2017-2018

Guide to U.S. 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 - 30 day supply	$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 - 90 day supply	$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 - 30 day supply	$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 - 90 day supply	$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 - 30 day supply	$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 - 90 day supply	$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: $2,550 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

HealthAdvocate

Your Lifeline for Healthcare Help

Top Reasons to Call Us...
866.695.8622

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.

McLarens, Inc. – Carrier Contact List

If you have questions about your Medical benefits, call:

Aetna – Group #614987
1-800-847-9026
www.aetna.com

If you have questions about your Dental benefits, call:

Aetna – Group #614987
1-877-238-6200
www.aetna.com

If you have questions about your Vision benefits, call:

EyeMed Vision Care – Group #9924069
1-866-800-5457
www.eyemedvisioncare.com

If you have questions about your Life or Disability benefits, call:

Prudential – Group #24681
1-800-524-0542 (Life)
1-800-842-1718 (Disability)
1-877-889-2070 (Life Conversion)
www.prudential.com

If you need assistance resolving an insurance claims issue, finding the right healthcare provider for your needs, getting cost estimates, answering questions about your condition or prescriptions, call:

Health Advocate
1-866-695-8622
www.HealthAdvocate.com

If you have questions about your Healthcare or Dependent Care Flexible Spending Account call:
EBS
1-888-327-2770
www.ebsbenefits.com/member-center

If you have questions for your US Human Resoures Department, email:
us.benefits@mclarens.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 2017 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 2017/2018 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 June 2017 that rate is 6.25%. 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 2017 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. **Please Note:** ***You are not able to enroll in the McLarens Defined Contribution 401(k) Retirement plan on the ADP Employee portal where you enroll in other benefits. You must contact T. Rowe Price to enroll.*** Contact McLarens’ Human Resources at us.benefits@mclarens.com with questions.

2017 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.

* Michelle's Law Notice

Effective January 1, 2010, if you have a dependent child older than age 18 who is enrolled at a post-secondary institution (e.g., college or university) on a full-time basis, he or she may be eligible to continue to be covered as a dependent if he or she loses full-time student status due to a serious injury or illness. In order to be eligible to continue coverage as a dependent under Michelle's Law:

- the dependent child must be enrolled in the McLarens Group Benefit plan immediately before the first day of the medically necessary leave of absence;
- a doctor's written certification of the medically necessary leave of absence must be submitted to the health insurance company; and
- proof of full-time student status before the leave of absence may also be required to be submitted to the health insurance company.

Continued dependent coverage will be extended for at least one year after the first day of the leave of absence, but may end earlier if the dependent child does not meet the dependent eligibility requirements under, such as meeting the limiting age for dependent eligibility under the plan. If dependent coverage under Michelle's Law ends, the dependent may be eligible for continuation coverage under COBRA.

If an eligible dependent remains enrolled in HealthFlex under Michelle's Law, the dependent child will continue to be in the same benefit options that he or she was in prior to the medical leave of absence.

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, 2017
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)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective October 1, 2016

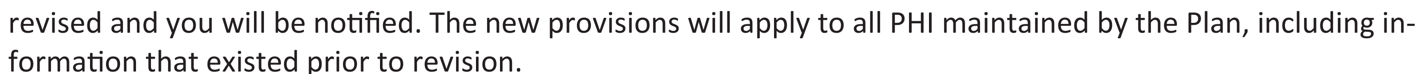
This notice describes the ways your medical information may be used and disclosed by the group health benefit programs and certain designated Business Associates of the Plan, such as the medical claims administrator that is Aetna as of October 1, 2016 (collectively the "Plan") sponsored by McLarens, Inc. (the "Company"). The Plan is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of protected health information and to provide you with this notice of the Plan's legal duties and privacy practices.

This notice also provides information about how you may access your health information. Please review it carefully.

Protected health information ("PHI") means individually identifiable health information that is created or received by the Plan that relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for the provision of health care to you, and that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In addition to HIPAA, special protections under state or other federal laws may apply to the use or disclosure of your PHI. The Plan will comply with other federal laws where they are more protective of your privacy. If state law provides privacy protections that are more stringent than those provided by HIPAA, the Plan will maintain your PHI in accordance with the more stringent state-law standard only to the extent the law is not preempted by federal law.

