Peters McDonald's Group

Management Employees

2026

EMPLOYEE BENEFIT SUMMARY

BENEFIT PLANS AND CONTRIBUTIONS

EFFECTIVE JUNE 1, 2026 TO MAY 31, 2027

Table of Contents

What's inside this benefit guide?

The actual terms of your benefit program are described in the Carrier's Summary of Benefits and Coverage (SBC) Book. Please refer to the appropriate benefit book when making final benefit decisions.

Introduction to Your Employee Benefits

In support of our philosophy to provide our eligible management team and their families with a complete compensation package, we are pleased to offer you the opportunity to participate in a quality benefits program.

What's New This Year?

Great News! There are no changes to your medical benefit plans this year. Blue Care Network will continue to provide medical coverage. Dental & vision plans are provided by ***Delta Dental Plans of Michigan*** on a stand alone basis providing more flexibility in your elections.

Your costs to participate in the medical plans are designed to be affordable and updated annually to reflect changes in the plans and the affordability rules established by the Affordable Care Act. Payroll Deductions are illustrated on Page 8.

This guide is designed to make it easy for you to understand your benefits and other pertinent information. Although it will provide summaries of some of the services available to you, it is not a substitute for the benefit book provided by the healthcare carrier.

What are my Benefit Options?

- ☑ Choice of two Blue Care Network Medical Plans
- ☑ Delta Dental of Michigan Dental Plan
- ☑ Delta Dental of Michigan VSP Vision Plan

BCN Medical includes "Virtual Care by Teladoc Health". With this service you will have access to online Medical visits 24/7 and Behavioral Health services anywhere in the U.S.

This affordable service provides easy-to-use online "Virtual Doctor Visits" for minor, non-emergency illnesses.

- ☑ All Department & General Managers, Office & Banking Managers, Directors & Supervisors, Primary Maintenance, and Human Resources & Operations personnel are provided $25,000 Life/AD&D coverage underwritten by The Hartford Insurance Company at no additional cost to you.

Who is Eligible?

All Management, Maintenance, and Office employees mentioned above working a minimum of 30 hours per week are eligible to participate in the Medical, Dental and Vision Benefits.

When will my Benefits Begin?

Newly Hired Managers become eligible for benefits: 1st of the month following 60 days of active employment.

Current employees, promoted to Management become eligible for benefits: 1st of the month following 60 days of active employment in Management class.

What employers are included in Peters McDonald's Group?

If you work for any of these employers, your benefits are included in this booklet. (1) La-Di Inc. (2) Dee Mac Inc. (3) JR Mac Inc. (4) Chad Mac Inc. (5) LJP, LLC (6) LJP2 Inc. (7) BNA Management Inc. (8) Peters Management Group

Introduction to Your Employee Benefits

Eligibility, Instructions and Information to consider when choosing your benefits

Who You Can Cover

You can cover any "eligible dependent". Eligible dependents include:

Your legally recognized spouse.

Legal children until the end of the calendar year in which they turn age 26 for Medical, Dental and Vision.

New Hire Enrollment Instructions

To enroll for coverage, you will need to complete the following items and return them to your General Manager as soon as possible but no later than 30 days after your eligibility date.

☑ New Enrollment
- Employee Enrollment Form

Open Enrollment Instructions

The open enrollment period will occur annually in May with changes to your coverage effective June 1st.

The elections you make during open enrollment will be effective for the period June 1, 2026 through May 31, 2027.

Please complete the following items and return them to your General Manager as soon as possible.

☑ New Enrollment
- New Employee Enrollment Worksheet

☑ Adding or Deleting Dependents or Other Changes – Please complete the Employee Change of Status Worksheet

Mid-Year Status Changes (*Can I change coverage in the middle of the year?)*

Once you make your elections for coverage, you cannot change them until the next open enrollment period.

Your benefit election is generally irrevocable for the period of coverage unless you experience a qualified change in status event that affects your eligibility for coverage and you request a benefit change that is consistent with and on account of the qualified event.

