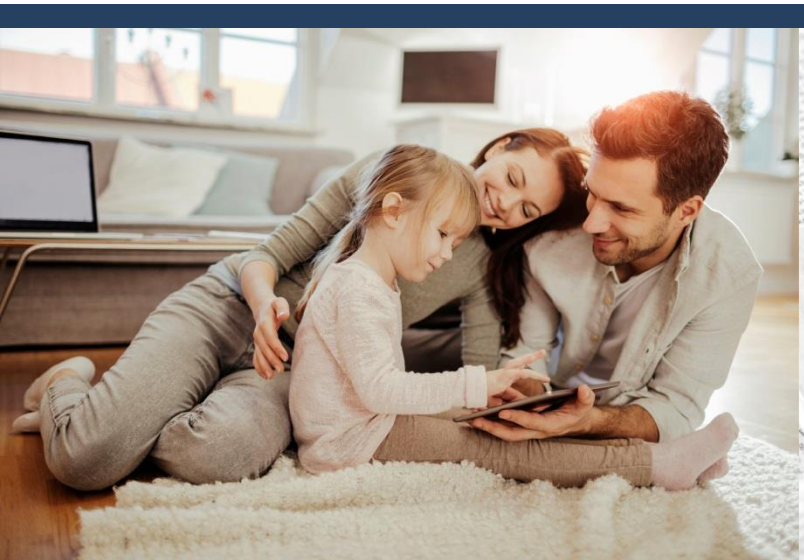
McLarens
GLOBAL CLAIMS SERVICES

2016-2017

Summary of Employee Benefits



Medical Coverage - Aetna		
Type of Plan	**Choice POS II**	
Deductible (Calendar Year)	**In-Network**	**Out-of-Network**
Individual	$750	$2,500
Family	$1,500	$5,000
Out-of-Pocket-Maximum (Calendar Year)	**Includes deductible, Coinsurance and Copays (Medical & Rx)**	
Individual	$3,500	$5,000
Family	$7,000	$10,000
Coinsurance	Plan pays 100% after the deductible	Plan pays 50% after deductible
Lifetime Maximum	Generally Unlimited (*Some benefits may have limitations*)	
Physician's Office Visits		
Primary Care	$30 Copay, deductible waived	Plan pays 50% after deductible
Specialist	$50 Copay, deductible waived	Plan pays 50% after deductible
Preventive Care Services	Plan pays 100%	Plan pays 50% after deductible
Maternity *(Physician Services)*	$50 Copay for initial visit	Plan pays 50% after deductible
Hospital Inpatient Expenses *(Facility Charges)*	$500 Per admission, after deductible	Plan pays 50% after deductible
Hospital Outpatient Expenses *(Facility Charges)*	$150, Copay, after deductible	Plan pays 50% after deductible
Emergency Room	$200 Copay per visit	$200 Copay per visit
Urgent Care	$75 Copay	Plan pays 50% after deductible
Mental Health/Behavioral Treatment Services		
Inpatient	$500 Per admission, after deductible	Plan pays 50% after deductible
Outpatient	$50 Per visit	Plan pays 50% after deductible
Alcohol/Drug Abuse Treatment Services		
Inpatient	$500 Per admission, after deductible	Plan pays 50% after deductible
Outpatient	$50 Per visit	Plan pays 50% after deductible
Prescription Drugs		
Retail Pharmacy	$15 for Tier 1 drugs $30 for Tier 2 drugs $50 for Tier 3 drugs	$15 for Tier 1 drugs $30 for Tier 2 drugs $50 for Tier 3 drugs Then, covered up to 100% of submitted cost
Mail Order Maintenance Drug	$30 for Tier 1 drugs $60 for Tier 2 drugs $100 for Tier 3 drugs	Not Covered
Contact Information	www.aetna.com	1.800.872.3862

