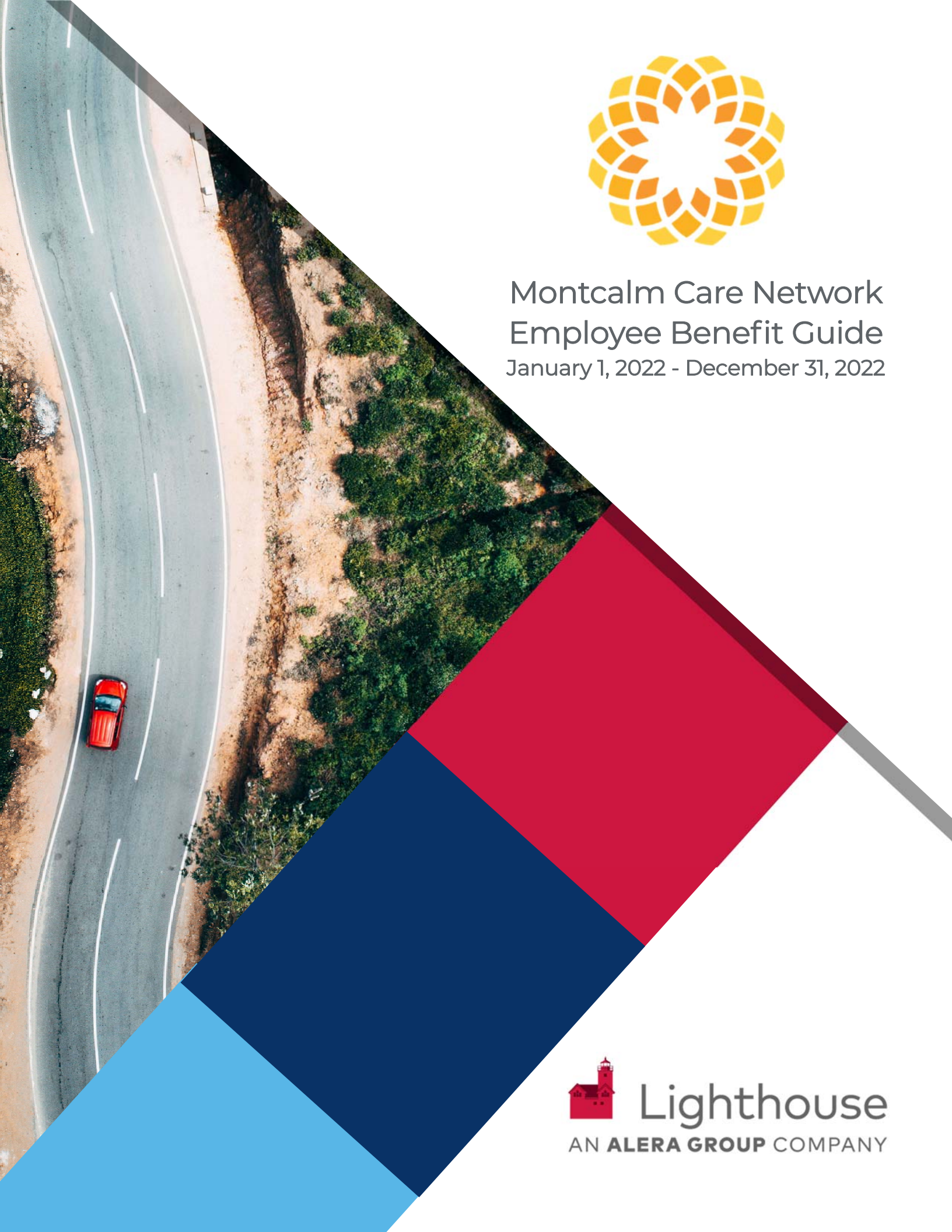


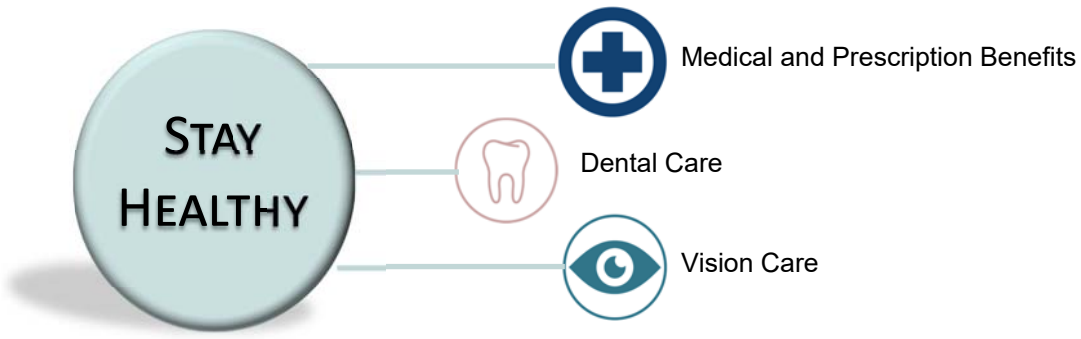
Montcalm Care Network Employee Benefit Guide

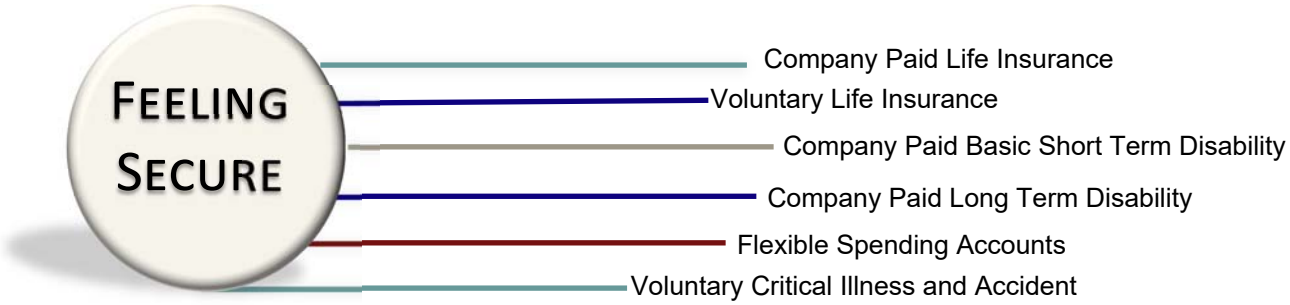
January 1, 2022 - December 31, 2022

Lighthouse
AN ALERA GROUP COMPANY

Our employees are our most valuable asset.

At Montcalm Care Network we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure and maintain a work/life balance.





ELIGIBILITY

Medical Plan Eligibility:
Full-time employees working 30+ hours per week
- ◊ Your spouse
- ◊ Your dependent children to the end of the year in which they turn Age 26

Eligibility begins the first of the month following date of hire

Dental Plan Eligibility:
Full-time employees working 30+ hours per week
- ◊ Your spouse
- ◊ Your dependent children up to the end of the year in which they turn Age 26

Eligibility begins the first of the month following date of hire

Vision Plan Eligibility:
Full-time employees working 30+ hours per week
- ◊ Your spouse
- ◊ Your dependent children to the end of the year in which they turn Age 26

Eligibility begins the first of the month following date of hire

Opt Out Credit:
Montcalm Care Network is offering an opt-out payment for employees who opt-out of coverage under Montcalm's Medical, Dental, and Vision plan. You must still complete enrollment in the Employee Navigator system.
- ◊ $100.00 a month for singles
- ◊ $200.00 a month for double/family coverage opt-out

Employees must have other medical coverage to be eligible for opt-out payment.
Opt-out payment is taxable income

Employer Paid Basic Life/AD&D and
Full-time employees working 40 hours per week
Eligibility begins the first of the month following date of hire

Voluntary Life/AD&D Eligibility:
Full-time employees working 30+ hours per week
- ◊ Your spouse
- ◊ Your dependent children up to the end of the month in which they turn Age 26

Eligibility begins the first of the month following date of hire

Employer Paid Short-Term Disability Eligibility:
Full-time employees working 40 hours per week Eligibility begins the first of the month following date of hire

Employer Paid Long-Term Disability Eligibility:
Full-time employees working 40 hours per week Eligibility begins the first of the month following date of hire

Critical Illness, Accident and Hospital Indemnity: Full-time employees working 30+ hours per week Eligibility begins the first of the month following date of hire

Flexible Spending Plan Eligibility:
Full-time employees working 30+ hours per week Eligibility begins the first of the month following date of hire

Annual Open Enrollment
Our plan year takes effect January 1. Open enrollment is held annually in the Fall for you to make changes to your benefit selections.

