Grand Traverse Pavilions

A COMMUNITY CARING FOR GENERATIONS

Employee Benefit Guide

Health | Life | Family

January 1, 2024 - December 31, 2024

CONTENTS

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please contact HR.

HIGHSTREET

Peterson McGregor Insurance

We are committed to a comprehensive Employee Benefit Program that helps our employees stay healthy, feel secure, and maintain a work/life balance. We are excited about the benefit package outlined here, and hope you are pleased with the plans available to you and your family!

Eligibility

All qualifying employees and their eligible dependents.
Eligible Dependents are defined as follows:

- **Lawful spouse:** The individual to whom you are legally married and who is not legally separated or divorced from you.
- **Dependent Child:** Child related to you or your spouse by birth, marriage, legal adoption, or legal guardianship.

For Medical: Dependents who are less than 26 years old may be enrolled for coverage until the end of the year in which they turn 26 (married or unmarried).

For Dental: Dependents who are less than 19 or 24 if a full-time student, may be enrolled for coverage until the end of the year in which they turn 19 or 24.

For Vision: Dependents who are less than 26 years old may be enrolled for coverage until the end of the month in which they turn 26.

New Hire Coverage

As a new hire, you are eligible for all benefits following the new hire waiting period, 1st of the month following 30 days. You then have up to 30 days from the date of eligibility to make your elections. If you do not make your elections during that period you will not be eligible to make elections until the next open enrollment period.

Annual Elections (Open Enrollment)

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all of the different benefits offered, so you can identify which offerings are best for you and your family.

It is important that you make your benefit elections carefully. Once you make them the IRS requires that you will have to wait until the next open enrollment period to change them unless you experience a *Qualifying Life Event*.

You have 30 days from the date of the qualifying event to notify HR of any changes that need to be made to your coverage.

QUALIFYING LIFE EVENTS

- **Marriage, divorce or legal separation**
- **Birth or adoption of a child**
- **Change in child's dependent status**
- **Death of a spouse, child or other qualified dependent**
- **Change in residence due to an employment transfer for you or your spouse**
- **Commencement or termination of adoption proceedings**
- **Change in your spouse's employment status or a change in coverage under another employer-sponsored plan**

COBRA Continuation Coverage

When you or any of your dependents no longer meet the eligibility requirements of the provided plans you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

Medicare

If you (and/or your dependents) have Medicare, or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see ***Important Notice from Grand Traverse Pavilions About Your Prescription Drug Coverage and Medicare,*** in the back of this guide for additional details.

Need more information on Medicare? Please see the Medicare Connections section of the Contacts page.

Questions? Please don't hesitate to reach out to the HR Department.

Contacts

	Carrier	Phone & Website	Network	Group #	ID card Issued	App Availa-ble
Medical	Blue Care Network of Michigan	1-800-662-6667 www.bcbsm.com	HMO	00165637	Yes	Yes
Dental	DELTA DENTAL	1-800-542-0149 www.deltadentalmi.com	PPO	4984	No	Yes
Vision	eyemed	1-866-939-3633 www.eyemed.com	Insight	1020002	No	Yes
Life	unum	1-800-275-8686 www.unum.com	N/A	0912779-001	No	Yes
Supplemental Life	unum	1-800-275-8686 www.unum.com	N/A	912781-912780-R0794024	No	Yes
AFLAC - Martina Vollman	Aflac	1-231-944-0252 martina.vollman@us.aflac.com www.aflac.com	N/A	N/A	No	Yes
Pet Insurance	Nationwide	1-877-738-7874 www.petinsurance.com/gtpavilions	N/A	N11048	No	Yes
Flexible Spending Account	TASC	1-800-422-4661 www.tasconline.com	N/A	N/A	Yes	Yes

Highstreet Peterson McGregor Insurance

Hannah Bazzo, Account Manager – Benefit Inquiries
(231) 944-7042
hbazzo@team-pma.com

Raquel Paulus, Employee Benefits Specialist
(231) 944-7030
rpaulus@team-pma.com

Medicare

By choosing a Senior Benefits Specialist, you will have an advocate who will provide an extraordinary experience and knowledge to research and help you understand the Medicare options available to you pre and post-retirement. We understand the choices and decisions you are being asked to make at a time when you may face great uncertainty in your life.

We can help you with:

- Enrollment and Support
- Finding Supplemental Medicare options.

We listen, we evaluate, and we offer options based on your individual needs.

