# YOUR BENEFITS GUIDE



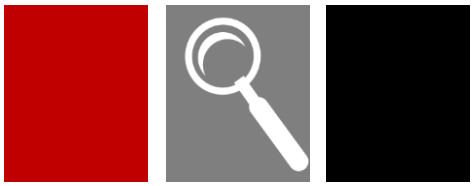
# 2027 Open Enrollment

Have questions or need assistance enrolling?

Call **Health Advocate** at (877) 650-8875

MARTIN TRANSPORTATION SYSTEMS

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# IMPORTANT HIGHLIGHTS FOR 2027

Open Enrollment: November 15 – November 30, 2026  Coverage Effective: January 1, 2027

This Benefits Guide summarizes the primary benefit programs offered by MTS. Please review your benefit options and the important updates below for the 2027 plan year.

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### Flock Benefits Enrollment

- **Flock Benefits Administration:** Log in to Paychex Flex at www.paychexflex.com and select My Benefits to review your elections and make changes. Enrollment is supported on computers, tablets and mobile devices.
- **Enrollment Assistance:** For questions about your benefits or assistance enrolling, contact Health Advocate at (877) 650-8875.

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### Medical

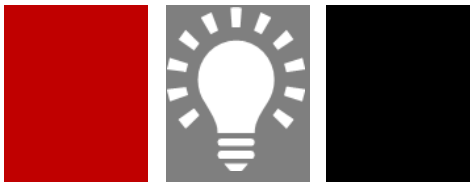
- **Medical Contributions:** Weekly employee contributions will increase effective January 1, 2027. See page 7 for updated rates.
- **GLP-1 Medications:** Medications prescribed for weight loss will no longer be covered effective January 1, 2027.

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### Basic Life, Voluntary Life, and Disability

- **Beneficiaries:** Please review your coverage elections and ensure your beneficiary information is current.
- **Voluntary Life Insurance:** Currently enrolled employees and spouses may increase coverage by one increment ($10,000 employee / $5,000 spouse) without Evidence of Insurability (EOI), provided the new total does not exceed the guaranteed issue amount ($200,000 employee / $40,000 spouse).
- **Late Entrants:** Employees who previously waived voluntary life coverage must complete EOI for the full amount elected.
- **Dependent Child Life:** EOI is not required; employees must elect coverage to add dependents.
- **Voluntary Short-Term Disability:** EOI is not required, but any new benefit amount will be subject to a Pre-Existing Condition Limitation.
- **Voluntary Long-Term Disability:** EOI is required for new enrollments or increases to existing coverage.

# HOW TO ENROLL OR LOG IN



Open Enrollment Period: November 15 – November 30, 2026  Coverage Effective Date: January 1, 2027

Enroll in your benefits through Flock Benefits Administration, accessible from Paychex Flex under My Benefits. Flock supports enrollment on a computer, tablet or mobile device. Flexible Spending Accounts (FSAs) are enrolled separately through Benefits Account (PBA) from the Paychex Flex main menu.

## How to Enroll Using Flock Benefits Administration

### 1. Access My Benefits

- **Log in:** Visit www.paychexflex.com and log in to your Paychex Flex account.
- **Open Flock:** Select My Benefits to access Flock Benefits Administration.

### 2. Review Your Profile

- **Verify:** Confirm your personal information is accurate.
- **Update:** Make changes in Paychex Flex or contact the Benefits Department if needed.

### 3. Review Your Benefits

- **Start enrollment:** In Flock, select Benefits from the left menu and click Enroll/Update.
- **Review:** View your current elections and available benefit options.

### 4. Add or Verify Dependents

- **Dependents:** Review existing dependents and add eligible dependents who need coverage.
- **Assign coverage:** Select the dependents you wish to cover and assign the appropriate plans.

### 5. Select Your Benefits

- **Review plans:** Click a plan card and select Plan Details to review coverage.
- **Make changes:** Review your existing elections and make any desired changes.
- **Continue:** Follow the prompts to complete each step, including waiving benefits if applicable.

