my>HR 2020-21

Benefits Plus Enrollment Guide

Benefit Plan Year: July 1, 2020 - June 30, 2021

The Choice is Yours...

- Health Care Coverage
- Dental Care
- Vision Plan
- Optional Employee Life Insurance
- Dependent Life Insurance
- Additional Accidental Death & Dismemberment Insurance
- Health Care and Dependent Care Reimbursement Accounts
- Group Legal Plan

MUNSON HEALTHCARE
Manistee Hospital

Munson Healthcare Manistee Hospital Benefits Plus Enrollment Guide

Index

About This Enrollment Guide

This brochure is a summary of the flexible benefits program offered to eligible employees of Munson Healthcare. Complete details on each benefit are outlined in appropriate legal plan documents and insurance contracts. If there is a difference between the legal plan documents and insurance contracts and this brochure, the legal plan documents, and insurance contracts govern. Copies of these documents and contracts are available on my>HR or by contacting the Benefits Office. Participation in this program or any of the benefit plans is voluntary.

Munson Healthcare reserves the right to change, amend, discontinue or end any of its benefit plans for active employees, beneficiaries and retirees for any reason at any time. We encourage you to contact the Benefits Office if you have any questions.

Benefits Plus:

Munson Healthcare's Flexible Benefits Program

With Benefits Plus, your benefits package is flexible so you can select the benefits that will suit the health, dental, optical, and financial needs for you and your family today and tomorrow.

The choices you make will determine your personalized benefit package from your effective date through June 30 of this benefit year. This Enrollment Guide will help you through the enrollment process. This is only a brief description of each benefit. Plan summaries and certificates are located on the Munson Healthcare intranet under Human Resources, Benefits.

The Before-tax Advantage

With the exception of Dependent Life Insurance, Short and Long-Term Disability Insurance, and the Group Legal Plan, all benefits under Benefits Plus are available to you on a before-tax basis. This means that Federal, State, and Social Security taxes are not applied to your wages until after the premiums for your benefits coverage are deducted; accordingly, your take-home pay is more than if the benefits were taken on an after-tax basis.

Enrolling in Benefits Plus

You'll find all the information you need on the my>HR site of the Munson Healthcare intranet. You can also find it on **munsonhealthcare.org** under "For Employees." You can access this information 24/7 from any internet connected computer. Browse through your benefit plan details from the comfort of your home.

Eligible employees are those in full and part-time benefited positions; budgeted and scheduled a minimum of 20 hours per week.

Eligible dependents include your legal spouse and your children. Children may remain on your benefit plans until the end of the month in which they reach age 26.

Things you may want to have handy, as you complete your enrollment:

- Birth and marriage certificates for family members not previously covered
- Dates of birth and Social Security numbers for the family members you are adding

In addition, **please designate and/or update your Primary and Contingent Beneficiaries** for Employee Life and AD&D Insurance by clicking on the Beneficiary link in my>HR Employee Self-Service. Open enrollment is a good time to review and update your Beneficiaries. You may update them at any time.

Open Enrollment

You have an opportunity each year to make a new benefit election that will be effective for the fiscal year (July 1 - June 30). The window of time for making this election will be announced in April and is generally held in May. Outside of Open Enrollment, a qualifying event is required for changes to benefits. If you miss the open enrollment window, your current election will be defaulted, with the exception of medical coverage on a spouse and participation in Health and Dependent Care Reimbursement Accounts. **Positive elections for spouse and Health and Dependent Care Reimbursement Accounts are required annually**.

Adding Dependent Coverage?

If you are adding dependents you need to complete any required documentation by the last day of the Open Enrollment period or within 30 days of a qualifying event.

See page 23 for Required Documentation for Covering Family Members.

Changes in Employment or Family Status During Plan Year (outside of open enrollment)

You may be allowed to change your Benefits Plus choice during the year if you experience a qualifying event, which includes:

- Change in Employee's Legal Marital Status: Marriage, death of a spouse, divorce, legal separation, and annulment
- Change in Number of Dependents: Birth, adoption, placement for adoption or legal guardianship, and death of a child
- Change in Employment Status: For example, termination or commencement of employment by the employee, spouse, or dependent; commencement of, or return from, an unpaid leave of absence; a strike or lockout; a change in worksite or any other change in status that affects eligibility for benefits
- Change in Residence: Change in residence of employee, spouse, or dependent
- Change in Dependent Status: Dependent starts or stops meeting the requirements to be eligible for any coverage under this Plan
- Change in an Election under another Plan: If your spouse or dependent is covered under another employer's health plan that relates to a period that is different from the Plan Year for this Plan (for example, your spouse's open enrollment period is in December, your open enrollment period is in May, and your spouse desires to drop dependent coverage under his/her plan and enroll eligible dependents in this Plan.) However this does not permit a mid- year change to the Health Care Reimbursement Account or the Dependent Care Reimbursement Account

If you or your spouse experience a qualifying event or family status change and you wish to change your Benefits Plus choices, contact the Benefits Office to determine eligibility and receive the appropriate forms. Any change must be made within 30 days of the qualifying event and will be effective the date of the qualifying event. Without a qualifying event, you cannot change or cancel your choices during the year.

Health Care Coverage

Health Care Benefit Option

Health care coverage is an option under the Benefits Plus program. This section will describe the health care options available to you within Benefits Plus.

It is not surprising that most employees would probably say health care coverage is their most important employee benefit. Without it, many would find it financially difficult to cope with unexpected health care expenses.

Even though health care coverage is important, not everyone has the same coverage needs. You may enjoy excellent health and rarely see a doctor. Or, you may have a condition that requires ongoing medical care. You may have younger children, who make more frequent trips to the doctor. That's where Benefits Plus works to your advantage. Under Benefits Plus, you have a choice of selecting:

- Health Maintenance Organization (HMO)
- Point of Service (POS)
- No health care coverage

Your Health...Your Choice of Options

Both health care options available to you cover similar services, but have differing co-payments and coverage levels. Both options have an emphasis on preventative care, reflecting Munson Healthcare's commitment to helping employees stay healthy.

Priority provides coverage for the following health care services:

- Physician services – including consultations and referrals
- Inpatient and outpatient hospital services – including all services commonly supplied by the hospital (room and board, oxygen, intensive care, special duty nursing when medically necessary, etc.)
- Mental health outpatient care – evaluative and crisis treatment
- Medical treatment for abuse of, or addiction to, drugs and alcohol, including detoxification
- Diagnostic laboratory, x-ray and therapeutic radiology
- Preventative services, including: periodic health examinations, and well-child care from birth

You should review your health care expenses for the last few years, in order to decide the best plan for you. Also consider the other kinds of medical services that you and your family are likely to need.