Events may include:
- a change in marital status
- change in number of dependents
- change in employment status
- significant plan cost or coverage changes
- loss of coverage under a Government plan
- a judgment, decree or order
- Medicare or Medicaid entitlement,
- a qualified Family Leave of Absence
- or a HIPAA special enrollment event.

Coverage changes must be consistent with you or your dependents' "status change" that affects eligibility under an employer's plan.

Employees have 30 days after a status change to make a change in benefits. Changes not made within 30 days must wait for the next open enrollment period.

Introduction to Your Employee Benefits

Actively at Work Requirement

If an employee is not in active employment because of injury, sickness, temporary layoff or leave of absence on the date that coverage would otherwise become effective, some benefits may be delayed.

If a family member is totally disabled on the date coverage would otherwise begin, some benefits may not begin until he or she is no longer totally disabled. Generally, your family member is totally disabled if he or she is confined in a hospital or similar institution; is unable to perform two or more activities of daily living because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

When Coverage Ends

Your coverage will end when you are no longer an eligible employee of PETERS MCDONALD'S GROUP. Dependent coverage will end when your coverage ends, or earlier if the individual is no longer an eligible dependent (i.e., divorce or child reaches limiting age).

Certain coverage may continue after your termination date through a Conversion, COBRA or Portability option. Premiums are fully paid by the employee in each of these options.

Medical Plan Waiver Option

If you are waiving this coverage because you are currently covered by another medical plan, you will not lose future eligibility for this plan. However, you must enroll in this plan within 31 days of your current plan benefits ending. This provision applies to both you and your dependents.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you will be able to enroll yourself and your dependent, provided you elect coverage within 31 days of the qualifying event.

Compliance with the ACA

The medical plan offered to you provides minimum essential coverage and the minimum value standard (pays at least 60% of allowed charges) as defined by the Affordable Care Act.

The lowest cost medical plan will be available to you at an affordable cost for single coverage as defined by the Affordable Care Act.

Overview of Your Employee Benefits

What are my benefits and how much will they cost me?

Overview of Employee Benefits

Summaries of employee benefits are included on the following pages.

The benefit charts included in this document are provided as an easy to read summary; they are not contracts. Additional limitations and exclusions may apply. For an official description of benefits, please see each carrier's benefit book.

Covered Services

Your medical benefits provided include:

- ☑ Routine physical examinations covered at 100%
- ☑ Hospital care and surgical procedures
- ☑ Outpatient services
- ☑ Mental Health and Substance Abuse Rehabilitation
- ☑ Prescription drugs

About your Medical and Prescription Drug Benefits

The Blue Care Network HMO

This plan is a Health Maintenance Organization (HMO) plan to help make coverage as affordable as possible for participants.

Members select a primary care physician (PCP) who provides and coordinates your care. Your (PCP) is your partner in maintaining your good health and will provide care for most of your basic health care needs. This includes preventive services such as immunizations and physical exams. Each member in your family can choose their own Primary Care Physician (PCP).

If you need specialty care, tests or hospitalization, your PCP will authorize these services for you.

To find a PCP (Primary Care Physician) near you go to the BCBSM website: www.bcbsm.com

- Click: **Find Care – for Individuals and Families.**
- Under "Find a Doctor" - Click: **Search without logging in.**
- Choose a location: Enter: **Your Zip Code or City and State.**
- Click: Orange button **"I don't know my network" –** Click: **"Find a different plan"**
- Under employee group plans, choose **"Blue Care Network HMO"**
- Click: Green **"Confirm selection"** button.
- Select a category—Choose: **Doctors by specialty—Enter: PCP (Primary Care Physician)**
- List will come up in your area.
- Click: **The doctor of your choice for further information.**
- National Provider ID (NPI) will be listed under the doctor you choose: ***This number you need to put on your PCP Selection form.***