### 6. Submit Your Enrollment

- **Submit:** Click Submit Enrollment to finalize your choices.
- **Confirm:** Review your selections under Benefit Summary to confirm submission.

## Flexible Spending Accounts (FSAs)

To enroll in or change your Healthcare or Dependent Care FSA election for 2027, log in to Paychex Flex and select Benefits Account (PBA). FSA enrollment is separate from Flock Benefits Administration.

## Health Advocate / Benefits Assistance

For questions about your benefits or assistance with enrollment, contact Health Advocate at (877) 650-8875.

For questions about personal information, eligibility, or FSA enrollment, contact the MTS Benefits Department.

# BENEFIT BASICS



Here at MTS, you have access to a variety of benefits to provide financial wellness for you and your family. Please read this guide to learn more about your benefits.

## Eligibility

Most employees are eligible for the benefits described in this guide. You are eligible for benefits if you work at least 30 hours per week. Most of your benefits are effective on the first day of the month following 60 days of employment. Your dependents can also enroll for coverage, including:

- Your legal spouse as defined by federal law;
- Your child(ren) up to age 26 which includes natural children, adopted children, stepchildren, children deemed eligible by the employer under a Qualified Medical Child Support Order (QMCSO) and children with proven legal guardianship as approved by the court. When a covered dependent child turns 26, his or her medical and dental coverage will end at the end of the plan year (December 31). Vision coverage will end at the end of the month when they turn 26.

Your benefits will take effect on January 1, 2027, and will remain in effect until December 31, 2027. Remember that you may only change coverage if you experience a qualifying life event, as described below.

## Qualifying Life Events

Generally, you may only make or change your existing benefit elections during the open enrollment window. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- New entitlement to Medicare or Medicaid
- Child reaches age 26

**You must notify Benefits within 30 days of a qualifying life event.** Depending on the type of event, you may need to provide proof of the event, such as a marriage license. Benefits will let you know what documentation you should provide. If you do not contact Benefits within 30 days of the qualified event, you will have to wait until the next open enrollment window to make changes (unless you experience another qualifying life event).

**For More Information About Your Benefits**

**Phone:** Call Health Advocate at (877) 650-8875

**Online:** www.paychexflex.com, then click My Benefits

# WEEKLY CONTRIBUTIONS



The company pays a significant portion of your total benefit costs; the weekly contributions below reflect your share.

## MEDICAL

| Enrollment Tier | HIGH PLAN Weekly Contribution | LOW PLAN Weekly Contribution |
|---|---|---|
| **Employee Only** | $65 | $42 |
| **Employee + 1 dependent** | $100 | $80 |
| **Employee + 2 or more dependents** | $125 | $100 |

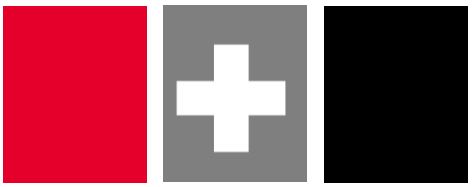
## DENTAL

| Enrollment Tier | HIGH PLAN Weekly Contribution | LOW PLAN Weekly Contribution |
|---|---|---|
| **Employee Only** | $6.22 | $4.58 |
| **Employee + Spouse** | $12.35 | $9.52 |
| **Employee + Child(ren)** | $17.90 | $12.81 |
| **Employee + Family** | $24.00 | $17.46 |

## VISION

| Enrollment Tier | Weekly Contribution |
|---|---|
| **Employee Only** | $1.48 |
| **Employee + Spouse** | $1.68 |
| **Employee + Child(ren)** | $1.72 |
| **Employee + Family** | $3.17 |

# MEDICAL PLANS



This chart compares the basic provisions of the two Blue Cross Blue Shield of Michigan Simply Blue PPO medical plan options and shows the **amount you will pay** for certain medical services. To verify if your provider is in-network call (877) 671-2583 or visit www.bcbsm.com, click Find a Doctor.

