JACKSON-DAWSON

EMPLOYEE BENEFITS ENROLLMENT GUIDE

PLAN YEAR | 2013

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

Priority Health Plan
(800) 942-0954
www.priorityhealth.com
CLAIMS ADDRESS:
P.O. Box 232
Grand Rapids, MI 49501-0232

HealthEquity
(866) 346-5800
www. memberservices@healthequity.com
CLAIMS ADDRESS:
15 W. Scenic Pointe Drive, Suite 400
Draper, UT 84020

AlwaysCare
(888)-729-5433 (ext: 2013)
CLAIMS ADDRESS:
Always Care Benefits
P.O. Box 80139
Baton Rouge, LA 70898-0139

National Vision Administrators, LLC
(800) 672-7723
www.e-nva.com
CLAIMS ADDRESS:
P.O. Box 2187
Clifton, NJ 07015

UNUM
(800)421-0344
www.unum.com
CLAIMS ADDRESS:
The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158

MEDICAL PLANS

Priority Health

PPO

JACKSON DAWSON COMMUNICATIONS
SCHEDULE OF MEDICAL BENEFITS
PREFERRED PROVIDER ORGANIZATION (PPO) PLAN
HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
Effective Date: April 1, 2013
Benefit Year: The 12 month period beginning each January 1 and ending each December 31.

Network Benefits are provided by network providers (except as otherwise provided by this SPD), and may require prior certification with the Benefit Administrator (except in a medical emergency). For a current status of Priority Health network providers, call the Customer Service Department at **616 956-1954 or 800 956-1954**. A listing of Priority Health network providers is also available on the Internet at prioritynealth.com.

Out-of-Area Network Benefits are provided by PHCS or Multiplan providers when medical care is needed while traveling or living outside the Priority Health service area. Benefits will be paid at the network level. For a current PHCS/Multiplan provider listing, please contact PHCS/Multiplan at **888 785-7427** or check the listing online at multiplan.com. Claims for these out-of-area network benefits may be submitted to Priority Health.

Non-Network Benefits are provided by non-network providers. Services may require the satisfaction of deductibles and coinsurance amounts, and are subject to reasonable and customary charges. Some benefits must be prior certified with the Benefit Administrator (except in a medical emergency).

Prior Certification: Prior certification is required for all inpatient hospital or facility services. Non-emergency admissions must be prior certified at least five working days before admission. Emergency admissions must notify the Benefit Administrator as soon as reasonably possible after admission. You or your physician must call **800 269-1260** to prior certify services. If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, you must notify our Behavioral Health Department as soon as possible for assistance. Call our Behavioral Health department at **616 464-8500** or **800 673-8043** for assistance. You do not need prior approval from Priority Health for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Other services requiring prior certification are:

- Home Health Care
- Skilled Nursing, Sub acute & Long-term Acute Facility Care
- Inpatient Rehabilitation Care
- Durable Medical Equipment over $1,000
- Hospice Care
- Transplants
- Imaging Services
- Prosthetic Devices over $1,000

The full list of services that require prior certification is included in the SPD and may be updated from time to time. A current listing is also available by calling the Priority Health Customer Service Department at 616 956-1954 or 800 956-1954. Other services may be prior certified by you or your provider to determine medical/clinical necessity before treatment. Prior certification is not a guarantee of coverage or a final determination of benefits under this plan.

Deductibles:

The deductible is the dollar amount of covered services you must incur during the benefit year before benefits will be paid. The network deductible is applicable to all covered services except:

- Preventive health care services that are listed in Priority Health's preventive health care guidelines.
- Routine obstetrical services (deductible **will** apply to delivery, facility charges and anesthesia charges associated with the delivery).

If you have individual coverage, you must meet the individual deductible below. If you have more than one person in your family, you have family coverage and only the family deductible applies. The family deductible can be satisfied by only one family member or by any combination of family members.

The network and non-network deductible are calculated separately. You must meet the deductible at the network benefit level before benefits will be paid for services you seek under the network benefits. If you choose to use the non-network benefits, you must meet the deductible at the non-network benefits level before benefits will be paid for services you seek under the non network benefits. Network deductible amounts do not apply to non-network deductible amounts, nor do non-network deductible amounts apply to network deductible amounts.

The deductible amounts renew each benefit year. This plan does not carry over any deductible amounts incurred in the prior benefit year.

The deductible will include any monies paid for covered pharmacy services.

Notwithstanding the above, the following costs shall not apply towards the deductible: Services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); penalties paid for failure to prior certify services; and any amounts paid by participants for non-network benefits that exceed reasonable and customary.

Out-of-Pocket Maximums:

The out-of-pocket maximum limits the total amount of covered expenses that you or your covered dependents will pay during a benefit year. The network and out-of-network out-of-pocket amounts are calculated separately. Once the network benefits out-of-pocket maximum is met, all further covered medical and pharmacy services incurred at the network benefits level will be paid at 100% of Priority Health's contracted rate for the remainder of the benefit year. Once the non-network benefits out-of-pocket maximum is met, all further covered medical services incurred at the non-network benefits level will be paid at 100% of the lesser of billed charges or reasonable and customary charges for the remainder of the benefit year.