In general, the Plan receives and maintains health information only as needed for claims or Plan administration. The primary source of your health information continues to be the health care provider (for example, your doctor, dentist or hospital) that created the records. Some health benefits are provided through insurance where the Plan sponsor does not have access to PHI. If you are enrolled in any insured arrangements, you will receive a separate privacy notice from the insurer. Please note that the group health benefit programs covered by this notice are part of an organized health care arrangement because they are all sponsored by the Company. This means that the benefit programs may share your PHI with each other, as needed, for purposes of payment and health care operations.

The Plan is required to operate in accordance with the terms of this notice. The Plan reserves the right to change the terms of this notice. If there is a material change to the Plan's uses or disclosures of PHI, your rights or the Plan's legal duties or privacy practices, the notice will be



revised and you will be notified. The new provisions will apply to all PHI maintained by the Plan, including information that existed prior to revision.

Uses and Disclosures Permitted Without Your Authorization or Consent
The Plan is permitted to use or disclose PHI without your consent or authorization in order to carry out treatment, payment or health care operations. Information about **treatment** involves the care and services you receive from a health care provider. For example, the Plan may use information about treatment of a medical condition by a doctor or hospital. Information about **payment** involves activities by the Plan to provide coverage and benefits.

Payment activities include determinations of eligibility and claims management. (For example, claims are made for services you receive from a doctor.) The Plan may use and disclose your PHI for **health care operations** to make sure the Plan is well run, administered properly and does not waste money. For example, the Plan may use information about your claims to project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may also disclose your PHI to undertake underwriting, premium rating and other insurance activities relating to changing health insurance contracts or health benefits. However, federal law prohibits the Plan from using or disclosing PHI that is genetic information (for example, family medical history) for underwriting purposes, which include eligibility determinations, calculating premiums and any other activities related to the creation, renewal or replacement of a health insurance contract or health benefits. The Plan may contact you to provide information about treatment alternatives or other health-related benefits that may be of interest to you.

The Plan may disclose health information to the Company, if the information is needed to carry out administrative functions of the Plan. In certain cases, the Plan or insurers may disclose your PHI to the Company. Some of the people who administer the Plan work for the Company. Before your PHI can be used by or disclosed to these employees, the Company must certify that it has: (1) amended the Plan documents to explain how your PHI will be protected, (2) identified the Company employees who need your PHI to carry out their duties to administer the Plan, and (3) separated the work of these employees from the rest of the workforce so that the Company cannot use your PHI for employment-related purposes or to administer other benefit plans. For example, these designated employees will be able to contact an insurer or third-party administrator to find out about the status of your benefit claims without your specific authorization.

The Plan may disclose information to the Company that summarizes the claims experience of Plan participants as a group, but without identifying specific individuals, to get new benefit insurance or to change or terminate the Plan. For example, if the Company wants to consider adding or changing organ transplant benefits, it may receive this summary health information to assess the costs of those services.

The Plan may also disclose limited health information to the Company in connection with the enrollment or disenrollment of individuals into or out of the Plan.
The Plan may also use or disclose your PHI for these additional purposes without your written consent or authorization:

• To business associates of the Plan that perform certain administrative services for the Plan and agree in writing to protect the privacy of your information. In addition to performing services for the Plan, business associates may use PHI for their own management and legal responsibilities and for purposes of aggregating data for Plan design and other health care operations.

• The Plan and its business associates may disclose PHI to certain other entities (including other health plans and health care providers) for the other entity's treatment, payment or health care operations purposes.

• To individuals involved with your care or payment for your care. The Plan may disclose your PHI to adult members of your family or another person identified by you who is involved with your care or payment for your care if: (1) you authorize the Plan to do so, (2) the Plan informs you that it intends to do so and you do not object, or (3) the Plan infers from the circumstances based upon professional judgment that you do not object to the disclosure. The Plan will, whenever possible, try to get your written objection to these disclosures (if you wish to object), but in certain circumstances it may rely on your oral agreement or disagreement to disclosures to family members.
• To personal representatives. The Plan may disclose your PHI to someone who is your personal representative. Before the Plan will give that person access to your PHI or allow that person to take any action on your behalf, it will require him/her to give proof that he/she may act on your behalf; for example, a court order or power of attorney granting that person such power. Generally, the parent of a minor child will be the child's personal representative. In some cases, however, state law allows minors to obtain treatment (for example, for pregnancy or substance abuse) without parental consent, and in those cases, the Plan may not disclose certain information to the parents. The Plan may also deny a personal representative access to PHI to protect people, including minors, who may be subject to abuse or neglect.
• For any purpose required by law, such as responding to a court order.