Medical Benefit Summaries

MEDICAL PLAN BENEFITS		
Blue Care Network (BCN) HMO Plan Options	**BCN HMO $4,000 Deductible**	**BCN HMO $1,500 Deductible**
	In-Network Only	**In-Network Only**
Deductibles	$4,000 Individual / $8,000 Family	$1,500 Individual / $3,000 Family
Coinsurance	30%	20%
Total Out of Pocket Maximum	$8,150 individual / $16,300 Family	$8,150 individual / $16,300 Family
Preventive Care Services	100% (no deductible)	100% (no deductible)
Office Visit (Primary Care Doctor)	$30 Copay	$20 Copay
Virtual Primary Care Visit	$30 Copay (BCN PROVIDER)	$20 Copay (BCN PROVIDER)
Specialist Office Visit	$50 Copay	$40 Copay
Urgent Care Facility	$60 Copay	$50 Copay
Emergency Room Visit	$250 Copay after deductible	$250 Copay after deductible
Diagnostic test & X-rays	70% after deductible	80% after deductible
Maternity (Routine Prenatal Care)	100% (no deductible)	100% (no deductible)
Hospital Care	70% after deductible	80% after deductible
Surgical Care	70% after deductible	80% after deductible
Inpatient Mental/Substance Abuse Treatment	70% after deductible	80% after deductible
Outpatient Mental/Substance Abuse Treatment	$30 Copay	$20 Copay
Rehabilitation Services	$50 Copay after deductible	$40 Copay after deductible
Prescription Drugs: Preferred Generic Non-Preferred Generic Preferred Brand Non-Preferred Brand Preferred Specialty Non-Preferred Specialty	Tier 1: $10 Copay Tier 2: $30 Copay Tier 3: $60 Copay Tier 4: $80 Copay Tier 5: 20% (Max $200) Tier 6: 20% (Max $300)	Tier 1: $10 Copay Tier 2: $30 Copay Tier 3: $60 Copay Tier 4: $80 Copay Tier 5: 20% (Max $200) Tier 6: 20% (Max $300)

The benefits described above are intended to be only a Summary Description.
For details, please review the Certificate of Coverage Agreement.

Dental, Vision, & Life/AD&D Summaries

Dental Benefits Delta Dental		
	In-Network	Out-of-Network
Deductible: Individual Family	 $50 $150	 $50 $150
Preventive Care	100%	100%
Basic Care	80%	80%
Major	50%	50%
Calendar Year Maximum	$1,000	$1,000

Note: If at least one Covered Service is paid in a Benefit Year and the total benefit paid does not exceed $500 in that Benefit Year, $250 will carry over to the next Benefit Year's maximum not to exceed an additional $1,000 benefit.

Vision Benefits Delta Vision VSP		
	In-Network	**Out-of-Network**
Eye Exams	$10	Up to $45
Lenses	$25	Single - Up to $30 Bifocal - Up to $50 Trifocal - Up to $65 Lenticular - Up to $100
Frames	$130 allowance	Up to $70
Contact Lenses: Elective Medically Necessary	 $130 Covered in Full	 Up to $105 Up to $2100

Hartford Life and AD&D Insurance	
Feature	**Description**
Eligible Employees	See page 2 for eligible employee classes
Life Insurance Benefit	$25,000
AD&D	$25,000
Age Reduction Schedule	35% at age 65, 70, 75 and 25% at age 80,85
Employee Contributions	Employees in an eligible class are provided these benefits at no additional cost.

Employee Contributions

Peters McDonald's Group shares the cost of your benefits with you the employee. Your cost as an employee to participate in the $4,000 Deductible Plan is designed to meet the affordability provisions of the ACA.

The amount you are responsible to pay is automatically deducted from your paycheck. ¢Kλă Ř2Ŝă y2ú λyŎfdzŘŜ l·yê l·ŘŘλúλ2yl·f Ŏ2ăúă ŦƵ Ŏ2πLJl·èY Ŝyúăż Ƶ 2ŭKŜ 2dzúπ2ŦπLJ2Ŏ1Ŝú ŜÈLJŜyãŜă úKl·ú l·ƵŜ è2dzƵ ƵŜăLJ2yãλŏλfλúè See each carrier's booklet for additional information about medical expenses.