Family Continuation

Your health care plan provides coverage for children until the end of the month during which they reach age 26.

Health Care Enrollment Guidelines

If you are married, you do not automatically have to choose Employee Plus One or Employee Plus Family health care coverage. If appropriate, you can choose Employee Only or No Health Care Coverage.

Spousal Eligibility

Health care coverage benefits will be available to spouses of Munson Healthcare employees only if they meet certain eligibility criteria. A spouse would be eligible for Munson Healthcare coverage if:

- He/she is not employed, or
- Health care coverage is not available through his/her employer, or
- The cost to purchase single health care coverage is greater than $100 per month, or
- The spouse is employed by Munson, or
- The spouse is enrolled in a plan through his/her employer.

If the coverage is available through the spouse's employer for less than $100 per month, and the spouse chooses not to be covered under his/her plan, the spouse will not be eligible for any health care coverage through the Munson Healthcare plan.

See page 23 for Required Documentation for Covering Family Members.

Covering Your Spouse and/or Adding Dependents

In order for your spouse to be eligible for medical coverage, proof of Spousal Eligibility must be provided, for **each year** that you elect medical coverage for your spouse. Spousal Eligibility is captured by answering a few questions, as part of the online enrollment process using my>HR. **You must enroll via my>HR to complete these questions or your spouse will not be covered until the next enrollment period unless you experience a Qualifying Event** and have completed the proper paperwork.

myWellness

Mission

Our mission is to support employees in their wellness journey, improve the collective health of our workforce, and model to our communities a worksite culture that supports and inspires healthy lifestyle choices.

Feel better. Live better.

myWellness is an employee and family-focused benefit with programs designed to help you focus on being healthier. You will find resources, links, and new content to help you eat right, find fun ways to exercise, and take a little time for yourself. Munson Healthcare wants to make sure employees and their families have the tools and resources to achieve or maintain optimal health. Whether you are looking to achieve a healthy weight, prevent chronic disease like diabetes, be more active, improve your diet, or simply have fun with your co-workers, **myWellness** has something for you.

Below are some of the wellness benefits offered at Munson Healthcare, depending on your location:

- Community Supported Agriculture (CSAs)
- Core4
- Diabetes Prevention Program
- Employee Assistance Program
- Health coaching
- Massage therapy
- Onsite gyms and gym discounts
- myClubs
- Tobacco Cessation
- Traffic Light Program
- Weight Watchers at Work
- Yoga, Zumba and other fitness classes

The **myWellness** guidelines and resources will help you make informed choices. Being healthy is good for you, for everyone who loves you, and for all the people who count on you. It is up to all of us to lead the way by being great examples of good health.

Visit the **myWellness** website at **munsonhealthcare.org/mywellness** to access your wellness benefits that go beyond health insurance.

Additional Resources

Being healthy goes beyond doctor visits and includes both mind and body. In addition to the **myWellness** offerings you can find helpful resources on the Priority Health Wellbeing Hub at **Priorityhealth.com** and visit **munsonhealthcare.org/mywellness/eap** for resources on how to stay healthy and happy.

Priority Health HealthbyChoice Incentives℠ Plan

If you select Priority Health medical coverage during open enrollment, you will be enrolled in the HealthbyChoice Incentives℠ Plan. **Your coverage may change if you choose not to participate in the wellness features built into this plan. Please read this section very carefully**.

HealthbyChoice Incentives℠ is a simple, wellness-based health plan that rewards employees who take steps to understand their health risks and pledge to make lifestyle improvements.

What is it?

It's a wellness plan linked to your medical coverage. The design encourages you to make healthier lifestyle choices in exchange for lower costs. We often hear that 70% of all chronic health conditions are preventable. But you need to know what to do to manage your health properly. The key to this equation is forming a relationship with your primary care physician and having your health risks measured on a regular basis. The journey to optimum health begins with measurement.

How does it work?

There are 2 benefit levels (see detailed description in the pages to follow):

- **Choice – pay less for copayments/out-of-pocket, coinsurance and deductibles**
- **Standard – pay more for copayments/out-of-pocket, coinsurance and deductibles**

What is required to be at the Choice level?

- **No need to complete online health assessment***
- **If new to the plan, you start at the Choice level benefit**
- **You AND your covered spouse must meet *the physician* requirement within the first 4 months: (122 days from the start of medical coverage)**

**(New for Benefit Year 2020-21)*

Have your health care provider submit a qualification form indicating:

a. Tobacco non-user
b. Blood pressure under 140/90 (150/90 for those 60+ years old)
c. BMI (body mass index) under 30; or waist circumference: <41" (male), <35" (female)

If you and/or your covered spouse don't meet the 3 health indicator above, you can still maintain Choice level benefits if you do the following additional items within the 122 days:

- **Complete fasting cholesterol test and fasting blood sugar test**
- **Agree to provider treatment program**

The Qualification form only requires additional labs when 1 (or more) of the first 3 criteria are NOT met.

Everyone has the opportunity to remain at the Choice level if they participate in the requirement. Only those who choose not to participate, or miss the deadline, will move to the Standard level. If the employee participates, but the spouse does not, everyone covered on the employee's plan will move to the Standard level of benefits.

In Summary:

- **Meet the requirement – keep Choice level of benefits through this benefit year, ending June 30, 2021, and for the 4-month qualifying period of the following benefit year through October 31, 2021**
- **Don't meet the requirement – you and everyone covered under your policy will have the Standard level of coverage November 1, 2020 through October 31, 2021**

You and your covered spouse must qualify within 122 days of the start of your medical coverage.

If you are new to the Priority Health plan and have an effective date of coverage that falls between February 1, 2020 and June 30, 2020, you will have until October 31, 2020 to complete the HBCI requirement.

Health Care Comparison

Option 1:

Priority Health Benefits: HMO Choice Benefit Level

Both Employee and Spouse must satisfy Choice Level requirement to remain at Choice Level. **The HMO Plan requires use of Priority Health participating providers**. There is no coverage for providers who do not belong to the Priority Health network (see dependent rider in certificate of coverage for exceptions).

