2024 Open Enrollment Guide

MyCHOICE

Marwood Nursing and Rehab

McLaren
HEALTH CARE

WELCOME TO McLAREN'S BENEFITS OPEN ENROLLMENT FOR 2024

McLaren's annual Benefits Open Enrollment will be held Monday, October 30 through Monday, November 13, 2023. This is the time of the year when benefits-eligible McLaren employees can re-evaluate their benefits needs and make changes to their benefits selections. This Open Enrollment Guide contains information about the benefits options available for benefits-eligible employees in the 2024 plan year. Please review this Open Enrollment Guide before completing your Open Enrollment.

Dependent Child Certification Form:

The Dependent Child Certification Form can ONLY be completed online in your Open Enrollment Session.

Please proceed to Employee Self-Service, MyHR, to complete your Open Enrollment Session and to complete a Dependent Child Certification Form. The Dependent Child Certification Form must be completed if you have a dependent who will be at least 18 years of age on December 31, 2023 and not more than 22 years of age on December 31, 2023 AND is a full-time student and your tax dependent (and you are enrolling your child in dental or vision benefits).

IMPORTANT NOTE:

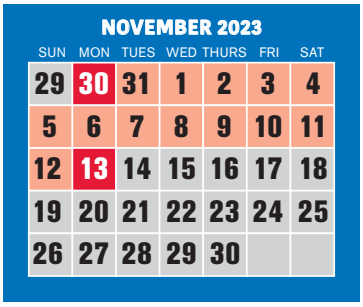
This is a summary of your benefits options provided by McLaren Health Care Corporation. This information is meant to be a general guide. If there is a difference between the information presented in this benefits enrollment guide and the contents of the official plan documents, the Plan documents will prevail.

Marwood NURSING AND REHAB

A SUBSIDIARY OF:

McLaren HEALTH CARE

YOUR BENEFITS AT A GLANCE



KEY DATES

Open Enrollment Begins
Monday, October 30

Open Enrollment Ends
Monday, November 13 @ 5 p.m. EST

FOR THIS YEAR'S OPEN ENROLLMENT, YOU MUST PARTICIPATE IN OPEN ENROLLMENT IF:

- You want to enroll or continue in a Flexible Spending Account (FSA) in plan year 2024. (e.g., enroll in a Medical Reimbursement FSA, enroll in a Dependent Care FSA). Participants in an FSA must enroll every year.
- You want to enroll or continue Dental and/or Vision coverage for a dependent who is 18-22 years old and is a full-time student and your tax dependent. The Dependent Child Certification Form can be found online in your Open Enrollment session.
- You want to change your medical, dental or vision plan. (e.g., go from Premier to Marwood (MHA), from Delta 1000 to Delta 1500, from EyeMed Core to EyeMed Buy-Up).
- You want to change who is covered on your medical, dental or vision plan. (e.g., add a dependent or remove a dependent).
- You want to change your life insurance or long-term disability coverage, if eligible.

BENEFITS BASICS

Eligibility

For You

Full-time and part-time employees are eligible to participate in the health, dental, and vision plans as well as the other benefits described in this enrollment guide, unless otherwise indicated. Full time employees are regularly scheduled to work 70 or more hours per pay period. Part-time employees are regularly scheduled to work 40 to 69 hours per pay period.

For your dependents

If you are eligible for coverage, you can also enroll your eligible dependents for health, dental, vision, and voluntary life coverage.

Eligible dependents include:

- Your legal spouse
- Your children up to age 26 (for health) even if employed or married
- Your children up to age 23 (for dental and vision) if they are full-time students and tax dependents
- Your disabled children age 19 and over if not married and if disabled before age 19

Children include your natural children, stepchildren, adopted children, children placed for adoption, and children for whom you have legal guardianship. Dependent children do not include grandchildren or other family relations unless you have legal guardianship.

Eligibility Documentation

When you complete your online enrollment, you are required to upload documentation that supports the eligibility of your dependents. **Documentation MUST be uploaded for any "new" spouse or child(ren) added for 2024 that you did not cover on your benefits in 2023.**

Please see below as to the acceptable documentation to upload for verifying eligibility of your dependents:

Type of Dependent	Acceptable Documentation to Upload
Spouse	Marriage Certificate **AND** **One of the following:** – Driver's licenses or state issued identification of employee **AND** spouse with matching addresses – Driver's license of spouse only if the address matches the address on file – Current mortgage statement or other proof of joint ownership of the home[1] – Current rent/lease agreement[1] – Page 1 of Federal or State Tax Return (1040, 4506, 4506-T, 8679 or M8453) from one of the prior two years, listing spouse[2] – Auto/homeowner insurance bill, with same address currently in effect[1] – Utility bills, with same address currently in effect[1]
Child – Biological	– Long-form birth certificate
Child – Adopted – Legal Guardianship	– Adoption papers – Reissued birth certificate *(listing adoptive parent's names)* – Court-approved guardianship papers
Child – Stepchild	– Long-form birth certificate **AND** – Marriage certificate of parents
Child – Disabled	– Letter from Social Security Administration showing that your dependent has been receiving SSI or RSDI based on disability (before the age of 19) **OR** – Letter from a doctor stating that your dependent was disabled before the age of 19 (along with the medical condition).

1. *You may upload one document displaying both names or one in the employee's and one in the spouse's with matching addresses.*
2. *To protect your privacy, black out Social Security numbers and all financial information or monetary amounts appearing on any documents submitted.*

BENEFITS BASICS *CONTINUED*

Enrollment
Generally, there are two times when you can enroll for benefits: when you first become eligible and during the annual benefits open enrollment. Each fall, Open Enrollment is held so you can make changes to your benefits elections for the upcoming calendar year. Coverage elected during Open Enrollment is effective January 1, 2024 through December 31, 2024.

Changing Your Benefits
Once you enroll, your elections remain in effect for the entire calendar year. Because you pay for many of your benefits with pretax dollars, the IRS does not allow you to change your benefits elections during the year unless you experience a change in status event described below.

Change in status events include, but are not limited to:

- Birth, adoption, or placement for adoption of a child
- Marriage or annulment
- Divorce, legal separation (see important note)
- Gain or loss of coverage through your spouse's employer
- A child's gain or loss of eligibility status
- Death of a spouse or dependent child
- A change in work status that affects benefits eligibility (e.g., casual to full-time)
- A qualified medical child support order
- Eligibility for Medicare
- The start or end of a leave of absence

You have 30 days from the date of a change in status event to change your coverage. Any change to your benefits will be effective on the first of the month following the date of the change, provided you notify Human Resources within 30 days after the status event. Exceptions to this rule are marriage, birth and adoption, which are effective on the date of the event.

Paying for Your Benefits

You and McLaren share the cost of many of your benefits. The rate sheet provided with this Open Enrollment guide shows your portion of the cost. For health, dental, vision, and flexible spending accounts benefits, you pay your contributions with pretax dollars. Paying with pretax dollars reduces your taxable income, so you pay less in taxes.

When Coverage Ends

Unless otherwise stated, your benefits coverage ends on the last day of the month in which the event occurs.

Coverage for your dependents ends on the earliest of the following dates:

- The day your coverage ends (or)
- End of the month your dependent no longer meets eligibility requirements (in most situations)

Cobra

If your coverage ends, you may be able to continue your health, dental, vision, and medical reimbursement FSA coverage through COBRA.

See your summary plan description or Corporate Benefits for more information about COBRA coverage.

IMPORTANT NOTE:

Divorce/Legal Separation *– To ensure that your former spouse can enroll in COBRA, your divorce or legal separation must be reported to Human Resources within 60 days of the divorce judgment or legal separation.*

HEALTH

With today's rising medical costs, we all need some kind of protection against health care expenses that, in the event of a major illness or accident, could put a family's entire financial future at risk.

Comprehensive medical coverage can help make the rising cost of healthcare more affordable. Health plans offered through MyChoice cover a wide range of services, including doctor visits, surgery, hospitalization, preventive care, prescription drugs, and more.

How the Plan Works

MyChoice provides two McLaren Health Advantage (MHA) PPO health plans:

- MHA Premier and
- Marwood MHA

(A BlueCross BlueShield traditional plan option is available to employees who live outside the McLaren Health Advantage network area. Contact Corporate Benefits to see if you qualify.)

Both McLaren Health Advantage PPOs cover the same health care services, including preventive care, office visits, hospital services, emergency care, and prescription drugs, including but not limited to those listed in the charts on pages 8 and 9; however, your coinsurance, copays, deductibles and out-of-pocket maximum costs may differ significantly depending on the health plan you choose and the providers you seek treatment from.

NOTE: *You receive the highest level of benefits when you use McLaren's domestic network or McLaren's direct contracted network. Use the charts on pages 8 and 9 to compare your options.*

Health Plan Definitions

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (e.g., 10%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health plan's allowed amount for a covered service is $100 and you have met your deductible, your coinsurance payment of 10% is $10 (payable to that health care provider). The health plan would pay the remainder of the allowed amount.

Copay – A fixed dollar amount (e.g., $25) you pay for a covered health care service. The fixed amount can vary by type of covered health care service.