Open enrollment for 2022 will be **held from November 16, 2021 through November 30, 2021**. All enrollments will be done through Employee Navigator. If you do not enroll within this time frame, you must wait until the annual open enrollment period next year to make changes unless you have a qualifying event.

New Hire Enrollment
As a new employee, it is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event.

Qualifying Events
Outside the normal open enrollment period, you must notify HR within 30 days of the qualifying event to change your benefits. If you do not enroll within this time frame, you must wait until the subsequent annual open enrollment period next year.

- **Special Enrollment:** If you acquire a new dependent or if your spouse involuntarily loses eligibility under his/her employer sponsored plan, you may add them during the plan year within 30 days of this event.
- **Loss of Coverage:** If you are covered under another plan and lose coverage during the plan year, you have 30 days to enroll in the plan.
- **Family Status Change:** If you have a change in family status during the plan year, you are also allowed to make a change to your plan at that time within 30 days of the event.
    - **What is a family status change?** Marriage, death, adoption/birth of a child, or Legal Separation. This is not a complete list of the legal regulations. If you have questions, please contact Human Resources.
- **Dependent children up to age 26 can be covered:** You may enroll your dependent child (ren), during new hire or open enrollment. Children covered by the plan will remain covered until the end of the year they reach age 26 (unless otherwise noted) or if you drop them from your plan.

EMPLOYEE NAVIGATOR

Once again, you will complete your enrollment online via Employee Navigator. Everyone must log in to the system and enroll even if you are declining coverage. There will be an option under each benefit for you to decline coverage and for you to give the reason why you are declining.

Register for an Online Account:

Go to www.employeenavigator.com

Click on "Register as a new user"

1. Complete your personal information, first and last name as they appear on your registration email, the last 4 digits of your SSN, your birth date, as well as the company identifier - **NMCN**
2. Your username will default to your email address. You can change this once registered.
3. Enter your desired password (6 characters containing at least a number and symbol (upper & lower-case letter strongly recommended)
4. Once you complete your registration, a confirmation email will be sent. Click on the **Login** link in your email to complete your enrollment.
5. The link brings you to the landing page. Enter your username and password to enter.

Returning Users: Log In To Your Online Account

Go to www.employeenavigator.com

- Click Login on in the upper right corner
- Enter your Username that you setup in the past. Your username defaults to your email address, but it is possible to change this once registered.
- Enter your password – 6 characters containing at least a number and symbol
- If you forgot your password click on the "Reset a forgotten password" and follow the instructions for an employee.

Complete Your Enrollment

Once logged in, click on Start Enrollment to get started. Walk through your enrollment step by step:

1. **Employee Information:** enter any missing information or edit any incorrect information, then click, Save & Continue
2. **Dependent Information**: dependents that you currently cover under medical, dental or vision should be listed. Due to IRS reporting requirements, we are asking you to provide information for all of your dependents, not just ones you cover. Click add dependent + in order to add; Edit to update, correct or add any information for currently listed dependents. Your eligible dependents are your spouse and natural, adopted or step children that are under age 26.
3. **Benefits:** for some benefits you must first select who will be covered before you make your plan selection.
   - If you wish to decline a benefit, click Don't want this benefit? and indicate your reason for declining.
   - When you're done making your plan selections, click Save & Continue to move to the next benefit selection.

Montcalm Care Network maintains its commitment to provide you and your dependents with a quality health care plan at an affordable cost. We will continue to offer three great plan options for 2022!

1. **Blue Cross Blue Shield PPO $500**
2. **Blue Cross Blue Shield PPO $2,000**
3. **Blue Cross Blue Shield PPO HDHP HSA $3,000**

Things to remember about Blue Cross Blue Shield (BCBS) PPO Plans:

- You do not need to designate a Primary Care Physician (PCP) and you may self-refer within the BCBS network with no referrals required from a PCP.
- A PPO plan allows you to seek care from any provider of your choosing. By using in-network facilities and providers you will significantly reduce your out of pocket cost.
- The BCBS medical plans have one of the largest PPO networks of participating physicians and medical facilities across the country. There are several ways you can find out if your doctor participates in the Blue Cross and Blue Shield network:
- Call your physician's office
- Log on to www.bcbsm.com and select the Find a Doctor link and choose the PPO plan option
- Call BCBS Customer Service at 1-877-671-2583
- Your coverage travels with you and your dependent(s) who may live away from home. You are always covered for emergency care no matter where you are. Just call the BlueCard number: 1-800-810-BLUE (2583) or the number on the back of your ID card. Summary of Benefits Coverage's (SBC) are available online in Employee Navigator.