Benefit	HMO Choice Level **TIER 1**	HMO Choice Level **TIER 2**
Deductible	$400 per person/$800 family	$750 per person/$1,500 family
Coinsurance	85% *(see coinsurance out of pocket maximum)*	70% *(see coinsurance out of pocket maximum)*
Coinsurance Out of Pocket Maximum	$1,400 per person/$2,800 per family	$1,750 per person/$3,500 per family
Reasonable and customary	Not applicable	Not applicable
Annual Maximum Benefit	Not applicable	Not applicable
Ambulance Service (Air and Ground)	$150 co-pay	$150 co-pay
Durable Medical Equipment *	70% co-pay	50% co-pay
Emergency Room Visit	$150 co-pay; waived if admitted	$150 co-pay; waived if admitted
High-Tech Imaging (capped at 10 copays)	$150 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies	$200 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies
Home Health Care*	100% coverage	85% coverage
Inpatient Hospital Services*	85% coverage	70% coverage
Maternity Care (Routine) – Pre- and Post-Natal	100% coverage	100% coverage
Maternity Care – Inpatient*	85% coverage	70% coverage
Mental Health – Inpatient*	85% coverage	85% coverage
Mental Health – Outpatient	$20 co-pay per visit	$20 co-pay per visit
Preventive Care	100% coverage	100% coverage
Primary Care Provider Office Visits	$20 co-pay	$20 co-pay
Specialist Office Visits	$35 co-pay	$35 co-pay
Outpatient Services*	85% coverage	70% coverage
Physical and Occupational Therapy	$20 co-pay	$30 co-pay
Chiropractic Care *(including maintenance) 30 visits max. per contract year*	$20 co-pay	$20 co-pay
Speech Therapy (30 visits max. per contract year)	$20 co-pay	$30 co-pay
Cardiac and Pulmonary Rehabilitation *(30 visits max. per contract year)*	$20 co-pay	$30 co-pay
Prescription Drugs Pharmacy *(including oral contraceptives) 90 day supply for 2x co-pay at Munson Healthcarepharmacies Mail order through Munson Pharmacy only*	$10 co-pay Tier 1 drugs $40 co-pay Tier 2 / Tier 4 drugs $70 co-pay Tier 3 / Tier 5 drugs	$20 co-pay Tier 1 drugs $60 co-pay Tier 2 / Tier 4 drugs $90 co-pay Tier 3 / Tier 5 drugs
Prosthetic/Orthotic Appliances*	50% co-pay	50% co-pay
Skilled Nursing Care* *(45 days per contract year)*	85% coverage	70% coverage
Urgent Care Visit	$75 co-pay	$75 co-pay
True Out of Pocket Limit *(Includes deductible, coinsurance, and all copayments for covered services. The Out of Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services.)*	$7,350 per person/$14,700 per family	$7,350 per person/$14,700 per family

** Deductible applies; deductibles and coinsurance in both Tiers accumulate towards each other.*

Health Care Comparison

Option 1:

Priority Health Benefits – HMO Standard Benefit Level

Both Employee and Spouse must satisfy Choice Level requirement to remain at Choice Level. **The HMO Plan requires use of Priority Health participating providers**. There is no coverage for providers who do not belong to the Priority Health network (see dependent rider in certificate of coverage for exceptions).

Benefit	HMO Standard Level **TIER 1**	HMO Standard Level **TIER 2**
Deductible	$2,400 per person/$4,800 per family	$2,750 per person/$5,500 per family
Coinsurance	75% *(see coinsurance out of pocket maximum)*	60% *(see coinsurance out of pocket maximum)*
Coinsurance Out of Pocket Maximum	$2,400 per person/$4,800 per family	$2,750 per person/$5,500 per family
Reasonable and customary	Not applicable	Not applicable
Annual Maximum Benefit	Not applicable	Not applicable
Ambulance Service (Air and Ground)	$150 co-pay	$150 co-pay
Durable Medical Equipment *	70% co-pay	50% co-pay
Emergency Room Visit	$150 co-pay; waived if admitted	$150 co-pay; waived if admitted
High-Tech Imaging (capped at 10 copays)	$150 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies	$200 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies
Home Health Care*	100% coverage	85% coverage
Inpatient Hospital Services*	75% coverage	60% coverage
Maternity Care (Routine) – Pre- and Post-Natal	100% coverage	100% coverage
Maternity Care – Inpatient*	75% coverage	60% coverage
Mental Health – Inpatient*	75% coverage	75% coverage
Mental Health – Outpatient	$40 co-pay per visit	$40 co-pay per visit
Preventive Care	100% coverage	100% coverage
Primary Care Provider Office Visits	$40 co-pay	$40 co-pay
Specialist Office Visits	$55 co-pay	$55 co-pay
Outpatient Services*	75% coverage	60% coverage
Physical and Occupational Therapy	$40 co-pay	$50 co-pay
Chiropractic Care *(including maintenance) 30 visits max. per contract year*	$40 co-pay	$40 co-pay
Speech Therapy (30 visits max. per contract year)	$40 co-pay	$50 co-pay
Cardiac and Pulmonary Rehabilitation *(30 visits max. per contract year)*	$40 co-pay	$50 co-pay
Prescription Drugs Pharmacy *(including oral contraceptives) 90 day supply for 2x co-pay at Munson Healthcare pharmacies Mail order through Munson Pharmacy only*	$10 co-pay Tier 1 drugs $40 co-pay Tier 2 / Tier 4 drugs $70 co-pay Tier 3 / Tier 5 drugs	$20 co-pay Tier 1 drugs $60 co-pay Tier 2 / Tier 4 drugs $90 co-pay Tier 3 / Tier 5 drugs
Prosthetic/Orthotic Appliances*	50% co-pay	50% co-pay
Skilled Nursing Care* *(45 days per contract year)*	75% coverage	60% coverage
Urgent Care Visit	$75 co-pay	$75 co-pay
True Out of Pocket Limit *(Includes deductible, coinsurance, and all copayments for covered services. The Out of Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services.)*	$7,350 per person/$14,700 per family	$7,350 per person/$14,700 per family

** Deductible applies; deductibles and coinsurance in both Tiers accumulate towards each other.*

Health Care Comparison

Option 2:

Priority Health Benefits - In Network: POS Choice Benefit Level

Both Employee and Spouse must satisfy Choice Level requirement to remain at Choice Level. **The POS Plan does not require use of Priority Health participating providers**. However, the coverage level is higher when participating providers are used (in-network). This page describes in network coverage.