Deductible – The amount you owe for health care services, before your health plan begins to pay. For example, if your deductible is $200, your health plan will not pay for covered health care services until your deductible has been met. The deductible may not apply to all services.

Out-of-Network – If your doctor, hospital or health care facility is NOT In-Network, you will have higher coinsurance, deductibles, and out-of-pocket maximums. It costs you more to go Out-of-Network.

Out-of-Pocket Maximum – The most you pay during a plan year (usually a calendar year) before your health plan begins to pay 100% of the allowed amount.

Tier 1 – If your doctor, hospital or health care facility is In-Network, you will get your health care at lower prices. If you go to a Tier 2 provider or Out-of-Network, the cost for your health care will be more expensive.

Tier 2 – This is a group of health care providers that are contracted. If your doctor, hospital or health care facility is in Tier 2, you will have higher deductibles and coinsurance amounts but you will be protected from balance billing.

McLAREN HEALTH ADVANTAGE (MHA)
MHA Premier/Marwood MHA

Non-Hospital Services and Hospital Services
When you use either a McLaren facility and employed providers (domestic network) or the McLaren Health Advantage network, you will receive the highest level of benefit coverage and generally pay less out-of-pocket.

You may use providers outside these networks and still receive benefits; however, you may receive a lower level of benefit coverage and likely pay more out-of pocket.

To locate a Health Advantage provider:

1. Go to www.mclarenhealthplan.org
2. Select the “Members” box.
3. Select the “Find A Provider” box.
4. Find a Provider – Select “McLaren Health Advantage”
5. Click on the drop down box for Specialty
6. Enter your country, city or zip code, then select “Find” at the bottom of the page.

PLAN COMPARISON CHARTS

MHA Premier	Tier 1	Tier 2	Out-of-Network
Annual Deductible[1]			
Single	$500	$2,000	$2,000
Family	$1,000	$4,000	$4,000
Medical Coinsurance Out-of-Pocket Maximum[1]			
Single	$1,000	$5,000	$5,000
Family	$2,000	$10,000	$10,000
Professional Services			
Preventive Services	100%	not covered	
Office Copay[2]	$25 copay	50% after deductible	50% after deductible
Specialist Copay	$40 copay	50% after deductible	50% after deductible
Emergency Medical Care			
Emergency Room	$150 copay	$150 copay	$150 copay[3]
Urgent Care Center	$50 copay	$50 copay	$50 copay[3]
Facility Services			
In-Patient Hospitalization	80% after deductible	50% after deductible	50% after deductible
Out-Patient Services	80% after deductible	50% after deductible	50% after deductible
Other Services			
Chiropractic Care (limited to 24 visits per year)	80% after deductible	50% after deductible	50% after deductible
Surgical Services & Anesthesia	80% after deductible	50% after deductible	50% after deductible
Obstetrical & Newborn Care	80% after deductible	50% after deductible	50% after deductible
Laboratory & Radiology Services[4]	80% after deductible	50% after deductible	50% after deductible
Catastrophic Services	80% after deductible	50% after deductible	50% after deductible

1 *Deductibles and coinsurance expenses accumulate separately for Tier 1, Tier 2, and Out-of-Network services.*
2 *Primary Care Physicians include: General Practice, Family Practice, Internal Medicine, OB/GYN and Pediatrics.*
3 *Facilities and providers contracted through Zelis Healthcare can only be accessed for Urgent Care and other limited circumstances. See your Benefit Booklet for more details.*
4 *When seeking outpatient laboratory services, use a Joint Venture Hospital Laboratory (JVHL).*

PLAN COMPARISON CHARTS

Marwood MHA	Domestic/Direct Contract Network (McLaren Health Advantage)	Secondary Network	Out-of-Network
Annual Deductible[1]			
Single	$200	$750	$2,000
Family	$400	$1,500	$4,000
Annual Coinsurance Limit[1]			
Single	$1,000	$1,500	$5,000
Family	$2,000	$3,000	$10,000
Professional Services			
Preventive Services	100%	not covered	
Office Copay[2]	$15 copay	$25 copay	50% of R&C after deductible
Specialist Copay	$30 copay	$30 copay	50% of R&C after deductible[3]
Emergency Medical Care			
Emergency Room	$100 copay	$100 copay[4]	100% of R&C less $100 copay[4]
Urgent Care Center	$25 copay	$25 copay[4]	100% of R&C less $25 copay[4]
Facility Services			
In-Patient Hospitalization	90% after deductible	80% after deductible	50% of R&C after deductible
Out-Patient Services	90% after deductible	80% after deductible	50% of R&C after deductible
Other Services			
Chiropractic Care (limited to 24 visits per year)	$30 copay for first visit consecutive visits covered 100%	$30 copay for first visit consecutive visits covered 100%	50% of R&C after deductible
Surgical Services & Anesthesia	90% after deductible	80% after deductible	50% of R&C after deductible
Obstetrical & Newborn Care	90% after deductible	80% after deductible	50% of R&C after deductible
Laboratory & Radiology Services[5]	covered at 100%	80% after deductible	50% of R&C after deductible
Catastrophic Services	90% after deductible	80% after deductible	50% of R&C after deductible

1 *Deductibles and coinsurance expenses accumulate separately for the McLaren Health Advantage Network, Secondary Networks, and Out-Of-Network services.*

2 *Primary Care Physicians include: General Practice, Family Practice, Internal Medicine, OB/GYN and Pediatrics.*

3 *R&C stands for Reasonable and Customary.*

4 *Secondary network facilities and providers contracted through Zelis Healthcare can only be accessed for Urgent and Emergency Services.*

5 *When seeking outpatient laboratory services, use a Joint Venture Hospital Laboratory (JVHL).*

When you enroll in health coverage, you automatically receive coverage for prescription drugs.

How the Plan Works

MyChoice gives you two convenient ways to purchase prescription drugs:
at a **Retail Pharmacy** or through **Mail Order**.

PRESCRIPTION DRUGS

Retail Program
For your short-term medication needs, you can purchase up to a 30-day supply at participating retail pharmacies. You can also purchase a 90-day supply of generic medications at participating retail pharmacies for a single copay. If you use a pharmacy that's not part of the network, you must pay for the prescription, then submit a claim for benefits up to the plan's contracted amount.

For a list of participating pharmacies, go to **www.mclarenhealthplan.org**, move your cursor over **"Are you a Member?"** and select **McLaren Health Advantage** from the menu options. Then, click on **Find A Provider**. Enter your county, city or zip code and select **Pharmacy** from the drop down menu in the **Specialty** box and click **Find**.

Mail Order Program
The mail order program saves you money when you take medication for an ongoing or chronic condition. You can purchase up to a 90-day supply of **brand name** prescription drugs and have your prescriptions shipped directly to your home. Be sure your doctor writes your prescription for a 90-day supply.

Pharmacy Benefit Manager (PBM)
MedImpact Direct *is the mail order pharmacy vendor.*

To learn more about the mail order program, go to **www.mclarenhealthplan.org**, move your cursor over "**Are you a Member?"** and select **McLaren Health Advantage** from the menu options. Then, click on **Member Materials**, select **Pharmacy Benefit Manager (PBM) Effective January 1, 2019** *(found under the "Customer Information" topic).*

If you have any questions regarding the mail order program, contact MedImpact Direct toll-free at **(888) 274-9689**.

Prescription Drugs				
	Retail (In-Plan)		Mail Order (In-Plan)	
	30 Day	90 Day	30 Day	90 Day
Preferred Generic	$10	$10	Not Available	Not Available
Preferred Brand	$30	$90	Not Available	$30 for a 3 mos supply
Non-Preferred Generic Non-Preferred Brand & Speciality Brands	$50	$150	Not Available	$50 for a 3 mos supply
	Retail (Out-of-Plan)		Mail Order (Out-of-Plan)	
Preferred Generic	$10 copay plus 25%		Not Covered	
Preferred Brand	$30 copay plus 25%		Not Covered	
Non-Preferred Generic Non-Preferred Brand & Speciality Brands	$50 copay plus 25%		Not Covered	

DENTAL

The secret to a healthy smile is prevention, so be sure to brush, floss, and get regular dental check ups. Not only will you help keep cavities and gum disease at bay, you can also avoid other serious health conditions linked to poor dental care.

How the Plan Works

With MyChoice, you have three options for dental coverage:

- Delta 1000
- Delta 1200
- Delta 1500

All three options cover preventive care, basic, and major services; however, your coinsurance and annual maximum benefit will vary significantly depending on the option you choose.

Under all three options, you can see any dentist you choose, but dental benefits are highest when you choose a provider in the Delta Dental network. If you use a non-Delta Dental provider, however, you'll receive lower benefits and be responsible for charges exceeding reasonable and customary (R&C) limits.

For a list of Delta Dental providers, visit **www.deltadentalmi.com**, select **"Find a Dentist"** at top of page, scroll down and select **"Search PPO and Premier"**.

Delta Dental also provides each enrollee a personalized convenient online Consumer Toolkit that contains your Delta Dental benefit information, helpful articles and health tips designed to keep you smiling. To utilize your Delta Consumer Toolkit, go to **www.deltadentalmi.com** and **"Log In"** or become a **"New User"**.