| | HIGH PLAN PPO | | LOW PLAN PPO | |
|---|---|---|---|---|
| **PLAN PROVISION** | **IN-NETWORK** | **OUT-OF-NETWORK** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| Annual Deductible (Individual/Family) | $750/$1,500 | $1,500/$3,000 | $2,500/$5,000 | $5,000/$10,000 |
| Coinsurance | 20% | 40% | 20% | 40% |
| Coinsurance Maximum | $2,000/$4,000 | $4,000/$8,000 | $2,500/$5,000 | $5,000/$10,000 |
| Out-of-Pocket Maximum (Includes Deductible) | $6,350/$12,700 | $12,700/$25,400 | $6,350/$12,700 | $12,700/$25,400 |
| Preventive Care | 100% | Not Covered | 100% | Not Covered |
| Primary Physician Office Visit (1) | $40 copay | 40%* | $40 copay | 40%* |
| Specialist Office Visit (1) | $40 copay | 40%* | $40 copay | 40%* |
| Online Visits / Telemedicine | $20 copay | 40%* | $20 copay | 40%* |
| X-Ray and Lab | 20%* | 40%* | 20%* | 40%* |
| Inpatient/Outpatient Hospital Services | 20%* | 40%* | 20%* | 40%* |
| Urgent Care | $40 copay | 40%* | $40 copay | 40%* |
| Emergency Room Care | $250 copay (copay waived if admitted) | | $250 copay (copay waived if admitted) | |
| Retail Prescription Drugs (30-day supply)<br>Generic<br>Brand Preferred<br>Brand Non-preferred<br>Specialty Generic and Preferred Brand<br>Specialty Non-Preferred Brand | <br>$10 copay<br>$50 copay<br>$100 copay<br>15% to $150 max<br>25% to $300 max | In-network copay + 25% of approved amount | <br>$10 copay<br>$50 copay<br>$100 copay<br>15% to $150 max<br>25% to $300 max | In-network copay + 25% of approved amount |
| Mail Order Prescription (90-day supply)<br>Generic<br>Brand Preferred<br>Brand Non-preferred<br>Specialty | <br>$20 copay<br>$100 copay<br>$200 copay<br>Not covered | N/A | <br>$20 copay<br>$100 copay<br>$200 copay<br>Not covered | N/A |

*After deductible is met

(1) Deductible and coinsurance applies to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam

Note: This is a summary only of your coverage. In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

# HPA – PHARMACY SAVINGS PROGRAM

## PHARMACY SAVINGS PROGRAM

**We are pleased to provide a Pharmacy Savings Program administered by Health Plan Advocate (HPA).**

**HPA assists with your prescription drug needs as your dedicated resource for questions and by connecting you to cost reduction strategies and opportunities.**



Here's how it works:

- The program is available to employees and dependents enrolled in our medical plan.
- All members with prescription drugs that (1) have a retail cost of $400 or more and (2) have an available method for cost reduction ("program-eligible drug") are eligible for the program. For all other prescription drugs, the plan's standard copays as outlined in the Schedule of Benefits will apply.
- If you or one of your dependents are taking a program-eligible drug, HPA will contact you to assist with program enrollment.
- For those who respond and participate in the program, your final copay for your program-eligible drug(s) will be $0 after meeting your deductible. Some saving methods have a "point-of-sale" copay, and this will be reimbursed to you by the plan. Members enrolled in an HDHP must meet their deductible on most medications before these copays are reimbursed.
- For those who choose not to respond to HPA, a copay of up to 50% may apply for your program-eligible drug(s).
- If you or your dependent has been identified as eligible for the program, be sure to respond to HPA so you can avoid the up to 50% copay and take advantage of the cost reduction and advocacy benefits of this program.

HPA looks forward to assisting you. For program-related or general questions, contact them directly.