SWING MANAGER Blue Care Network (BCN) - Medical Options		
*Per Pay Deduction	**BCN $4,000**	**BCN $1,500**
Employee Only	$ 95.62	$127.85
Employee + One	$525.37	$602.74
Family	$682.35	$779.06

DEPARTMENT MANAGER Blue Care Network (BCN) - Medical Options		
*Per Pay Deduction	**BCN $4,000**	**BCN $1,500**
Employee Only	$101.59	$133.83
Employee + One	$467.87	$545.24
Family	$624.85	$721.56

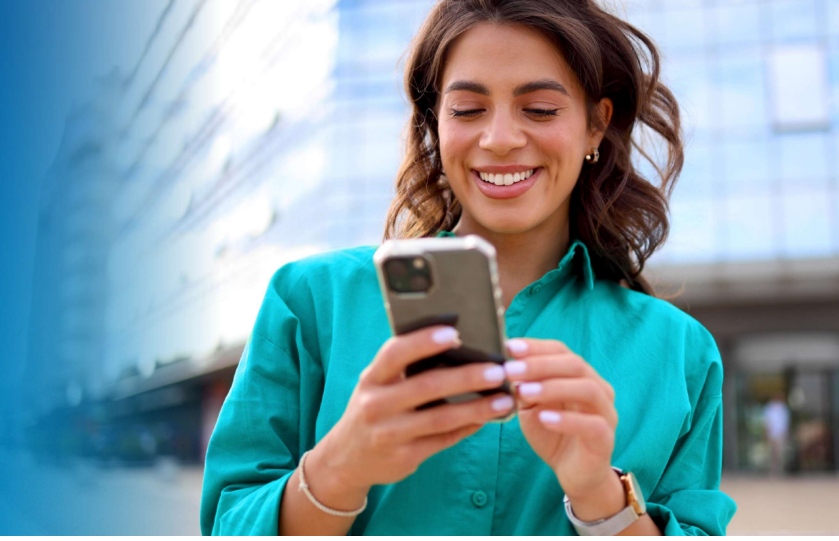
GENERAL MANAGER/OFFICE STAFF Blue Care Network (BCN) - Medical Options		
*Per Pay Deduction	**BCN $4,000**	**BCN $1,500**
Employee Only	$137.45	$169.69
Employee + One	$503.73	$581.10
Family	$660.71	$757.42

ALL MANAGEMENT EMPLOYEES DELTA DENTAL	
Employee Only	$17.82
Employee + One	$33.36
Family	$62.46

ALL MANAGEMENT EMPLOYEES DELTA VISION - VSP	
Employee Only	$2.96
Employee + Spouse	$5.93
Employee + Child(ren)	$6.34
Family	$10.14

READY TO HELP

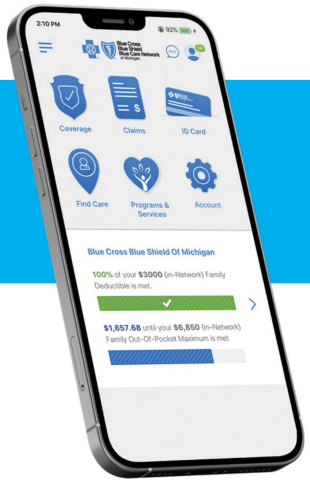
MICHIGAN



Tap in to your health care plan — anytime, anywhere

Understand your health care plan and how it works with the convenience of our mobile app. You'll have the information to manage your plan and get the most from your benefits, wherever you go.

- Review your claims, out-of-pocket balance and explanation of benefits statements to understand what your plan pays for your health care costs.
- Check your plan's benefits before making an appointment to avoid any surprise costs.
- Receive emails or text messages with real-time status updates for your prior authorization or referral requests.
- Find care in your plan's network for lower out-of-pocket costs.
- Compare prices for health care services* and check doctor and hospital quality.
- Show your virtual member ID card to your doctor's office staff so they can check your coverage.



Get our app.

If you need help, call the Web Support Help Line at **1-888-417-3479 (TTY: 711)**.
For information about our app, go to **bcbsm.com/app**.

*Cost estimates are available to most non-Medicare members.

Blue Cross Blue Shield Blue Care Network of Michigan

Virtual Care

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.