PM CONTACTS:

Jim McDonnell | 231-632-6840 | jmcdonnell@team-pma.com

Payroll Deductions Chart
Bi-Weekly Deductions - 26

MEDICAL - OPTION 1	Deductions per pay period **For additional information regarding plan rates, please see the summaries posted in the SmartLinx Benefit Portal.**
MEDICAL - OPTION 2	Deductions per pay period **For additional information regarding plan rates, please see the summaries posted in the SmartLinx Benefit Portal.**
MEDICAL - OPTION 3	Deductions per pay period **For additional information regarding plan rates, please see the summaries posted in the SmartLinx Benefit Portal.**
DENTAL	Deductions per pay period **For additional information regarding plan rates, please see the summaries posted in the SmartLinx Benefit Portal.**
DENTAL	Deductions per pay period **For additional information regarding plan rates, please see the summaries posted in the SmartLinx Benefit Portal.**
VISION	Deductions per pay period **For additional information regarding plan rates, please see the summaries posted in the SmartLinx Benefit Portal.**
LIFE AD&D|SUPPLEMENTAL LIFE	**The Life AD&D benefits is 100% paid for by Grand Traverse Pavilions. There is no cost to you. For the Supplemental Life rates are based on age and amount of coverage elected. For addition details please see the benefit summaries posted in the SmartLinx Benefit Portal.**
WORKSITE PLANS	**There are a variety of worksite plans available from Unum such as short and long term disability, as well as critical accident and critical illness plan. Costs for these plans will depend on age and coverage options selected. For additional information please see the benefit summaries posted in the SmartLinx Benefit Portal.**
AFLAC	**The cost of these plans will depend on your age and the coverage amount elected. For additional information please see the summaries posted in the SmartLinx Benefit Portal.**
PET INSURANCE	**The cost of this benefit will depend on number of pets enrolled and the coverage amount elected.**
FLEXIBLE SPENDING ACCOUNT	**The cost of this benefit will depend on your yearly election amount. For additional information please see the summaries posted in the SmartLinx Benefit Portal.**

Grand Traverse Pavilions
A COMMUNITY CARING FOR GENERATIONS

RN / Non-Union
Insurance Rates - 2024

Effective 01/01/24 through 12/31/24

Health Insurance

Option # 1 - Blue Care Network (BCN) HMO

	Monthly Premium	Monthly Employee contribution
Single Rate	**$553.48**	**$55.26**
Double Rate	**$1,328.35**	**$699.63**
Family Rate	**$1,660.44**	**$975.79**

Option # 2 – Blue Care Network (BCN) HMO

	Monthly Premium	Monthly Employee contribution
Single Rate	**$488.74**	**$1.04**
Double Rate	**$1,172.99**	**$569.48**
Family Rate	**$1,466.23**	**$813.11**

Option # 3 – Blue Care Network (BCN) HMO HSA

	Monthly Premium	Monthly Employee contribution
Single Rate	**$354.55**	**$0.00**
Double Rate	**$850.93**	**$308.56**
Family Rate	**$1,063.66**	**$486.95**

For **Option #3** Grand Traverse Pavilions will also contribute **$300.00/month** into the **HSA**.

Dental Insurance

Delta Dental – Base Plan

	Monthly Premium	Monthly Employee contribution
Single Rate	$36.03	$0
Double Rate	$109.31	$63.28
Family Rate	$109.31	$63.28

Delta Dental – High Plan

	Monthly Premium	Monthly Employee contribution
Single Rate	$46.92	$10.89
Double Rate	$136.92	$90.89
Family Rate	$136.92	$90.89

Grand Traverse Pavilions contributes **$36.03** towards a single plan and **$46.03** toward a double or family plan.

Vision Insurance

EyeMed

	Monthly Premium	Monthly Employee contribution
Single Rate	$6.84	$6.84
Double Rate	$12.99	$12.99
Family Rate	$19.08	$19.08

Grand Traverse Pavilions does not contribute to vision coverage.

The Organization will payroll deduct, pre-tax, any applicable insurance premiums from earnings, including any future premium increases for policies elected. This will continue until Human Resources is notified in writing to cancel any policies.