Benefit	POS In Network Choice Level **TIER 1**	POS In Network Choice Level **TIER 2**
Deductible	$400 per person/$800 per family	$750 per person/$1,500 per family
Coinsurance	85% *(see coinsurance out of pocket maximum)*	70% *(see coinsurance out of pocket maximum)*
Coinsurance Out of Pocket Maximum	$1,400 per person/$2,800 family	$1,750 per person/$3,500 family.
Reasonable and customary	Not applicable	Not applicable
Annual Maximum Benefit	Not applicable	Not applicable
Ambulance Service (Air and Ground)	$150 co-pay	$150 co-pay
Durable Medical Equipment *	70% co-pay	50% co-pay
Emergency Room Visit	$150 co-pay; waived if admitted	$150 co-pay; waived if admitted
High-Tech Imaging (capped at 10 copays)	$150 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies	$200 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies
Home Health Care*	100% coverage	85% coverage
Inpatient Hospital Services*	85% coverage	70% coverage
Maternity Care (Routine) – Pre- and Post-Natal	100% coverage	100% coverage
Maternity Care – Inpatient*	85% coverage	70% coverage
Mental Health – Inpatient*	85% coverage	85% coverage
Mental Health – Outpatient	$20 co-pay per visit	$20 co-pay per visit
Preventive Care	100% coverage	100% coverage
Primary Care Provider Office Visits	$20 co-pay	$20 co-pay
Specialist Office Visits	$35 co-pay	$35 co-pay
Outpatient Services*	85% coverage	70% coverage
Physical and Occupational Therapy	$20 co-pay	$30 co-pay
Chiropractic Care *(including maintenance) 30 visits max. per contract year*	$20 co-pay	$20 co-pay
Speech Therapy (30 visits max. per contract year)	$20 co-pay	$30 co-pay
Cardiac and Pulmonary Rehabilitation *(30 visits max. per contract year)*	$20 co-pay	$30 co-pay
Prescription Drugs Pharmacy *(including oral contraceptives) 90 day supply for 2x co-pay at Munson Healthcare pharmacies Mail order through Munson Pharmacy only*	$10 co-pay Tier 1 drugs $40 co-pay Tier 2 / Tier 4 drugs $70 co-pay Tier 3 / Tier 5 drugs	$20 co-pay Tier 1 drugs $60 co-pay Tier 2 / Tier 4 drugs $90 co-pay Tier 3 / Tier 5 drugs
Prosthetic/Orthotic Appliances*	50% co-pay	50% co-pay
Skilled Nursing Care* *(45 days per contract year)*	85% coverage	70% coverage
Urgent Care Visit	$75 co-pay	$75 co-pay
True Out of Pocket Limit *(Includes deductible, coinsurance, and all copayments for covered services. The Out of Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services.)*	$7,350 per person/$14,700 per family	$7,350 per person/$14,700 per family

** Deductible applies; deductibles and coinsurance in both Tiers accumulate towards each other.*

Health Care Comparison

Option 2:

Priority Health Benefits - In Network: POS Standard Benefit Level

Both Employee and Spouse must satisfy Choice Level requirement to remain at Choice Level. **The POS Plan does not require use of Priority Health participating providers**. However, the coverage level is higher when participating providers are used (in-network). This page describes in network coverage.

Benefit	POS In Network Standard Level **TIER 1**	POS In Network Standard Level **TIER 2**
Deductible	$2,400 per person/$4,800 family	$2,750 per person/$5,500 family
Coinsurance	75% *(see coinsurance out of pocket maximum)*	60% *(see coinsurance out of pocket maximum)*
Coinsurance Out of Pocket Maximum	$2,400 per person/$4,800 family	$2,750 per person/$5,500 family.
Reasonable and customary	Not applicable	Not applicable
Annual Maximum Benefit	Not applicable	Not applicable
Ambulance Service (Air and Ground)	$150 co-pay	$150 co-pay
Durable Medical Equipment *	70% co-pay	50% co-pay
Emergency Room Visit	$150 co-pay; waived if admitted	$150 co-pay; waived if admitted
High-Tech Imaging (capped at 10 copays)	$150 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies	$200 co-pay if outpatient; waived if part of hospital confinement, but if waived deductible/coinsurance applies
Home Health Care*	100% coverage	85% coverage
Inpatient Hospital Services*	75% coverage	60% coverage
Maternity Care (Routine) – Pre- and Post-Natal	100% coverage	100% coverage
Maternity Care – Inpatient*	75% coverage	60% coverage
Mental Health – Inpatient*	75% coverage	75% coverage
Mental Health – Outpatient	$40 co-pay per visit	$40 co-pay per visit
Preventive Care	100% coverage	100% coverage
Primary Care Provider Office Visits	$40 co-pay	$40 co-pay
Specialist Office Visits	$55 co-pay	$55 co-pay
Outpatient Services*	75% coverage	60% coverage
Physical and Occupational Therapy	$40 co-pay	$50 co-pay
Chiropractic Care *(including maintenance) 30 visits max. per contract year*	$40 co-pay	$40 co-pay
Speech Therapy (30 visits max. per contract year)	$40 co-pay	$50 co-pay
Cardiac and Pulmonary Rehabilitation *(30 visits max. per contract year)*	$40 co-pay	$50 co-pay
Prescription Drugs Pharmacy *(including oral contraceptives) 90 day supply for 2x co-pay at Munson Healthcare pharmacies Mail order through Munson Pharmacy only*	$10 co-pay Tier 1 drugs $40 co-pay Tier 2 / Tier 4 drugs $70 co-pay Tier 3 / Tier 5 drugs	$20 co-pay Tier 1 drugs $60 co-pay Tier 2 / Tier 4 drugs $90 co-pay Tier 3 / Tier 5 drugs
Prosthetic/Orthotic Appliances*	50% co-pay	50% co-pay
Skilled Nursing Care* *(45 days per contract year)*	75% coverage	60% coverage
Urgent Care Visit	$75 co-pay	$75 co-pay
True Out of Pocket Limit *(Includes deductible, coinsurance, and all copayments for covered services. The Out of Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services.)*	$7,350 per person/$14,700 per family	$7,350 per person/$14,700 per family

** Deductible applies; deductibles and coinsurance in both Tiers accumulate towards each other.*

Health Care Comparison

Option 2 continued:

Priority Health Benefits - Out of Network: POS Choice and Standard Benefit Levels

Both Employee and Spouse must satisfy Choice Level requirement to remain at Choice Level. **The POS Plan does not require use of Priority Health participating providers**. However, the coverage level is higher when participating providers are used (in-network). This page describes in network coverage.