Network out-of-pocket amounts do not apply to non-network out-of-pocket amounts, nor do non-network out-of-pocket amounts apply to network out-of-pocket amounts.

If you have individual coverage, all copayments, coinsurance and deductibles you paid towards covered services during the benefit year will be included when calculating your out-of-pocket maximums. If you have family coverage, all copayments, coinsurance and deductibles you and/or your covered family members paid collectively towards covered services during the benefit year will be included when calculating your out-of-pocket maximums.

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-of-pocket maximum: Expenses for services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); penalties paid for failure to prior certify services; and costs paid by participants to provider for non-network benefits that exceed reasonable and customary.

Note: If the non-notification penalty applies, the amount Priority Health pays will be reduced even if the out-of-pocket maximum has been reached.

The following information is provided as a summary of benefits available under your plan. This summary is not intended as a substitute for your Summary Plan Description. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the Summary Plan Description and any applicable amendments to the plan.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Deductibles	$2,000 per individual; $4,000 per family per benefit year.	$3,500 per individual; $7,000 per family per benefit year.
Coinsurance Percentage Rate	90% paid by the plan; 10% paid by the participant, unless otherwise noted.	70% paid by the plan; 30% paid by the participant, unless otherwise noted.
Out-of-Pocket Maximums	$4,000 per individual; $8,000 per family per benefit year. All services apply to out-of-pocket maximum except as noted. ***Please note the deductible <u>does</u> apply to the out-of-pocket maximum.***	$5,500 per individual; $11,000 per family per benefit year. All services apply to out-of-pocket maximum except as noted. ***Please note the deductible <u>does</u> apply to the out-of-pocket maximum.***
Maximum Individual Benefit year Benefit (Combined Network/Non-Network Benefit)	$2,000,000	
Reduction of Benefits Penalty (Non-Notification Penalty)	$250 if not prior certified.	