Grand Traverse Pavilions
A COMMUNITY CARING FOR GENERATIONS

General Unit / LPN
Insurance Rates - 2024

Effective 01/01/24 through 12/31/24

Health Insurance

Option # 1 - Blue Care Network (BCN) HMO

	Monthly Premium	Monthly Employee contribution
Single Rate	**$553.48**	**$55.26**
Double Rate	**$1,328.35**	**$699.63**
Family Rate	**$1,660.44**	**$975.79**

Option # 2 – Blue Care Network (BCN) HMO

	Monthly Premium	Monthly Employee contribution
Single Rate	**$488.74**	**$1.04**
Double Rate	**$1,172.99**	**$569.48**
Family Rate	**$1,466.23**	**$813.11**

Option # 3 – Blue Care Network (BCN) HMO HSA

	Monthly Premium	Monthly Employee contribution
Single Rate	**$354.55**	**$0.00**
Double Rate	**$850.93**	**$308.56**
Family Rate	**$1,063.66**	**$486.95**

For **Option #3** Grand Traverse Pavilions will also contribute **$300.00/month** into the **HSA**.

Dental Insurance

Delta Dental – Base Plan

	Monthly Premium	Monthly Employee contribution
Single Rate	$36.03	$0
Double Rate	$109.31	$73.28
Family Rate	$109.31	$73.28

Delta Dental – High Plan

	Monthly Premium	Monthly Employee contribution
Single Rate	$46.92	$10.89
Double Rate	$136.92	$100.89
Family Rate	$136.92	$100.89

Grand Traverse Pavilions contributes **$36.03** towards the monthly premium.

Vision Insurance

EyeMed

	Monthly Premium	Monthly Employee contribution
Single Rate	$6.84	$6.84
Double Rate	$12.99	$12.99
Family Rate	$19.08	$19.08

Grand Traverse Pavilions does not contribute to vision coverage.

The Organization will payroll deduct, pre-tax, any applicable insurance premiums from earnings, including any future premium increases for policies elected. This will continue until Human Resources is notified in writing to cancel any policies.

General Unit/LPN/ RN/Non-Union **2024**

For Blue Care Network Grand Traverse Pavilions will contribute:

Option 1

- $498.22 for single coverage
- $628.72 for double coverage
- $684.65 for family coverage

Option 2

- $487.70 for single coverage
- $603.51 for double coverage
- $653.12 for family coverage

Option 3 + $300 contribution from GTP into HSA

- $354.55 for single coverage
- $542.37 for double coverage
- $576.71 for family coverage

Please keep in mind that the option you select will be in place for the entire plan year, unless you have a Qualifying Life Event. The chart below gives a summary of the offered Medical coverage . All covered services are subject to medical necessity as determined by the Plan. Please refer to the Benefit Summaries for additional coverage information.
Employees are encouraged to search for in-network providers by visiting the carrier website listed on the Contacts page of this guide.

	Option 1 HMO	**Option 2** HMO	**Option 3** HMO HSA
Benefits	In-Network	In-Network	In-Network
Annual Deductible (Jan 1– Dec 31)			*Embedded*[1]
Individual	$500	$1,500	$3,200
Family	$1,000	$3,000	$6,400
Coinsurance	90% | 10%	80% | 20%	70% | 30%
Annual Coinsurance Maximum+			
Individual	$1,500	N/A	N/A
Family	$3,000		
Out-of-Pocket Maximum^			
Individual	$6,600	$6,350	$6,900
Family	$13,200	$12,700	$13,800
Hospitalization	90% after deductible	80% after deductible	70% after deductible
Primary Care Office Visits	$25 copay	$20 copay	70% after deductible
Online/Virtual Visits	$0 copay	$0 copay	100% after deductible
Specialist Office Visits	$35 copay	$40 copay	70% after deductible
Urgent Care	$40 copay	$50 copay	70% after deductible
Preventive Care	100%	100%	100%
Emergency Room	$100 copay	$150 copay after deductible	70% after deductible
Ambulance	90% after deductible	80% after deductible	70% after deductible
Digital Imaging (CT, MRI, MRA, PET)	$150 copay	$150 copay after deductible	70% after deductible
In-Network Prescription Drugs **			*All copays after deductible |*
Generic	$20	$10 / $30	$30
Preferred Brand	$60	$60	$60
Non-Preferred Brand	$80	$80	$80
Preferred Specialty	20% ($450 max)	20% ($200 max)	20% ($200 max)
Non-Preferred Specialty	20% ($600 max)	20% ($300 max)	20% ($300 max)

*Most but not all services are covered at 90%|80%|70% after deductible. Certain covered services may have a lesser coinsurance. Please refer to your SBC for additional information.

+The coinsurance maximum limits the total amount of coinsurance you will pay for certain covered services during a coverage period and is included in the out of pocket maximum.