Benefit	POS Out of Network **Choice Level**	POS Out of Network **Standard Level**
Deductible	$1,000 per person/$2,000 family	$5,000 per person/$10,000 family
Coinsurance	60% *(see coinsurance out of pocket maximum)*	50% *(see coinsurance out of pocket maximum)*
Coinsurance Out of Pocket Maximum	$3,000 per person/$6,000 family	$5,000 per person/$10,000 family.
Reasonable and customary	Applies	Applies
Annual Maximum Benefit	Not applicable	Not applicable
Ambulance Service (Air and Ground)	$150 co-pay	$150 co-pay
Durable Medical Equipment *	50% co-pay	50% co-pay
Emergency Room Visit	$150 co-pay; waived if admitted	$150 co-pay; waived if admitted
High-Tech Imaging (capped at 10 copays)	60% coverage	50% coverage
Home Health Care*	60% coverage	50% coverage
Inpatient Hospital Services*	60% coverage	50% coverage
Maternity Care (Routine) – Pre- and Post-Natal	60% coverage	50% coverage
Maternity Care – Inpatient*	60% coverage	50% coverage
Mental Health – Inpatient*	60% coverage	50% coverage
Mental Health – Outpatient	60% coverage	50% coverage
Preventive Care	60% coverage	50% coverage
Primary Care Provider Office Visits	60% coverage	50% coverage
Specialist Office Visits	60% coverage	50% coverage
Outpatient Services*	60% coverage	50% coverage
Physical and Occupational Therapy	50% coverage	50% coverage
Chiropractic Care *(including maintenance) 30 visits max. per contract year*	50% coverage	50% coverage
Speech Therapy (30 visits max. per contract year)	50% coverage	50% coverage
Cardiac and Pulmonary Rehabilitation *(30 visits max. per contract year)*	50% coverage	50% coverage
Prescription Drugs Pharmacy *(including oral contraceptives) 90 day supply for 2x co-pay at Munson Healthcare pharmacies Mail order through Munson Pharmacy only*	$20 co-pay Tier 1 drugs $60 co-pay Tier 2 / Tier 4 drugs $90 co-pay Tier 3 / Tier 5 drugs	$20 co-pay Tier 1 drugs $60 co-pay Tier 2 / Tier 4 drugs $90 co-pay Tier 3 / Tier 5 drugs
Prosthetic/Orthotic Appliances*	50% co-pay	50% co-pay
Skilled Nursing Care* *(45 days per contract year)*	60% coverage	50% coverage
Urgent Care Visit	60% coverage	50% coverage
True Out of Pocket Limit *(Includes deductible, coinsurance, and all copayments for covered services. The Out of Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services.)*	$14,700 per person/$29,400 per family	$14,700 per person/$29,400 per family

** Deductible applies; deductibles and coinsurance in both Tiers accumulate towards each other.*

***The visits for PT/OT, chiropractic, speech, and cardiac/pulmonary therapy are combined between in-network and out-of-network claims. If you are outside of the state of Michigan but in the United States, services provided by a Cigna PPO participating provider are covered at the Preferred (in-network) level of benefits. Contact Priority Health for more information on the Cigna PPO Network. Effective July 1, 2020, the PHCS network will no longer be a network choice outside of the state of Michigan.*

Dental Care Coverage

Because regular dental care is part of maintaining overall good health, Munson Healthcare believes that dental care should be part of its health care program. Benefits Plus offers two dental options: Option A and Option B.

Dental Options A and B

Option A and Option B have different levels of dental coverage. Keep in mind that both plans provide the same coverage for diagnostic/preventative and orthodontia services. Preventive dental care helps you avoid costly and more serious problems later on.

Deductible

A $25 deductible per person, total per benefit year, limited to a maximum deductible of $75 per family per calendar year will be assessed on all services except diagnostic and preventive services, sealants, X-rays and orthodontic services.

Dental Plan Comparison

	Option A	Option B
Deductible	$25/$75	$25/$75
Class I		
Diagnostic/Preventative	100%	100%
Emergency Palliative Treatment	100%	100%
Class II		
Radiographs	50%	75%
Oral Surgery	50%	75%
Minor Restorative Services	50%	75%
Periodontics	50%	75%
Endodontics	50%	75%
Class III		
Major Restorative Services	50%	75%
Implants	50%	75%
Prosthodontics	50%	75%
Maximum Payment per person Total per benefit year Class I-III	$1,000	$1,500
Class IV		
Orthodontic Services (to age 19)	50%	50%
Payment for Class IV Benefits will not exceed a lifetime max of	$1,000	$1,000

Information on Covered Dental Services

The following list provides examples of covered dental services.

Diagnostic/Preventive

- Periodic cleanings and oral examination (no more than two in any 12-consecutive month period)
- Topical application of stannous fluoride for individuals under age 14 (no more than one in any 12-consecutive month period)
- Space maintainer, fixed, unilateral

Sealants

- Sealants are most effective when they are applied to newly erupted teeth, before cavities have a chance to develop. To encourage early application, Delta Dental covers sealants on first permanent molars for children through age eight and second permanent molars for children through age 13.

Restorative/X-rays

- Intra-oral x-rays – complete services with or without bitewings (only one series in a 60-month period)
- Bitewing x-rays – (no more than one set in any 24-consecutive month period)
- Repairs and adjustments to dentures – (not covered if performed within six months of installation of denture)

Prosthodontics

Orthodontics for dependents under age 19

Dental Care Enrollment Guidelines

Your Dental Care choice and Health Care choice are separate from one another. In other words, if you are married and choose Employee Only Medical Care, you could enroll for Employee Plus One or Employee Plus Family Dental Care, if it is appropriate.

If you change dental plans, only those dependents currently enrolled will be eligible for coverage under the newly-selected option. Once dependents are dropped from your coverage they cannot be re-enrolled until the next open enrollment or a qualifying event.

Get access to the best in eye care and eyewear with MUNSON HEALTHCARE and VSP® Vision Care.

VSP® Vision care for life

Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

Enroll in VSP today.
You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

MUNSON HEALTHCARE and VSP provide you with a choice of affordable vision plans – choose the plan that's right for you.

Base **VSP Provider Network:** VSP Choice

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every plan year*	$0
Prescription Glasses		$20
Frame	• $120 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $65 Costco® and Walmart frame allowance • Every plan year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every plan year	Included in Prescription Glasses
Lens Enhancements	• Scratch-resistant coating • Polycarbonate lenses • Tints • Anti-reflective coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every plan year	$0 $31 - $35 $15 $41 $0 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20

Buy-Up **VSP Provider Network:** VSP Choice

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every plan year*	$0
Prescription Glasses		$10
Frame	• $200 allowance for a wide selection of frames • $250 allowance for featured frame brands • 20% savings on the amount over your allowance • $110 Costco® and Walmart frame allowance • Every plan year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every plan year	Included in Prescription Glasses
Lens Enhancements	• Scratch-resistant coating • Polycarbonate lenses • Tints • Anti-reflective coating • Progressives • Average savings of 20-25% on other lens enhancements • Every plan year	$0 $0 $0 $0 $0
Contacts (instead of glasses)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20

Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $45	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $105
Single Vision Lenses ..... up to $30		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Plan year begins in July

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

Life Insurance

Optional Life

Your future financial security should be an important consideration in selecting your Benefits Plus options. Over time, your need for life insurance may change when you buy a home, when you marry, or when you have children.