Medical Coverage - Aetna		
Type of Plan	**Health Fund Choice POS II**	
	In-Network	**Out-of-Network**
Health Fund Amount (Calendar Year)	Health Fund is on a calendar year basis. The fund received may be prorated based on your effective date of coverage.	
Individual	$500	
Family	$1,000	
Deductible (Calendar Year)		
Individual	$2,000	$2,500
Family (Aggregate)	$4,000	$5,000
Coinsurance	Plan pays 80% after deductible	Plan pays 60% after deductible
Out- of -pocket Maximum (Calendar Year)	Includes Deductible, Coinsurance and Copays (Medical & Rx)	
Individual	$4,000	$5,000
Family	$8,000	$10,000
Lifetime Maximum	Generally Unlimited (Some benefits may have limitations)	
Physician's Office Visit	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Specialist Office Visit	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Preventive Care Services	Plan pays 100% deductible waived	Plan pays 60% after deductible
Inpatient Maternity	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Hospital Inpatient Expenses	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Hospital Outpatient Expenses	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after fund and deductible	Plan pays 80% after deductible
Urgent Care	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Mental Health/Behavioral Treatment Services		
Inpatient	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Outpatient	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Alcohol/Drug Abuse Treatment Services		
Inpatient	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Outpatient	Plan pays 80% after fund and deductible	Plan pays 60% after deductible
Prescription Drugs		
Retail Pharmacy	$15 for Tier 1 drugs $30 for Tier 2 drugs $50 for Tier 3 drugs	$15 for Tier 1 drugs $30 for Tier 2 drugs $50 for Tier 3 drugs Then, covered up to 100% of submitted cost
Mail Order Maintenance Drug	$30 for Tier 1 drugs $60 for Tier 2 drugs $100 for Tier 3 drugs	Not covered
Contact Information	www.aetna.com	1.800.872.3862

Medical Coverage - Aetna		
Type of Plan	**HDHP / Health Savings Account (HSA) Eligible Choice POS II 2016 HSA Contribution Limits - Individual ($3,350) and Family ($6,750) 2017 HSA Contributions Limits- Individual ($3,400) and Family ($6,750) Those aged 55 or over can contribute and additional $1,000 each year**	
	In-Network	**Out-of-Network**
Deductible (Calendar Year)		
Individual	$2,500	$5,000
Family (Aggregate)	$5,000	$10,000
Coinsurance	Plan pays 80% after deductible	Plan pays 60% after deductible
Out of pocket (Calendar Year)	Includes Deductible, Coinsurance and Copays (Medical & Rx)	
Individual	$5,000	$10,000
Family	$10,000	$20,000
Lifetime Maximum	Unlimited (Some benefits may have limitations)	
Physician's Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive Care Services	Plan pays 100% deductible waived	Plan pays 60% after deductible
Inpatient Maternity	Plan pays 80% after deductible	Plan pays 60% after deductible
Hospital Inpatient Expenses	Plan pays 80% after deductible	Plan pays 60% after deductible
Hospital Outpatient Expenses	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after deductible	Plan pays 80% after deductible
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Mental Health/Behavioral Treatment Services		
Inpatient	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient	Plan pays 80% after deductible	Plan pays 60% after deductible
Alcohol/Drug Abuse Treatment Services		
Inpatient	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient	Plan pays 80% after deductible	Plan pays 60% after deductible
Prescription Drugs		
Retail Pharmacy	$15 for Tier 1 drugs, after deductible $30 for Tier 2 drugs, after deductible $50 for Tier 3 drugs, after deductible	After deductible, $15 for Tier 1 drugs After deductible, $30 for Tier 2 drugs After deductible, $50 for Tier 3 drugs Then, covered up to 100% of submitted cost
Mail Order Maintenance Drug	$30 for Tier 1 drugs, after deductible $60 for Tier 2 drugs, after deductible $100 for Tier 3 drugs, after deductible	Not covered
Contact Information	www.aetna.com	1.800.872.3862