^The out of pocket maximum includes deductible, flat dollar copays and coinsurance amounts for all covered services– including cost sharing amounts for prescription drugs.

**Prescription drug tier copays based on the use of in-network pharmacies. Out of Network not covered.

[1] Embedded deductible means that once a family member meets the individual deductible benefits start paying out for that family member only.

HealthEquity

Health Savings Account (HSA)

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

The HSA plan is a qualified High Deductible Health Plan and requires combination with a Health Savings Account. The HSA is a tax exempt account in which you may set aside money pre-tax and accumulate savings to help pay for eligible medical, dental and vision care expenses.

The Benefits

- It saves you money. HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- It is portable. The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- It is a tax-saver HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- You may use money in your HSA account to pay for expenses for yourself, your spouse and your dependent children. **Even if they are not covered under the HSA medical plan.**

Eligibility

- You must be covered under a high deductible health plan (HDHP) on the first day of the month.
- You have no other health coverage except what is permitted under IRS guidelines
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

Contributions

- You may contribute to your HSA up to the following maximums:

HSA CONTRIBUTION MAXIMUMS	2024
Single Limit	$4,150
Family Limit	$8,300
Catch-up (over age 55) Limit	$1,000

Employees who select the high deductible health plan with the HSAs will receive a $300 per month contribution from Grand Traverse Pavilions in the employee's HSA.

- Limits include any contributions from your employer
- Contribution amounts can be changed at any time throughout the year.
- **Any amount used for purposes other that to pay for 'qualified medical expenses' is taxable as income and subject to a 20% tax penalty.**

If you are enrolling in the HSA for the first time, an HSA account will automatically be set up for your with our HSA partner Health Equity. You will receive information directly from Health Equity about how to access and manage your funds.

Stay in network to access preferred providers. Employee's dental claims are subject to reasonable and customary charges when using out-of-network providers.

Employees are encouraged to search for in-network providers by visiting the carrier website listed on the contacts page of this guide.

	PPO (Point-of-Service) Low Plan	PPO (Point-of-Service) High Plan
Benefits	In-Network	In-Network
Deductible Jan 1- Dec 31)		
Individual	$50	$50
Family	$150	$150
Annual Maximum	$1,000 per person	$3,000 per person
Diagnostic & Preventive	*Deductible Waived*	*Deductible Waived*
Exams		
Cleanings (Two per year)	100%	100%
Fluoride Treatment		
Bitewing X-Rays	100% (Once per year)	100% (Once per year)
Sealants	100%	100%
Basic Services	*After Deductible*	*After Deductible*
Fillings		
Endodontics (Root Canal)	80%	90%
Periodontics (Gum Disease)		
Simple Extractions		
Major Services	*After Deductible*	*After Deductible*
Crowns, Inlays, Onlays	50%	60%
Bridges and Dentures		
Orthodontics	50%	50%
Lifetime Maximum	$1,000 up to age 19	$1,000 up to age 19

- ***Claims paid to out of network providers are subject to balance billing and other out of pocket costs**

COMMON DENTAL TERMS

Annual Maximum: The maximum dollar amount a plan will pay out for care in a 12 month period.

Balance Billing: When a provider bills a person for the difference between the provider's charge and the allowed amount.

Benefit: The amount a plan pays for a dental procedure or service.

Co-Insurance: The percentage of costs of a coverage service a person pays (20% for example) after they've paid their deductible.

Co-Pay: A fixed amount ($20, for example) a person must pay for a covered service after they've paid their deductible.

Deductible: The amount a person pays for covered services before their insurance plan starts to pay.

Exclusions: Services that a person's insurance or plan doesn't pay for or cover.

Maximum Allowable Charge: The maximum dollar amount a dental program will pay toward the cost of a dental service as specified in the program's contract provisions.

Maximum Benefit: The maximum dollar amount a dental plan will pay toward the cost of dental care in a given period.

Pretreatment Estimate: A written estimate of benefits available as of a specific date and time, given to an employee or treating dentist in advance of proposed treatment.

Preventive and Diagnostic Services: Dental procedures concerned with preventing dental diseases through protective and educational measures.(e.g. exams, cleanings, x-rays and fluoride).

Waiting Period: The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage.

The following is a high-level overview of our Vision coverage.

For complete coverage details, please refer to the benefit summary.

Employees are encouraged to search for in-network providers by visiting the carrier website listed on the contacts page of this guide.