• For public health activities as authorized by law or to comply with the law, such as reporting disease, injury, birth, death or public-health surveillance, investigations and interventions.

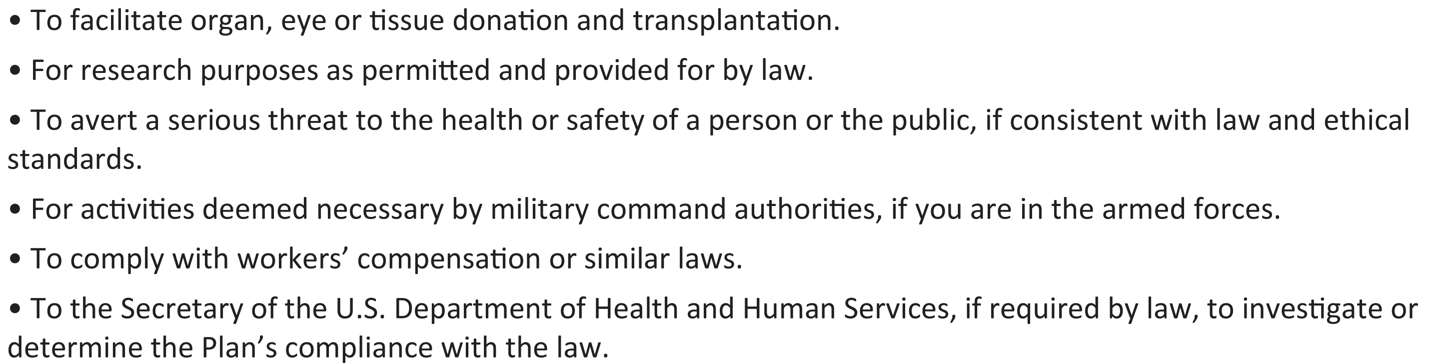
• To the proper government authorities if child abuse or neglect is reported, or if the Plan reasonably believes an individual is a victim of abuse, neglect or domestic violence.

• To a health oversight agency for oversight authorized by law for audits, investigations, proceedings and actions.

• In the course of any judicial or administrative proceeding (for example, responding to a subpoena or lawful request).

• To a law enforcement official (for example, a court order, warrant, subpoena or summons).

• To a coroner, medical examiner or funeral director (for example, to identify the deceased).



• To facilitate organ, eye or tissue donation and transplantation.

• For research purposes as permitted and provided for by law.

• To avert a serious threat to the health or safety of a person or the public, if consistent with law and ethical standards.

• For activities deemed necessary by military command authorities, if you are in the armed forces.

• To comply with workers' compensation or similar laws.

• To the Secretary of the U.S. Department of Health and Human Services, if required by law, to investigate or determine the Plan's compliance with the law.

Uses and Disclosures Requiring Authorization
Uses and disclosures other than those listed above will be made only with your written authorization. Types of uses and disclosures requiring authorization include use or disclosure of psychotherapy notes (with limited exceptions); use or disclosure for marketing purposes (with limited exceptions); and use or disclosure that constitutes the sale of your PHI.