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available in the member center on our web site at prioritythealth.com or you may request a copy from our Customer Service Department. Priority Health's Guidelines include preventive services required by legislation.		
Routine Physical Exams & Services	100% coverage. Deductible does not apply.	Covered at 70%. Deductible applies.
Women's Preventive Health Services	100% coverage. Deductible does not apply.	Covered at 70%. Deductible applies.
Routine Pap Smears	100% coverage. Deductible does not apply.	Covered at 70%. Deductible applies.
Routine Mammograms	100% coverage. Deductible does not apply.	Covered at 70%. Deductible applies.
Rectal/Colon Cancer Screening Test	100% coverage. Deductible does not apply.	Covered at 70%. Deductible applies.
Well Child Care	100% coverage. Deductible does not apply.	Covered at 70%. Deductible applies.
Immunizations	100% coverage. Deductible does not apply.	Covered at 70%. Deductible applies.
Medical Office Services		
Office and Home Visits	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Office Consultations, Pre-operative and Post-operative Visits	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Office Surgery	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Office Injections	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Allergy Services (including allergy testing, evaluations and injections, including serum costs)	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Diagnostic Radiology and Lab Services (Performed in physician's office or freestanding facility.)	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required. (Performed in physician's office or freestanding facility.)	Covered at 90%. Deductible applies. $250 if not prior certified.	Covered at 70%. Deductible applies. $250 if not prior certified.
Obstetrical Services by Physician (Including prenatal, delivery and postnatal care.)	90% coverage. Deductible does not apply to routine prenatal and postnatal services. (Deductible applies to delivery, facility and anesthesia charges for delivery.)	Covered at 70%. Deductible applies.
Pre-Natal Classes	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Dietitian Services (other than as provided in Priority Health's Preventive Health Care Guidelines)	90% coverage up to a maximum of six visits per benefit year. Deductible applies.	Not covered.
Education Services (other than as provided in Priority Health's Preventive Health Care Guidelines)	Covered at 90%. Deductible applies.	Not covered.
Hospital Services		
Inpatient Hospital and Inpatient Longterm Acute Care Services Prior approval is required except in emergencies or for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Prior certification phone number is **800 269-1260**.	Covered at 90%. Deductible applies. $250 if not prior certified.	Covered at 70%. Deductible applies. $250 if not prior certified.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Hospital Services (continued)		
Inpatient Professional and Surgical Charges	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Outpatient Hospital Facility Services	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Outpatient Hospital Professional and Surgical Charges	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Obstetrical Services in Hospital (facility and anesthesia services)	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Hospital Diagnostic Laboratory & Radiology Services	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Hospital Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required.	Covered at 90%. Deductible applies. $250 if not prior certified.	Covered at 70%. Deductible applies. $250 if not prior certified.
Certain Surgeries and Treatments(Physician fees only) **Reconstructive surgery:** Blepharoplasty of upper lids, breast reduction, panniculectomy**, rhinoplasty**, septorhinoplasty**, surgical treatment of male gynecomastia **Skin disorder treatments:** Scar revisions, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo **Varicose veins treatments** **Sleep apnea treatment procedures****	Physician fees are covered at 50%, of the first $2,000 for each certain surgery or treatment, 100% thereafter. Deductible applies. **Prior approval required for panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures. $250 penalty if not prior certified.	Physician fees are covered at 50%, of the first $2,000 for each certain surgery or treatment, 100% thereafter. Deductible applies. **Prior approval required for panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures. $250 penalty if not prior certified.
Treatment of Morbid Obesity • Physician's Weight Loss Programs • Bariatric Surgery – limited to one per lifetime. Prior certification required.	Physician fees are covered at 50%, of the first $2,000 for each certain surgery or treatment, 100% thereafter up to a benefit year maximum of $25,000. Deductible applies. $250 penalty if not prior certified.	Physician fees are covered at 50%, of the first $2,000 for each certain surgery or treatment, 100% thereafter up to a benefit year maximum of $25,000. Deductible applies. $250 penalty if not prior certified.
Note: If the services of a surgical assistant are required for a surgical procedure, the non-network covered expenses will be the lesser of: (1) the amount charged by the assistant; or (2) 20% of the amount allowable to the physician who performed the surgery.		
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered at 90%. Deductible applies.	Covered at 90%. Deductible applies.
Ambulance Services	Covered at 90%. Deductible applies.	Covered at 90%. Deductible applies.
Urgent Care Facility Services	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Behavioral Health Services - Prior certification by our Behavioral Health Department is required, except in emergencies, for inpatient services as noted below: Call 616 464-8500 or 800 673-8043.		
Inpatient Mental Health & Substance Abuse Services (including rehabilitation and partial hospitalization) Prior certification required except in emergencies.	Covered at 90%. Deductible applies. $250 if not prior certified.	Covered at 70%. Deductible applies. $250 if not prior certified.
Outpatient Mental Health & Substance Abuse Services (including medication management visits)	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Family Planning and Reproductive Services		
Infertility Counseling & Treatment Covered for diagnosis and treatment of underlying cause only. Limitations and exclusions apply.	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Vasectomy Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Tubal Ligation/Tubal Obstructive Procedures (included as part of the Women's Preventive Health Services benefits.)	Covered at 100%, deductible does not apply, when performed at outpatient facilities. If received during an inpatient stay, only the services related to the tubal ligation/tubal obstructive procedure are covered in full, deductible waived.	Covered at 70%. Deductible applies.
Birth Control Services Medical Plan (i.e. doctor's office) (included as part of the Women's Preventive Health Services benefits.) Includes; diaphragms, implantables, injectables, and IUD (insertion and removal), etc.	Covered at 100%, deductible does not apply.	Covered at 70%. Deductible applies.
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation) (Combined Network/Non-Network Benefit.)	Covered at 90% up to a combined benefit maximum of 50 visits per benefit year. Deductible applies.	Covered at 50% up to a combined benefit maximum of 50 visits per benefit year. Deductible applies.
Speech Therapy (Combined Network/Non-Network Benefit.)	Covered at 90% up to a combined benefit maximum of 50 visits per benefit year. Deductible applies.	Covered at 50% up to a combined benefit maximum of 50 visits per benefit year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Network/Non-Network Benefit.)	Covered at 90% up to a combined benefit maximum of 50 visits per benefit year. Deductible applies.	Covered at 50% up to a combined benefit maximum of 50 visits per benefit year. Deductible applies.
Other Services		
Prescription Drugs – Closed Formulary Includes disposable needles/syringes for diabetics. Zostavax vaccines, smoking cessation products and Any medications provided in the Priority Health's Preventive Health Care Guidelines, including certain women's prescribed contraceptive methods are covered at 100%, deductible and coinsurance waived. Brand-name oral and injectable contraceptives are subject to applicable deductible and coinsurance. Limitations apply. Expenses for non-covered prescription drugs will not be applied towards your deductible or out of pocket maximum.	Covered at 90%. Deductible applies. Infertility drugs are covered at 50%. Deductible applies. Mail order prescription drug program available.	

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (continued)		
Durable Medical Equipment Prior certification is required for charges over $1,000. Limitations apply.	Covered at 90%. Deductible applies. $250 penalty if not prior certified.	Covered at 50%. Deductible applies. $250 penalty if not prior certified.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000. Limitations apply.	Covered at 90%. Deductible applies. $250 penalty if not prior certified.	Covered at 50%. Deductible applies. $250 penalty if not prior certified.
Temporomandibular Joint Syndrome (TMJS) Treatment Limitations apply.	*Covered at 50%. Deductible applies.	Covered at 50%. Deductible applies.
Orthognathic Treatment Limitations apply.	*Covered at 50%. Deductible applies.	Covered at 50%. Deductible applies.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facilities (Combined Network/Non-Network Benefit.) Prior certification required.	Covered 90% up to a maximum of 45 days per benefit year. Deductible applies. $250 penalty if not prior certified.	Covered 70% up to a maximum of 45 days per benefit year. Deductible applies. $250 penalty if not prior certified.
Home Health Services Limitations apply. Prior certification required.	Covered at 90%. Deductible applies. $250 if not prior certified.	Covered at 70%. Deductible applies. $250 if not prior certified.
Hemodialysis, Radiation Therapy and Chemotherapy	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Custodial Care/Private Duty Nursing/Home Health Aides	Not covered. Medically necessary private duty nursing may be covered with prior authorization from the Benefit Administrator.	
Hearing Services Covered for treatment of medical conditions and diseases of the ear only. Hearing aids are not covered.	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Eye Care Covered for treatment of medical conditions and diseases of the eye only. Refractive errors and vision supplies are not covered.	Covered at 90%. Deductible applies.	Covered at 70%. Deductible applies.
Coverage Information		
Waiting Period Requirement	1st of the month following 30 days of employment.	
Minimum Hours Worked	30 hours worked per week.	
Part-Time Employee	Not applicable.	
Retiree Coverage	Not applicable.	
Dependent Children	Covered to the day in which they turn age 26. Over age 26 if mentally or physically incapacitated dependent.	
Pre-Existing Condition Limitation	Not applicable.	
Motor Vehicle Injuries	Coordinated with motor vehicle insurance.	