	EyeMed Insight Network Plan	
Benefits	In-Network	Out-of-Network
Eye Exam	$10 copay	Reimbursement up to $40
Frequency	Once every 12 consecutive months	
Lenses	$20 copay	Reimbursement predetermined
Frequency	One pair every 12 consecutive months	
Frames	$130 allowance	Reimbursement up to $91
Frequency	One frame every 12 consecutive months	
Contact Lenses Allowance	$130 allowance	Reimbursement up to $130
Exam Fit and Follow-Up Copay	Up to $40 copay	Not covered
Frequency	Once every 12 consecutive months	

- Claims paid to out of network providers are subject to balance billing and other out of pocket costs.
- Benefit eligibility is based on last date of service. For example, if you get an eye exam on 06/25/2024 you won't be eligible for another one until 06/25/2025.

Life AD&D

To help employees maintain better financial security we provide a group life and accidental death and dismemberment benefit. Below is an overview of our Life AD&D coverage.

For complete coverage details, please refer to the benefit summary, available upon request.

	LIFE AD&D
Employer Paid Benefits	
Life AD&D Amount	$5,000
Reduction Schedule	65% at age 70, 50% at age 75

Don’t make these benefits difficult for your family to claim. Please review your beneficiary information and update if necessary.

Supplemental Life AD&D

Should you decide that you need Life AD&D coverage, above and beyond what is provided to you, you may purchase additional coverage for yourself and any eligible family members. The following is a high-level overview of the optional coverage.

For complete coverage details, please refer to the benefit summary, available upon request.

	Supplemental Life AD&D
Supplemental *(Payroll Deducted) Benefits*	
Employee	$10,000 increments
Benefit Maximum	5x annual earnings or $500,000
Guarantee Issue	$150,000
Spouse	$5,000 increments
Benefit Maximum	100% employee benefits or $500,000
Guarantee Issue	$25,000
Child	Birth-6 months $1,000, 6 months+ $2,000 increments
Benefit Maximum	100% employee benefits or $10,000
Guarantee Issue	$10,000
Reduction Schedule	65% at age 70, 50% at age 75

To help you round out coverage that is right for you and your family we offer a variety of supplemental worksite plans that you can enroll in. These plans are optional and 100% paid for by you through payroll deduction. Below is a high level overview of some of the worksite plans available to you. For complete information including pricing please see the benefit summaries available on the SmartLinx.

Benefits	Short Term Disability
If you have an accident benefits begin	8th day
If you have an illness benefits begin	8th day
Benefit Duration	25 weeks
Weekly Benefit Maximum	60% - $100 to $700 in $50 increments
Pre-Existing Limitation	3/12

Benefits	Long Term Disability
Benefit Percentage	60% - in $100 increments
Monthly Benefit Maximum	$200 to $5,000
Elimination Period	180 days
Benefit Duration	To age 65
Own Occupation	2 years
Pre-Existing Limitation	3/12

Elimination Period– The amount of time that must pass before you receive benefits.

Pre-existing Condition– A 3/12 notation means that the policy will not cover any disabilities during the first 3 months after your effective date of insurance that is caused or contributed to by any sickness or injury for which the covered person sought treatment during the 12 months prior to the effective date of coverage.

Own Occupation– You are consider disabled if you are limited from performing the material and substantial duties of your regular occupation due to sickness or injury.

Benefits	Critical Illness
Coverage Amount (Employee)	Options $10,000 | $20,000
Coverage Amount (Spouse)	$10,000
Coverage Amount (Child)	50% of employee coverage
Age Reduction	50% at age 70
Guarantee Issue	Employee $20,000 | Spouse $10,000
Pre-Existing Limitation	12/12

Benefits	Accident
Type of Plan	On/off job
Emergency Room	$150
Hospital Admission	$1,000
Accidental death	Employee $50,000 Spouse $20,000 Child $10,000
Wellness Benefit	$50 per insured per calendar year

Pre-existing Condition– A 12/12 notation means that the policy will not cover any illness during the first 12 months after your effective date of insurance that is caused or contributed to by any sickness or injury for which the covered person sought treatment during the 12 months prior to the effective date of coverage.

Scan the QR Code below to see the Aflac products offered

Aflac helps with expenses health insurance doesn't cover, so you can care about everything else.*

Or, visit your benefits page at:
aflacenrollment.com/GrandTraverse Pavilions/469631732526

*Benefits are paid directly to you, unless assigned otherwise. Network Dental and Vision products may be paid directly to the provider.

Worldwide Headquarters | 1932 Wynnton Road | Columbus, GA 31999

Z2100860

Exp 8/22

Pet insurance from Nationwide®

With two budget-friendly options, there's never been a better time to protect your pet.

