each year, your supplemental life rate will increase if you or your spouse move to the next age band during the previous year. Rates are shown in BenXpress. These are separate elections.

| | Company Paid ("Basic") | Employee Paid ("Supplemental") |
|---|---|---|
| **Employee** | 1.5x salary, up to $1 million | Increments of $10,000 up to lesser of $500,000 or 5x salary |
| **Spouse** | Not provided | Increments of $5,000 up to lesser of $250,000 or 50% of EE supplemental amount |
| **Child(ren)** | Not provided | Increments of $2,000 up to $10,000 |

| | Benefit | When am I subject to Evidence of Insurability? |
|---|---|---|
| **Employee** | $10,000 increments up to a maximum of the lesser of 5 times your annual salary or $500,000 | A newly eligible employee can elect coverage up to $200,000 without EOI. If you are currently covered, you may increase coverage in increments of $10,000.<br>• An increase in coverage of $10,000 does not require you to complete the EOI process, as long as it does not exceed $200,000. An increase in coverage of more than $10,000 requires EOI (regardless of current coverage level)<br>• EOI is required for any amount over $200,000, or if you previously waived supplemental life and you are electing it for the first time |
| **Spouse** | $5,000 increments, up to a maximum of the lesser of $250,000 or 50% of the employee's supplemental amount | A newly eligible spouse can elect coverage up to $25,000 without completing the EOI process. If you are currently covered, you may increase coverage in increments of $5,000.<br>• An increase in coverage of $5,000 does not require EOI, as long as it does not exceed $25,000. An increase in coverage of more than $5,000 requires EOI (regardless of current coverage level)<br>• EOI is required for any amount over $25,000, or if you previously waived supplemental life and you are electing it for the first time |
| **Child(ren)** | $2,000 increments, up to a maximum of $10,000 | You may increase coverage in increments of $2,000.<br>• Increases in coverage never require EOI<br>• The total cost of coverage is the same, regardless of the number of children covered<br>*The maximum death benefit paid for a child from birth-6 months is $1,000.* |
| **Benefit Reductions** | Benefits reduce (for employee and spouse) from the original benefit level by 35% at age 70 and by 50% at age 75. | |

**Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect. Increases in coverage are not effective until your request has been approved in writing by the Hartford. Please refer to The Hartford booklet for details.*

The value of basic life insurance coverage over $50,000 is considered **imputed income**. Imputed income is the term the IRS applies to the value of a benefit that should be considered income for the purposes of calculating your taxable gross earnings. The value of your basic life insurance coverage over $50,000 is determined based on your age and the amount of coverage that you have. This amount will show on your bi-weekly paycheck as "Group Term Life" under the "Other Benefits and Information" section.

# DISABILITY

## Salary Continuation (Short Term Disability)

ZF provides eligible employees with a Salary Continuation benefit administered by The Hartford. Income is paid for up to 26 weeks if you are disabled from work due to a non-work related illness or injury. Benefit payments will cease if you terminate employment while collecting Salary Continuation benefits. You will still have the option to apply for Long Term Disability benefits.

| Feature | Description |
|---|---|
| **Amount** | You will receive a portion of your pay. See Human Resources or your Hartford booklet for more information. |
| **Elimination Period** | • 0 days for disability caused by an injury, hospital confinement, or outpatient surgical procedure<br>• 7 days for disability caused by a sickness |
| **Benefit Duration** | • 26 weeks for disability caused by injury<br>• 25 weeks for disability caused by sickness |
| **Definition of Disability** | You are prevented by injury, sickness, mental illness, or substance abuse, from performing the "Essential Duties" of "Your Occupation," and as a result, you are earning less than 20% of your pre-disability earnings. |

## Long Term Disability

ZF offers a Long Term Disability plan to provide income to employees who are disabled for an extended period of time. This coverage is insured through The Hartford.