Dental Coverage - Aetna		
Type of Plan	**PPO (PDN with PPO II Network)**	
	In-Network	**Out-of-Network** *Reasonable and Customary Apply*
Deductible - Applies to Basic and Major Services only (Calendar Year)		
Individual	$50	$50
Family	$150	$150
Annual Maximum	$1,500	$1,500
Preventive	100% Exams, X-rays, Cleanings, Fluoride	100% Exams, X-rays, Cleanings, Fluoride
Basic	80% Root Canal, Periodontics, Simple Extractions, Fillings	80% Root Canal, Periodontics, Simple Extractions, Fillings
Major	50% Inlays/Onlays, Crowns, Dentures, Oral Surgery, Implants, General Anesthesia	50% Inlays/Onlays, Crowns, Dentures, Oral Surgery, Implants, General Anesthesia
Orthodontia - Applies to Child Only, to age 19	50%	50%
Orthodontia Lifetime Maximum	$1,000	
Contact Information	www.aetna.com	1.800.872.3862
Vision Coverage - Eyemed		
Eye Exam	**Every 12 Months**	
	$10 Copay	Reimbursed up to $30
Prescription Lenses	**Every 12 Months**	
Single	$25 Copay	Reimbursed up to $25
Bifocal	$25 Copay	Reimbursed up to $40
Trifocal	$25 Copay	Reimbursed up to $60
Progressive	Standard - $90 Copay Premium - Copay varies	N/A
Frames	**Every 12 Months**	
	$140 Allowance +20 % off balance over $140	Reimbursed up to $70
Contact Lens Benefit	**Every 12 Months - in lieu of glasses**	
Conventional	$140 Allowance + 15% off balance over $140	Reimbursed up to $112
Contact Information	www.eyemed.com	1.866.800.5457
In-Network Retail Providers	* For Eyes Optical Co. * LensCrafters * Pearle Vision * Site for Sore Eyes * Sears Optical * Sterling Optical * Sterling Vision Care * SVS Vision * Texas State Optical * Target Optical * JC Penney Optical * Private Practitioners	

Life and AD&D - Prudential		
Basic Coverage		
Employee Basic Life	Two Times Basic Annual Earnings, to a maximum of $400,000	
Employee Basic AD&D	Accidental Death: 100% of Life Benefit Accidental Dismemberment: Benefit Included	
Monthly Contribution	None	
Voluntary Life Coverage-Prudential		
Employee	Increments of $10,000 up to $150,000 without Evidence of Insurability (Guarantee Issue available at initial eligibility), up to $500,000 or 7x BAE with Evidence of Insurability.	
Open Enrollment Increase	Annual increase in Employee's coverage without EOI up to the lesser of 4x BAE, not to exceed $40,000	
Spouse	Increments of $5,000 up to $30,000 without Evidence of Insurability (Guaranteed Issue available at initial eligibility), up to $250,000 or 50% of employee's amount with Evidence of Insurability.	
Employee and Spouse Monthly Contributions based on age and coverage amounts elected	**Age**	**Employee & Spouse Cost Per $1,000**
	<25	$0.08
	25-29	$0.08
	30-34	$0.10
	35-39	$0.12
	40-44	$0.15
	45-49	$0.24
	50-54	$0.40
	55-59	$0.73
	60-64	$1.13
	65-69	$1.83
	70-74	$4.97
	75+	$4.97
Eligible Child(ren)	$10,000 or $20,000 14 days - 19 years of age (26 if full-time student) Live birth to 14 days: Zero ($0) coverage	Monthly contribution: $0.960 for $10,000 $1.92 for $20,000
Voluntary AD&D	• Employee: Monthly rate of $0.018 per $1,000 • Spouse: Monthly rate of $0.020 per $1,000 • Child(ren): Monthly rate of $0.010 per $1,000	
Short Term Disability (STD) - Prudential		
Amount of Benefit	60% of weekly earnings, reduced by other income up to a maximum benefit of $2,500 per week	
When Benefits Begin	On the 7th day of disability, upon approval by Prudential	
Benefit Duration	13 Weeks	
Monthly Contribution	None	
Long Term Disability (LTD) - Prudential		
Amount of Benefit	60% of monthly earnings, (including bonus, commission and overtime), reduced by other income up to a maximum benefit of $10,000 per month	
When Benefits Begin	On the 91st day of disability, upon approval by Prudential	
Benefit Duration	Later of age 65 or Social Security Normal Retirement Age; Own Occupation period determined by benefit class.	
Monthly Contribution	None	