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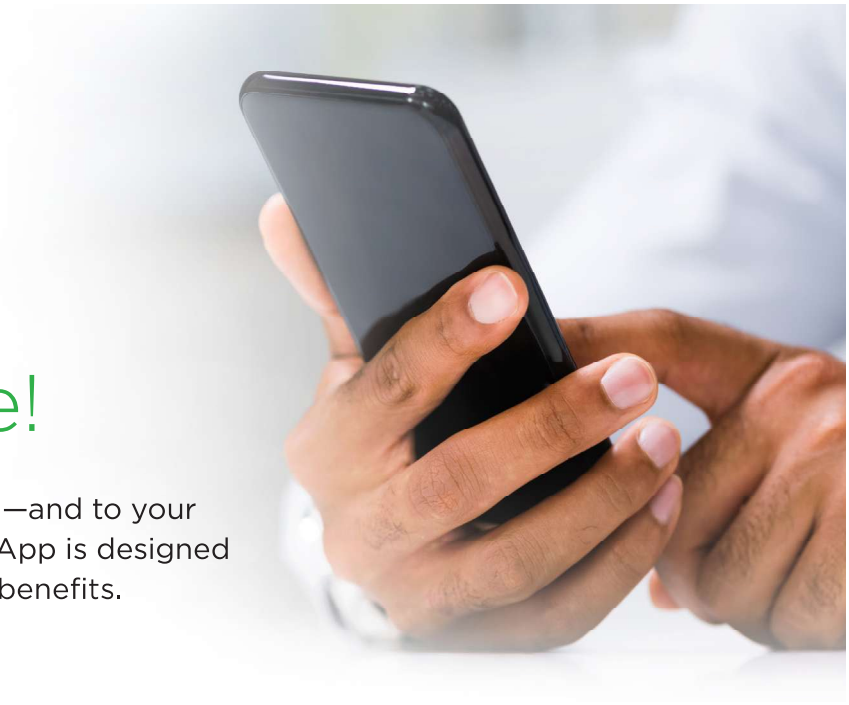
DELTA DENTAL®

Maximize your oral health, wherever you are!



Your oral health is important to Delta Dental—and to your overall health! The free Delta Dental Mobile App is designed to help you get the most out of your dental benefits.

As the primary subscriber, you can:

Coverage and claims information

- Review your dental policy coverage details such as deductibles, maximums and other benefits.
- Look up detailed claims information for your most recent dentist visits.
- Add your spouse or dependents so they can easily access the whole family's coverage.

Mobile ID card

- View, share and save your ID card right from your phone.
- Use Apple Passbook and Google Wallet for quick access.

Find a dentist

- Search and compare dental offices to find one that suits your needs.
- Save your family's preferred dentists to easily schedule dental care.

Dental Care Cost Estimator

- Easily get estimated cost ranges on common dental care needs for dentists in your area.
- Tailor possible care cost by selecting your preferred dentist.

Get started

- Scan the QR code to the right or search for the Delta Dental Mobile App in your Apple or Android device app store.
- Only the primary subscriber can create a login using the mobile app.

Scan to download the Delta Dental app

Secure access to your benefits via Member Portal on your mobile browser or desktop

Delta Dental's free and easy to use online Member Portal gives you secure, 24/7 access to all your dental benefit information. Visit **www.memberportal.com** to log in.

- If you are new to Member Portal, click the "Sign up" link to register. You will need the subscriber's member ID. In most cases, the member ID is the same as the subscriber's Social Security number.
- Member Portal is available for both the primary subscriber and spouse.

DELTA DENTAL®

The Link Between Oral and Overall Health

Regular dental visits are important to keeping your smile healthy, but did you know that more than 120 signs and symptoms of nondental disease can be detected in a routine oral exam?[1] During routine checkups, dentists not only look for cavities and gum disease, but also monitor symptoms that may point to overall health concerns. If certain signs are detected, dentists can urge patients to seek medical attention to better manage their oral and overall health.

BRAIN—People with severe gum disease have 4.3 times higher risk for cerebral ischemia stroke than those with mild or no gum disease.[2]

MOUTH—Many everyday medications can affect your oral health. A common side effect is dry mouth, which could increase your risk for tooth decay. Those who use inhalers are also at risk for a fungal infection called oral candidiasis (thrush). This appears as white spots in your mouth and can be painful.[3]

HEART—Gum disease and heart disease have similar underlying causes, including the buildup of dental plaque over time. When left untreated, plaque can spread below the gum line, allowing bacteria to enter the bloodstream and increase the risk for systemic diseases such as heart disease.[4] It's important for those with high-risk medical conditions to keep bacteria in their mouths as low as possible to prevent infections in the heart.