| Feature | Description |
|---|---|
| **Amount** | 60% of your monthly covered earnings to a maximum monthly benefit of $25,000 per month |
| **Elimination Period** | 26 weeks |
| **Benefit Duration** | Benefits are payable up to your Social Security Normal Retirement Age or the maximum benefit period stated in your Hartford booklet. |
| **Definition of Disability** | For the elimination period and the first 24 months, you are considered disabled if you are prevented from performing one or more of the "Essential Duties" of "Your Occupation," and as a result your current monthly earnings are less than 80% of your pre-disability earnings. See your Hartford booklet for the definition of disability after 24 months. |
| **Pre-existing Condition Definition** | Benefits are not payable for a disability that results from or is caused by or contributed to a pre-existing condition, unless, at the time you become disabled (1) you have not received medical care for the condition for 90 consecutive days while insured under the policy; or (2) you have been continuously insured under the policy for 365 consecutive days.<br><br>A pre-existing condition is any accidental bodily injury, sickness, mental illness, pregnancy, or episode of substance abuse; or any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, mental illness, pregnancy, or substance abuse for which you received medical care during the 90-day period before your most recent effective date of |

## Employee Assistance Program (EAP)

Life presents opportunities and challenges. The Hartford's **Ability Assist**, offered by ComPsych, helps you and your family cope with life, from the everyday to the unexpected. You and your family members have access to Ability Assist at no additional cost to you whether you are enrolled in medical coverage or not. The following list includes some of the services available:

- Job pressures
- Stress and depression
- Relationships
- Retirement planning
- Finding child care
- Dealing with grief/loss
- Impact of disability
- Finance issues

**On the Phone.** Counselors are available 24 hours per day, 7 days per week, 365 days per year through a toll-free number for confidential assessments and consultations. Call 1-800-96-HELPS (1-800-964-3577).

**Face-to-Face.** This service includes up to three face-to-face emotional or work-life counseling sessions per occurrence per year. This means you and your family members won't have to share visits. Each individual can get counseling help for his/her own unique needs. Legal and financial counseling are also available by telephone during normal business hours.

### Guidance Resources Online

Guidance Resources Online is available to you to provide information, resources, referrals, and answers to everyday questions at your convenience. When you visit www.guidanceresources.com as a first time user, you will be asked to register and you will need the following information:

- Company/Organization ID: HLF902
- Company Name: abili

### Life Conversations

Life Conversations is a single source to help families prepare for the future and navigate difficult end-of-life decisions. Call 1-866-854-5429 or visit www.hartfordlifeconversations.com for help with:

- Selecting the appropriate amount of life insurance
- Creating a will (visit www.estateguidance.com/wills,code: WILLHLF)
- Planning a funeral and grief counseling (visit www.everestfuneral.com/hartford, code: HFEVLC)

### Health Champion

This service can guide you through health care options, connect you with the right resources, and advocate for timely and fair resolution of issues. Health Champion is staffed by administrative and clinical experts who can help walk you through all aspects of health care issues such as:

- Cost estimation for covered and non-covered treatment options
- Step-by-step guidance on claims and billing issues
- Preparation for upcoming doctor's visits, lab work, tests and surgeries
- Coordination with appropriate health plan providers
- Referral to community resources and applicable support groups

Guidance consultants are available 24 hours/day, seven days a week by calling 1-800-96-HELPS (1-800-964-3577).

# ADDITIONAL BENEFITS

## Baby Yourself

This **prenatal** wellness program through BCBS AL helps ensure that expectant mothers and their babies receive the best possible health care during pregnancy. Expectant mothers receive support and educational materials from a registered nurse and useful gifts that help both parents understand the changes and challenges that accompany pregnancy. Call 1-800-222-4379.

## BeHealthy.com

The BeHealthy website for BCBS-AL members provides you with the **information and tools** you need to help you make the right decisions about your health care. All personal information on the website is kept confidential. This is also the website you should visit to complete the *Health Quotient (HQ)* to satisfy the health assessment portion of the ZF Wellness Incentive Program. Visit www.behealthy.com.