In accordance with the terms and conditions of the SPD, you are entitled to covered services when these services are:

A. Medically/clinically necessary; and
B. Not excluded in the SPD.

If you seek services when prior certification is required and you do not receive prior certification, except in emergencies, you will be charged a penalty. You will also be responsible for services rendered that are beyond those prior certified as medically/clinically necessary.

If the hospital confinement extends beyond the number of prior certified days, the additional days will not be covered unless:

- The extension of days is medically/clinically necessary, and
- Prior certification for the extension is obtained before exceeding the number of prior certified days.

For emergency admissions, the Benefit Administrator should be notified by the end of the next business day following the admission or as soon as reasonably possible.

Coverage maximums up to a certain number of days or visits per benefit year are reached by combining either network or non-network benefits up to the limit for one or the other but not both. (Example: If the network benefit is for 60 visits and the non-network benefit is for 60 visits, the maximum benefit is 60 visits, not 120 visits.)

The plan will pay benefits up to the maximum annual individual benefit limit. This limit applies individually to each participant. When benefits in that amount have been paid or are payable for a participant, all benefits under this medical plan for that person will terminate for the remainder of the benefit year.

HEALTH SAVINGS ACCOUNT

HealthEquity

HealthEquity - Health Savings Accounts

Health Savings Account Basics

- Jackson-Dawson Communications will provide funding into your HSA account. If you have single coverage the amount will be $125 per quarter ($500 per year). If you insure dependents the amount will be $250 per quarter ($1,000 per year).

- An HSA is an investment account in which funds:
    - Go into tax free (through section 125 or above the line on your 1040)
    - Accumulate tax free
    - Can be withdrawn tax free (for qualified medical expenses)
    - Can be left in the account for future use (roll over)

- An HSA is owned by you

- An individual who is covered under a qualified HDHP, but not simultaneously covered under a non-qualified plan can contribute to an HSA
    - Spouse's insurance Policy
    - Medicare

- Annual contributions are limited to the following:
    - $3,250 for single coverage
    - $6,450 if you insure dependents
    - If you are over age 55 "catch up" contributions are permitted ($1,000 in 2013)
    - If you are enrolled in the plan for less than 12 months your contributions are not limited however you must remain enrolled in the HDHP for the subsequent calendar year.

- Your HSA can be funded:
    - Through pre-tax payroll deduction
    - In lump sum deposits
    - Any time prior to April 15th

- You are responsible for maintaining the records of your qualified withdrawals:
    - Non-qualified withdrawals are taxable at your normal tax rate
    - Prior to age 65 non-qualified withdrawals are subject to a 10% penalty

DENTAL

AlwaysCare

Dental Insurance

Welcome to AlwaysCare! We are pleased to offer Dental benefits for you and your family effective 4/1/2013.

Selection of Providers: Members may choose any licensed dental provider. Members have access to our national network of over 144,000 participating access points where they can take advantage of discounts AlwaysCare has negotiated on their behalf. Further, in areas with relatively few participating providers, members have access to our list of an additional 46,000+ "certified" providers who, according to an independent resource, despite not participating in our network, offer excellent value for their customers. Members using participating providers will eliminate balance billing and reduce out-of-pocket expenses. No claim forms needed with participating providers. Visit www.AlwaysCareBenefits.com or call 1-888-729-5433, Ext. 2013 for a list of participating providers.

Deductible: Maximum 3 per family. Applies to Basic (Class B) and Major (Class C) Services.	**In-Network: $0 Annual. No Limit** (Applies to Class B and C Services) **Non-Network: $50 Annual. Maximum 3 per family** (Applies to Class B and C Services)			
Coinsurance: The plan pays the following percentages of maximum allowable charges for each class:			In Network	Out of Network
	Class A	Preventive	100%	100%
	Class B	Basic	80%	80%
	Class C	Major	50%	50%
Benefit Maximums: (Class A, B, and C benefits).	$1000 per benefit year			
Carryover Benefit:	$250, Threshold Limit $500, Carryover Account Maximum $1000.			

Covered Procedures and Waiting Periods:

Preventive Services (Class A): No waiting period.