Flexible Spending Account (FSA) - EBS	
Overview	Allows participants to pay for eligible healthcare (Medical, Dental and Vision) and/or dependent daycare expenses with pre-tax dollars. May not change election during the calendar year, except due to change in family status.
Deferral Limits	Health Care: $2,500 per calendar year Dependent Care: $2,500 per calendar year, if filing single or separate income tax returns. $5,000 per calendar year, if you are married and file a joint income tax return.
If you are opening a Health Savings Account (HSA), you can only participate in a limited purpose health care FSA for Dental and Vision Expenses Only	
Health Advocate	
Benefit Questions & Claim Resolutions	A medical benefits or claims expert can help you with complex conditions, find specialist, address eldercare issues, clarify insurance coverage, work on claims denials and help negotiate medical bills and more.
Contact Information	www.healthadvocate.com 1.866.695.8622

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Find the right doctors
We'll also locate the right hospitals, dentists and other leading healthcare providers anywhere in the country.

Schedule appointments
We can help expedite the earliest appointments with providers including hard-to-reach specialists and arrange treatments and tests.

Help resolve insurance claims
Our experts get to the bottom of your issue to assist with negotiating billing and payment arrangements.

Assist with eldercare
We address senior issues such as Medicare and related healthcare issues facing your parents and parents-in-law.

Get cost estimates
You'll receive comparable costs of common medical procedures in your area to help you make informed decisions.

Work with insurance companies
Our team works on your behalf to obtain appropriate approvals for needed services.

Answer questions
We help you become informed about test results, treatments and medications prescribed by your physician.

Assist in the transfer of medical records
We'll also handle the details of transferring X-rays and lab results.

...and much more

Help is Only a Phone Call Away

You will be assigned a Personal Health Advocate. And you, your spouse, dependent children, parents and parents-in-law are eligible to use our service.

