Peters McDonald's Group Management Employees

EMPLOYEE BENEFITS SUMMARY

BENEFIT PLANS AND CONTRIBUTIONS

EFFECTIVE JUNE 1, 2024 TO MAY 31, 2025

Table of Contents

What's inside this benefit guide?

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

Presented by: Salus Group

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?

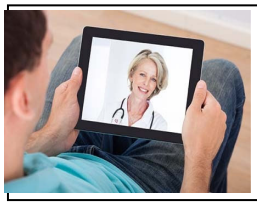
Great News! There are only minor changes to your medical benefit plans this year. Blue Care Network will continue to provide medical coverage. Dental & vision plans are provided by ***Delta Dental Plans of Michigan*** on a stand alone basis providing more flexibility in your elections.

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 9.

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



Blue Care Network Medical Plans include online health care, 24 hours a day, 7 days a week, in the U.S. This affordable service provides easy-to-use online "Virtual Doctor Visits" for minor, non-emergency illnesses.

- ☑ All Department & General Mangers, 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 dependents". 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, 2024 through May 31, 2025.

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 Enterprises Inc. 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 plans offered to you provide 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 Blue Care Network 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

A Health Maintenance Organization (HMO) consists of doctors, hospitals and other healthcare providers who agree to accept an "approved amount" as payment in full for covered services less your deductible, coinsurance, and/or copay.

The advantages of using a HMO provider are:

- Overall costs are lower because providers are limited and agree to reimbursements.
- Reduced out-of-pocket expenses.
- No claim forms.
- Referrals are required prior to receiving treatment to keep costs low.
- Emergency Services are paid anywhere in the world at the Network Level.

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

- Click: **Find A Doctor Button**
- Under Get started button—Not Yet a member? Click: **Search without logging in**
- Your location: Enter: **Your Zip Code or City and State**
- Your Plan– **Click: All Plans—Choose Employer Group Plans—Choose Blue Care Network (HMO)**
- 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 will be listed under the doctor you choose: ***This number you need to put on your PCP Selection form***

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 **1-800-835-2362** 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.

Medical Benefit Summaries

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.

Medical Benefits	Blue Care Network (HMO) $4,000 Deducible Plan	Blue Care Network (HMO) $1,500 Deductible Plan
	In-Network Only	**In-Network Only**
Deductibles (Individual/Family)	$4,000 Individual / $8,000 Family	$1,500 Individual / $3,000 Family
Co-insurance	70%	80%
Total Out of Pocket Max (Includes copays, co-insurance payments and deductibles)	$8,1500 Individual / $16,300 Family	$8,150 Individual / $16,300 Family
Preventive Care Services	100% (No Copay)	100% (No Copay)
Office Visit Copay	$30 Copay	$20 Copay
Specialist Copay	$50 Copay	$40 Copay
Urgent Care Copay	$60 Copay	$50 Copay
Emergency Room Copay	$250 Copay (annual deductibles apply)	$250 Copay (annual deductibles apply)
Diagnostic Tests & X-Rays	70%	80%
Advanced Diagnostics ***(CT, CTA, MRI, etc.)***	$150 Copay (annual deductibles apply)	$150 Copay (annual deductibles apply)
General Hospital Care	70%	80%
Maternity Services	70%	100%
Surgical Services	70%	80%
Physical, Speech, and Other Therapies	$50 Copay (when referred)	$40 Copay (when referred)
Prescription Drugs	Tier 1A - $10 Copay Tier 1B - $30 Copay Tier 2 - $60 Copay Tier 3 - $80 Copay Tier 4 - 20% ($200 Max.) Tier 5 - 20% ($300 Max.)	Tier 1A - $10 Copay Tier 1B -$30 Copay Tier 2 - $60 Copay Tier 3 - $80 Copay Tier 4 - 20% ($200 Max.) Tier 5 - 20% ($300 Max.)

This is intended as an easy to read summary and providers only a general overview of your benefits. Additional limitations/ exclusion may apply. For a complete description of benefits, please see the applicable Blue Care Network and Blue Cross Blue Shield certificate and riders. Also review the Summary of Benefits and coverage (SBC) provided by your employer.