- Routine exams (2 per 12 months)
- Prophylaxis (2 per 12 months)
  - (1 additional cleaning or periodontal maintenance per 12 months if member is in 2nd or 3rd trimester of pregnancy)
- Bitewing x-rays (maximum of 4 films) (1 per 12 months)
- Fluoride treatment for children up to age 16 (1 per 12 months)
- Sealants for children up to age 16 (permanent molars 1 per 36 months)
- Space maintainers for children up to age 16 (1 per 24 months)
- Adjunctive Pre-Diagnostic Oral Cancer Screening (1 per 12 months for age 40+)

Basic Services (Class B): No waiting period.

- Simple restorative services (Fillings)
- Simple extractions
- Full mouth / panoramic x-rays (1 per 24 months)
- Emergency treatment (1 per 12 months)
- Oral surgery (extractions and impacted teeth) & Anesthesia (subject to review, covered with complex oral surgery)
- Simple Periodontics
- Surgical Periodontics
- Endodontics (Root Canals)

Major Services (Class C): No waiting period.

- Inlays and Onlays
- Crowns, Bridges, Dentures and Endosteal Implants
- Repair of Crown, Denture, or Bridge

AlwaysCare Hearing℠ Savings Plan

- **Available at no cost to all AlwaysCare Members**
- **Material discounts between 30%-60% on all major name brand hearing instruments and accessories**
- **Battery program discounts up to 40% off retail pricing**

Dental Carryover Benefit
Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! If an Insured submits qualifying claims for covered expenses during a benefit year and, in that benefit year, receives benefits that are less than their group's Threshold Limit, the Insured will be credited a Carryover Benefit. Carryover Benefits will be accrued and stored in the Insured's Carryover Account to be used in the next benefit year. If an Insured reaches his or her Certificate Year Maximum Benefit, we will pay a benefit from the Insured's Carryover Account up to the amount stored in the Insured's Carryover Account. The accrued Carryover Benefits stored in the Carryover Account may not be greater than the Carryover Account Limit.

The Limits for this Policy/Certificate are: Carryover Benefit **$250**, Threshold Limit **$500**, Carryover Account Limit **$1000**.

Other Specifications:

- An Insured's Carryover Account will be eliminated, and the accrued Carryover Benefits lost, if the Insured has a break in coverage of any length of time, for any reason.
- Eligibility for a Carryover Benefit will be established or reestablished at the time the first Qualifying Claim in a benefit year is received for Covered Expenses incurred during that benefit year.
- In order to be eligible to accumulate the Carryover Benefit, an Insured must be enrolled in the plan at least four months prior to the start of the new policy year. Example: If the plan effective date is January 1st, the Insured must be enrolled by September 1st.
- Only claims incurred on or after the start of the next Policy Year will count toward the Threshold Limit.
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Policy Year that starts one year from the date the rider first applies.
- If charges for Class C Services are not payable for an Insured due to a benefit waiting period for certain covered procedures, this rider will not apply to the Insured until the end of such waiting period. And, if the waiting period ends within the three months prior to the start of this plan's next benefit year, this rider will not apply to the Insured until the next benefit year.
- Carryover Benefits will not be applied to an Insured's Carryover Account until the benefit year that starts one year from the date the rider first applies.
- Definitions:
- "Benefit Year" means Calendar Year or Policy Year, according to the type of plan applicable under the Policy/Certificate to which this rider is attached.
- "Carryover Account" means the amount of an Insured's accrued Carryover Benefits.
- "Carryover Account Limit" means the maximum amount of cumulative Carryover Benefits that an Insured can store in his or her Carryover Account.
- "Carryover Benefit" means the dollar amount, which will be added to an Insured's Carryover Account when he or she receives benefits in a benefit year that do not exceed the Threshold Limit.
- Qualifying Claim means a claim under Procedure Classes A, B and C and Class D, Orthodontia and must include 1 exam and one cleaning.
- "Threshold Limit" means the maximum amount of benefits for all procedure classes A, B, C and D that an Insured can receive during a benefit year and still be entitled to receive the Carryover Benefit.

Dependent Children: Dependent age guidelines vary by state. Please refer to your policy certificate or contact customer service at 888-729-5433, Ext. 2013.

Services Not Listed: If you expect to require a dental or vision service not included on this brochure, it may still be covered. Please contact customer service at 1-888-729-5433 Ext. 2013 to confirm your exact benefits.

Alternate Treatment: AlwaysCare Benefits, Inc. covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment, but will be responsible for the cost difference resulting from the more expensive procedure.

Exclusions/Limitations: AlwaysCare Members whose dental plan includes coverage of crowns and bridges will have the option of choosing an endosteal implant to replace a missing tooth instead of a conventional fixed 3-unit bridge, when a 3-unit bridge is approved for coverage. Crowns placed on implants will also be covered. Other implants or implant related services are not covered.