PANCREAS—Research shows a strong connection between periodontal (gum) disease and diabetes. People with diabetes not only are more likely to have gum disease, but can have a more advanced stage of the condition compared to those without diabetes.[5] Gum disease can also make it more difficult to control blood sugar, making the body more resistant to the insulin produced by the pancreas.

BONES—Those with osteoporosis often take drugs called bisphosphonates for treatment and reduced risk of bone fractures. However, the drug can cause a rare but serious side effect called bisphosphonate related osteonecrosis of the jaw (BONJ). Gum disease can increase the risk of BONJ, as well as certain dental procedures, like extractions.[6]

REPRODUCTIVE TRACT—Oral health is especially important for women who are pregnant. Hormone changes during pregnancy can affect oral health, and as many as 40 percent of pregnant women experience gum disease.[7] By delaying important dental treatment, expectant mothers may put themselves and their baby at risk. In fact, high maternal levels of the bacteria that cause cavities may contribute to low infant birth weight.[8]

1 James W. Little et al., *Dental Management of the Medically Compromised Patient* (St. Louis: Mosby, 2012) 2 Armin J. Grau et al., "Periodontal Disease as a Risk Factor for Ischemic Stroke," *Stroke* 35, no. 2 (2004): 496-501. 3 American Dental Association, "Medications and Oral Health," web. 4 TE Van Dyke and AJ van Winkelhoff, "Infection and Inflammatory Mechanisms," *Journal of Clinical Periodontology* 40, suppl. 14 (2013): S1–S7 5 Delta Dental Plans Association, "Research Review September 2009. Oral and General Health—Exploring the Connection. Associations Between Periodontal Disease and Diabetes Mellitus," web. 6 V Thumbigere-Math, et al., "Periodontal disease as a risk factor for bisphosphoneate-related osteonecrosis of the jaw," *Journal of Periodontology* 85, no. 2 (2014): 226-33. 7 American College of Obstetricians and Gynecologists, "Oral Health Care During Pregnancy and Through the Lifespan—Committee Opinion No. 569," *Obstetrics & Gynecology* 122, no. 2, part 1 (2013): 417–22. 8 Li, Y et al., "Mode of Delivery and Other Maternal Factors Influence the Acquisition of Streptococcus Mutans in Infants," *Journal of Dental Research* 84, no. 9 (2005): 806–11.

FLI-6208 v1 Delta Dental of Arkansas, Indiana, Kentucky, Michigan, New Mexico, North Carolina, Ohio, and Tennessee PA 5/19

IMPORTANT NOTICE FROM PETERS MANAGEMENT GROUP 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 your employer's health and welfare benefits plan 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. **Your employer determined that the prescription drug coverage offered by its health and welfare benefits 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?

Plan Participants who also are eligible for Medicare have the following three options concerning prescription drug coverage *:

- You may stay in the Plan and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later

date without penalty, either (1) during a Medicare prescription drug open enrollment period (October 15–December 7 of each year); or (2) if you lose Plan coverage. This is the best option for most Plan participants who are eligible for Medicare.

- You may or may not stay in the Plan and also enroll in Medicare prescription drug coverage at this time. The Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer, and thus the value of your Medicare prescription drug coverage will be greatly reduced. Your current coverage under the Plan pays for other health benefits as well as prescription drugs and may or may not change if you choose to enroll in Medicare prescription drug coverage.