Dental, Vision, & Life/AD&D Summaries

Delta Dental	In Network	Out of Network
Deductibles (individual/ family)	$50 / $150	$50 / $150
Preventive & Diagnostic	100% (deductibles waived)	100% (deductibles waived)
Basic Services	80% after deductible	80% after deductible
Major Services	50% after deductible	50% after deductible
Calendar Year Maximum	$1,000	$1,000
Carryover Benefit - requires annual dental visits or benefit is forfeited.	$250 is added to the plan until the calendar maximum reaches $2,000	$250 is added to the plan until the calendar maximum reaches $2,000

Delta VSP Vision	In Network	Out of Network
Eye Exams	$10.00	Up to $45
Eye Glasses (Lenses)	$25.00	Single vision—up to $30 Bifocal —up to $50 Trifocal —up to $65 Progressive —up to $50 Lenticular—up to $100
Frame Allowance	$130 Allowance 20% discount over the limit	Up to $70
Contact Lenses Elective Necessary	 $130 Allowance Covered in full after copay	 Up to $105 Up to $210
Exam & Materials Frequency	12/12/24	12/12/24

The Hartford Group Term Life/AD&D Insurance	
Eligible Employees	See Page 2 for eligible employee classes
Benefit Schedule	$25,000
Benefit Reduction Schedule	Coverage reduces by 35% @ 65, 70, 75, and 15% @ 80, 85, 90, and 95. Benefits terminate at retirement.
Waiver of Premium Benefit	Premiums are waived after 9 months of total disability
Living Benefit Option (Accelerated Benefit)	Covered employees provided a documented life expectancy of 12 months or less may receive up to 80% of benefit in advance.
Accident Death & Dismemberment (AD&D)	$25,000 - pays in addition to the base benefit.
Employee Contributions	Employees in an eligible class are provided these benefits and no additional cost.

Employee Contributions

BCN (HMO) $4,000 Deductible Plan Medical Plan Swing Managers & Primary Maintenance		
Per Paycheck Deductions	Employee Only	$ 75.51
	Two Person	$430.75
	Family	$564.08

BCN (HMO) $1,500 Deductible Plan Medical Plan Swing Managers & Primary Maintenance		
Per Paycheck Deductions	Employee Only	$102.96
	Two Person	$496.62
	Family	$646.42

BCN (HMO) $4,000 Deductible Plan Medical Plan Department Managers		
Per Paycheck Deductions	Employee Only	$83.06
	Two Person	$394.15
	Family	$527.48

BCN (HMO) $1,500 Deductible Plan Medical Plan Department Managers		
Per Paycheck Deductions	Employee Only	$110.51
	Two Person	$460.02
	Family	$609.81

BCN (HMO) $4,000 Deductible Plan Medical Plan GMs / Administration		
Per Paycheck Deductions	Employee Only	$110.75
	Two Person	$421.83
	Family	$555.16

BCN (HMO) $1,500 Deductible Plan Medical Plan GMs / Administration		
Per Paycheck Deductions	Employee Only	$138.20
	Two Person	$487.70
	Family	$637.50

Delta Dental Dental Plan		
Per Paycheck Deductions	Employee Only	$15.07
	Two Person	$28.22
	Family	$52.84

Delta Dental VSP Vision Plan		
Per Paycheck Deductions	Employee Only	$2.69
	Employee + Spouse	$5.38
	Employee + Child(ren)	$5.76
	Family	$9.20

Annual Benefits Notices

Peters Management Group

801 S. Euclid Avenue

Bay City, MI 48706

(989) 686-4056

Created on: April 22, 2024

Medicare Part D Creditable Coverage Notice

Important Notice from LA-DI (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 LA-DI (Peters Management Group) 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. LA-DI (Peters Management Group) has determined that the prescription drug coverage offered by Blue Care Network HMO Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current LA-DI (Peters Management Group) coverage will be affected. Plan participants cannot keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan's medical and prescription drug coverage will be terminated.

If you do decide to join a Medicare drug plan and drop your current LA-DI (Peters Management Group) coverage, be aware that you and your dependents will be able to get this coverage back.

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 LA-DI (Peters Management Group) and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Daniel S. Ward, RHU, at (248) 359-0583. 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 LA-DI (Peters Management Group) changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: April 22, 2024

Name of Entity/Sender: Larry Peters

Contact--Position/Office: Owner/Operator

Address: 801 S. Euclid Avenue
Bay City, MI 48706

Phone Number: (989) 686-4056

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.

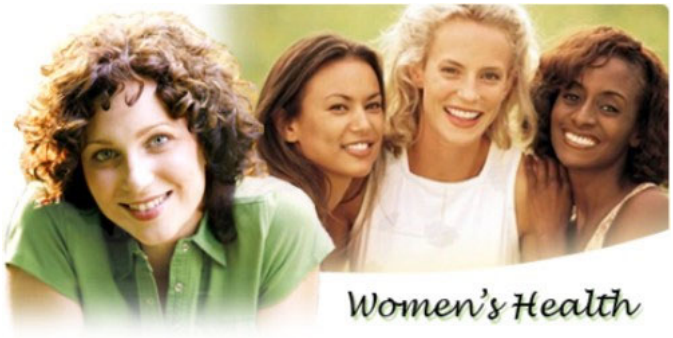
However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and insurers may not, under Federal law, require that a provider 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

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.