The following dental services are not covered:

- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
- the correction of congenital malformations;
- the replacement of lost, discarded, or stolen appliances;
- replacement of bridges, dentures, crowns, inlays, onlays or dentures unless more than [5] years old and cannot be made serviceable;
- appliances, services or procedures relating to: (i) the change or maintenance of vertical dimension; (ii) restoration of occlusion; (iii) splinting; (iv) correction of attrition, abrasion, erosion or a fraction; (v) bite registration; or (vi) bite analysis;
- services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
- charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments, and related procedures;
- dentures for teeth missing prior to effective date of coverage; some exceptions apply and are detailed in the Certificate of Coverage;
- multiple x-rays done on same date of service will be combined to a full-mouth x-ray;
- cosmetic restorations on posterior permanent teeth and all primary teeth will be given alternate benefit;
- Anesthesia is covered with complex oral surgery only. Charges are subject to review. Pre-treatment estimate is recommended.

Takeover Benefits:

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to us.

Application of takeover benefits is subject to Underwriting review and approval.

New hires with prior-like dental coverage (lapse in coverage must be less than 63 days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e. one page benefit summary, certificate of creditable coverage, etc.).

Late entrants: Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coverage with AlwaysCare will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.

The prior carrier is responsible for reimbursement of costs for procedures begun prior to the effective date.

This brochure is a brief overview of the AlwaysCare[SM] dental plan. It does not list all benefits, nor does it list all exclusions and limitations. For more complete information, please refer to the Certificate, or the employer's Master Policy, which will be issued when coverage becomes effective.

VISION PLAN

NVA (National Vision Administrators)

Schedule of Vision Benefits

Co-payment *$10 Exam / $25 Lenses*	Participating Provider	Non-Participating Provider
Examination Once Every 12 Months	▪ *Covered 100%* ▪ *After $10 copay*	Reimbursed Amount ▪ *Up to $45*
Lenses Once Every 12 Months ▪ *Single Vision* ▪ *Bifocal* ▪ *Trifocal* ▪ *Lenticular* ▪ *Polycarbonates (under age 19)*	Standard Glass or Plastic ▪ *Covered 100%* ▪ *After $25 copay*	▪ *Up to $45* ▪ *Up to $55* ▪ *Up to $80* ▪ *Up to $80* ▪ *N/A*
Frame Once Every 12 Months	Retail Allowance ▪ *Up to $130* *(20% discount off balance)**	▪ *Up to $45*
Contact Lenses Once Every 12 Months Elective Contact Lenses *Medically Necessary****	In lieu of Lenses ▪ *Up to $130 Retail①* *(15% discount (Conventional) or 10% discount (Disposable) off balance)*** ▪ *Covered 100%*	In lieu of Lenses ▪ *Up to $105* ▪ *Up to $210*

**Does not apply to Wal-Mart / Sam's Club locations*
***Does not apply to Wal-Mart / Sam's Club or Contact Fill locations*
****Pre-approval from NVA required*

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- *$10 Solid Tint*
- *$12 Fashion / Gradient Tint*
- *$10 Standard Scratch-Resistant Coating*
- *$12 Ultraviolet Coating*
- *$40 Standard Anti-Reflective*
- *$20 Glass Photogrey (Single Vision)*
- *$30 Glass Photogrey (Multi-Focal)*
- *$75 Polarized*
- *$50 Progressive Lenses Standard*
- *$65 Transitions Single Vision Standard*
- *$70 Transitions Multi-Focal Standard*
- *$25 Polycarbonate (Single Vision) 19 & over*
- *$30 Polycarbonate (Multi-Focal) 19 & over*
- *$30 Blended Bifocal (Segment)*
- *$55 High Index*

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices Wal-Mart / Sam's Club will not provide the lens options at the fees listed in the fixed option pricing list. Wal-Mart / Sam's Club stores accept NVA for materials. Doctors affiliated with Wal-Mart / Sam's Club are not Wal-Mart / Sam's Club employees; therefore, participation for exams varies.

NVA® is a registered mark of National Vision Administrators, L.L.C

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

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National Vision Administrators, L.L.C.

Jackson-Dawson Communications, Inc.

Summary of Vision Care Benefits

National Vision Administrators, L.L.C. (NVA) has been contracted by your group to offer a comprehensive vision care plan to you and your eligible family members. Founded in January of 1979, NVA manages vision benefit services for approximately seven million lives nationwide. Group Effective 04/01/2011

How Your Vision Care Program Works

- *For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back.*
- *When scheduling your appointment, please notify the NVA participating provider of your choice that your vision coverage is administered by NVA.*
- *The provider will contact NVA to verify eligibility.*
- *At the time of your appointment, simply present your NVA identification card to the provider or indicate clearly that your benefit is administered by NVA.* A vision claim form is not required at an NVA participating provider.
- *The provider will inform you of your eligibility status prior to rendering services.*
- *Be sure to inform the provider of your medical history and any prescription or over-the-counter medications you may be taking.*

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com or contact NVA's Customer Service Department toll-free at 1.800.672.7723.

Eligibility: Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses once every 12 months from last date of service.

Customer Service: To verify eligibility, locate a participating provider and receive answers to all your vision care related inquiries, please call NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD: 973.574.2599).

- *NVA's Interactive Voice Response (IVR) system is available twenty-four (24) hours per day, seven (7) days per week. The IVR allows you to locate a participating provider in your area, check eligibility as well as the status of your claim(s).*
- *An NVA Customer Service Representative can be contacted twenty-four (24) hours per day, seven (7) days per week.*

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723


This document has been printed on recycled paper.