Life and Accidental Death & Dismemberment (AD&D) Insurance under Benefits Plus can help make you and your family's financial future more secure.

Through Benefits Plus, you have the option of choosing voluntary Life Insurance for you, your spouse and/or your child(ren). See Dependent Life page for more information on covering Spouse/Child(ren).

Insured	Minimum Coverage	Maximum Coverage	Guarantee Issue*
Employee	$1,000	$500,000 (to 5 x salary)	$250,000
Spouse	$1,000	$100,000	$25,000
Child(ren)	$1,000	$15,000	n/a

"Salary" means your annualized base rate of compensation, not including overtime, bonuses, shift differential, or any other compensation.

*At the time you hire/move into a full or part-time benefited position, this optional life coverage is a guarantee issue (GI) up to 3 x base salary or $250,000, whichever is less. This means you may elect up to $250,000 or 3 x base salary coverage, whichever is less, without providing evidence of insurability.

During an Annual Enrollment Period or following a Qualifying Event mid-year, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance up to the GI amount of the lesser of 3 x annual salary up to $250,000, without satisfying evidence of insurability requirements. If you choose to enroll in Voluntary or Spousal Life coverage for the first time during Open Enrollment or following a Qualifying Event, rather than as a new hire, any amount you elect will be subject to evidence of insurability. Any amounts subject to evidence of insurability will become effective on the date the Insurance Company agrees in writing to insure you or your spouse.

Basic Life and AD&D coverage reduces by 50% at age 75. Optional supplemental coverage reduces by 50% at age 70.

The AD&D portion of our life insurance pays benefits if you die or suffer the loss of a limb or your sight because of an accident. In the event of injury or death, a specific benefit amount is paid according to the following schedule:

Event	AD&D Pays
Death	Your full AD&D coverage amount is paid to you or your beneficiary.
Loss of both hands	
Loss of both feet	
Loss of sight in both eyes	
Loss of one hand and one foot	
A loss of one hand and sight in one eye	
Loss of speech and hearing	
Loss of one foot and sight in one eye	
Loss of one hand	One-half of your AD&D coverage amount is paid to you.
Loss of one foot	

Tax Considerations

According to federal law, only the first $50,000 of combined life insurance coverage (Munson-provided and optional) is tax exempt. If your total coverage is more than $50,000 an amount, called "imputed income" will be added to your W-2 earnings using IRS Tax Table 1.

For example:

Annual earnings:	$20,000
Life Insurance coverage (MMC and optional coverage)	$60,000
Less: Tax-free portion	$50,000
Taxable portion	$10,000

In this example, you would not be taxed on the $10,000 but you would pay taxes on the cost of the premium for this amount. For example, let's assume you are 42 years old. In the above case, your W-2 form would show imputed income of $20.40 based on the IRS Table I Calculation. This calculation is done with each paycheck so that the appropriate amount of income tax and Social Security is deducted. This shows up as Group Term Life (GTL) on each pay under earnings.

Life and AD&D Insurance Enrollment Guidelines

For determining your Life and AD&D Insurance amount for open enrollment, your annual wage will be based on your current base annual earnings. Remember, your annual wage is your base rate of compensation, not including overtime, bonuses, shift differential, or any special compensation.

Dependent Life Insurance

Benefits Plus offers Dependent Life Insurance coverage as a means of providing your family with additional financial security. The loss of a loved one can often bring with it unexpected expenses and a loss of income. There is perhaps no time when financial security is needed more.

The following Dependent Life Insurance options are available:

Insured	Minimum Coverage	Maximum Coverage	Guarantee Issue*
Spouse	$1,000	$100,000	$25,000
Child(ren) 6 months to age 26	$1,000	$15,000	n/a
Child(ren) birth to 6 months	$1,000	$1,000	n/a

The employee does not need to select Optional Life to participate in the Dependent Life Insurance.

*At the time you hire/move into a full or part-time benefited position, this coverage is a guarantee issue. This means you may elect any option and there will be no evidence of insurability required.

If you do not elect any coverage as a new employee and wish to add spousal coverage at a later Open Enrollment or following a Qualifying Event, your spouse will need to complete an evidence of insurability form that will be sent to the insurance company for approval.

Dependent Life Insurance covers children from birth to 26 years old. The cost is a flat dollar amount per $1,000, regardless of your age, your child/ren's age/s, and the number of children you have.

Dependent Life coverage on a spouse reduces by 50% at age 70.

If your spouse cannot perform the normal activities of a person of the same age and gender prior to the date his/her coverage would begin, coverage will not begin until he/she is able to do so.

Please note that this is an after-tax benefit.

Only one insured spouse may cover eligible children as insured dependents.

Additional Accidental Death & Dismemberment

Insurance For You and Your Family

Accidents happen suddenly. You don't expect them. There's no way to anticipate them and they don't always happen to somebody else.

As safety conscious as you are on the job, on the road, at home, on vacation – you can't always control all of the circumstances that could place you in physical danger. And you can't evaluate in advance the extent to which your family's security could be affected by the financial consequences of an accident.

But, through the economical plan outlined on the following pages, you can be prepared to deal with some of the financial consequences of an accident by providing for your family's future security easily and quickly.

This brochure describes briefly the main provisions of the plan and the range of benefits that you may select.

Under the Family Plan, you may insure your family members as follows: Your spouse and your child/ren* under 26 years of age.

* *Child/ren include step, foster and legally adopted children, and child/ren whom adoption procedures are pending – who meet the above qualifications.*

Your newborn children are automatically covered from birth to 31 days if you are covered under the Employee Plan. If you wish to continue coverage after the 31st day, you must apply for the Family Plan at the additional cost.

Coverage

The plan offers full 24-hour accident protection anywhere in the world on or off the job, on business – on vacation – at home. Air travel is included while you and your family members are flying as passengers only, subject to the exclusions as shown.