866.695.8622 HealthAdvocate.com

McLarens Defined Contribution 401(k) Retirement Plan	
Overview	McLarens Defined contribution 401(k) Plan has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. As a participant in the 401(k) plan, you may elect to contribute a portion of your compensation to the plan on a pre-tax or an after tax ROTH basis.
Eligibility	New Hires are eligible for participation in the 401(k) and applicable company matching funds on the first day of the bi-weekly pay period following completion of 30 days employment, provided they are at least eighteen (18) years of age, and are employees scheduled to work at least 20 hours per week for longer than six months.
Automatic Enrollment and Automatic Increase	New Hires are automatically enrolled at a deferral rate of 3%, unless they elect a different rate by completing the on-line 401(k) enrollment through the T Rowe Price website: www.rps.troweprice.com no later than 30 days after their employment start date. A person may enroll at a higher rate than 3%, and may also elect a zero percent contribution rate in order to waive the automatic enrollment. If you are automatically enrolled at 3% or you enroll for an amount less than 6%, each January 1 your contribution rate will automatically increase by 1% until your contribution rate reaches 6%. You may opt out of auto increase or enroll for a different percent or for a different effective date on the T. Rowe Price website.
Employee deferral rate changes	Following the New Hire enrollment period, effective September 1, 2016 you may make changes in your deferral rate at any time and they will be effective the first day of the next feasible pay period following your entry of the change on the T Rowe Price website.
Employee Contribution Limits	Currently you may contribute up to 75% of your base earnings up to the maximum contribution allowed by the IRS. The 2016 IRS maximum is $18,000, unless you are over age 50 and eligible for an additional catch-up contribution of $6,000 for a total of $24,000. The limit in the McLarens plan will automatically be updated each time the IRS changes the maximum amounts. If you are classified as a highly compensated employee, you may have additional limits or may receive a partial refund after year end testing is performed.
Company Match	McLarens provides a discretionary match and for 2016/2017 will match 50% of your contribution up to 6% of your base earnings, which provides up to a maximum company match of 3% of your base earnings. The company match is calculated and credited to your account on a bi-weekly pay period basis. The company match is a discretionary match and the formula for the match and timing of payment are subject to change at the Company's discretion.
Vesting Schedule	There is currently a graduated vesting schedule on the company match with 50% vesting after completion of 2 years of service, 75% vesting after completion of 3 years of service, and 100% vesting after completion of 4 years of service. You are always 100% vested in your contributions and any funds you rollover to the plan from a previous employer's plan.
Loans	A participant is permitted to take a loan from their 401(k) account and repay themselves. The maximum amount that can be borrowed is 50% of the vested account balance up to a maximum of $50,000. The interest rate is established periodically and generally is 2 percentage points above the Prime rate. As of August 2016 that rate was 5.50%. A maximum of two (2) loans are permitted to be outstanding at the same time. Repayment terms vary based on the purpose of the loan. A general purpose loan has a maximum maturity period of five (5) years, and if used for the purchase of a principal residence, the maximum maturity period is fifteen (15) years.
Record Keeper & Investment Options	The record keeper for the McLarens 401(k) plan as of September 1, 2016 is T. Rowe Price and they provide the investment choices available to you. Once you register for the T. Rowe Price website, and set up your account, you will be able to enroll in the 401(k), select your contribution rate, and make investment elections. If you do not make an investment election on the T. Rowe Price website, the Qualified Default Investment Account as designated by the Company will be applied. As of September 2016, the Company has designated the appropriate T. Rowe Price Target Date Fund closest to the assumed retirement age of 65 based on your birthdate.
Enrollment process	You enroll by registering on the T. Rowe Price website www.rps.troweprice.com or calling 1-800-922-9945 between 7 am and 10 pm Eastern time. The McLarens 401(k) plan number is 106030. Contact McLarens' Human Resources at us.benefits@mclarens.com with questions.

2016 Patient Protection and Affordable Care Act and Health Plan Notices

*Patient Protection Model Disclosure

Aetna plans generally allow the designation of a primary care provider. You have the right to designation any primary care provide who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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

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

* Women's Health and Cancer Rights Act of 1998

"Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema").

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current McLarens, Inc., coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current McLarens, Inc., Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with McLarens, Inc., Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through McLarens, Inc., Inc. 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:

1. Visit www.medicare.gov
2. 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
3. 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:	August 31, 2016
Name of Entity/Sender:	McLarens, Inc.
Contact--Position/Office:	Human Resources
Address:	5555 Triangle Pkwy, Suite 200 Norcross GA 30092
Phone Number:	770-729-5465

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, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

McLarens, Inc.

Condra Harvill
5555 Triangle Parkway, Suite 200
Norcross, GA 30092
770-729-5465

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

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

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

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

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

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

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

October 1, 2016

This Notice of Privacy Practices applies to the following organizations.

All Locations.

*Condra Harvill * condra.harvill@mclarens.com * 770-729-5465*

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

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 Human Resources - 770-729-5465.

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 McLarens, Inc.		4. Employer Identification Number (EIN) 51-0289022
5. Employer address 5555 Triangle Parkway, Suite 200		6. Employer phone number 770-729-5465
7. City Norcross	8. State GA	9. ZIP code 30092
10. Who can we contact about employee health coverage at this job? Condra Harvill		
11. Phone number (if different from above) 770-729-7465	12. Email address condra.harvill@mclarens.com	

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 or more hours per week.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse, Domestic Partners and Children of eligible employees.

  - ☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

McLarens
GLOBAL CLAIMS SERVICES

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under McLarens' Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. McLarens retains the right to modify or eliminate these benefits at any time and for any reason.

Prepared by

CBIZ Benefits & Insurance Services