BLUE CROSS BLUE SHIELD MEMBER ADDED SERVICES:

- BCBS Online Visits app - Track spending balances, search your claims and see a detailed break down of care and prescription costs, compare costs of medical procedures and prescriptions, find in-network doctors, specialists and labs
- Blue Cross Online Visits - It's as simple as using your smartphone, tablet of computer to meet with:
  - A doctor for minor illnesses such as cold, flu or sore throat when their primary care doctor isn't available.
  - A behavioral health professional or psychiatrist to help work through different challenges such as anxiety or grief.
  - Family members on your plan can also use online visits!

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary of Benefits & Coverage (SBC).

Blue Cross Blue Shield of Michigan			
	Plan #1 – BCBS PPO $500	**Plan #2 –** BCBS PPO $2,000	**Plan #3 –** BCBS PPO HSA $3,000
Deductible	$500 / $1,000	$2,000 / $4,000	$3,000 / $6,000 (Embedded)
Coinsurance Level	Plan pays 80% Employee pays 20%	Plan pays 80% Employee pays 20%	Plan pays 80% Employee pays 20%
Coinsurance Max	$2,500 / $5,000	$2,500 / $5,000	N/A
True Out-of-Pocket Max	$8,150 / $16,300	$8,150 / $16,300	$6,900 / $13,800
Preventative Care	100% covered	100% covered	100% covered
Office Visit	$20 Copay	$30 Copay	80% after deductible
Specialist Visit	$20 Copay	$30 Copay	80% after deductible
Urgent Care	$20 Copay	$30 Copay	80% after deductible
Imaging	80% after deductible	80% after deductible	80% after deductible
Inpatient & Outpatient Hospital	80% after deductible	80% after deductible	80% after deductible
Emergency Room	$150 Copay	$150 Copay	80% after deductible
Ambulance	80% after deductible	80% after deductible	80% after deductible
Prescription			
Generic (Tier 1)	$10 copay	$10 copay	$10 copay, after deductible
Preferred Brand Name (Tier 2)	$40 copay	$40 copay	$40 copay, after deductible
Non-Preferred Brand Name (Tier 3)	$80 copay	$80 copay	$80 copay, after deductible

MEDICAL CONTRIBUTIONS

2022 Medical Employee Per Pay Rates (24 Pays) (Section 125 Cafeteria Plan)			
	Plan #1 – BCBS PPO $500	Plan #2 – BCBS PPO $2,000	Plan #3 – BCBS PPO HSA $3,000
Single	**$43.15**	**$21.62**	**$16.36**
Double	**$103.55**	**$51.90**	**$39.26**
Family	**$129.44**	**$64.87**	**$49.08**

Plan Cost Comparisons

Plan #1 Vs. Plan #2			
Annual Employee Cost	Single	Double	Family
Plan #1 Straight PPO $500	$1,035.60	$2,485.20	$3,106.56
Plan #2 Straight PPO $2,000	$518.88	$1,245.60	$1,556.88
Difference in Payroll Contributions **(Annual Savings to Employees)**	**$516.72**	**$1,239.60**	**$1,549.68**
Plan #1 Vs. Plan #3			
Annual Employee Cost	Single	Double	Family
Plan #1 Straight PPO $500	$ 1,035.60	$2,485.20	$3,106.56
Plan #3 PPO HDHP HSA $3,000	$392.64	$942.24	$1,177.92
Difference in Payroll Contributions **(Annual Savings to Employees)**	**$642.96**	**$1,542.96**	**$1,928.64**
Plan #2 Vs. Plan #3			
Annual Employee Cost	Single	Double	Family
Plan #2 Straight PPO $2,000	$518.88	$1,245.60	$1,556.88
Plan #3 PPO HDHP HSA $3,000	$392.64	$942.24	$1,177.92
Difference in Payroll Contributions **(Annual Savings to Employees)**	**$126.24**	**$303.36**	**$378.96**

Tip! Deposit the savings into your HSA to use for out-of-pocket medical, dental, and vision expenses!