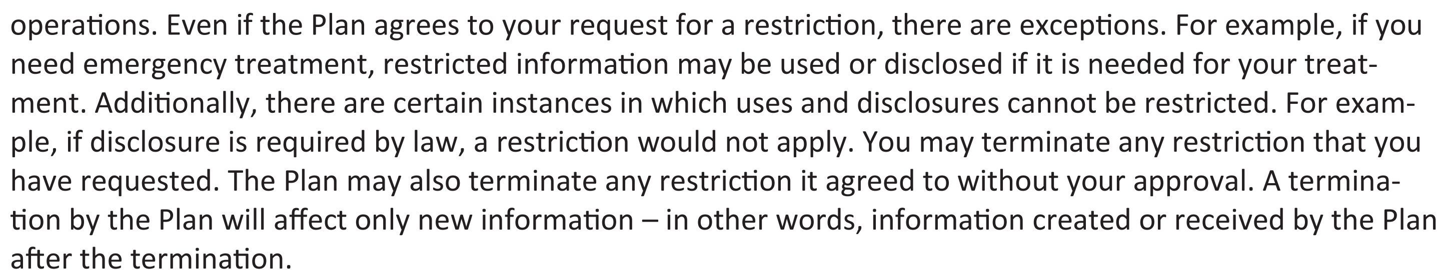
If you authorize a use or disclosure, you have the right to revoke that authorization. Your decision to revoke an authorization must be timely, submitted in writing and delivered to **the Plan's Privacy Official** using the contact information at the end of this notice. Your revocation will apply only to future disclosures of PHI. Once the Plan has taken action with respect to your authorization, the authorization can no longer be revoked for PHI already released.

Protected Health Information
The privacy of health information that can be used to identify you or provides information about you is protected. Not all health information is protected.

Health information that does not identify you or cannot be used to identify you is not protected. In addition, the protections described in this notice do not apply to health information that the Company can have under applicable law (for example, the Family and Medical Leave Act, the Americans with Disabilities Act, workers' compensation laws, federal and state occupational health and safety laws and other state and federal laws), or that the Company properly can get for employment-related purposes through sources other than the Plan and that is kept as part of your employment records (for example, pre-employment physicals, drug testing, fitness for duty examinations, *etc.*).

Individual Rights
You have the following rights:

You may request restrictions on certain uses and disclosures of your PHI.
You may request a restriction on use or disclosure for the purposes of treatment, payment or health care operations. Your request must be in writing. The Plan is not required to agree to this restriction if it would prevent the Plan from carrying out payment or health care



operations. Even if the Plan agrees to your request for a restriction, there are exceptions. For example, if you need emergency treatment, restricted information may be used or disclosed if it is needed for your treatment. Additionally, there are certain instances in which uses and disclosures cannot be restricted. For example, if disclosure is required by law, a restriction would not apply. You may terminate any restriction that you have requested. The Plan may also terminate any restriction it agreed to without your approval. A termination by the Plan will affect only new information – in other words, information created or received by the Plan after the termination.

You may also request that your health care provider not disclose your PHI to the Plan for a health care item or service if you have paid for the item or service out-of-pocket in full. Please note that if your health care provider does not disclose the item or service to the Plan, the amount you paid for the item or service will not count toward your annual deductible or any out-of-pocket maximums under the Plan. The provider may also charge you the out-of-network rate for the item or service.

You have a right to receive confidential (alternative) communications of PHI.
You may request that PHI be communicated to you at an alternate address or by alternate means if your request clearly states that you could be endangered by disclosure of all or part of your PHI. Your request must be made in writing and must specify an alternate address or method of contact. The Plan will accommodate reasonable requests, though it will require that any alternative used still allow for payment information to be effectively communicated and for payments to be made.

You have the right to access or copy your PHI.
You have a right to inspect and copy certain PHI maintained by the Plan. Remember that your health care provider has the most complete records of your health care, including information the Plan does not have, use or maintain.

We recommend that you contact your provider to review your health information. If you want to see the information maintained by the Plan, you must make the request in writing to **the Plan's Privacy Official** using the contact information at the end of this notice. The Plan may charge a cost-based fee for supplies, labor and postage. If you ask for a summary or explanation of your personal health information, the Plan may charge you for the cost of preparing the summary or explanation.

Your right of access is limited. For example, you do not have the right of access to psychotherapy notes, to information used in judicial or administrative proceedings or to information that is subject to the federal Privacy Act or under a promise of confidentiality. The Plan may deny you access to your PHI in the Plan's records. You may, under some circumstances, request a review of that denial.

If the Plan or its business associate maintains electronic records of your PHI, you may request an electronic copy of your PHI. You may also request that your electronic records be sent to a third party.

You have a right to amend PHI about you that is maintained by the Plan.
Your request must be in writing and you must give a reason for the request. Your right to amend is limited. For example, you can only amend information that is available to you under your right of access. The Plan may deny your request if the information was not created by the Plan and the creator of the information is available to respond to your request. The Plan may deny your request if the information is accurate and complete.