Benefit Coverage

The dental plan covers a wide range of services and supplies, including but not limited to those listed in the Plan comparison chart below.

Note: *To determine if a service is covered, contact Delta Dental before you seek treatment.*

Delta Dental Benefit Options		Delta 1000	Delta 1200	Delta 1500
Deductible – Class II and III	Individual	None	$50	$25
	Family	None	$100	$75
Class I * – Preventive[1]		100%	100%	100%
Class II – Basic Restoration[2]		60%	70%	80%
Class III - Major Restoration[3]		50%	60%	60%
Class IV – Orthodontia[4]		not covered	50%	50%
Orthodontia – Lifetime Maximum		not covered	$1,000	$1,750
Annual Maximum Benefit* – (per covered individual)		$1,000	$1,200	$1,500

1 Exams, X-rays, Cleanings
2 Fillings, Gum Disease Treatment, Root Canals, Sealants
3 Crowns, Bridges, Implants, Dentures
4 Braces for children to age 19

** Diagnostic & Preventive services (Class I Benefits) will be exempt or excluded from the annual maximum benefit.*

Whether you have 20/20, or less-than-perfect vision, routine eye exams can spot eye conditions and other health problems such as diabetes, high blood pressure, and rheumatoid arthritis. Many serious eye conditions have no early warning symptoms, so an eye exam today may prevent a health problem tomorrow.

VISION

How the Plan Works

The EyeMed Core benefit is offered to eligible full-time employees. This benefit helps to cover the cost of regular eye exams. You pay a $10 copay when you use an in-network provider. If you use a non-network provider, the EyeMed Core benefit gives you a $45 allowance to help you pay for the cost of your exam.

With MyChoice, full-time employees also have the option of participating in the EyeMed Buy-Up benefit. The EyeMed Buy-Up benefit covers frames, lenses and contacts. When you enroll for coverage, you can see any provider you choose, but you receive the highest benefits when you use an EyeMed participating network provider.

Part-time employees only have the option of enrolling in the EyeMed Buy-Up benefit.

For a list of participating providers, visit **www.eyemedvisioncare.com** and click on **"Find an eye doctor"** (found in the upper right corner of the home screen). Choose your Network from the drop down menu. Select the **"Access Network"** and select **"Use My Location"** or enter your 5 digit zip code and select **"Search By Zip"**. The website also features eye care articles, answers to frequently asked questions, information about laser vision correction, and more.

EyeMed Core	In-Network	Non-Network
Exam	You pay $10	plan pays $45

EyeMed Buy-Up[1]		In-Network	Non-Network
Exam		$10 copay	plan pays up to $45
Single Vision Lenses		$25 copay	plan pays up to $30
Bifocal Lenses		$25 copay	plan pays up to $55
Trifocal Lenses		$25 copay	plan pays up to $80
Lenticular Lenses		$25 copay	plan pays up to $80
Contact Lenses	Conventional	$225 allowance; then employee pays 85% of balance over $225	plan pays up to $150
	Disposable	$225 allowance; then employee pays balance over $225	plan pays up to $150
Frames		$130 allowance; then employee pays 80% of balance over $130	plan pays up to $55
Exams		once every calendar year	once every calendar year
Lenses		once every calendar year	once every calendar year
Frames		once every calendar year	once every calendar year

1 A more complete summary is available from your Benefits Analyst.

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts (FSA) are convenient and cost effective. When you use an FSA, you pay less for expenses like deductibles, copays, coinsurance and child care expenses because the money is not taxed when it's deducted from your paycheck or when you use it to pay for eligible expenses. By lowering your taxable income, you pay less in federal and most state income taxes.

Your dollars go further when you take advantage of your FSA benefits.
Contributing to an FSA can lower the taxes you pay by hundreds of dollars because the money you set aside in your FSA is PRETAX, including Social Security and Medicare. ***Use your tax money for YOU.***

Contributing to an FSA	Medical Reimbursement FSA	Dependent Care FSA
You Can Contribute...	$130 per year minimum $3,050 per year maximum	$130 per year minimum $5,000 per year maximum[1]
To Reimburse Yourself For...	Medical, Dental, and Vision expenses not paid by insurance[2]	Day Care expenses for your eligible dependents[2]

1 If you're married and file separate tax returns, the maximum you can contribute is $2,500 per year. *2 Rules and restrictions apply.*

MyChoice offers two FSAs:

Medical Reimbursement FSA and Dependent Care FSA

Medical Reimbursement FSA

The Medical Reimbursement FSA is used for health care expenses that are not covered by your insurances (e.g., medical, dental, vision, prescription), such as health plan deductibles, emergency room copays, orthodontia expenses, prescription copays, hearing expenses, office visit copays, etc. (insurance premiums are not on the list of eligible expenses). The FSA election amount is yours to use on the first day of the plan year (Medical FSAs only, not for Dependent Care FSA).

Medical Reimbursement FSA participants will receive a debit card they may use at the place of service to pay for eligible expenses. The card number may also be given to a provider when paying for services when eligible expenses have been billed to you. Most charges for medical services and prescriptions will be substantiated automatically.

Retain your receipts in case McLaren Health Advantage asks you to provide substantiation for the charge or in case you are audited by the IRS.

For a list of eligible health care expenses, see IRS Publication 502, "Medical and Dental Expenses," available in the Forms & Instructions section of the **IRS website** at **www.irs.gov**. You may request a copy by calling the **IRS toll-free** at **(800) 829-3676**.

Note: *Over-the-counter drugs are only eligible for reimbursement when accompanied by a doctor's prescription.*

Dependent Care FSA

- The Dependent Care FSA is used to pay for any day care expenses *(for children under the age of 13)*, before-school care (if not included in tuition), after-school care (if not included in tuition), adult day care expenses, etc.
- If you are married, both you and your spouse must be employed to be eligible for the Dependent Care FSA, unless your spouse is disabled or is a full-time student at least five months of the year.
- The Dependent Care FSA is NOT to be used to pay for your dependent's medical expenses. The Medical Reimbursement FSA is used to pay for your dependent's medical expenses.

For a list of eligible expenses, see IRS Publication 503, "Child and Dependent Care Expenses," available in the Forms & Instructions section of the **IRS website** at **www.irs.gov**. You may request a copy by calling the **IRS toll-free** at **(800) 829-3676**.

Important Information Regarding Your FSA Debit Card

Please do not throw away your FSA debit card.

Continue to use your FSA debit card until the expiration date listed on the front of your card. Shortly before the expiration date, Health Advantage will mail you a "new" debit card.

FLEXIBLE SPENDING ACCOUNTS *CONTINUED*

Planning an FSA Amount

How to calculate an FSA election amount to deduct from your paycheck:
When you are deciding how much money you want to contribute to one or both FSAs, it is important to know the best value comes from FSA participation that is close to the amount you expect to spend on eligible health or dependent care expenses. If you do not spend all of the money in your Medical Reimbursement FSA Account, you are allowed to rollover up to $610 of unused FSA funds into the following plan year.

The $610 Rollover Rule *DOES NOT APPLY* to the Dependent Care FSA account.

For a Medical Reimbursement FSA, first review your health plan, dental plan, vision plan, etc. Look at the out-of-pocket expenses (e.g., deductibles, coinsurance, copayments, etc.) for each benefit plan. Use this past year's expenses as a guide, list how many prescription copays you paid, how many medical copays you paid, how many dental services you paid for, how many vision services you paid for, etc. Once you have added up your expenses, then you can decide your Medical FSA election amount for the year.

When determining your Dependent Care FSA election amount, look at how much you spent on last year's child day care expenses and/or adult day care expenses.

Once you decide on the FSA election amount(s) that you would like to have deducted from your paycheck for 2023, when you enroll, that amount is divided by the number of pay periods in the year to determine how much will be deducted from your paycheck each pay day and then deposited into the applicable spending account. As you incur expenses, you use the money in the spending account to pay the providers or reimburse yourself (for charges that you paid directly to the provider).

Your FSA election amount must be used to pay for expenses incurred during the calendar year in which your contributions are made. **You will have until March 31, 2024 to submit claims for expenses incurred in 2023.** If you have money left over in your Medical Reimbursement FSA account at the end of the year, you are allowed to rollover up to $610 of unused FSA funds into the following plan year.

FSA Reimbursement for Medical (not paid with your FSA debit card) & Dependent Care expenses

You may receive your reimbursement in one of two ways:

1. **Receive a check** (mailed to you) for the FSA reimbursement amount you requested, or
2. **Direct deposit** makes it easier and quicker to receive your FSA reimbursement. Have your reimbursement directly deposited into your checking or savings account instead of waiting for a check to be mailed to you.

IMPORTANT NOTE: *Submit your request for reimbursement along with an itemized receipt or bill that shows the date, type of service, and amount you paid.*

The **FSA Direct Deposit** and **FSA Reimbursement Forms** can be accessed and downloaded by visiting www.mclarenhealthplan.org. Once on this page, move your cursor over **"Are you a Member?"** and select **McLaren Health Advantage** from the menu of options.