USING YOUR HSA

WHAT IS AN HSA BANK ACCOUNT & WHY SHOULD I SAVE?

A HSA is a tax-exempt savings account established for the purpose of paying for qualified medical expenses of an individual and/or his or her spouse and tax dependents.

SETTING UP YOUR HSA

Once you are covered by a qualified health plan you may set up your HSA.
Once you set up your HSA, any payroll deductions you have elected may begin. It is important to get your HSA set up as quickly as possible because you cannot turn in expenses incurred before the account was set up.

ADDING MONEY

The government sets the annual dollar maximum that can be contributed to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage.

WHAT HAPPENS TO MY ACCOUNT OR DOLLARS I SAVED IF I SEPARATE EMPLOYMENT FROM MONTCALM CARE NETWORK OR RETIRE?

HSAs are controlled and owned by the employee, meaning individuals keep their HSA's even if they change jobs or change medical coverage, including any contributions they have already made to their accounts.

HSA'S ARE A GREAT SAVINGS AVENUE FOR RETIREMENT

Once you attain the age of 65, you can pull from your HSA for any reason other than for qualified medical expenses and pay ordinary income tax.

USING HSA MONEY

You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical expense, you can choose to not reimburse yourself and let the money in your HSA build up or you can reimburse yourself for the expense from your HSA.

If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or non-medical expenses. Visit www.irs.gov/publications and refer to publication 969.

Note: It is your responsibility to familiarize yourself with IRS regulations on HSAs and maintain records of all transactions pertaining to your HSA for audit purposes.

ELIGIBLE EXPENSES

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. In general, eligible health care expenses are those that qualify toward the deductibles, copays, and coinsurance with your health insurance. If you use money for a dental, vision or medical expense that is not covered by the medical plan, it is important you understand your medical plan deductible still needs to be met if an expense is incurred.

2022 (Section 125 Cafeteria Plan)		
Single Coverage Annual Maximum	$3,650 (includes employer funding)	
Double & Family Coverage Annual Maximum	$7,300 (includes employer funding)	
Employer Funding Annual Maximum	Single: $500	Family: $1,000
Catch Up	*An additional $1,000 can be deposited annually if individual is 55-65 years old*	

Triple Tax Advantage!

1. HSA contributions are tax-free
2. Interest and other earnings on HSA contributions accumulate tax-free
3. Amounts distributed from an HSA for qualified medical expenses are tax-free

DENTAL BENEFITS

Montcalm Care Network's dental plan is offered through Delta Dental. The chart below provides a general summary of the plan benefits. Please refer to the Delta Dental benefit summary for more information.

Please Note: Delta Dental does not provide ID cards! To access your coverage, simply tell your dental provider that you have Delta Dental and they can look up your coverage via your social security number.

Benefits	Dental Plan
Deductible Individual Family	None
Benefit Year Maximum Preventative/Basic/Major Services	$1,000
Preventative Services (deductible does not apply) Routine exams, fluoride, space maintainers & X-rays	100%
Basic Restorative Services Fillings, Extractions, Root Canals, Oral Surgery	80%
Major Restorative Services Bridges, Dentures, Bridge Repairs, Crowns	50%
Orthodontia *(only dependent children under age 19 are eligible)*	50%
Orthodontia Lifetime Maximum *(per dependent child)*	$1,000

6 TIPS FOR MAKING THE MOST OF YOUR DENTAL PLAN!

1. **Understand your plan** – you will be far less likely to end up with denials and unexpected dental bills.
2. **Read your EOB** – your explanation of benefits is provided to you every time a claim is paid or denied. Compare it to your itemized receipt to make sure your claim is paid correctly.
1. **Ask for a pre-determination of benefits** – Delta Dental will process the estimate and let you know how much will be covered.
2. **Know your plan's limits** – contact Delta Dental before you have your services to find out how much is still payable BEFORE you have extensive treatment.
3. **Plan multi-stage treatment accordingly** – you can plan the stages of treatment to maximize your insurance benefit. If you have extensive treatment, you may be able to plan so that the annual maximum renews between the stages.
4. **Go to your exams and cleanings regularly** – problems that are detected early require less work and cost less.