(616) 575-0211 EXT. 206
PHARMSAVINGS@HEALTHPLANADVOCATE.COM

HPA Health Plan Advocate

# ABLETO – BEHAVIORAL HEALTH & MEDICARE

AbleTo is a virtual behavioral health provider contracted with your health plan that offers convenient and confidential care for mild to moderate depression and anxiety. AbleTo provides access to over 2,000 licensed therapists nationwide. Go to www.ableto.com/bcbsm

## Get Care from the Comfort of Home

**How to get started.**

- Go to www.ableto.com/bcbsm
- Click Get Started to sign up and schedule an appointment with a therapist of your choice.
- Select a convenient day, time and device (phone or video) for your sessions. You'll receive an appointment confirmation
- Attend your sessions through the AbleTo app, available in the App Store and Google Play, or online at www.ableto.com/bcbsm.
- Have your initial consultation. Your program will be tailored based on your personal care needs, medical history and preferences.




## MEDICARE INFORMATION

**Medicare Information for Employees who are 65+ see below:**

We've also created a call center for those transitioning from group coverage to individual Medicare coverage. Anytime you have questions about your Medicare options while reading through this folio, call us at 1-855-996-1788, 8 a.m – 9 p.m. Monday through Friday, with weekend hours October 1 – March 31. Or, contact a Blue Cross-authorized, independent agent.

**Medicare information if you are not yet 65 and not eligible for Medicare see below:**

**8) For employees not eligible for Medicare, what are the options for health coverage?**

As our valued member, you have lots of help in this process. Health plan advisors are standing by to answer your questions and guide you: 1-844-737-6596. To do a little research on your own, go to bcbsm.com/myblue and choose *Shop for Insurance*. Remember, we're here for you when you're ready to chat.

# TELADOC HEALTH - DIABETES MANAGEMENT

Take charge of your health through Diabetes management contracted with your health plan. Smart devices, expert support and health management strategies available at no cost.




## Diabetes management, your way

Get an advanced blood glucose meter and as many strips and lancets as you need, paid for by your plan sponsor—all at no cost to you.

- Personalized tips with each blood sugar check
- Real-time support when you're out of range
- Strip re-ordering right from your meter
- Optional alerts to keep contacts in the loop
- Send a Health Summary Report directly from your meter
- Automatic uploads mean no more paper logbooks

### Get started

Join by visiting **TeladocHealth.com/Register/BCBSM**
or call **800-835-2362** and use registration code: **BCBSM**

Program includes trends and support on your secure Teladoc Health account and mobile app but does not include a phone, tablet or smartwatch.

Las comunicaciones del programa Teladoc Health están disponibles en español. Al inscribirse, podrá configurar el idioma que prefiera para las comunicaciones provenientes del medidor y del programa. Para inscribirse en español, llame al 800-835-2362 o visite TeladocHealth.com/HolaBCBSM

The program is offered at no cost through your employer's sponsored Blue Cross Blue Shield of Michigan and Blue Care Network health plan to members and covered dependents with diabetes.

# TELADOC HEALTH – VIRTUAL CARE

With Virtual Care by Teladoc Health, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet, or computer. Virtual Care is included with Blue Cross Blue Shield of Michigan.

## Virtual care that's always there



### GET CARE WHEN YOU NEED IT, WHEREVER YOU ARE.

With **Virtual Care** by Teladoc Health®, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer.

Virtual Care is included with your Blue Cross Blue Shield of Michigan and Blue Care Network health care plan.

### 24/7 CARE

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.

Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

### MENTAL HEALTH

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression.

Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.

### SIGN UP TODAY

**Visit bcbsm.com/virtualcare for a link to download the Teladoc Health app.**

Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call **1-855-838-6628** with any questions about your account or to arrange a telephone visit.

READY TO HELP

MICHIGAN

*All Virtual Care services from Teladoc Health are separate from virtual care other providers may offer. Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.*

Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.
Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

# DENTAL PLANS

Your dental plans, offered through Delta Dental of Michigan, provide coverage for routine exams and cleanings and pay for a portion of other services, as shown in the chart below. To verify if your dentist is in-network call (800) 524-0149 or visit www.deltadentalmi.com click Find a Dentist.