Then, click on the **Member Materials** icon, this page contains:

- Direct Deposit Authorization Form
- Flexible Spending Account (FSA) Dependent Care Reimbursement Form
- Flexible Spending Account (FSA) Health Care Reimbursement Form

*(All found under the **"Benefit and Customer Information"** topic.)*

FLEXIBLE SPENDING ACCOUNTS *CONTINUED*

Medical Reimbursement FSA $610 Rollover

Medical Reimbursement FSA participants may rollover up to $610 of unused FSA funds in the Medical Reimbursement FSA into the following plan year (this does NOT apply to the dependent care FSA accounts). The rollover amount does not count against the indexed $3,050 salary reduction limit. Participants are allowed to rollover up to $610 and still make a salary reduction up to $3,050 into their Medical Reimbursement FSA.

This FSA change allows for more flexibility and less risk in the FSA program for the FSA participants. You no longer need to precisely budget your out-of-pocket health care expenses - reducing the risk of "overfunding" and forfeiting FSA funds. No more rushing to spend Medical Reimbursement FSA funds on unnecessary items by year-end.

More About FSAs

No Transfers
If you participate in both spending accounts, you cannot transfer money between your two accounts or use money in one account to pay expenses related to the other.

No Contribution Changes
Once you decide on the FSA election amount, you cannot change the amount until the next calendar year unless you experience a "change in status" event.

Dependent Care FSA vs. Federal Tax Credit
You may use the Dependent Care FSA or the Child and Dependent Care Tax Credit but not for the same expenses. Talk to your financial advisor to find out how you can save the most on your taxes when it comes to child care.

LIFE INSURANCE

Employer-Paid Basic Life Insurance
McLaren provides all eligible full-time employees with basic life insurance equal to 1x the employee annual salary.

Voluntary Term Life Insurance
If you have a family, own a home, or simply have debts, then you may want to purchase additional life insurance. McLaren offers term life insurance which you may purchase through Lincoln Financial Group.

Voluntary Term Life Insurance	
For You*	1x or 2x your annual salary subject to combined maximum of $750,000. Benefits reduce by 50% at age 70.
For Your Spouse*	Must elect 2x additional times voluntary coverage to be eligible for $10,000 or $20,000 spouse coverage. Coverage terminates at spouse age 70.
For Your Dependent Children	Must elect 2x additional times voluntary coverage to be eligible for $5,000 or $10,000 dependent coverage.

How the Plan Works

For New Electing Participants (Employee)
You may purchase voluntary term life coverage for 1x or 2x your annual salary. During Open Enrollment, if you decide to enroll in Voluntary Life Insurance you are not requred to complete an Evidence of Insurability form. If you decide to enroll in 2x your annual salary at a later time, you will be required to complete an Evidence of Insurability form. Benefits reduce by 50% at age 70, and terminate at retirement.

For Current Participants (Employee)
During Open Enrollment, if an employee increases their life insurance one level (e.g. 1x to 2x), it is a guaranteed issue. The employee will not be required to complete an Evidence of Insurability form. However, if your election exceeds one level or a previous application has been withdrawn or declined, an Evidence of Insurability form must be submitted.

For Your Spouse
If you enroll in voluntary term life insurance and you are married, you can purchase term life insurance for your spouse. Coverage amounts begin at $10,000 or $20,000. Benefit terminates for spouse at age 70.

Employee Premium Rates *(monthly)* Participant AGE on January 1, 2024 RATE per $1000 of coverage			
AGE	RATE	AGE	RATE
<30	$0.068	50-54	$0.296
30-34	$0.068	55-59	$0.420
35-39	$0.087	60-64	$0.562
40-44	$0.116	65-69	$0.847
45-49	$0.192	70-74	$1.474
		75 and over	$2.823

To Calculate Your Premium

Divide the amount of coverage you want by 1,000, multiply that number by the rate per $1,000 of coverage for your age group (see the chart above).

For example, if you are age 28 and want $100,000 in coverage, you will pay $6.80 per month.

($100,000/1,000 x $0.068 = $6.80)

For Your Dependent Children
During Open Enrollment, you may also purchase Voluntary Term Life Insurance for your dependent child(ren) in amounts of $5,000 or $10,000. Coverage can begin as early as age 14 days and can continue until your child reaches age 19. If your child is a full-time student, you may continue coverage up to age 25. Evidence of insurability is not required for children. Contact your Benefits Analyst to remove the Child Life Insurance deduction if your dependent child is no longer eligible for coverage.

Your Beneficiary
When enrolling in life insurance (employer-paid basic life and/or voluntary term life), remember to designate a beneficiary. The beneficiary or beneficiaries receive your benefit amount in the event of your death.

Dependent Children Premium Rates *(monthly)*	
COVERAGE AMOUNT	RATE PER MONTH
$5,000	$2.38
$10,000	$4.75

***NOTE:** A single premium covers 1 or more eligible dependent children (e.g., you **do not** have to multiply premium by 2 to cover 2 children).*

SUPPLEMENTAL INSURANCE

Marwood Nursing and Rehab offers employees the opportunity to enroll in the Aflac supplemental insurance products listed below. The monthlly premium will be deducted from employee payroll on a bi-weekly basis is a post-tax deduction.

The following **Aflac Supplemental Insurance Products** are available for eligible Marwood Nursing and Rehab employees voluntary enrollment:

Cancer Insurance
Aflac is here to help you better cope financially if a positive diagnosis of cancer ever occurs. Added comfort and protections means the freedom to focus on more important things.

Supplemental Dental Insurance
It's no secret that routine dental care contributes to good medical health. The dental supplemental insurance provides benefits for a variety of services with no networks, deductibles or pre-certification requirements.

Off the Job Accident Insurance
Take advantage of Alfac's accident insurance policy to maintain peace of mind and help pay for emergency treatment, as well as for treatment-related transportation and lodging.

Critical Illness Insurance
Critical Illness Insurance helps with the treatment costs of life-changing illness or health events so you can stay focused on recuperation.

Hospital Supplemental Insurance
Available to help with expenses not covered by major medical which can help prevent high out of pocket costs associated with a hospital stay.

Make an appointment to enroll in Supplemental Insurance

Contact Marwood's Aflac representative Shari Robinson-Powers

Phone: (586) 917-0036

– or –

Email: shari_robinsonpowers@us.aflac.com

LONG-TERM DISABILITY

Employer-Paid Long-Term Disability
McLaren provides all eligible full-time salaried executives with employer-provided long-term disability coverage at 60% of the employee's base salary (subject to the plan limitations). Coverage begins after 181 calendar days.

Voluntary Long-Term Disability
While it is true that injuries and accidents can happen at any time, the biggest contributors to disabilities might surprise you. Illnesses like arthritis, heart attacks, diabetes, and cancer are the leading causes of long-term disabilities. Lifestyle choices and personal behavior that lead to obesity are also contributing factors.

A disability can prevent you from working–sometimes for an extended period of time. Taking advantage of the voluntary long-term disability benefit can protect you and your family from the financial ruin that an extended disability can cause.

How the Plan Works *(full-time hourly emplyees)*

If you are a full-time hourly employee, you may enroll in one of the three voluntary long-term disability options:

Option A (25%) or Option B (40%) or Option C (50%)

Voluntary Long-Term Disability Plan for Full-Time Hourly Employees	
Benefit Options	25% of wages, 40%, or 50%
Monthly Benefit	up to $5,000 per month
Elimination Period	90 days
Definition of Disability	own occupation: first 24 month
Maximum Benefit Period	5 years or to age 65 benefits may be reduced after age 65
Evidence of Insurability	not required
Pre-existing Condition	12/24*

("12/24" means a condition diagnosed or treated within the 12 months prior to enrolling in long-term disability will not be covered/paid for 24 months).

Option 25% (monthly)	
AGE	RATE
<25	$ 0.240
25-29	$ 0.296
30-34	$ 0.387
35-39	$ 0.509
40-44	$ 0.698
45-49	$ 0.961
50-54	$ 1.379
55-59	$ 1.634
60 and over	$ 2.274

Option 40% (monthly)	
AGE	RATE
<25	$ 0.321
25-29	$ 0.403
30-34	$ 0.558
35-39	$ 0.764
40-44	$ 1.059
45-49	$ 1.494
50-54	$ 2.118
55-59	$ 2.659
60-64	$ 2.569
65 and over	$ 2.569

Option 50% (monthly)	
AGE	RATE
<25	$ 0.369
25-29	$ 0.469
30-34	$ 0.673
35-39	$ 0.928
40-44	$ 1.281
45-49	$ 1.814
50-54	$ 2.577
55-59	$ 3.135
60 and over	$ 4.416

EMPLOYEE ASSISTANCE PROGRAM

How the Plan Works

EAP is available to employees of Marwood Nursing and Rehab to discuss issues including:

Marital/Family Problems:

- Communication
- Intimacy
- Blended Family Issues
- Separation/Divorce
- Discipline
- Children

Personal Problems:

- Self-Esteem
- Anxiety
- Bereavement
- Parenting Issues
- Depression/Anger
- Grief
- Health Concerns

Work Related Problems:

- Co-worker Issues
- Workload
- Stress Management
- Management
- Career Development

Addictions:

- Alcohol
- Prescription Drugs
- Shopping
- Elicit Drugs
- Gambling

The EAP also offers:

- SAP (Substance Abuse Professional) Services
- Education and Training Sessions
- Critical Incident and Stress Debriefing
- Organizational Consultation
- Supervisor and Employee Orientations

How does EAP work?
Simply call EAP to schedule an appointment. You will speak confidentially with a consultant about your issues.