2022 Dental Employee Per Pay Cost (Section 125 Cafeteria Plan)	
Single	$5.50
Double	$11.00
Family	$14.00

Vision Benefits

Montcalm Care Network's vision plan is offered through EyeMed. EyeMed's broad network offers access to thousands of independent providers, top optical retailers, and online options. EyeMed members can use Glasses.com and ContactsDirect.com as in-network providers. For a complete list of in-network providers near you, use the Enhanced Provider locator at www.eyemed.com or call 1-866-804-0982.

The chart below provides a general summary of the plan benefits.

Benefits	In-Network Coverage
Exam (every 12 months)	$0 copay
Retinal Imaging	Up to $39
Frame Allowance (every 12 months)	$180 allowance; 80% of charge over $180
Lenses (every 12 months) Standard Plastic Lenses *(single vision, bifocal, trifocal & lenticular)* Progressive Lenses	$0 copay Range from $75 - $120 copay
Contact Lenses (every 12 months)	$0 copay $180 allowance

2022 Vision Employee Per Pay Cost (Section 125 Cafeteria Plan)	
Single	$0.50
Double	$1.00
Family	$1.50

GROUP TERM LIFE / ACCIDENTAL DEATH & DISABILITY (AD&D)

Group Basic Term Life and AD&D Insurance is administered by Mutual of Omaha. Montcalm Care Network provides this benefit, at no cost, to all full-time benefit eligible employees. Life Insurance provides a monetary benefit to your beneficiary in the event of death while employed at Montcalm Care Network AD&D Insurance is equal to your Life Insurance benefit amount and payable to your beneficiary in the event of your death as a result of an accident. It may also pay benefits in certain injury instances.

Plan	Benefit Amount
Employee Basic Life and AD&D	$25,000
Benefit Reduction	Benefits reduce to: 65% at Age 65; 45% at Age 70; 30% at Age 75; 10% at Age 80; coverage terminates upon retirement

SHORT TERM DISABILITY

Short Term Disability (STD) pays a weekly benefit if you miss work, for an extended period of time, due to an accident or illness. Montcalm Care Network offers a Short Term Disability program for all eligible full-time employees at no cost to the employee through Mutual of Omaha.

Benefit Amount	
Monthly Benefit	60% of pre-disability earnings
Elimination Period	0 days – Accident; 7 days – Illness.
Benefit Duration	13 Weeks
Maximum Weekly Benefit	$800

LONG TERM DISABILITY

Long Term Disability (LTD) provides income protection should you be unable to work due to a disability that continues beyond a 90-day period. This coverage will supplement your income for as long as you are disabled up until your Social Security Normal Retirement Age as long as you are employed with Montcalm Care Network. Montcalm Care Network offers a Long Term Disability program for all eligible full-time employees. Starting in 2022, this benefit is provided at no cost to the employee!

Benefit Amount	
Monthly Benefit	60% of pre-disability earnings
Elimination Period	90 Days
Benefit Duration	Social Security Normal Retirement Age
Maximum Benefit	$5,000 Monthly Maximum
Pre-Existing Condition	3 months prior/12 months insured
Definition of Disability	24 Months Own Occupation

In addition to the Group Life benefit, you have the opportunity to enroll in Voluntary Term Life coverage. This benefit allows for additional life insurance coverage for you, as well as coverage for your spouse and children.

Voluntary Life Insurance is offered through Mutual of Omaha. The cost of coverage is 100% employee paid through payroll deductions. Employees must elect coverage for themselves in order to elect dependent coverage. **Rates are based on age and the amount of coverage elected. Your specific rates can be found in Employee Navigator.**

Benefit Amount	
Employee	Increments of $10,000 up to a maximum of $250,000 (limited to 5X annual salary) Guarantee Issue (for newly eligible employees): $50,000 Benefit Reduction: 65% at Age 65; 45% at Age 70; 30% at Age 75; 20% at Age 80; Coverage terminates upon retirement
Spouse	Increments of $5,000 up to a maximum of $50,000 (limited to 100% of employee's benefit) Employee must elect coverage in order to elect coverage for spouse Guarantee Issue: $25,000
Child(ren)	Increments of $2,000 up to $10,000 (limited to 100% of the employee elected benefit) Employee must elect coverage in order to elect coverage for children Guarantee Issue: $10,000

Mutual of Omaha

Montcalm Care Network is continuing to offer additional insurance coverages through UNUM. You will have the opportunity to enroll in Voluntary Hospital Indemnity, Voluntary Critical Illness and Voluntary Accident, coverage. These plans are intended to help you offset financial effects due to illness and injury. Below are brief descriptions of each plan. Individual rates can be found under your profile in Employee Navigator. Full details on covered benefits are provided in your plan summaries.