Benefits at Participating Providers:

Highlights of your vision care benefit:

- The option of receiving services in- or out-of-network
- Extensive national provider network
- Enhanced in-network benefits:
  - *100% covered Vision examination (after copay if applicable)*
  - *100% covered standard spectacle lenses (after copay if applicable)*
  - *Frame allowance covers countless fashionable frames in full*
  - *Allowance towards the cost of contact lenses and fitting fees*
  - *No claim forms; providers will submit claims directly to NVA.*

Examinations: A comprehensive eye examination is covered which includes a case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, and Tonometry testing (glaucoma). Comprehensive eye examinations can aid in the early detection of ocular diseases and other serious medical conditions.

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office.

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Discounts: In addition to your funded benefit you are eligible to access the EyeEssential[SM] Plan discount on additional purchases during the plan period.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. To obtain direct reimbursement according to your plan design, you can print a claim form from www.e-nva.com. Please complete this form and submit along with an original or copy of the itemized receipt. If you cannot print the claim form you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA's Clifton, NJ office. **Remember**, obtaining vision care services from a non-participating provider will result in greater out-of-pocket expense.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage.

Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Valuable Member Discounts

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S.

Members are entitled to significant discounts and a free initial consultation with all in-network providers.

All providers are contracted to extend members discounts on standard prices or promotional prices, ensuring the member will pay less than the public.

- 15% off standard prices - or - 5% off promotional pricing

All-Inclusive Discount

- All in network providers extend the discount on the entire cost of the procedure, maximizing member savings.

Additional Member Value – Members are entitled to these additional benefits available exclusively at select providers (over 70 locations nationwide).

- Special "set prices" ranging from $695 to $1,895 per eye on select technologies.
- Free initial consultation and comprehensive LASIK exam
- Advanced laser technologies including Wavefront and IntraLase (All-Laser LASIK)
- Attractive financing options available

The process is simple:

- *Find a provider (Call 1-877-295-8599 or visit* www.e-nva.com)
- *Schedule a pre-operative exam to determine if laser vision correction is right for you*
- *Schedule a treatment*
- *Pay discounted member price directly to the provider*

Contact Fill: NVA provides you with the convenience and savings of Contact Fill, our mail order contact lens replacement service. You may access Contact Fill's services online at www.contactfill.com or by calling them toll-free at 866.234.1393. Contact Fill provides contact lens wearers with significant savings packaged with the convenience of home delivery. Plan discounts applicable at participating retail locations do not apply to purchases made through Contact Fill due to the already low prices.

Please enter NVAFSNEW for free shipping and handling on your first order. Expires 03-31-15

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:

- *Locate a nearby participating provider by name, zip code, or City/State*
- *Verify eligibility for you or a dependent*
- *View benefit program and specific details*
- *Review claims*
- *Print ID cards (when allowable)*
- *Nominate a non-participating provider to join the NVA network*

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number **51614000001** or the group number on the identification card you will be receiving prior to your effective date and enter in your search parameters. It's that easy!

Jackson-Dawson Communications, Inc.

EyeEssential℠ Plan

	Participating Provider	Non-Participating Provider
Please Note: After you have exhausted your funded benefit, you are eligible to access the NVA EyeEssential℠ Plan. The EyeEssential℠ Plan is an In-Network Benefit Only. Benefit Frequencies are unlimited.		
	Member Cost	
Examination:	Retail less $10	Not Applicable
Contact Lens Evaluation/Fitting:	Retail less 10%	Not Applicable
Lenses:	Glass or Plastic	Not Applicable
Single Vision	$35.00	
Bifocal	$55.00	
Trifocal	$70.00	
Lenticular	$70.00	
Frame:	Retail less 35%	Not Applicable
Contact Lenses①:		
Conventional	Retail less 15%	Not Applicable
Disposable	Retail less 10%	Not Applicable

①Discount is not applicable to mail order; however, you may get even better pricing through Contact Fill.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- *$12 Solid / Gradient Tint*
- *$75 Polarized*
- *$15 Standard Scratch-Resistant Coating*
- *$12 Ultraviolet Coating*
- *$45 Standard Anti-Reflective*
- *$50 Progressive Lenses Standard*
- *$65 Transitions Single Vision Standard*
- *$70 Transitions Multi-Focal Standard*
- *$35 Polycarbonate (Single Vision)*
- *$35 Polycarbonate (Multi-Focal)*

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices Wal-Mart / Sam's Club stores participate in the Eye Essentials program but do not accept the discount prices above. Doctors affiliated with Wal-Mart / Sam's Club are not Wal-Mart / Sam's Club employees; therefore, participation for exams varies.