You have a right to receive an accounting of some (but not all) disclosures made by the Plan.
You may request an accounting of disclosures of your PHI made within the six-year period just before the date of your request. Your request must be in writing. The accounting will not include disclosures the Plan is permitted to make for treatment, payment and health care operations, or those made with your authorization. The accounting will not include disclosures made to you or close family members involved in your care. The accounting will not include disclosures made for purposes of national security, incidental to otherwise permitted or required disclosures, as part of a limited data set or to correctional institutions or law enforcement officials. Your right to an accounting may be suspended in the event of certain government activities. If you request more than one accounting within a 12-month period, the Plan may charge you a cost-based fee for the additional requests.

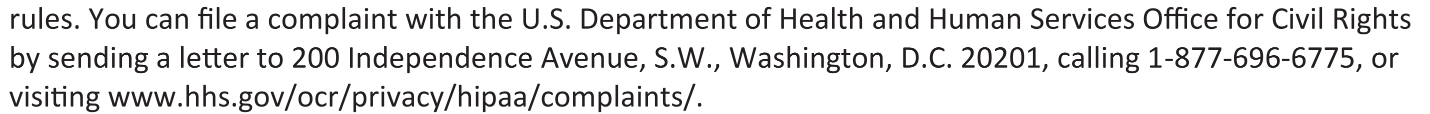
You have a right to receive a paper copy of this notice.
If you have agreed to receive this notice by e-mail, you also have a right to receive a paper copy upon request.

You have a right to receive notification of a breach of your PHI.
You will be notified if your unsecured PHI is acquired, accessed, used or disclosed in a manner that is not permitted under HIPAA and the security or privacy of your PHI is compromised.

Complaints
You may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

Complaints to the Plan should be directed to **the Plan's Privacy Official** using the contact information at the end of this notice. If your complaint is with an insurer, you may file a complaint with the individual named in the insurer's notice of privacy practices to receive complaints. Retaliation against a person who files a complaint is prohibited.

To file a complaint with the Secretary of the U.S. Department of Health and Human Services, you must submit your complaint in writing, either on paper or electronically, within 180 days of the date you knew or should have known that the violation occurred. You must state who you are complaining about and the acts or omissions you believe are violations of HIPAA's privacy



rules. 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/.

Contact the Plan about This Notice

For further information about the content of this notice or about filing a complaint, call McLarens US Human Resources at 770.729.5465 or email us.benefits@mclarens.com.

Send written requests or other written communication to the Plan's Privacy Official:

Condra D. Harvill, SPHR
Vice President, Global Human Resources
McLarens
5555 Triangle Parkway, Suite 200
Norcross, GA 30092

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 via email at us.benefits@mclarens.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
McLarens, Inc.		51-0289022
5. Employer address		6. Employer phone number
5555 Triangle Parkway, Suite 200		770-729-5465
7. City	8. State	9. ZIP code
Norcross	GA	30092
10. Who can we contact about employee health coverage at this job?		
Human Resources via email at us.benefits@mclarens.com		
11. Phone number (if different from above)	12. Email address	
	rachel.estermyer@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:

All Full-time Employees working 30 or more hours per week - offered minimum value and intended to meet affordable criteria.
Straight Commission Employees - offered minimum value - Not intended to meet affordable criteria.

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

Spouses and Domestic Partners. Dependent Children until age 26.

  - ☐ 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?**

- [x] **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? 1st of the month following date of hire. (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*?
[x] 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? $ Full-time - Lesser of $105.58 OR 9.5% of earnings every 2 weeks; Straight Commission - $831.83 monthly OR $383.92 every 2 weeks
b. How often? [ ] Weekly [x] Every 2 weeks [ ] Twice a month [x] 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? Full time - change in premium effective 10/1/2017; Straight Commission - change in premium effective 10/1/2017
- [ ] Employer won't offer health coverage
- [x] 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? $ Full-time - Lesser of $107.69 OR 9.5% of earnings every 2 weeks; Straight Commission - $848.47 monthly or $391.60 every 2 weeks
b. How often? [ ] Weekly [x] Every 2 weeks [ ] Twice a month [x] 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)

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

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

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

__________________________________ __________________________________

Employee Name – Please Print Employee Social Security Number

__________________________________ ________/__________/________

Employee Signature Date

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