



**Peters McDonald's Group
Crew Employees**



2025

**EMPLOYEE BENEFIT
SUMMARY**

BENEFIT PLANS AND CONTRIBUTIONS EFFECTIVE

JUNE 1, 2025 TO MAY 31, 2026

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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 crew team members and their families with a complete compensation package, Peters McDonald's Group is pleased to offer you the opportunity to participate in a quality benefits program.



**What's New
This Year?**

You are eligible for this plan because you have averaged 30 or more hours per week during the last 12 months of your employment with Peters McDonald's Group. When we measure your hours, we take into account all your hours of service including vacation, holiday, illness, jury duty, or military leave of absences (if applicable).

You are now eligible to participate for the next 12 months as long as you continue to be employed and pay your share of the premium regardless of the actual hours you work. Your costs for participation 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?

- Blue Care Network Medical Plan
- 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.

Who is Eligible?

Variable Hour employees working 30+ hours per week (based upon criteria established by the ACA) are eligible to enroll for Medical coverage as mandated by the Affordable Care Act. Eligibility will be based upon our standard measurement period (existing employees) or an initial measurement period (new employees).

When will my Benefits Begin?

Your benefits will begin 1st of the month following completion of your measurement period.

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, 2025 through May 31, 2026.

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

- New Enrollment
 - 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, degree 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 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

BLUE CARE NETWORK HMO \$6350 MEDICAL PLAN BENEFITS	
Plan Benefits	In-Network Only
Deductibles	\$6,350 Individual/\$12,700 Family
Coinsurance	None
Total Out of Pocket Maximum	\$6,350 individual/\$12,700 Family
Preventive Care Services	100% (no deductible)
Office Visit (Primary Care Doctor)	100% after deductible
Virtual Primary Care Visit	100% after deductible
Specialist Office Visit	100% after deductible
Urgent Care Facility	100% after deductible
Emergency Room Visit	100% after deductible
Diagnostic test & X-rays	100% after deductible
Maternity (Routine Prenatal Care)	100% (no deductible)
Hospital Care	100% after deductible
Surgical Care	100% after deductible
Inpatient Mental/Substance Abuse Treatment	100% after deductible
Outpatient Mental/Substance Abuse Treatment	100% after deductible
Rehabilitation Services	100% after deductible
Prescription Drugs:	
Generic	Tier 1: 100% after deductible
Preferred Specialty	Tier 2: 100% after deductible
Non-Preferred Specialty	Tier 3: 100% after deductible
<p>The benefits described above are intended to be only a Summary Description. For details, please review the Certificate of Coverage Agreement.</p>	

Dental and Vision Summaries

Dental Benefits Delta Dental		
	In-Network	Out-of-Network
Deductible:		
Individual	\$50	\$50
Family	\$150	\$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	\$130	Up to \$105
Medically Necessary	Covered in Full	Up to \$2100



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 \$6,350 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. This does not include any additional costs for co-payments, medicines or other out of pocket expenses that are your responsibility. See each carrier's booklet for additional information about medical expenses.

Blue Care Network - \$6,350 Deductible	
Per Pay Deduction	
Employee Only	\$ 67.54
Employee + One	\$327.46
Family	\$438.85

Delta Dental	
Per Pay Deduction	
Employee Only	\$16.81
Employee + One	\$31.47
Family	\$58.92

Delta Vision - VSP	
Per Pay Deduction	
Employee Only	\$2.88
Employee + Spouse	\$5.76
Employee + Child(ren)	\$6.16
Family	\$9.84





Blue Cross
Blue Shield
Blue Care Network
of Michigan

Confidence comes with every card.®

**READY
TO HELP**



Tap in to your health care plan — anytime, anywhere

Our **mobile app** helps you understand your health care plan and how it works. From your deductible to claims to out-of-pocket costs, you'll have the information to manage your plan and get the most from your benefits, wherever you go.

- View your claims and explanation of benefits statements to understand what providers charged and why. Sign up for email and push notifications.
- Check your plan's benefits before you make an appointment to receive care.
- Know your deductible and how much you've paid toward your out-of-pocket balance.
- Track the progress of your prior authorization or referral requests. Receive an email or text with real-time status updates.
- Find care in your network and compare the cost.* Check doctor and hospital quality.
- Show your virtual member ID card to your doctor's office staff so they have the information they need to look up your coverage.

If you need help registering for your account, call the Web Support Help Line at **1-888-417-3479**.

Get the app.

Scan this QR code with
your smartphone camera:



Or text **APP** to
222764.

For details about our app, go to bcbsm.com/app.

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

If you text us, you'll receive our mobile app download link. Message and data rates may apply. Visit bcbsm.com for our *Terms and Conditions of Use* and *Privacy Practices*.



Virtual Care 2024

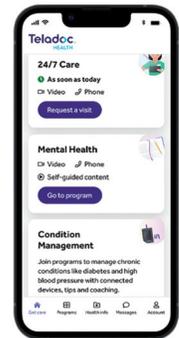
Previously Blue Cross Online VisitsSM

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 bcsm.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.



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

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

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 16, 2025

Name of Entity/Sender: Daniel S. Ward, RHU, ChHC, LIC

Contact--Position/Office: Plan Administrator

Address: 38233 Mound Rd. Bldg. F
Sterling Heights, MI 48310

Phone Number: (248) 359-0583

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 March 17, 2025. 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
<p>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</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/df/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>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</p>	<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@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://dhcfnv.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 March 17, 2025, 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)
 Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid. 1-877-267-2323,

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.

Notice of Privacy Practices

Peters Management Group
801 S. Euclid Ave
Bay City, MI 48706
989-686-4056

Privacy Official:

Daniel Ward, RHU, ChHC, LIC
38233 Mound Rd, Building F
Sterling Heights, MI 48310
(248) 359-0583
Dward@thesalusgroup.com
Effective Date: 01/01/2025

Your Information. Your Rights. Our Responsibilities.

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 paper or electronic medical record
- Correct your paper or electronic medical record
- 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

Your Choices

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

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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 an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record 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 information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is 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 or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

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” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

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 you have given someone 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 at:

Daniel Ward, RHU, ChHC, LIC
38233 Mound Rd, Building F
Sterling Heights, MI 48310
(248) 359-0583
Dward@thesalusgroup.com

- 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 www.hhs.gov/ocr/privacy/hipaa/complaints/.
- 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 your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

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
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

Treat you

We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

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. For more information, see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

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 here 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

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.



PETERS McDONALD'S GROUP

IMPORTANT EMPLOYEE BENEFITS CONTACT INFORMATION

 <p>Blue Cross Blue Shield Blue Care Network of Michigan</p>	<p>1-800-662-6667</p>	<p>www.bcbsm.com</p>
 <p>DELTA DENTAL DeltaVision In partnership with VSP*</p>	<p>1-800-524-0149 1-800-877-7195</p>	<p>www.deltadentalmi.com www.vsp.com</p>
 <p>SALUS GROUP</p>	<p>Daniel S. Ward, RHU, ChHC, LIC Vice-President of Franchise Sales 248-359-0583</p>	<p>Ashley Tretts Account Manager/Client Service Representative (586) 554-7424</p>

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