Exclusions

The policy does not cover any loss:

1. to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or **2.** caused by suicide, or intentionally self-inflicted injuries; or **3.** caused by or resulting from war or any act of war, declared or undeclared; or **4.** caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve-National Guard Benefit (any premium paid to us for any period not covered by the Policy while the Insured is in such service will be returned pro rata); or 5. caused by or resulting from riding in, getting into or out of any aircraft, except as shown under the Coverage of Aircraft provision, unless: a. the insured is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and b. the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured, or any other employer of the Insured, unless a specified written agreement has been obtained from us; or 6. sustained during the insured's commission or attempted commission of an assault or felony.

Additional exclusions may be listed in your certificate of coverage.

The Benefit

Accidental Death and Dismemberment

If bodily injuries result in death, dismemberment or paralysis within one year of the date of the covered accident, the plan will pay as follows:

Loss of life	Full Benefit Amount
Loss of two or more members	Full Benefit Amount
Loss of speech and hearing	Full Benefit Amount
Quadriplegia**	Full Benefit Amount
Loss of one member*	One-Half Benefit Amount
Loss of speech or hearing	One-Half Benefit Amount
Paraplegia or Hemiplegia**	One-Half Benefit Amount
Loss of thumb and index finger of same hand	One Quarter Benefit

*Member means hand, foot or eye **Quadriplegia means total paralysis of both upper and lower limbs; Paraplegia means total paralysis of both lower limbs; Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

Only one amount, the largest of which you are entitled, is paid for all losses resulting from one accident.

Family Plan

If you wish to insure your spouse and/or dependent children under the Family Plan, the amount of insurance applicable to members of the family is based on the composition of the family at the time of the loss and is expressed as a percentage of your Selected Benefit Amount as follows:

Based on family members at the time of the accident:
50% for spouse, if no covered children
40% for spouse, if covered children
15% for children, if no covered spouse
10% for children, if covered spouse

NOTE: Age limits apply to this coverage, beginning at age 75. See the certificate of coverage or contact the benefits office for details.

Only one insured spouse may cover eligible children as insured dependents.

Health and Dependent Care Spending Accounts
with PlanSource

Why Have an FSA Account?
The primary advantage of an IRS approved Flexible Spending Account (FSA) is to reduce your taxable income. The secondary advantage is to help offset your eligible out-of-pocket expenses. By using pre-taxed dollars deducted directly from your paychecks, you can cover qualified expenses that would normally be paid with your taxed income. This saves you from paying Federal, State, and Social Security (FICA) taxes on those funds set aside in your FSA.

What is a Health Care FSA?
A health care FSA is an employer-sponsored benefit that allows you to set aside pre-tax dollars to be used for qualified out-of-pocket medical expenses not covered by your health plan. An FSA will cover you and your dependents. Please consult your tax professional for more information on those individuals that may qualify as dependents for purposes of the FSA. The total amount of the election is available upon your plan's effective date and can be used on medical, dental, or optical expenses, as well as copays, prescriptions and much more.

What is a Dependent Care FSA?
A dependent care FSA is a flexible spending account that allows you to contribute a pre-taxed portion of your paycheck to pay for qualified dependent care expenses so that you, and your spouse (if applicable), can work, look for work, or attend school. These expenses are for Childcare, Daycare, and Eldercare expenses for qualified dependents. These funds become available after a payroll deposit is made each pay period. Please note: Dependent Care FSA funds are NOT for dependent medical expenses. Also, this should not be elected if you have a spouse that is not gainfully employed or attending school.

How to Use Your FSA Funds
- Pay with Benefits Card MasterCard (run as credit)
- Pay for expenses out of pocket to be reimbursed later (see next)
- Submit payment from the online claim portal to the institution requesting the payment.

How to Be Reimbursed
Online Portal – Log into you PlanSource account online. Then you can follow the steps to be paid from your FSA by entering claim info and adding documentation electronically.

Mobile App – Similar to online, but you can use your smart device's camera to take a picture and upload any documentation for the claim.

Paper Form – You can Fax or Mail the form to them, along with any necessary documentation for the claim.

Documentation
The IRS and PlanSource may conduct an audit of your account and regu- larly request receipts for Benefits Card transactions. Submit all requested documentation directly to PlanSource. You can submit documents online in the portal by scanning the documents and uploading them under pending claims, or use the mobile app by tapping on pending claims and clicking add receipts to add with your device's camera, or you may fax or mail them to PlanSource along with a reimbursement form.

What is needed:
- Itemized Receipts for card transactions showing what the expense was for, not just how much.
- EOB's for medical bills
- Contracts for orthodontia reimbursements

Please see the PlanSource FAQ Page for specific examples. Send these within 45 days of being notified by PlanSource that the documentation is needed, or your Benefits Card can be shut off.

What Happens if You Deposit Too Much?
Money left in your account at the end of the plan year is forfeited and cannot be refunded to you or carried over until the following plan year, in accordance with IRS regulations. However, you now have:
- Until September 15 in which to incur eligible expenses for reimbursement and
- Until the last business day in October to submit claims incurred between July 1 and September 15 of the subsequent plan year.

Contacting PlanSource
Please see the Munson Benefits Intranet page on how to register online at: **plansource.wealthcareportal.com**

Please also contact Member Services at:
888-266-1732 (select Option 2)
Available Mon. - Fri. 8am - 11pm EST

PLANSOURCE®
One Source. Many Benefits.

MetLife Legal Plan

Telephone and Office Consultations

The MetLife Legal Plan provides you with telephone and office consultations for an unlimited number of matters with the attorney of your choice. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action.

Legal Representation
Trials for covered matters are covered from beginning to end, regardless of length, when using a network attorney.
Estate Planning Documents
- Simple and complex wills
- Trusts *(Revocable and Irrevocable)*
- Powers of attorney *(Health care, Financial, Childcare)*
- Health care proxies
- Living wills
- Codicils

Financial Matters
- Foreclosure, repossession, and garnishment defense
- Negotiations with creditors
- Debt collection defense
- Personal bankruptcy
- Identity theft defense
- Tax audit representation *(municipal, state, or federal)*
- Tax collection defense

Real Estate Matters
- Sale, Purchase, or Refinancing of your Primary, Second, and Vacation Home
- Tenant negotiations
- Eviction defense
- Security Deposit Assistance
- Boundary or Title Disputes
- Property Tax Assessments
- Zoning Applications
- Home Equity Loans *(for Primary Second and Vacation Home)*

Defense of Civil Lawsuits
- Administrative hearings
- Civil Litigation defense
- Incompetency defense
- School hearings
- Pet liabilities

Family Law
- Adoption
- Guardianship and Conservatorship
- Name change
- Prenuptial agreement
- Protection from Domestic Violence

Identity Theft
- Identification theft recovery and counseling features at no additional cost through LifeStages Identity Management Services.