It's important to have regular dental exams and cleanings so problems are detected before they become painful—and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

You have a choice of two dental plans through Delta Dental of Michigan: the High Plan and the Low Plan. This chart shows what the plans pay:



More than 120 disease signs and symptoms can now be detected through a routine oral exam. Regular dental checkups are more important than ever, not only for oral health but for overall health.

Dentists also perform thorough oral cancer examinations, including inspection of the oral cavity and neck. Since cancers of the mouth, tongue and jaw are usually first discovered during dental examinations, dentists are at the forefront for saving lives.

| PROVISION | HIGH PLAN | LOW PLAN |
|---|---|---|
| Annual deductible Individual/Family | $50/$150 | $50/$150 |
| Annual Maximum per person | $1,500 | $1,000 |
| Diagnostic and Preventive, to include cleanings, fluoride treatments, sealants, space maintainers, and x-rays | 100%, no deductible | 100%, no deductible |
| Basic Services to include fillings, periodontics/endodontics, oral surgery | 80%* | 50%* (Space maintainers covered in Basic) |
| Major Services to include crowns, bridges, full and partial dentures, and implants | 50%* | 50%* (Crowns only) |
| Orthodontia (Child only up to age 19) | 50%*; $1,500 lifetime maximum | Not Covered |

*After deductible is met.

# VISION PLAN

Your vision plan, offered through NVA with the NVA Provider network, provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. To find an in-network provider call (800) 672-7723 or visit www.e-nva.com click Find a Provider.

Your vision plan is provided through NVA. It provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can see any providers; however, you always save money if you see in-network providers. This chart shows what the plan pays.

Your coverage is designed to provide you with access to eye care that will protect and enhance your eyesight: your most important sense. Thorough eye exams are essential, not just for detecting vision problems, but as an important preventive measure for maintaining overall health and wellness.



| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Exam | $0 copay | Up to $50 |
| Hardware | $0 copay | See below |
| Frequency<br>• Exam<br>• Lenses<br>• Frames | Once every 12 months<br>Once every 12 months<br>Once every 24 months | |
| Frames | $130 allowance, then 20% off amount over the allowance | Up to $75 |
| Lenses<br>Single vision lenses<br>Bifocal lenses<br>Trifocal lenses<br>Lenticular lenses | Covered 100%<br>(other lens options covered at fixed fee amounts) | Up to $50<br>Up to $75<br>Up to $100<br>Up to $150 |
| Contact Lenses (in lieu of glasses) | $150 allowance | Up to $150 |

# FLEXIBLE SPENDING ACCOUNTS



A Flexible Spending Account (FSA) is a program that helps you pay for health care and dependent care costs using tax free dollars. You must complete one year of employment before participating.

Each pay period, you decide how much money you would like to contribute to one or both accounts. Your contribution is deducted from your paycheck on a pretax basis and is put into the Health Care FSA, the Dependent Care FSA, or both. When you incur expenses, you can access the funds in your account to pay for eligible health care or dependent care expenses.

This chart shows the eligible expenses for each FSA; how much you can contribute to each FSA each year, and how you benefit by using an FSA.

## Example

Here's a look at how much you can save when you use an FSA to pay for your health care and dependent care expenses.

| ACCOUNT TYPE AND ELIGIBLE EXPENSES | ANNUAL CONTRIBUTION LIMITS | BENEFIT |
|---|---|---|
| **HEALTH CARE FSA** Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications) | Maximum contribution is $3,500 per year | Saves on eligible expenses not covered by insurance; reduces your taxable income |
| **DEPENDENT CARE FSA** Dependent care expenses (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time | Maximum contribution is $7,500 per year ($3,750 if married and filing separate tax returns) | Reduces your taxable income |




### Important Information About FSAs

Your Flexible Spending Account (FSA) elections are effective from January 1 through December 31. Please plan your contributions carefully. Our Health Care FSA allows you to carry over $700 in unused funds to the 2027 plan year (min. $25). The Dependent Care FSA provides a 2½ month grace period. Any money remaining in your Health Care FSA over $700 and any amount in your Dependent Care FSA as of March 31 will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations.