- **If your employer offers a Health Savings Account (HSA) once you enroll in Medicare, you and your employer will **not** be eligible to make any further contributions to your Health Savings Account. And under your plan's HSA coverage, if any, you must meet the high deductible amounts before the plan will pay for most prescription drugs.*

- **If your organization has 20 or less employees, you may stay in the plan and also enroll in Medicare prescription drug coverage at this time. The plan will pay prescription drug benefits as the secondary payer in most instances. The plan will pay benefits as a secondary payer, and thus the value of your plan coverage will be greatly reduced.*

- You may reject all coverage under the plan and choose coverage under Medicare as your primary and only payer for all medical and prescription drug expenses. If you do so, you will not be able to receive coverage under the plan, including prescription drug coverage, unless and until you are eligible to re-enroll at the next enrollment period for which you are eligible, if any. Your current coverage pays for other types of health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current health and prescription drug benefits if you reject coverage under the plan and choose to enroll in Medicare, including a Medicare prescription drug plan, as your primary and only payer.

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 your employer 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 November to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact your HR Representative 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 your employer 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).**

Questions? Please contact your Group Representative at 248-359-0583 or Valerie Hovland, Compliance V.P. for Salus Group, an NFP Company at 586-999-5551, or valerie.hovland@nfp.com if you have any questions or concerns pertaining to Medicare Part D prescription coverage.

125 Premium Only Plan (POP)

This benefit allows you to make your medical contributions with pre-tax dollars. **This benefit will save you valuable tax dollars and put more money in your "take home" check.**

The Section 125 Premium Only Plan lets you pay your portion of group medical premiums with pre-tax dollars. With Section 125, premium payments are deducted from your paycheck before Federal and Social Security taxes (and, in some cases, before State taxes).

By paying premiums with pre-tax dollars, you reduce taxable income and **take home a larger portion of your income**.

For an employee who pays $2,922 per year toward medical premium, the increases in take-home pay could be up to $876. The exact amount will depend on your personal tax situation.

Here are a few facts you should know about the Section 125 Premium Only Plan:

- Participation in the plan does not affect benefits or the amount of premium for these benefits - it simply allows you to pay for these benefits on a pre-tax basis.
- Your future W-2 (tax withholding) statements will reflect your reduced taxable income (gross income minus your pre-tax premium payments).
- You cannot change this election during the plan year unless there has been a significant change in cost of coverage on account of and consistent with a change in status (such as marriage or divorce, birth or adoption of a child, death of a spouse or child, termination or commencement of employment of a spouse, taking an unpaid leave of absence or switching from part-time to full-time status or vice versa by you or your spouse).
- Your portion of the premium paid with before-tax dollars will automatically increase or decrease, as the case may be, to reflect the changes in the medical and dental benefit premiums.
- Because you'll be paying less in Social Security taxes, participation in the Section 125 Plan may reduce your future Social Security benefits.

Because the Section 125 Premium Only Plan is an important part of eligible employee benefit program you will automatically be included Premium Only Plan unless you request in writing that you do not want to participate and provide it with your Enrollment Election form to the Human Resources Department.

Important Notifications

Newborns' and Mothers' Health Protection Act Statement of Rights

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) Notice

Enrollment Notice

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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Annual Notice

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? Call your plan administrator for more information.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 3/31/2026)

Notice of Privacy Practices

Effective February 15, 2026

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Employer contact for privacy information: **Name:** Peters Management Group

Email: maggien.pmg@gmail.com **Phone:** (989) 686-4056

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your

information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

The terms of this notice may be changed, and the changes will apply to all information we have about you. The new notice will be available upon request, on our benefits portal, or we will mail a copy to you.

Notes

PETERS McDONALD'S GROUP

IMPORTANT EMPLOYEE BENEFITS CONTACT INFORMATION

Blue Cross Blue Shield Blue Care Network of Michigan	1-800-662-6667	www.bcbsm.com
DELTA DENTAL DeltaVision In partnership with VSP	1-800-524-0149 1-800-877-7195	www.deltadentalmi.com www.vsp.com
THE HARTFORD	1-800-523-2233	www.thehartford.com
NFP An Aon Company	Daniel S. Ward, RHU, ChHC, LIC Vice President of Franchise Sales 248-359-0583	Ashley Tretts Account Manager/Client Service Representative (586) 554-7424

The information contained in this summary should in no way be construed as a promise or guarantee of employment or benefits. The PETERS MCDONALD'S GROUP Enterprises Inc. reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this notice and the actual plan policies, the policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, and policies available from the HR Department.