## Health Coaching

If you are diagnosed with one of **five chronic health conditions**—asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes or heart failure—your ZF medical coverage offers personal medical coaching and advocacy support to help you manage and cope with your condition.

Coaching is also available to members without a chronic condition, to offer practical information and tools for improved health and a healthier lifestyle. Coaching is focused on nutrition, exercise, weight management, stress management and other topics.

## Healthy Mouth, Healthy Body

As part of the dental plan, an additional **preventive cleaning** is available if you or a member of your family have one of several health issues including diabetes or pregnancy. Studies have shown that individuals who fall into these categories benefit greatly from an added cleaning per year. For more information, contact your Human Resources department.

## Travel Assist & Identity Theft

Travel Assist provides help, primarily in **medical emergencies**, when you are traveling more than 100 miles from home for 90 days or less. For example, Travel Assist could arrange for an emergency medical evacuation to the nearest facility providing proper care. All services are provided at no cost, but you must coordinate through the Travel Assist program at the time of need (reimbursement for expenses after-the-fact is not provided). Identity Theft services such as prevention, detection and resolution guidance and assistance is also provided.

## Preventive Screenings & Check-Ups

An annual physical and screenings based on individual risk factors are an important part of maintaining good health. Visit the following link for a detailed listing of **preventive services** covered under our medical plans: www.bcbsal.org/preventiveservices. Reminder, under our BCBS AL plans, preventive services are covered at 100% in-network, and are not subject to deductible or coinsurance. This is true even in Medical Plans 1 and 2. If you haven't received your annual physical yet this year, call to schedule one today.

In addition to your annual medical physical exam, you should be receiving preventive vision and dental examinations as well. It is recommended that you receive a glaucoma eye exam every 5 years beginning at age 35, and a dental exam one to two times per year, beginning at age 3.

## Tuition Assistance

ZF North America, Inc. believes in your continued growth and development. For that reason, we encourage you to participate in a variety of **educational and training** programs—both in house and at outside educational institutions. Tuition, books and other required course materials and registration fees will be paid for an approved curriculum after you have received a grade of "C" or better. Please contact your Human Resources department for more details.

# 401(K) RETIREMENT PLAN



We all want to enjoy a comfortable and worry-free retirement. To help you save for the future, ZF offers a **401(k) plan** that allows you to save through easy pre-tax payroll deductions. There is even a Roth option available to defer compensation on a post-tax basis. Plus, ZF boosts your savings by **matching** your contributions.

Here's how it works:

- You may defer up to 50% of your base pay on a tax-deferred basis up to the annual maximum limit as designated by the IRS. Catch-up contributions are allowed for employees age 50 and older.
- ZF matches 100% of the first 3% of your contributions and 50% of the next 2% of your contributions, for a maximum match of 4%.

For example, if you earn $40,000 a year and contribute 6%, or $2,400, to your 401(k) account each year:

- ZF would match the first 3% dollar for dollar (.03 x $40,000 = $1,200).
- ZF would match the next 2% at 50% (.02 x $40,000 = $800 x $0.50 = $400).
- This equals a total matching contribution of $1,600, and a total annual contribution of $4,000.

Through Fidelity, your 401(k) plan offers a broad range of investment opportunities, along with guidance and educational materials to help you make informed investment choices. For more information, visit Fidelity's web site, www.401k.com or call 1-800-890-4015.

## Company Discretionary Contribution

A discretionary retirement plan contribution may be made to your 401(k) account annually based on the company's performance. If allocated, the contribution will be based on your eligible earnings. If you are an active employee as of December 31 of a Plan Year, you are eligible. There is no guarantee of an annual contribution. Historically, this has been a 4% contribution.

# IMPORTANT NOTICES

## Qualified Changes in Status/Changing Your Pre-Tax Contribution Amount Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year (the plan year is January 1 - December 31). The IRS permits you to change your pre-tax contribution amount mid-year only if you have a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment, or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.
- Electing coverage under your state's Marketplace (also known as the Exchange) during annual enrollment or as a result of a special enrollment.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

*These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.*

## HIPAA Notice of Special Enrollment Rights

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

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

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

The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this packet.

## Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 is also known as "Janet's Law." This law requires that our health plan provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Benefits will be payable on the same basis as any other illness or injury under the health plan, including the application of appropriate deductibles, coinsurance and copayment amounts. Please refer to your benefit plan booklet for specific information regarding deductible and coinsurance requirements. If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

## Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

## Summary of Material Modification

The information in this packet and in the benefit guide applies to the ZF North America, Inc. Welfare Benefit Plan, Plan Number 501. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

## Communications Disclosure

The benefit enrollment communications contain a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or benefit plan documents, the benefit proposals or official plan documents will prevail.

See the official benefit plan documents for a full list of exclusions. ZF North America, Inc. reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

## Notice Regarding Wellness Program

ZF's Wellness Incentive Program is 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 a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to have a medical exam with your physician (which may include a blood test) or to have a biometric screening, which will include a blood test screening for metabolic syndrome. You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees and spouses who choose to participate in the wellness program will receive an incentive of up to $500 (payable to the employee or deposited in the employee's Health Savings Account) for completing the HRA and screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees and spouses who do so will receive the incentive.

Additional incentives of up to $300 may be available for employees and spouses who participate in certain health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the ZF Benefits department at (734) 416-6200.

The information from your HRA and the results from your biometric 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, such as disease or chronic condition management resources. You also are encouraged to share your results or concerns with your own doctor.

***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 ZF North America, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, the administrator for the screenings and HRA (such as your personal doctor, the health plan TPA, etc.) 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 is (are) medical professionals, such as a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

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.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the ZF Benefits department at (734) 416-6200.

# MEDICARE NOTICE

PPO &
Medical Plan 1

## Important Notice from ZF North America, Inc. About Your Prescription Drug Coverage and Medicare

### Notice of Creditable Coverage

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. ZF North America, Inc. has determined that the prescription drug coverage offered by the PPO and Medical Plan 1 plans is , on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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***When Can You Join A Medicare Drug Plan?***

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

***What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?***

If you decide to join a Medicare drug plan, your current ZF North America, Inc. coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current ZF North America, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

***For More Information About This Notice Or Your Current Prescription Drug Coverage…***
Contact the person listed below for further information.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ZF North America, Inc. changes. You also may request a copy of this notice at any time.

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

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

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

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

| | |
|---|---|
| Date: | October 2016 |
| Name of Entity/Sender: | ZF North America, Inc. |
| Contact--Position/Office | Benefits Manager/Human Resources |
| Address: | 15811 Centennial Drive<br>Northville, MI 48168 |
| Phone Number: | (734) 416-6200 |

# MEDICARE NOTICE

Medical Plan 2

## Important Notice from ZF North America, Inc. About Your Prescription Drug Coverage and Medicare

### Notice of Non-Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ZF North America, Inc. 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. ZF North America, Inc. has determined that the prescription drug coverage offered by Medical Plan 2 is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from Medical Plan 2. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Medical Plan 2. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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***When Can You Join A Medicare Drug Plan?***

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you decide to drop your current coverage with ZF North America, Inc., since it is employer-sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under Medical Plan 2.

***If you are enrolling in Medical Plan 2 after having coverage through the PPO or Medical Plan 1 (known as the ZF HDHP in 2016):*** Since you are losing creditable prescription drug coverage under ZF North America, Inc., you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Since the coverage under Medical Plan 2, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

***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 Medical Plan 2 coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current ZF North America, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through ZF North America, Inc. changes. You also may request a copy of this notice at any time.