NEW - Hospital Indemnity

Hospital insurance is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization and in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. Employees can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. Lump sum benefits are paid directly to the employee.

Schedule of Benefits	
Admission and ICU Admission (1 day per year)	$1,000
Daily Stay - Hospital (per day up to 365 days)	$100
Daily Stay - Hospital ICU (per day up to 15 days)	$100
Short Stay (1 day per year)	$259

unum

Critical Illness

Critical Illness Insurance can complement existing medical coverage and help offset the costs of catastrophic illness not covered by your medical plan.

Voluntary Critical Illness	Plan Highlights
Coverage Options:	Employee, Spouse and Children
Pre-Existing Condition:	If treated in the 12 months prior to the plan effective date, you will be excluded for the first 12 months of coverage
Benefit Amounts:	Employee: $10,000, $20,000 or$30,000 Spouse: 50% of the employee coverage amount as long as you have purchased coverage for yourself Child: 50% of the employee election amount (At no cost)
Benefit Waiting Period:	30 days
Covered Conditions Include:	Heart Attack, Stroke, End Stage Renal (Kidney) Failure, Major Organ Failure, Coma because of Severe Traumatic Brain Injury, Benign Brain Tumor, Cerebral Palsy, Cleft Lip or Palate, Cystic Fibrosis. Adding coverage for Cancer is available as an option in the Lighthouse Connect system.

Accident

Accident Insurance is used to help cover out of pocket expenses for injuries due to accidents that happen off the job, whether they be minor or catastrophic.

Voluntary Accident Plan	Plan Highlights
Coverage Options:	Employee Only, Employee + Spouse, Employee + Child and Family
Accidental Death Benefit:	Once per lifetime; if payable: Employee: $50,000; Spouse: $25,000; Child: $12,500
Emergency Care Benefit *Physician's Office/Urgent Care*	$75
Hospital Admission: *Non-ICU and ICU*	Admission/ICU admission is payable once per covered accident $1,000
Emergency Room Treatment:	$150
Medical Testing Benefit: *X-Ray, MRI, Ultrasound, NCV, CT/ CAT, EEG*	$50 - $200
Ambulance Benefit: *Ground/Air Transportation*	$300/$1,000

Flexible Spending Accounts

Your Flexible Spending Account administrator is Varipro.

A flexible spending account is a tax-free account that reimburses employees for medical or dependent care expenses. FSAs are offered through a Section 125 (cafeteria) plan. Since there are various types of FSAs, funds must be kept separate. **Your FSA elections run calendar year and must be elected every year during open enrollment.**

Health FSA

Health FSAs reimburse employees for qualified medical, dental, and vision expenses for yourself, your spouse, and IRS defined dependents. Varipro will provide you with a debit card to allow you to pay for expenses at the time of service. You will want to keep a receipt of any expenses paid in order to prove that FSA dollars were used for qualified expenses in the event of an audit.

Annual FSA Maximum	
Medical FSA	$2,850

**For a full list of eligible expenses, visit www.irs.gov/publications and refer to Publication 969*

Sample Eligible Expenses *for a Medical FSA

- Unreimbursed medical expenses (deductibles, coinsurance, copay etc.)
- Dental Services (excluding cosmetic)
- Orthodontia
- Glasses, contacts and eye exams
- Lasik eye surgery
- Prescriptions
- A list of qualified expenses can be found at www.irs.gov

Dependent Care FSA

Dependent Care FSAs reimburse employees for the care of dependent children under age 13 or the care of a disabled spouse, parent, or child who is residing with the employee by a third party, and care must be needed in order to keep the employee gainfully employed. Also, care must be administered during normal working hours. Disbursements cannot be made until the expense is incurred.