Our popular My Pet Protection® pet insurance plans now feature more choices and more flexibility

- **Get cash back on eligible vet bills:** Choose your reimbursement level of 50% or 70%[1]
- **Available exclusively for employees:** Plans with preferred pricing only offered through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Choose your level of coverage with My Pet Protection®

50% reimbursement

$20-$35/month[2]

70% reimbursement

$27-$47/month[2]

How to use your pet insurance plan

1. Visit any vet, anywhere.
2. Submit claim.
3. Get reimbursed for eligible expenses.

http://www.petinsurance.com/gtpavilions • 877-738-7874

[1]Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

[2]Starting prices indicated. Final cost varies according to plan, species and ZIP code.

Nationwide®

Nationwide® pet insurance

My Pet Protection® plan summary

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible **without worrying about the cost**.

My Pet Protection coverage highlights

We offer a choice of reimbursement options so you can find coverage that fits your budget. All plans have a $250 annual deductible and $7,500 maximum annual benefit. Coverage includes*:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets and supplements
- And more

Plus, every My Pet Protection policy includes these additional benefits to maximize your value:

- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit

Included with every policy

vethelpline®

- 24/7 access to veterinary experts ($110 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

PetRxExpress℠

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations

Additional highlights

- Exclusive product for employer groups only
- Preferred pricing for employees
- Multiple-pet discounts
- Guaranteed issuance

Get a fast, no-obligation quote today.

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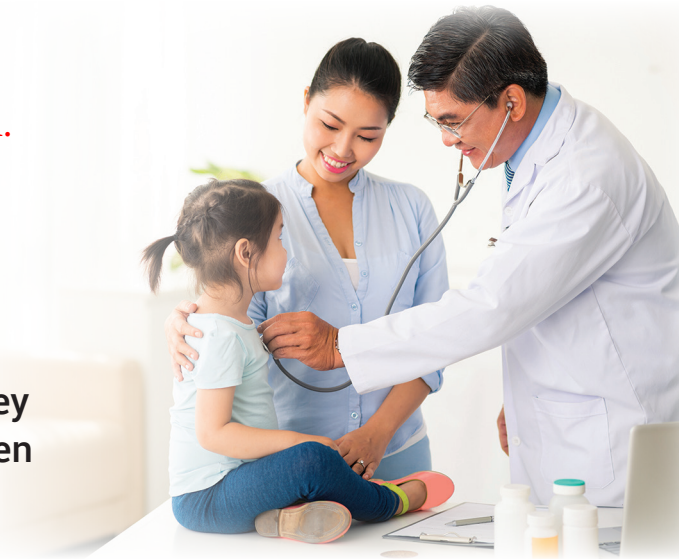
*Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions.

Nationwide®

TASC

If you elect the HDHP with the HSA you are INELIGIBLE to participate in the health care FSA.



Save money with FSA pretax benefit accounts.

A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions and vaccinations
- Eye exams; prescription glasses/lenses

DEPENDENT CARE

- Daycare expenses
- Before & after school care
- Nanny/nursery school
- Elder care

TIPS

- You can choose to enroll in a Healthcare FSA, Dependent Care FSA, and more
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

Increase your take-home pay by reducing your taxable income.

Minimum Contribution $500
Maximum Healthcare Contribution $3,200
Maximum Dependent Care Contribution $5,000
Roll Over Max $640

Each $1 you contribute to your FSA reduces your taxable income by $1.
With less tax taken, your take-home pay increases!

Consider this example:
(For illustration only)

Richard has:

- Gross monthly pay of $3,500
- $600 per month in eligible expenses

Here is his net monthly take-home pay:

Without FSA	With FSA
($600 spent using post-tax dollars)	($600 spent using pretax dollars)
$1,932	$2,098

That's a net increase in take-home pay of $166 every month!

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at www.tasconline.com/tasc-calculators/tasc-flexsystem-calculator/

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

ENROLL TODAY

MERS 457 Supplemental Savings Program

MERS® Municipal Employees' Retirement System

About the Program

The MERS 457 Supplemental Retirement Program offers you a flexible retirement account you manage. You decide how much to contribute, how to invest the assets, and how to plan for the future. One of the benefits of the program is that you have access to your account when you leave employment, even if that's before age 60.