Employer's Children's Health Insurance Program (CHIP) Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. 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)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
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: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: 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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices / dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx 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: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

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://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp 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, 2023, 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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all
medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the McLaren Health & Welfare Plan] with respect to mental health or substance use disorder benefits, please contact your plan administrator at (248) 349-0583.

No Surprises Act

The No Surprises Act of the Consolidated Appropriations Act, 2021 (the "CAA"), protects you from "surprise billing" or "balance billing" when you get emergency care at an out-of-network hospital or when you receive care from an out-of-network provider who is working at a hospital or ambulatory surgical center in your health plan's network.

A "balance bill" is a bill charged to you by an out-of-network provider or facility to make up the difference between what your health plan pays and the provider charges for the items or services rendered. "Surprise billing" is an unexpected balance bill you receive from a provider or facility. This can happen when you receive care from a facility that is in-network but one of the providers at the facility is out-of-network.

Under the No Surprises Act, you are protected from balance billing for emergency services provided by out-of-network providers, including services you may get after you are in stable condition (unless you give written consent and give up your protections against balanced billing for post-stabilization services). You are also protected from surprise bills from services you receive from out-of-network providers while at an in-network hospital or ambulatory surgery center, such as services for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. The most the providers can bill you is your in-network cost-sharing amount, and they can't ask you to give up your protections from being balance billed. If you receive other services at in-network facilities, out-of-network providers cannot balance bill you unless you provide written consent. Written consent can never be required. Further, you can always choose to get care at an in-network facility or from an in-network provider instead of getting care from an out-of-network provider or facility.

The Plan covers emergency services without requiring you to get approval for such services in advance, which is known as prior authorization. Further, the Plan covers emergency services even if those services are provided by providers who are outside the plan's network. Your required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received by an out-of-network provider or facility will be the same as what you pay a provider or facility in the Plan's network. That amount will be included in your explanation of benefits. Finally, the amount of any cost-sharing you pay for emergency services or out-of-network services will count towards your applicable maximum annual deductible and out-of-pocket limits under the Plan.

Contact the Plan Administrator for more information.

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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

Notice of Privacy Practices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of PETERS MCDONALD'S GROUP Enterprises Inc. group health plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information". Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to:

(1) your past, present or future physical or mental health or condition;
(2) The provision of health care to you; or
(3) The past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please **contact y**our General Manager.

Effective Date…
This Notice is effective June 1, 2024.

Our Responsibilities…
We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail to the employees last known address on file.

How We May Use & Disclose Your Protected Health Information…
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclosure your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations…
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Notice of Privacy Practices

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following.

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary:

(1) for the institution to provide you with health care;
(2) to protect your health and safety or the health and safety of others; or
(3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researches when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures…

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures…

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

A Spouses and Other Family Members. With only limited exceptions, we 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 a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Notice of Privacy Practices

Your Rights…
You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to your Human Resources Manager. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to your Human Resources Manager.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to your Human Resources Manager. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include:

(1) disclosures for purposes of treatment, payment, or health care operations;
(2) disclosures made to you;
(3) disclosures made pursuant to your authorization;
(4) disclosures made to friends or family in your presence or because of an emergency;
(5) disclosures for national security purposes; and
(6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to your Human Resources Manager. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), we comply with any restriction request if:

(1) except as otherwise required by law, the disclosure is to health plan purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and
(2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to the Human Resources Manager. In your request, you must tell us:

(1) what information you want to limit;
(2) whether you want to limit our use, disclosure, or both; and
(3) to whom you want the limits to apply - for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Human Resources Manager. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, your Human Resources Manager.

Complaints…
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact your Human Resources Manager. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Notes

Notes

PETERS MCDONALD'S GROUP
IMPORTANT EMPLOYEE BENEFITS CONTACT INFORMATION

Blue Care Network of Michigan A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association	1-800-662-6667	www.bcbsm.com
DELTA DENTAL®	Dental: 1-800-524-0149 Vision: VSP Customer Service: 1-800-877-7195 Monday-Saturday 9a.m.- 8p.m.	www.deltadentalmi.com
SALUS GROUP	Daniel S. Ward, RHU, ChHC, LIC Vice President of Franchise Sales 248-359-0583	Ashley Tretts 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.