What is the cost?
The service is employer sponsored. There is no cost to you or your household members to use this service. If the consultant feels additional services are required, EAP will assist you with a referral and the process. At this time, your insurance may be accessed.

If my employer pays for EAP, how is the program confidential?
Confidentiality is an important component of EAP services. While periodic reports are given to the employer regarding the number of employees using the program, no identifying information is included.

Are the EAP consultants qualified?
All of our EAP consultants have a Master's degree in the social science field and are licensed through the state of Michigan.

For more information, or to schedule an appointment please call (810) 982-4980.

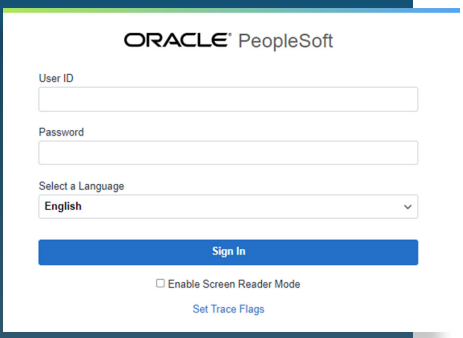
McLAREN PORT HURON INDUSTRIAL HEALTH EMPLOYEE ASSISTANCE PROGRAM (EAP)

Industrial Health's Employee Assistance Program is a confidential service that provides professional information, assessment, and referral services to area employees and their household members who are experiencing personal, family or work problems that may negatively affect their job performance.

ENROLLING WITH PEOPLESOFT–MyHR

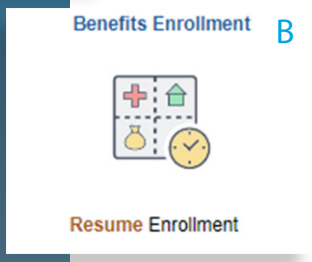
Follow these steps to enroll in your 2024 benefits

Log On



- Using your internet browser (Chrome preferred), navigate to **PeopleSoft–MyHR (myhr.mclaren.org).**
- Log into PeopleSoft–MyHR using your **User Name** and **Password**.
- Authenticate your identity using the Duo application.

If you have any problems with your user name and password, or with the Duo authentication tool, contact the National Service Desk at (844) 642-8324.



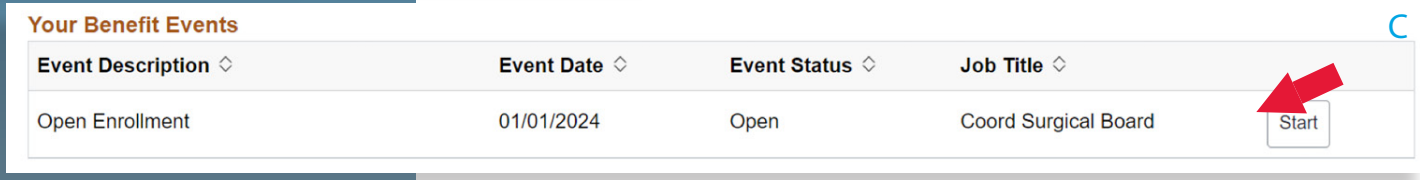
Open Enrollment

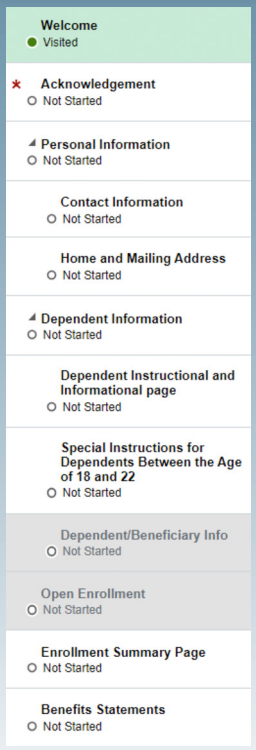
A Click on **Benefits** tile.

B Click on **Benefits Enrollment** tile.

C Click the **Start** button to begin your 2024 Open Enrollment session.

D Clicking "Start" will advance you to your Open Enrollment session.





Open Enrollment Session Steps

You will begin your Open Enrollment session at the Welcome page. You will move through each item listed (now called Activity Guides) on the left side of your screen. You may move through the Activity Guide steps by either clicking on the "Next >" button on each screen in the upper right corner or click on the menu item on the left of the screen.

1 Welcome to the 2024 McLaren Benefits Open Enrollment
Please review this page for information regarding this year's Open Enrollment.

2 Acknowledgement
Please read acknowledgement information and click on the check box at the bottom of the agreement. Then click on the "Save" button in the upper right hand corner of this page. You will not be able to move through your Open Enrollment elections until you complete this step.

3 Personal Information
Click on the activity guide step **"Personal Information"** and then click on your **"Contact Information"** activity guide step. Please review this page and make any changes necessary if this information is not correct. If this information is correct, you will click on the **"Home and Mailing Address"** activity guide step. If any information listed is incorrect, you may make changes by clicking on the arrow at the end of the address

ENROLLING WITH PEOPLESOFT-MyHR *CONTINUED*

line. Enter any new data on the pop-up box, then press "Save". Your new information will be saved.

4 Dependent Information

Click on the **"Dependent Information"** activity guide step and then click on **"Dependent Instructional and Informational page"** activity guide step. Please review the information at the top of this page regarding instructions for the 2024 Open Enrollment if you are adding a dependent. After you review the information, click on the **"Special Instructions for Dependents Between the Age of 18 and 22"** activity guide step. Please review this information if you have a dependent child between the age of 18 and 22. The last step under the Dependent Information activity guide is the **"Dependent/Beneficiary Info"** activity guide step. Please review each individual you have listed on this page. You may review each individual's information by clicking on the arrow at the far right of the screen for that individual. You may make changes on this page for any listed dependent/beneficiary. Click the "Save" button at the top right of the page to save your changes, or "Cancel" button at the upper left if you do not want to make any changes. **Note:** If you are covering a dependent between the ages of 18 - 22 on dental and/or vision, please complete the Dependent Child Certification Form in the Dependent Child Cert Form column for that dependent by clicking on the word "Required" (in blue) on the line for the dependent and complete the pop up form.

• *You may also add a new Dependent/Beneficiary's information on this page by selecting the "Add Individual" button and completing the information on the page and select "Save" after you have added the information. If you do add a dependent for medical/dental/vision, you will see a message on the screen indicating supporting documents are required for the changes made. You can upload the required document by clicking on "View" under the Attachment column. You can upload required document by selecting the "Add Attachment" button. Click on "My Device" and select the document to upload from the list from your device, then click the "Open" button. Then click the "Upload" button. Once the File Attachment window shows Upload Complete, you may click the "Done" button and your document will be uploaded into the Open Enrollment system for review by your Benefits Analyst for approval. Click the "Done" button in the upper right hand corner of the page. If your new dependent is between the ages of 18-22 (as of December 31, 2023) and you are covering the new dependent for dental and/or vision, please complete the Dependent Child Certification Form by clicking on "Required" (in blue) in the line for the new dependent.*

5 Open Enrollment

This Enrollment Overview displays which benefit options are open for edits. All of the benefit changes you elect will become effective January 1, 2024.

To make a change to any benefit option with a blue highlighted line above the benefit, simply click on the tile and a new window will open for you to make your changes. Here you can change plans or waive coverage. You can also add dependents by clicking on the check box before their name or delete any listed dependents by unchecking the check box before their name. You may also add additional eligible dependents on this screen by clicking on the "Add/Update Dependent" button in the middle of the page and follow the same method previously detailed in Step 4 to add a new dependent.

You may also click on the "Overview of All Plans" button to review costs for all available plans for all coverage levels.

If you have made any changes to the plan, click the "Done" button in the upper right hand corner of the page and this will take you back to the Open Enrollment tiles for the rest of your benefits. Use this same process to make changes to other benefits, if desired.

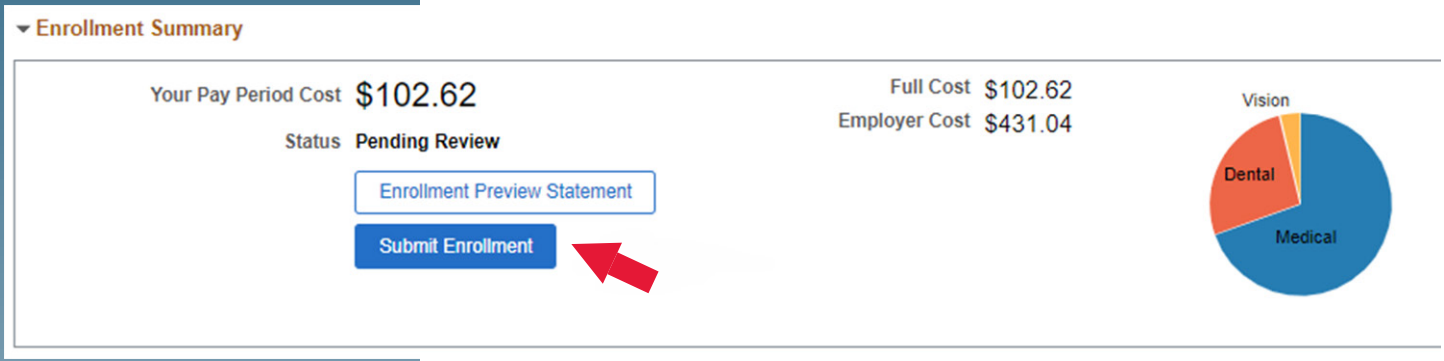
Note: You cannot make any changes to Short Term Disability, Long Term Disability or Employee Assistance Program as they are Employer-Paid benefits.