Contributions

The MERS 457 Program is flexible because you determine how much you want to contribute, either a flat dollar amount or a percentage of pay, and you can start, stop, increase or decrease your contributions, without fees or penalties. Your contributions can be made pre-tax or Roth (if your employer has adopted this option). *So how do you decide? Let's start with the basics.*

With a **pre-tax** election you make contributions with pre-tax dollars, so you get a tax break up front, helping to lower your current income tax bill. Your money—both contributions and earnings—grow tax-deferred until you withdraw them. At that time, withdrawals are considered to be ordinary income and taxed at your current tax rate.

With a **Roth** contribution, it's basically the reverse. You make your contributions with after-tax dollars, meaning there's no upfront tax deduction. However, withdrawals of both contributions and earnings are tax-free at age 59½, as long as you've held the account for five years.

So it all comes down to deciding when it's better for you to pay the taxes—now or later. You can access online calculators on the MERS website to help you determine the best option for your goals.

Why Should You Enroll?

Help meet your retirement goals
Experts suggest that you should plan on needing at least 80% of your current income in retirement, so chances are you're going to need to rely on personal savings, over and above your Social Security and other retirement benefits.

Low cost
As a nonprofit organization, the MERS program is the most cost-effective way of saving – putting more of your money to work for you.

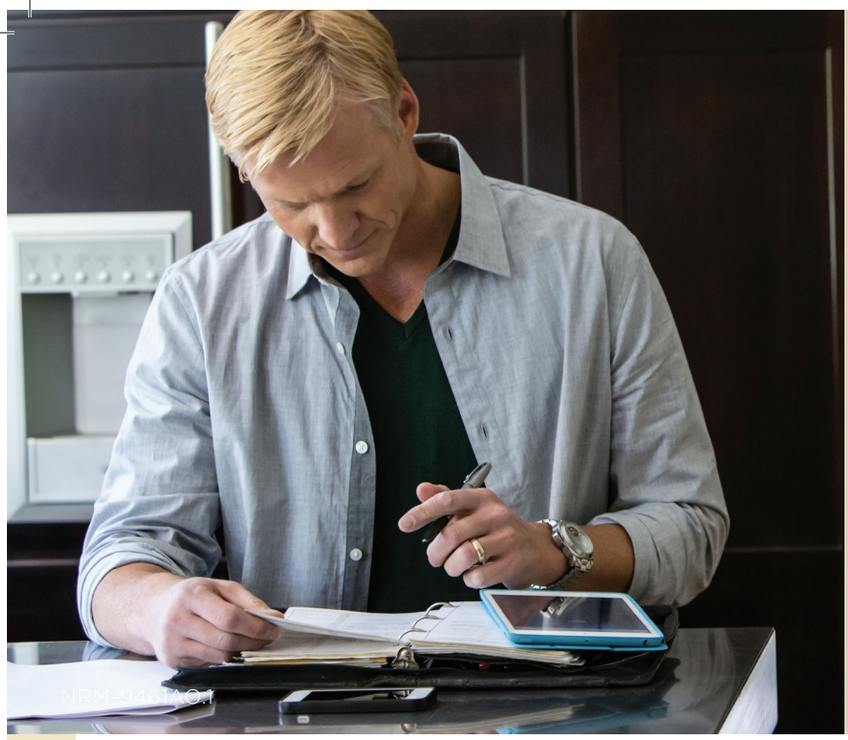
It's easy!
You contribute through the convenience of automatic payroll deduction.

One-stop planning
Experienced retirement educators are available to help with any questions you may have.

Our convenient online calculators enable you to estimate what your financial future may look like and help you decide what makes the most sense to reach your goals. Find the *457 Savings Calculator* under Resources at *www.mersofmich.com*.

Who is MERS?

MERS is an independent, professional retirement services company that serves local units of government across the state of Michigan. MERS listens and works in partnership with our members to deliver a superior value that meets our members' needs.



457 can supplement your pension and help you have a more comfortable retirement.

What is 457?

A 457 deferred compensation plan is a supplemental retirement-savings program that offers a tax-advantaged way to invest for potentially more retirement income. Pre-tax contributions and any earnings are taxed as ordinary income when withdrawn.*

Why join a 457 plan?

By investing through your employer's 457 deferred comp plan, you may be able to fill a potential gap between what your pension provides and income you may need. Consider this: a 65-year-old couple retiring this year may need $220,000 (in today's dollars) to cover medical expenses throughout retirement.[1]

How do you put money in your account?