| ACCOUNT TYPE EXAMPLE | WITH FSA | WITHOUT FSA |
|---|---|---|
| Your taxable income | $50,000 | $50,000 |
| Pretax contribution to Health Care and Dependent Care FSA | $2,000 | $0 |
| Federal and Social Security taxes* | $15,696 | $16,350 |
| After-tax dollars spent on eligible expenses | $0 | $2,000 |
| Spendable income after expenses and taxes | $32,304 | $31,650 |
| Tax savings with the Medical and Dependent Care FSA | $654 | N/A |

*This is an example only your actual experience. It assumes a 25% Federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will also save on any state and local taxes.

# LIFE AND DISABILITY INSURANCE



What would your family do if your income was lost due to death or disability? Life and disability insurance are important for your financial security, and are offered through Dearborn Group.

## Basic Life/AD&D Insurance

Life insurance is an important part of your financial security, especially if you support a family. Accidental Death & Dismemberment (AD&D) insurance provides a benefit in the event of your accidental death or dismemberment.

The company provides basic life/AD&D insurance to all eligible employees at no cost. Coverage is automatic.

| ACCOUNT TYPE | BENEFIT |
|---|---|
| Employer-provided basic life/AD&D insurance | • $25,000 employee<br>• $5,000 spouse (life only)<br>• Up to $2,000 child(ren) (life only) |

## Voluntary Life Insurance

Voluntary Life insurance can provide additional financial protection to your loved ones during your working years. The benefit is paid to your beneficiaries to help with funeral costs and ongoing financial obligations such as daily living expenses, child education and mortgage payments.

The company offers eligible employees the ability to purchase voluntary life insurance at group rates.

| ACCOUNT TYPE | BENEFIT |
|---|---|
| Voluntary Life Insurance | Employee - $10,000 increments to $500,000 max<br>Spouse – 50% of employee amount to $100,000 max<br>Child(ren) – Up to $10,000 |

## Disability Insurance

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. The company offers eligible employees the ability to purchase disability income benefits at group rates.

Contact Benefits to obtain rates and a detailed summary of your disability benefits.

| COVERAGE AND BENEFITS |
|---|
| **VOLUNTARY SHORT-TERM DISABILITY**<br>Covers 60% of your base earnings to a $1,000 weekly maximum<br>Benefit begins after 15 days of disability |
| **VOLUNTARY LONG-TERM DISABILITY**<br>Covers 60% of your base annual earnings, to a $6,000 monthly maximum<br>Benefit begins after six months of disability |

# ADDITIONAL BENEFITS



MTS offers you and your family additional benefits to enhance your benefits package.

## Employee Assistance Program – ComPsych Guidance Resources

If you find yourself in need of some professional support to deal with personal, work, financial or family issues, your Employee Assistance Program (EAP) can help. You and your immediate family (spouse or dependent children) can use the EAP for help with:

- Marriage and family problems
- Job-related issues
- Stress, anxiety and depression
- Parent and child relationships
- Legal and financial counseling
- Grief and loss
- Financial planning
- Various other related issues

**Help is just a click or phone call away: www.guidanceresources.com , (866) 899-1363**

## Discounts and Services

Through your benefits with Dearborn Group you are eligible for several discounts and services. Contact Benefits for more information.

- Travel Assist Services
- Online Will Preparation, and Online Funeral Planning

## Affiliate Vehicle Discount Program

Chrysler Rewards Program Pin: S53898
www.chrysleraffiliates.com

Ford X-Plan Pin: CYSBB
www.fordpartner.com

GM Supplier Discount Pin: 888322
www.gmsupplierdiscount.com

## Cell Phone Discount Program

AT&T Employee Discount
www.att.com/shop/discountprogram

Verizon Employee Discount
www.verizonwireless.com/discount-program

# 401(K) RETIREMENT SAVINGS PLAN

The MTS 401(k) Retirement Savings Plan offers an easy way to save for your future through payroll deductions.