Flexible Spending Account Enrollment Instructions:

You cannot finish your Open Enrollment session without making a selection to either "Enroll" and enter an amount or "Waive" the benefit for both the Flex Spending Health – U.S. and the Flex Spending Dependent Care.

IMPORTANT:

Once you have completed any changes you wish to make to your current benefits, you must click the blue **"Submit Enrollment"** button in the Enrollment Summary box at the top of the page OR use the blue "Submit Enrollment" button located at the bottom of the Open Enrollment page in order for your benefits to be submitted to Corporate Benefits.



6. Enrollment Summary Page

This page will show you all the steps you have completed or visited so far in the Open Enrollment session.

7 Benefits Statements

To view your submitted enrollment, click on the arrow at the end of the Open Enrollment 2024 row, click on the **"Print View"** button in the upper right hand corner of the page and an Election Preview page will be displayed in a new tab on your screen. To return to your Open Enrollment session, close the tab by clicking the "X" in the Election Preview window tab. Then, click the 'X" at the end of the "Benefits Statement" row.

To close your Open Enrollment session, click on the three dots at the top right of the Open Enrollment page and select "Home". At the Home page, click on the three dots at the top of the page and click "Sign Out".

Modifying Your 2024 Open Enrollment Elections

- **You may revise and submit your elections as many times as you want during Open Enrollment which begins Monday October 30 and ends Monday November 13, 2023 at 5 p.m. EST.**

NOTES

YOUR QUESTIONS ANSWERED

1. Do I need to do anything during Open Enrollment if I don't want to make any changes?

For this year's Open Enrollment, you **MUST** participate in Open Enrollment if:

- You want to enroll or continue in a Flexible Spending Account (FSA) in plan year 2024. Participants in an FSA must enroll every year.
- You want to enroll or continue Dental and/or Vision coverage for a dependent who is 18-22 years old and is a full-time student and your tax dependent. The Dependent Child Certification Form can be found online in your Open Enrollment Session.
- You want to change your Medical, Dental or Vision plan.
- You want to change who is covered on your Medical, Dental or Vision plan.
- You want to change your Life Insurance or Long-Term Disability coverage, if eligible.

2. When will our 2024 benefits coverage be effective?

Coverage elected during Open Enrollment is effective on January 1, 2024 and will be in effect through December 31, 2024.

3. What happens if I miss Open Enrollment?

This year, if you do not participate in Open Enrollment your 2023 benefits will rollover into 2024 *(**EXCEPT** for Flexible Spending Accounts, enrollment is required every year).*

4. When do I need to submit a Dependent Child Certification Form?

The form must be completed online in your Open Enrollment Session for a dependent child who will be at least 18 years of age on December 31, 2023 and not more than 22 years of age on December 31, 2023 and is enrolled in Dental and/or Vision coverage for 2024 *(and are full-time students and tax dependents).*

5. If I am enrolling a dependent on my Health insurance for the first time or continuing to cover a Dependent (age 18-22) on my Dental/ Vision insurance, do I need to provide any documentation?

Yes. If you are enrolling or continuing coverage for a Dependent (age 18-22) on Dental/Vision insurance for 2024, or if you are enrolling a new dependent you will need to provide supporting documentation. For a new dependent, please upload a copy of your marriage license, a birth certificate, etc. into your Open Enrollment Session. For a Dependent (age 18-22) on Dental/Vision insurance, you MUST complete the Dependent Child Certification Form which can be found online in your Open Enrollment Session.

6. Are the deductibles and out-of-pocket maximums separate for the different networks within the Health insurance plans?

Yes, deductible and out-of-pocket maximums are maintained separately for each network.

7. How long may my child remain on my Health insurance?

Children of an employee are eligible for coverage under the health plan until their 26th birthday, regardless of student status. Coverage is generally extended to the end of the month in which the child turns age 26. Different rules apply to Dental and Vision coverage.

8. How long may my child remain on my Dental or Vision insurance?

Children of an employee can remain on the Dental and/or Vision coverage to the end of the calendar year in which they have their 18th birthday. Children who are age 18 to 22 may be covered on the Dental and Vision insurance as long as they are full-time students and tax dependents of the employee. Coverage is generally extended to the end of the year in which the child turns age 23 *(with completion of a Dependent Child Certification Form).*

9. How is the single deductible met?

The single deductible is met by any single covered member who incurs expenses subject to the deductible. When the total expenses reach the limit for the plan, the deductible has been met. For example, MHA Premier has an individual deductible of $500, once the person reaches $500 in expenses, the single deductible has been met.

10. How is the family deductible met?

The family deductible can be met by any combination of **two or more** covered members in the family incurring expenses subject to the deductible. For example, MHA Premier has a family deductible of $1,000, if the first family member reaches $500 of the deductible, then the second family member reaches $250 of the deductible and finally the third family member reaches $250 of the deductible, the

family deductible has been met ($500 + 250 + 250 = $1,000). If, however, only one family member has $1,000, in expenses, the family deductible has not been met *(because a single member's deductible is capped at the individual level)*.

11. If I miss the Open Enrollment period entirely, when can I make changes to my Health benefits?

You may make changes if you experience a change in status event *(i.e. loss of coverage, marriage, birth of a child, divorce, etc)*. You have 30 days from the date of the change in status event to notify Human Resources and change your coverage. Notices received after 30 days cannot be accepted and you will have to wait until the next Open Enrollment to make the desired changes.

12. If I elect coverage during my Open Enrollment and my spouse has Open Enrollment at a later date, can I make changes to my plan?

Yes, we will require documentation from the spouse's employer on company letterhead identifying the Open Enrollment deadline, effective dates and persons who are being added to or dropped from the other employer's policy.

13. May I enroll in the FSAs even if I don't elect Health insurance?

Yes, you do not need to enroll in any of the health care benefits in order to take advantage of the FSAs.

14. How does the Voluntary Long-Term Disability plan define total disability?

Total disability means that due to an injury or sickness, during the elimination and own occupation periods, you are unable to perform each of the main duties of you regular occupation due to an injury or sickness. Upon completion of the own occupation period, total disability means you are unable to perform the main duties of any gainful occupation which your training, education, or experience will reasonably allow. Contact your Human Resources Department or Benefits Analyst with questions regarding Long-Term Disability.

15. Can I print an Elections Statement after I have completed my Open Enrollment Session?

Yes, you can print an Elections Statement that shows you all of the benefits you elected during your Open Enrollment Session. To print out an Elections Statement, follow these steps:

1. On the Open Enrollment Page, after you have submitted your elections – click on the "Enrollment Preview Statement" button.
2. On the "Review Enrollment" page, click on the "Print View" button.
3. Once your Elections Statement pops up, click on the "Print" button.

However, if you go in to make any changes to your elections, please print out the most recent Elections Statement. In addition, your Elections Statement is subject to document verification.

16. I do not have access to a computer at work. How can I enroll online?

You may use any computer *(on-site kiosk, home, library, family member)* that has internet access with a Chrome browser for optimal use when enrolling online.

17. Will the online Open Enrollment system be available 24 hours a day?

The online Open Enrollment system will be available from October 30 through November 13 at 5 pm and can be accessed 24 hours a day through the PeopleSoft-MyHR system.

18. What should I do if I have problems accessing the PeopleSoft-MyHR system?

You may contact the National Service Desk by calling (844) 642-8324.