Dependent Care FSA Maximum Contributions	
Single/Head of Household	$5,000
Married filing Separate	$2,500

**For a full list of eligible expenses, visit www.irs.gov/publications and refer to Publication 969*

Sample Eligible Expenses*

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services provided outside your home (ie. Daycare)
- Nanny expenses attributed to dependent care
- Preschool fees
- Summer Day Camp – primary purpose must be custodial care not educational

Contact Information

Medical	Blue Cross Blue Shield (800) 972-9797 www.bcbsm.com
Dental	Delta Dental 800-524-0149 www.deltadentalmi.com
Voluntary Vision	EyeMed 1-866-939-3633 www.eyemedvisioncare.com
Group Life, Short-Term Disability, Long Term Disability and Voluntary Life/AD&D	Mutual of Omaha 1-800-228-7104 www.mutualofomaha.com
Critical Illness, Accident and Hospital Indemnity	UNUM 866-679-3054 www.unum.com
Flexible Spending Account	Varipro 800-732-3412 www.varipro.com
Lighthouse, An Alera Group Company	Jason Nickel, Senior Vice President 616-281-5670 jnickel@lighthousegroup.com Kayley Ripley, Account Manager 616-281-6605 kripley@lighthousegroup.com

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2022 Health Plan Disclosure Notices

Your Rights as a Plan Participant

Introduction:

As your employer, we recognize the importance of providing our employees with an employee benefit program. We are proud to offer our employees the option to enroll into our comprehensive health plan. As a valued participant of our employee benefit program, we appreciate the opportunity to share with you the rights you are guaranteed. These rights are protection with regard to the access to coverage, the level of coverage you have and laws that protect your privacy.

HIPAA Special Enrollment Periods: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Newborns and Mothers Health Protection: 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 issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 – Janet's Law: 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, contact the Human Resources Department.

HIPAA Notice of Privacy Practices: Your employer is committed to safeguarding participants' protected health information and complying with the privacy and security requirements of the federal laws known as HIPAA and HITECH. Your employer maintains a privacy practices which further details our commitment and policy. If you would like a copy of the notice, you can obtain one, without charge, by contacting your Human Resource Department.

Michelle's Law Notice: When a dependent child over the age of 26 loses student status under the eligibility policy of the group health plan coverage, as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for the earlier end date of up to one year, or until coverage would otherwise terminate under the group health plan. To maintain eligibility and continue coverage as a dependent during such leave of absence, the CLIENT HEALTH PLAN NAME must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and the dependent must be established as a disabled dependent as defined by the medical carriers. To obtain additional information, please contact your Human Resources Department

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. 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:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

CALIFORNIA-Medicaid
Website: http://dhcs.ca.gov/hipp
Health Insurance Premium Payment (HIPP) Program
Phone: 916-445-8322
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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
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
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

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

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.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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/oii/hipp.htm
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: http://www.nd.gov/dhs/services/medicalserv/medicaid/
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
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

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: http://gethipptexas.com/
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: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

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

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
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 January 31, 2021, 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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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% 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.[1]

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 _____

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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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] 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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Montcalm Care Network	38-3021401
5. Employer address	**6. Employer phone number**
611 North State Street	989-831-7576

7. City	8. State	9. ZIP code
Stanton	MI	48888

10. Who can we contact about employee health coverage at this job?	
Jan Krings	
11. Phone number (if different from above)	**12. Email address**
989-831-7576	jkrings@montcalmcare.net

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time employees working 30+ hours per week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

* Legal/Spouse Domestic Partner as defined by Federal/State Law
* Dependent Children to which they turn 26 years of age regardless of marital status, financial dependency, residency, student status, or employment status

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

CMS Notice of Creditable Coverage

Important Notice from Montcalm Care Network
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 Montcalm Care Network 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. Montcalm Care Network has determined that the prescription drug coverage 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 Montcalm Care Network coverage will not be affected. Individuals who elect Part D coverage can keep this coverage if they elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Montcalm Care Network coverage, be aware that you and your dependents will be able to get this coverage back, but only if you sustain a qualified family status change mid-year, or if you enroll at the next open enrollment.

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 Montcalm Care Network 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…

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 your coverage through Montcalm Care Network 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:	January 1, 2022
Contact Position/Office:	Jan Krings
Address:	611 North Street, MI 48888
Phone Number:	989-831-7576

Lighthouse

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