## Eligibility

You are eligible to participate in the plan after 6 months of service with the company and you have reached 18 years of age.

## Your Employee Contributions

Contributions from your pay are made on a pretax basis up to the IRS annual limit of $25,500. If you are 50 years of age or older, (or if you will reach age 50 by the end of the year), you may make a catch-up contribution of up to $8,500 in addition to the normal IRS annual limit in 2027.

## Your Employer Contributions

MTS supports your retirement savings with a weekly company match. Each week, MTS matches 25% of your 401(k) contributions, up to 20% of your eligible weekly pay. For every dollar you contribute, the company adds 25 cents, helping your savings grow steadily throughout the year.

## Vesting

Vesting refers to your right of ownership to the money in your account. You are immediately vested in 100% of contributions and earnings.

**For More Information**

For additional details about the 401(k) Retirement Savings Plan, to enroll, or to change your contribution rates or investment elections, please call, text, or visit the website below.



**Call**

(800) 986-3343

**Text**

Text the word “ENROLL” to 78259 or use the Principal Mobile App

**Visit**

www.principal.com/welcome

# GLOSSARY



Understand the medical terms that are used in your plan.

**Brand Name Drugs:** Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly choice.

**Coinsurance:** The percentage of a covered charge paid by the plan.

**Copayment (Copay):** A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

**Deductible**: The annual amount you and your family must pay each year before the plan pays benefits.

**Generic Drugs:** Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

**Mail Order Pharmacy:** Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

**In-Network:** Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

**Out-of-Network:** Use of a health care provider that does not participate in a plan's network.

**Inpatient:** Services provided to an individual during an overnight hospital stay.

**Outpatient:** Services provided to an individual at a hospital facility without an overnight hospital stay.

**Out-of-Pocket Maximum:** The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year, except for prescriptions under all medical plans except the HSA Plan.

**Primary Care Physician (PCP):** Physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary.

**Specialist:** A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

**Telemedicine:** The remote diagnosis and treatment of patients by means of telecommunications technology.

# PLAN CONTACTS



| PLAN | PROVIDER | PHONE NUMBERS | WEBSITE |
|---|---|---|---|
| Medical<br>Pharmacy Savings Program<br>Diabetes Management<br>Virtual Care | Blue Cross Blue Shield of MI<br>Health Plan Advocate<br>Teladoc Health<br>Teladoc Health | (877) 671-2583<br>(616) 575-0211 x 206<br>(800) 835-2362<br>(855) 838-6628 | www.bcbsm.com<br>pharmacysavings@healthplanadvocate.com<br>www.teladochealth.com/register/bcbsm<br>www.bcbsm.com/virtualcare |
| Dental | Delta Dental of MI | (800) 524-0149 | www.deltadentalmi.com |
| Vision | NVA<br>(National Vision Administrators) | (800) 672-7723 | www.e-nva.com |
| Flexible Spending Accounts | Paychex Benefit Account | (877) 244-1771 | www.paychexflex.com,<br>click PBA Benefit Account (FSA) |
| Life/Disability | Dearborn Group | (800) 721-7987 | www.mydearborngroup.com |
| Employee Assistance Program | ComPsych | (866) 899-1363 | www.guidanceresources.com |
| 401(k) Retirement Savings Plan | Principal | (800) 986-3343 | www.principal.com |
| Claims Assistance, Benefit Questions, Locating Providers, Assistance Enrolling | Health Advocate | (877) 650-8875 | |

# ANNUAL NOTICES

**If you 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 page 30 for more details.**

## IMPORTANT PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES, ERISA NOTICES, MEDICARE PART D CREDITABLE COVERAGE NOTICE, AND CONTACTS FOR MORE INFORMATION

Martin Transportation Systems, Inc. is providing these important notices to you at no fee. The notices in this package describe important rights that you have under the terms of the Martin Transportation Systems, Inc. Group Health Plan. If you have any questions or need additional information regarding these notices you can contact:

**Your Employer Representative**

Meghan Bultema
616-432-5516
Meghan.bultema@mtstrans.com

**Or by mail at:**

7300 Clyde Park Ave SW
Byron Center, MI 49315

The following notices are included in this communication in the following order:

- WHCRA Notice (Women's Health and Cancer Rights Act)
- CHIP Notice (Children's Health Insurance Program)
- Paperwork Reduction Act Statement
- HIPAA Special Enrollment Rights Notice
- Patient Protection Choice of Providers
- Patient Protections Against Surprise Medical Bills
- Medicare Part D Creditable Coverage Notice

## NOTICE OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your Employer Representative for more information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and co-insurance particulars that are applicable to other medical and surgical benefits provided under this Plan. Martin Transportation Systems, Inc. has provided the detailed information regarding deductible and co-insurance for the Martin Transportation Systems, Inc. Group Health Plan. For more information or to get a copy of the Summary Plan Description containing these details contact your Employer Representative.

**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)**.

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**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, 2026. Contact your State for more information on eligibility –**

| **ALABAMA – Medicaid** | **ALASKA – Medicaid** |
|---|---|
| Website: http://myalhipp.com<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br><br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program<br>Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |

| MAINE – Medicaid | MASSACHUSETTS – Medicaid and CHIP |
|---|---|
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br><br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740.<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website:<br>https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |

| NORTH CAROLINA – Medicaid | NORTH DAKOTA – Medicaid |
|---|---|
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website:<br>http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid** | **RHODE ISLAND – Medicaid and CHIP** |
| Website:https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br><br>CHIP Website: Children's Health Insurance Program (CHIP)-(pa-gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website:<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br><br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br><br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

**Paperwork Reduction Act Statement**

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

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

OMB Control Number 1210-0137 (expires 5/31/29)

**HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE**

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

**PATIENT PROTECTION CHOICE OF PROVIDERS**

In cases where the Martin Transportation Systems, Inc. Group Health Plan allows or required a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, Martin Transportation Systems, Inc. Group Health may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your Employer Representative.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Martin Transportation Systems, Inc. Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer Representative.

## PATIENT PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

**What is "balance billing" (sometimes called "surprise billing")?**

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

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

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

**You are protected from balance billing for:**

**Emergency services**

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

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

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

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

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

There are some states that have surprise bill or balance billing laws. These laws apply to fully insured plans and may impact self-funded plans, including state or municipal government plans and church group plans. Please check with your plan administrator and/or insurance certificate/booklet to see if state law applies to your coverage.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, you may contact:

- The US Department of Health and Human Services at:

    Phone: 800-985-3059
    Website: https://www.cms.gov/nosurprises/consumers

- Your state agency, which can be found at:
  https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

## Important Notice from Martin Transportation Systems, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Martin Transportation Systems, 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. Martin Transportation Systems, Inc. has determined that the prescription drug coverage offered by the Martin Transportation Systems Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

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

If you decide to join a Medicare drug plan, your current Martin Transportation Systems, Inc. coverage will not be affected. However, as long as you are actively working for Employer, coverage under the Health Benefit Plan will usually be your primary coverage. Therefore, you may not need to enroll in a Medicare prescription drug plan while you are actively working for Employer.

If you do decide to join a Medicare drug plan and drop your current Martin Transportation Systems, Inc. coverage, be aware that you and your dependents will be able to get this coverage back. You will generally not be able to re-enroll until the next open enrollment period.

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

You should also know that if you drop or lose your current coverage with Martin Transportation Systems, 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 Martin Transportation Systems, 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: | 10/27/2026 |
| Name of Entity/Sender: | Martin Transportation Systems, Inc. |
| Contact--Position/Office: | Benefits Department |
| Address: | 7300 Clyde Park Ave SW, Byron Center, MI 49315 |
| Phone Number: | (616) 432-5516 |




**About This Guide**

This benefit summary provides selected highlights of the Martin Transportation Systems, Inc. employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Martin Transportation Systems, Inc. reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.