BENEFITS CONTACTS

Benefit Plan / Carrier	Telephone Number		Website
Dental Plan			
Delta Dental Plan of Michigan	(800) 524-0149		deltadentalmi.com
Employee Assistance Program			
McLaren EAP	(810) 928-4980		
Family Medical Leave			
FMLA Source	(877) 462-3652		fmlasource.com
Flexible Spending Accounts (FSA)			
McLaren Health Advantage	(888) 327-0671		benefitspaymentsystem.com
Health Plan			
Blue Cross Blue Shield of Michigan	(877) 790-2583		bcbsm.com
McLaren Health Advantage	(888) 327-0671		mclarenhealthplan.org
Human Resources - Benefits*			
Corporate Benefits	(810) 342-4650	or	(866) 238-2419 (option 2)
Karmanos Cancer Institute - Jane Duncan	(248) 226-2106		
Lake Orion Nursing & Rehabilitation Center - Shelia Closs	(810) 342-4677		
Marwood Nursing & Rehabilitation Center - Kim Kargol	(810) 966-5391		
McLaren Bay Region - Amanda Cornacchio	(810) 342-4672		
McLaren Caro Region - Kim Affer	(989) 269-1544		
McLaren Central Michigan - Nikki Spencer	(810) 342-4674		
McLaren Flint - Amber Miller	(810) 342-4949		
McLaren Greater Lansing - Brenda Johns	(231) 487-3023		
McLaren Health Care - Amanda Cornacchio	(810) 342-4672		
McLaren Integrated HMO Group - Amber Miller	(810) 342-4949		
McLaren Health Management Group - Amber Miller	(810) 342-4949		
McLaren Lapeer Region - Amanda Cornacchio	(810) 342-4672		
McLaren Macomb - Nikki Spencer	(810) 342-4674		
McLaren Medical Group - Brenda Johns	(231) 487-3023		
McLaren Northern Michigan - Brenda Johns	(231) 487-3023		
McLaren Oakland - Shelia Closs	(810) 342-4677		
McLaren Port Huron - Shelia Closs	(810) 342-4677		
McLaren Thumb Region - Kim Affer	(989) 269-1544		
Life Insurance			
Lincoln Financial Group	(800) 423-2765		
Long-Term Disability (LTD)/Short-Term Disability (STD)			
Lincoln Financial Group	(800) 290-0164		
Retirement Plan			
Empower Retirement	(855) 756-4738		empowermyretirement.com
Vision Plan			
EyeMed	(866) 723-0596		eyemedvisioncare.com

** If you have any questions regarding your benefits, contact the Benefits Analyst listed for your subsidiary.*

YOU SHOULD KNOW...

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 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).

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section; however, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Enrollment Rights

You and your eligible dependents may enroll in the medical benefit program (or change medical benefit options) under the McLaren Health Care Employee Benefit Plan (the "Plan") under the following circumstances. Individuals Losing Other Coverage. If you declined coverage under the medical benefit program when it was first available because of other health coverage, and that coverage is later lost on account of:

- Exhaustion of COBRA continuation coverage, Lost eligibility for other coverage, or
- Termination of employer premiums toward the other coverage.

You and your eligible dependents may enroll in the medical benefit program on or before the date that is 30 days after the date you lost that other coverage.

Lost Eligibility for Other Coverage includes a loss of other health coverage as a result of your legal separation or divorce, a dependent's loss of dependent status, death, termination of employment or reduction in number of hours of employment, or you no longer reside, live or work in the service area of a health maintenance organization in which you participated. Coverage will be effective as of the first day of the next calendar month following receipt of the request for special enrollment.

You must request enrollment on or before the date that is 30 days after the qualifying life event.

New Eligible Dependents. If you initially declined enrollment for yourself or your eligible dependents and you later have a new eligible dependent because of marriage, birth, adoption or placement for adoption, you may enroll yourself and your new eligible dependents (including an eligible dependent spouse if you have a new eligible dependent child), as long as you request enrollment on or before the date that is 30 days after the marriage, birth, adoption or placement for adoption. For example, if you and your eligible dependent spouse have a child, you may enroll yourself, your eligible dependent spouse and your new child in the Plan's medical benefit program, even if you were not previously enrolled. You will not, however, be able to enroll existing

YOU SHOULD KNOW... *CONTINUED*

eligible dependent children for whom coverage has been waived in the past.

For marriage, birth, adoption or placement for adoption, you or your eligible dependent's participation will start as of the date of the marriage, birth, adoption or placement for adoption, as long as you timely request enrollment and you submit the Enrollment Form and proof of your dependent's status as an eligible dependent to Corporate Benefits, McLaren Corporate Human Resources, within 30 days after the marriage, birth, adoption or placement for adoption.

Medicaid and CHIP

If you or your eligible dependent children are eligible for, but not enrolled in, the Plan's medical benefit program and you or your eligible dependent children:

- Lose coverage under Medicaid or a State child health plan ("CHIP"), or
- Become eligible for a premium assistance subsidy through Medicaid or CHIP,

you and your eligible dependent children may enroll in the medical benefit program, as long as you request enrollment on or before the date that is 60 days after the loss of coverage or the date you or your eligible dependent children became eligible for the premium subsidy. Your or your eligible dependent's enrollment and coverage will take effect as of the date of the loss of coverage, or the date you or your eligible dependents became eligible for the premium subsidy, as long as you timely request to enroll.

These 30-day and 60-day periods are "special enrollment periods." To request special enrollment or to obtain more information, contact the Corporate Benefits, McLaren Corporate Human Resources.

Qualifying Life Events

You may qualify to enroll during special enrollment periods if you:

*You must request enrollment **on** or **before** the date that is **30 days** after the qualifying life event.*

Women's Health and Cancer Rights Act of 1998

The McLaren health plans cover surgery after a mastectomy to:

- Reconstruct the breast on which the mastectomy was performed
- Reconstruct the other breast to produce a symmetrical appearance

This coverage is required by law. Prostheses and physical complications in all stages of the mastectomy, including lymphedemas, are also covered.

The plan will determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts consistent with those that apply to other benefits under the plan.

Women's Preventive Care:

The Affordable Care Act requires that health plans cover and eliminate cost sharing for the following eight women's preventive services:

1. Well-woman visits
2. Gestational diabetes screening
3. Human Papillomavirus (HPV) DNA testing
4. Sexually-transmitted infections (STIs) counseling
5. Human Immunodeficiency Virus (HIV) screening and counseling
6. Contraception and contraceptive counseling
7. Breastfeeding support, supplies and counseling
8. Interpersonal and domestic violence screening and counseling

Effective January 1, 2013, any women seeking the above services will not be subject to cost sharing, coinsurance or deductibles.

Notice of Privacy Practices

For McLaren Health Care Employee Benefit Plan,
McLaren Health Care Retiree Welfare Benefit Plan
and McLaren Health Care Retiree Benefit Plan

Version effective: May 2020

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the rules to carry out this law (Privacy Rules), require health plans to notify participants and beneficiaries about the policies and practices the Plan has adopted to protect the confidentiality of their health information, including health care payment information.

This Notice describes the privacy policies of the group health benefits, including the medical, prescription drug , dental, vision, health reimbursement account and health flexible spending account benefit programs, and the employee assistance program, offered under the McLaren Health Care Employee Benefit Plan, McLaren Health Care Retiree Welfare Benefit Plan, or the McLaren Health Care Retiree Benefit Plan (the "Plan" or "Plans") sponsored by McLaren Health Care Corporation and on which subsidiaries participate (the "Corporation"). These policies protect medical information (including genetic information) relating to your past, present and future medical conditions, health care treatment and payment for that treatment (Protected Health Information or PHI).

The law requires the Plan to maintain the privacy of your PHI, to provide you with this Notice of its legal duties and to abide by the terms of this Notice. In general, the Plan may only use and/or disclose your PHI where required or permitted by law or when you authorize the use or disclosure. The Plan may also only use the minimum amount of your PHI that is necessary to accomplish the intended purpose of the use or disclosure as permitted by HIPAA.

HEALTH INFORMATION NOT COVERED BY THIS NOTICE

This Notice does not cover:

- Health information that does not identify you and with respect to which there is no reasonable basis to believe that the information could be used to identify you, or
- Health information that the Corporation can have under applicable law (e.g., the Family and Medical Leave Act, the Americans with Disabilities Act, workers' compensation laws, federal and State occupational health and safety laws, and other State and federal laws), or that the Corporation properly can get for employment-related purposes through sources other than the Plan and that is kept as part of your employment records (e.g., pre-employment physicals, drug testing and fitness for duty examinations)

WHEN THE PLAN MUST DISCLOSE YOUR PHI

The Plan must disclose your PHI:

- To you,
- To the Secretary of the United States Department of Health and Human Services (DHHS) to determine whether the Plan is in compliance with HIPAA, and
- Where required by law. This means the Plan will make the disclosure only when the law requires it do so, but not if the law would just allow it to do so.

WHEN THE PLAN MAY DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

Treatment. The Plan does not provide medical treatment directly, but it may disclose your PHI to a health care provider who is giving treatment. The Plan may also send your PHI to health care providers for patient safety or other treatment-related reasons. For example, the Plan may disclose the types of prescription drugs you currently take to an emergency room physician, if you are unable to provide your medical history due to an accident.

Payment. The Plan may disclose your PHI, as needed, to pay for your medical benefits. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill the Plan might pay. The Plan may also use or disclose your PHI in other ways to administer benefits – for example, to process and review claims, to coordinate benefits with other health plans, to exercise its subrogation rights, to obtain payment under stop-loss insurance or re-insurance policies and to do utilization review and pre-authorizations.

Health Care Operations. The Plan may use and/or disclose your PHI to make sure the Plan is well run, administered properly and does not waste money. For example, the Plan may use information about your claims to project future benefit costs or audit the accuracy of its claims processing functions. The Plan may also disclose your PHI for placing a contract under a stop-loss or re-insurance policy. Among other things, the Plan may also use your PHI to undertake underwriting, premium rating and other insurance activities relating to changing health insurance contracts or health benefits. However, federal law prohibits the Plan from using or disclosing PHI that is genetic information (e.g., family medical history) for underwriting purposes, which include eligibility determinations, calculating premiums, and any other activities related to the creation, renewal or replacement of a health insurance contract or health benefits.