That's the easiest part! Your contributions are automatically deducted before taxes from your pay, contributed to your 457 plan account, and then invested as you direct.*

Deferred comp is designed for long-term investing. However, if you leave employment with your 457 plan sponsor, you can withdraw money without paying a 10% penalty. Consider that, if you're thinking about early retirement.

What about the risks of investing?

Investing involves market risk, including possible loss of principal. But you also face several other risks. While your Nationwide Retirement Specialist cannot offer investment, tax or legal advice, we'll help you put the various risks into perspective and explain strategies that may help you deal with them.

How do I get started in a 457 plan?

Contact your Nationwide Retirement Specialist:

Chris Minkin JD, CRC
(989) 714-1661
chris.minkin@nationwide.com

Retirement Specialists are registered representatives of Nationwide Investment Services Corporation, member FINRA.

**Note: If your employer's 457 plan offers and you take advantage of a Roth option, your contributions are taken after taxes are applied, but withdrawals of contributions and their potential earnings would be tax-free (subject to certain conditions).*

Sources: [1]Source: Fidelity Benefits Consulting, 2014.

Nationwide®

The Women's Health and Cancer Rights Act
The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:
- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and copays consistent with other coverage provided by the Plan.

Newborns' and Mothers' Health Protection Act
Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting the mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

Mental Health Parity Act
According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental health benefits under the Grand Traverse Pavilions' Medical Plans are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

Health Insurance Portability and Accountability Act
We, in accordance with HIPAA, protect your Protected Health Information (PHI). We will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides your medical and dental benefits or as mandated by law.

Continuation Required By Federal Law for You and Your Dependents
Federal law enables your or your dependents to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependent(s) to continue health insurance if their coverage ceases due to your death, divorce, legal separation, or with respect to dependent children, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your employer's group health plan(s) and is subject to federal law, regulations and interpretations. For additional information, contact Human Resources.

HIPAA Special Enrollment Rights - Loss of Other Coverage – If you are declining enrollment for yourself and/or dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents other coverage. To be eligible for this special enrollment opportunity, you must request enrollment within **30 days** after your other coverage ends or after the employer stops contributing toward the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption – If you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself and/or your dependents. To be eligible for this special enrollment opportunity, you must request enrollment within **30 days** after the marriage, birth, adoption or placement for adoption. Contact Human Resources to request a special enrollment.

Medicaid or CHIP
If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

For More Information or Assistance To request special enrollment or obtain more information, please contact Human Resources.

REMEMBER: The Affordable Care Act requires most individuals to obtain health coverage or pay a penalty. Due to the passage of the Tax Cuts and Jobs Act in 2017 the penalty starting in 2019 going forward will be $0.

Notice of Patient Protections
Blue Care Network generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Care Network at (800) 662-6667.

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

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Care Network at (800) 662-6667.

New Health Insurance Marketplace Coverage
Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.
Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.
If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact *HR at (231) 932-3090.* The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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 July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
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
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
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

FLORIDA – Medicaid Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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/agencies/dms

LOUISIANA – Medicaid
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
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

MASSACHUSETTS – Medicaid and CHIP
Website:
https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
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

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
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
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

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
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
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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 July 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

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)

Important Notice from Grand Traverse Pavilions 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 Grand Traverse Pavilions, 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:

- 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.
- Grand Traverse Pavilions has determined that the prescription drug coverage offered by Grand Traverse Pavilions Medical Plans 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 through 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 Grand Traverse Pavilions medical plan coverage will be affected.

You cannot be enrolled in a Medicare Part D drug plan and an employer sponsored group plan at the same time. If you enroll in a Medicare Part D drug plan your medical coverage under Grand Traverse Pavilions group health plan will be terminated for you and all of your enrolled dependents.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the Grand Traverse Pavilions medical plan during the open enrollment period under the Medical Plan after you drop your Medicare Part D drug plan.

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 Grand Traverse Pavilions, and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Grand Traverse Pavilions 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: 01/01/2024
Name of Entity: Grand Traverse Pavilions

Contact: Kathryn Holibaugh
Phone: (231) 932-3090

Office Address: 1000 Pavilions Circle, Traverse City, MI 49684

Model General Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: Kathryn Holibaugh

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Grand Traverse Pavilions 1000 Pavilions Circle, Traverse City, MI 49684 Kathryn Holibaugh 231-932-3090

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Your Information. Your Rights. Our Responsibilities

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

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 using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **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.

Run our organization -We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services -We can use and share your health information to bill and get payment from health plans or other entities.

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/index.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**.**

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.

HIGHSTREET

Peterson McGregor Insurance