Traffic Offenses
- Defense of any traffic ticket *(excludes DUI)*
- Driving Privileges Restoration *(includes license suspension due to DUI)*

Document Preparation
- Affidavits
- Deeds
- Demand letters
- Mortgages
- Notes
- Document Review of any personal legal document

Immigration Assistance
- Advice and Consultation
- Review of Immigration Documents
- Preparation of Affidavits and Powers of Attorney

Juvenile Matters
- Juvenile court defense, including criminal matters
- Parental responsibility matters

Consumer Protection
- Disputes over consumer goods and services
- Small claims assistance

Elder Law Matters
Consultations and document review for issues related to your parents including Medicare, Medicaid, prescription plans,nursing home agreements, leases, notes, deeds, wills and powers of attorney as they affect the participant.

Personal Property Protection
- Consultations and document review for personal property issues
- Assistance for disputes over goods and services

Additional Features
E-Services
- Attorney Locator
- Law Firm E-Panel®
- Life Guide
- Free, downloadable legal documents
- Links to resources for financial planning, insurance, and work/life matters

Family Matters™
- Available for an additional fee
- Separate plan for parents of participants for estate planning documents

Reduced Fees
Network attorneys provide representation for personal injury, probate, and estate administration matters at reduced fees.

For more information: Visit **legalplans.com** and enter LEGAL, or call the Client Service Center at **800-821-6400**.

Required Documentation for Covering Family Members

The medical, dental, life, vision and legal plans cover employees, as well as their legally married spouses. A major health care reform provision which may affect you is the new federal requirement that health plans allow dependents to remain on their parents' plan until the end of the month during which they reach age 26.

You may cover these dependents even if they are:
- Married (although you may not cover your son or daughter's spouse or children)
- Living away from you or even out of state
- Financially independent

You may add dependents up to the end of the month during which they reach age 26 who already came off your plan during our last renewal (open enrollment). When adding a dependent to your medical and/or dental benefits, documentation of eligibility is required. Acceptable documents follow.

Blank out social security numbers on all documents, information will be kept confidential.

Spouse
- Marriage Certificate (not license) OR copy of most recent Tax Return (SUBMIT FRONT PAGE AND SIGNATURE PAGE ONLY, BLANK OUT ALL SOCIAL SECURITY NUMBER AND EARNINGS INFORMATION)

Natural Child(ren) and Step Child(ren) to age 26 (through end of birth month)
- Birth Certificate

Legally Adopted Child, Child Placed for an Adoption, Court Appointed Dependent/ Guardianship to age 18
- Copy of adoption papers or amended birth certificate naming the enrollee as the parent
- Copy of Legal Guardianship Papers

Totally and Permanently Disabled Child(ren) 26 or Over
Submit all of the following that apply

- Physician letter with a Statement of Total and Permanent Disability, completed and signed by the dependent's physician (stamped signature not acceptable)
- Birth Certificate

Covering Your Spouse and/or Adding Dependents
In order for your spouse to be eligible for medical coverage, proof of Spousal Eligibility must be provided, for **each year** that you elect medical coverage for your spouse. Spousal Eligibility is captured by answering a few questions, as part of the online enrollment process using my>HR. **You must enroll via my>HR to complete these questions or your spouse will not be covered until the next enrollment period unless you experience a Qualifying Event** and have completed the proper paperwork.

Insurance Effective Dates

Month Hired	Medical Benefit *Physicians and Administrators are eligible for medical benefits on date of hire.	Dental, Optional Life, AD&D, Health Care Reimbursement, Dependent Care Reimbursement, Optical, Long-Term Disability, Basic Life, Dependent Life, and Legal Plan
January	March 1st	May 1st
February	April 1st	June 1st
March	May 1st	July 1st
April	June 1st	August 1st
May	July 1st	September 1st
June	August 1st	October 1st
July	September 1st	November 1st
August	October 1st	December 1st
September	November 1st	January 1st
October	December 1st	February 1st
November	January 1st	March 1st
December	February 1st	April 1st

Reminders

Friendly reminder about Out-Of-Plan coverage under your HMO:

If the standard of care treatment (medically appropriate treatment) for your condition is not available from a Participating Provider, your Primary Care Provider (PCP) will ask Priority Health for approval to refer you to a Non-Participating Provider. All referrals to, or services received from Non-Participating Providers (providers not listed in the Priority Health Provider Directory) must have prior approval from Priority Health. Referral by your PCP is not sufficient for coverage of services received from Non-Participating Providers. If you do not receive written approval from Priority Health prior to obtaining services from a Non-Participating Provider, you will be responsible for payment. A copy of the Priority Health Provider Directory is available by calling the Customer Service Department at **800-446-5674** or on the website at **priorityhealth.com.** POS Members: The above applies if you wish to receive care at the preferred benefit level under your POS plan from a Non-Participating Provider.

Friendly reminder to POS members about selecting a PCP:

POS members are not required to select a Primary Care Provider. However, if a PCP is not selected, all covered services are applied at the alternate benefit level, including those performed at a participating facility/physician. Therefore, it is **highly recommended that all members on the POS plan select a PCP**. 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. If you are not sure if you have selected a PCP, please call the Priority Health Customer Service Department at **800-446-5674** to check. If you have not selected one, the Customer Service Representative will assist you in the selection process so that you are able to maximize your benefits.

Women's Health and Cancer Rights Act of 1998

Did you know that your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy- related services? These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment from complications resulting from a mastectomy (including lymphedema). Call Priority Health Customer Service at **800-446-5674** for more information.

Notes

Contacts

Priority Health
Medical Coverage Customer Service
800-446-5674
priorityhealth.com

Delta Dental
800-524-0149
deltadentalmi.com

VSP® Vision Care
800-877-7195
VSP.com

MetLife Legal
800-821-6400
legalplans.com

PlanSource
888-266-1732
plansource.wealthcareportal.com

Benefits

Munson Healthcare Cadillac Hospital
231-876-7322
HR-CAD@mhc.net

Munson Healthcare Charlevoix Hospital
231-547-8505
CHX-HR@mhc.net

Munson Healthcare Grayling Hospital
989-348-0723
HR-GRY@mhc.net

Munson Healthcare Manistee Hospital
231-398-1104
MST-HR-list@mhc.net

Paul Oliver Memorial Hospital
231-352-2285
HR-POMH@mhc.net

All Other Munson Healthcare Locations
231-935-6894 or 231-935-6938
benefits@mhc.net

MUNSON HEALTHCARE
Manistee Hospital

munsonhealthcare.org

04/20