***For More Information About Your Options Under Medicare Prescription Drug Coverage…***

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

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

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).

| | |
|---|---|
| Date: | October 2016 |
| Name of Entity/Sender: | ZF North America, Inc. |
| Contact--Position/Office | Benefits Manager/Human Resources |
| Address: | 15811 Centennial Drive<br>Northville, MI 48168 |
| Phone Number: | (734) 416-6200 |

# MEDICAID & CHIP NOTICE

## 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, 2016. Contact your State for more information on eligibility.**

**ALABAMA – Medicaid**
Website: www.myalhipp.com
Phone: 1-855-692-5447

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

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

**COLORADO – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

**FLORIDA – Medicaid**
Website: http://flmedicaidtplrecovery/hipp/
Phone: 1-877-357-3268

**GEORGIA – Medicaid**
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

**INDIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid:
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

**IOWA – Medicaid**
Website: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

**KANSAS – Medicaid**
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

**KENTUCKY – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

**LOUISIANA – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

**MAINE – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

**MINNESOTA – Medicaid**
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

**MISSOURI - Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

**MONTANA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

**NEBRASKA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

**NEVADA – Medicaid**
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

**NEW HAMPSHIRE – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-603-271-5218

**NEW JERSEY – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

**NEW YORK – Medicaid**
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

**NORTH CAROLINA – Medicaid**
Website: http://www.ncdhhs.gov/dma
Phone: 1-919-855-4100

**NORTH DAKOTA – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

**OKLAHOMA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

**OREGON – Medicaid**
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

**PENNSYLVANIA – Medicaid**
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

**RHODE ISLAND – Medicaid**
Website: http://www.eohhs.ri.gov/
Phone: 1-401-462-5300

**SOUTH CAROLINA – Medicaid**
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

**SOUTH DAKOTA – Medicaid**
Website: http://dss.sd.gov
Phone: 1-888-828-0059

**TEXAS – Medicaid**
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

**UTAH – Medicaid and CHIP**
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

**VERMONT– Medicaid**
Website: http://www.greenmountaincare.org/
Telephone: 1-800-250-8427

**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

**WASHINGTON – Medicaid**
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022, ext.15473

**WEST VIRGINIA – Medicaid**
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

**WISCONSIN – Medicaid**
Website:https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

**WYOMING – Medicaid**
Website: https://wyequalitycare.acs-inc.com/
Telephone: 1-307-777-7531

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To see if any more states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

- U.S. Dept. of Labor, Employee Benefits Security Administration: http://www.dol.gov/ebsa
  Phone: 1-866-444-EBSA (3272)
- U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services: http://www.cms.hhs.gov/
  Phone: 1-877-267-2323, Menu Option 4, Extension 61565

# CONTACT INFORMATION

BCBS of Alabama
*Medical (& Dental for EEs in AL)*
1-888-215-8477
www.alabamablue.org

Quit for Life
*Tobacco Cessation*
1-888-768-7848
www.quitnow.net

Baby Yourself
*Prenatal Program*
1-800-222-4379
www.alabamablue.org

Express Scripts
*Prescription Drugs*
1-800-987-5248
www.express-scripts.com

Teladoc
*24/7 doctor visits*
1-800-477-4549
www.teladoc.com/alabama

BASIC
*Flexible Spending Accounts*
1-800-372-3539
E-mail: flex@basiconline.com
www.basiconline.com

Delta Dental of Michigan
*Dental (for EEs outside of AL)*
1-800-524-0149
www.deltadentalmi.com

VSP
*Vision*
1-800-877-7195
www.vsp.com

Fidelity
*HSA and 401(k)*
1-800-890-4015
www.401k.com

The Hartford
*Life, AD&D and Disability*
1-877-663-4278
www.thehartfordatwork.com

The Hartford: Ability Assist
*Employee Assistance Program (EAP)*
1-800-96-HELPS (1-800-964-3577)
www.guidanceresources.com

Lincoln Financial
*Accident and Critical Illness*
1-877-815-9256
www.lfg.com

BenXpress
*Benefit Administration and Enrollment System*
www.benxpress.com/zf

iBenefits
*An app for ZF benefits, for use on your smartphone or tablet*
Company Code: ZFbenefits2017

*You should always feel free to contact your local Human Resources department with any questions or concerns.*

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