To the Corporation. In certain cases, the Plan may disclose your PHI to the Corporation.

- Some of the people who administer the Plan work for the Corporation. Before your PHI can be used by or disclosed to these Corporate employees, the Corporation must certify that it has: (1) amended the Plan documents to explain how your PHI will be protected; (2) identified the Corporation employees who need your PHI to carry out their duties to administer the Plan; and (3) separated the work of these employees from the rest of the workforce so that the Corporation cannot use your PHI for employment-related purposes or to administer other benefit plans. For example, these designated employees will be able to contact an insurer or third-party administrator to find out about the status of your benefit claims without your specific authorization.
- The Plan may disclose information to the Corporation that summarizes the claims experience of Plan participants as a group, but without identifying specific individuals, to get new benefit insurance or to change or terminate the Plan. For example, if the Corporation wants to consider adding or changing organ transplant benefits, it may receive this summary health information to assess the costs of those services.

YOU SHOULD KNOW... *CONTINUED*

- The Plan may also disclose limited health information to the Corporation in connection with the enrollment or disenrollment of individuals into or out of the Plan.

To Business Associates. The Plan may hire third parties that may need your PHI to perform certain services on behalf of the Plan. These third parties are Business Associates of the Plan. Business Associates (and their subcontractors) must protect any PHI they receive from, or create and maintain on behalf of, the Plan. For example, the Plan may hire a third-party administrator to process claims, an auditor to review how an insurer or third-party administrator is processing claims, an insurance agent to assess coverages and help with claim problems or a service provider to provide health benefits (such as wellness benefits).

To Individuals Involved with Your Care or Payment for Your Care. The Plan may disclose your PHI to adult members of your family or another person identified by you who is involved with your care or payment for your care if: (1) you authorize the Plan to do so; (2) the Plan informs you that it intends to do so and you do not object; or (3) the Plan infers from the circumstances, based upon professional judgment, that you do not object to the disclosure. The Plan will, whenever possible, try to get your written objection to these disclosures (if you wish to object), but in certain circumstances, it may rely on your oral agreement or disagreement to disclosures to family members.

To Personal Representatives. The Plan may disclose your PHI to someone who is your personal representative. Before the Plan will give that person access to your PHI or allow that person to take any action on your behalf, it will require him or her to give proof that he or she may act on your behalf – for example, a court order or power of attorney granting that person such power. Generally, the parent of a minor child will be the child's personal representative. In some cases, however, State law allows minors to obtain treatment (e.g., sometimes for pregnancy or substance abuse) without parental consent, and in those cases, the Plan may not disclose certain information to the parents. The Plan may also deny a personal representative access to PHI to protect people, including minors, who may be subject to abuse or neglect.

To Spouses and Other Family Members. With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If you have requested restrictions or confidential communications (see "Your Individual Rights"), and if the Plan has agreed to the request, the Plan will send mail as provided by the request.

For Treatment Alternatives or Health-Related Benefits and Services. The Plan may contact you to provide information about treatment alternatives or other health-related benefits or services that may be of interest to you.

For Public Health Purposes. The Plan may: (1) report specific disease or birth/death information to a public health authority authorized to collect that information; (2) report reactions to medication or problems with medical products to the Food and Drug Administration to help ensure the quality, safety or effectiveness of those medications or medical products; or (3) if authorized by law, disclose PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or medical condition.

For Fundraising. The Plan may use, and disclose to a business or to an institutionally related foundation, certain types of PHI for the purpose of raising funds. The type of information that may be disclosed without your authorization is: (1) demographic information relating to an individual; (2) dates of health care provided to an individual; and (3) health insurance status. The Plan may also contact you to raise funds as permitted by HIPAA, and you have a right to opt out of receiving such communications.

To Report Violence and Abuse. The Plan may report information about victims of abuse, neglect or domestic violence to the proper authorities.

For Health Oversight Activities. The Plan may disclose PHI for civil, administrative or criminal investigations, oversight inspections, licensure or disciplinary actions (e.g., to investigate complaints against medical providers), and other activities for the oversight of the health care system or to monitor government benefit programs.

For Lawsuits and Disputes. The Plan may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. The Plan may also disclose PHI in response to a subpoena, a lawsuit discovery request or other lawful process, but only if the Plan has received adequate assurances that the information to be disclosed will be protected. The Plan may also disclose PHI in a lawsuit if necessary for payment or health care operations purposes.

For Law Enforcement. The Plan may disclose PHI to law enforcement officials for law enforcement purposes and to correctional institutions regarding inmates.

To Coroners, Funeral Directors and Medical Examiners. The Plan may disclose PHI to a coroner or medical examiner – for example, to identify a person or determine the cause of death. The Plan may also release PHI to a funeral director who needs it to perform his or her duties.

For Organ Donations. The Plan may disclose PHI to organ procurement organizations to facilitate organ, eye or tissue donations.

For Limited Data Sets. The Plan may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

To Avert Serious Threats to Health or Safety. The Plan may disclose PHI to avert a serious threat to your health or safety or that of members of the public.

For Special Governmental Functions. The Plan may disclose PHI to authorized federal officials in certain circumstances. For example, disclosure may be made for national security purposes or for members of the armed forces if required by military command authorities.

For Workers' Compensation. The Plan may disclose PHI for workers' compensation if necessary to comply with these laws.

For Research. The Plan may disclose PHI for research studies, subject to special procedures intended to protect the privacy of your PHI.

For Emergencies and Disaster Relief. The Plan may disclose PHI to organizations engaged in emergency and disaster relief efforts.

In addition to the Privacy Rules, special protections under State or other federal law may apply to the use and disclosure of your PHI. The Plan will comply with these State or federal laws where they are more protective of your privacy, but only to the extent these laws are not superseded by federal preemption.

WITH YOUR WRITTEN AUTHORIZATION

In most cases, if you give us permission in writing, we may use and disclose your health information to the extent you have given us authorization. If you give us permission, you have the right to change your mind and revoke it. This must be in writing, too. We cannot take back any uses or disclosures already made with your permission. Note: We are prohibited from and will not use your genetic information for underwriting purposes even with your permission or authorization

YOUR PRIVACY RIGHTS

You have the following rights regarding your PHI that we maintain.

Right to Inspect and Copy. In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying your records.

Right to Amend. You may ask us to change your records that are in our possession if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.

Right to a List of Disclosures. At your request, the Plan must provide you with a list of the Plan's disclosures of your PHI made within the six-year period just before the date of your request, except disclosures made:

- For purposes of treatment, payment or health care operations,
- Directly to you or close family members involved in your care,
- For purposes of national security,
- Incidental to otherwise permitted or required disclosures,
- As part of a limited data set,
- To correctional institutions or law enforcement officials, or
- With your express authorization.

You may request one accounting, which the Plan must provide at no charge, within a single 12-month period. If you request more than one accounting within the same 12-month period, the Plan may charge you a reasonable fee.

Right to Request Restrictions on Our Use or Disclosure of your PHI. You have the right to ask for limits on how your PHI is used or disclosed. We are not required to agree to such requests. A restriction cannot prevent uses or disclosures that are required by the Secretary of DHHS to determine or investigate the Plan's compliance with the Privacy Rules or that are otherwise required by law. You may also request that your health care provider not disclose your PHI for a health care item or service to the Plan for purposes of payment or health care operations if you have paid the item or service out-of-pocket in full. Please note that if your health care provider does not disclose the item or service to the Plan, the amount you paid for the item or service will not count toward your annual deductible or any out-of-pocket maximums under the Plan. The provider may also charge you the out-of-network rate for the item or service.

Right to Receive Notification of a Breach. If our actions result in a breach of your unsecured PHI we will notify you of that breach.

Right to Request Confidential Communications. You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send you information at your work address instead of your home address. The Plan will accommodate any reasonable request, though it will require that any alternative used still allow for payment information to be effectively communicated and for payments to be made.

Genetic Information. Genetic information is health information. We are prohibited from and do not use or disclose your genetic information for underwriting purposes.

CHANGES TO THIS NOTICE

The Plan reserves the right to change the terms of this Notice and to make the new revised Notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan before the date of the revised Notice. If you agree, the Plan may provide you with a revised Notice electronically. Otherwise, the Plan will provide you with a paper copy of the revised Notice. In addition, the Plan will post the revised Notice on its website used to provide information about the Plan's benefits.

OTHER INFORMATION

Copies of Our Notice of Privacy Practices. You may ask for a copy of our current Notice at any time. If the Notice was sent to you electronically, you may request a paper copy.

Complaints. If you have any questions about this Notice of Privacy Practices, or questions or complaints about the handling of your health information, you may contact the Information Privacy Office, in writing or call or submit a report to our Compliance Line. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be penalized for filing a complaint.

Who to contact. To exercise any of the rights described above, please submit a written request to the Plan's Information Privacy Office by mail at the address below, by email to privacy@mclaren.org or by fax to 810-342-1450.

McLaren Health Care
Information Privacy Office

One McLaren Parkway
Grand Blanc, MI 48439

Compliance Line: 1-866-642-2667

McLaren
HEALTH CARE

Corporate Human Resources
One McLaren Parkway
Grand Blanc, Michigan 48439

mclaren.org