National Vision Administrators, L.L.C.
www.e-nva.com
800-672-7723

LIFE & DISABILITY

UNUM

- Basic Life and AD&D
- Optional & Dependent Life Insurance
- LTD (Long Term Disability)

Coverage Highlights

Eligibility	**All Full-Time Employees working at least 30 hours per week**
Effective Date	**1st day following 30 days of continuous employment**
Life Benefit Amount	You are eligible for **$10,000**
AD&D Benefit Amount	Your AD&D benefit is equal to your life benefit. AD&D Benefit Schedule: If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss. The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident. Also, the accident must occur while you are insured under the plan. The most Unum will pay for any combination of Covered Losses from any one accident is the full amount. **Covered Losses ..... Benefit Amount** Life ..... The Full Amount Both Hands, Both Feet or Sight of Both Eyes ..... The Full Amount One Hand and One Foot ..... The Full Amount One Hand and Sight of One Eye ..... The Full Amount One Foot and Sight of One Eye ..... The Full Amount Speech and Hearing ..... The Full Amount One Hand or One Foot ..... One Half The Full Amount Sight of One Eye ..... One Half The Full Amount Speech or Hearing ..... One Half The Full Amount Thumb and Index Finger of Same Hand ..... One Quarter The Full Amount
Reduction of Benefits	Coverage amounts(s) will reduce according to the following schedule: **Age: ..... Insurance amount reduces to:** **70 .....** 65% of original amount **75 .....** 50% of original amount

Coverage Highlights	
Standard Features	
Eligibility	**All Full-Time Employees working at least 30 hours per week**
Effective Date	**1st day following 30days of continuous employment**
When coverage is effective	If you apply prior to the policy effective date, your coverage effective date is the effective date of the policy. If you apply on or after the policy effective date, your coverage is effective the later of: • The first day following 30 days of continuous employment, if you apply prior to your eligibility date, or • The first of the month following the date your application is approved, if you apply after your eligibility date. Insurance will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. [**NOTE:** Coverage for totally disabled dependents will be delayed until the first of the month next following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.]
Life Benefit Amount	Employee: You are eligible to apply for up to **5** times your annual earnings, in increments of $10,000. Your benefit will be rounded up to the next $10,000, not to exceed $**100,000**. Eligible Spouse: Your spouse is eligible for up to **100%** of your life benefit amount, in increments of $5,000, not to exceed **$25,000**. Eligible Children: Your children are eligible for up to **100%** of your life benefit amount, in increments of $2,000, not to exceed **$10,000**.
Reduction of Benefits	Coverage amounts(s) for employee and spouse will reduce according to the following schedule: **Employee Age: ..... Insurance amount reduces to:** **70 .....** 65% of original amount **75 .....** 50% of original amount Coverage may not be increased after a reduction.
Earnings Definition	Your definition of earnings is **Base Salary**
Underwritten Coverage	If you are applying for up to **$100,000** or your spouse is applying for up to **$25,000**, coverage is offered without medical questions (**guarantee issue**).

Coverage Highlights	
Eligibility	**All Full-Time Employees working at least 30 hours per week**
Effective Date	**1st day following 30 days of continuous employment**
Monthly Benefit Amount	**60%** of monthly earnings to **$1,000 maximum (Base Plan)** **60%** of monthly earnings to **$6,000 maximum (Buy Up Plan)** Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled.
Earnings Definition	Your definition of earnings is **Base Salary**
Elimination Period	**180** days (Base Plan) **90** days (Buy Up Plan)
Duration of Benefit	Your duration of benefits is based on your age when the disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability and in accordance with the **To Age 65 – ADEA I** duration schedule.
Conversion	If you are covered under this group LTD plan for 12 consecutive months and your employment ends, you may be eligible to purchase LTD coverage under Unum's group conversion policy.
Definition of Disability	**2 Year Regular Occupation with residual** You are disabled when Unum determines that: • you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and • you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury. After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
Exclusions and Limitations	
Pre-existing Condition	You have a pre-existing condition if: • you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the **3** months just prior to your effective date of coverage; and • the disability begins in the first **12** months after your effective date of coverage.
Mental and Nervous	The lifetime cumulative maximum benefit period for all disabilities due to mental illness is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities: • are not continuous; and/or • are not related. Payments would continue beyond 24 months only if you are confined to a hospital or institution as a result of the disability.
Coverage Exclusions	Your plan does not cover any disabilities caused by, contributed to by, or resulting from your: • loss of a professional or occupational license or certification • intentionally self-inflicted injuries while sane • active participation in a riot • commission of a crime for which you have been convicted • War, declared or undeclared, or any act of war • Incarceration • pre-existing condition (see above definition)

FEDERAL MANDATES

Women's Health Care & Cancer Rights (WHCRA)

Special Enrollment Events/Changes in Family Status

Newborn's & Mother's Health Protection

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

Medicare Part D Creditable Coverage

HIPAA Notice

Women's Health & Cancer Rights Act (WHCRA) Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Special Enrollment Events/Changes in Family Status

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

Losing eligibility for coverage includes a loss of other health coverage as a result of your legal separation or divorce, a dependent's loss of dependent status, death, termination of employment or reduction in number of hours of employment, meeting or exceeding a lifetime
limit on health benefits, or you no longer reside, live or work in the service area of a health maintenance organization in which you participated. Your enrollment will take effect no later than the first of the month following your loss of coverage and the date the Company receives your request for enrollment, as long as your request to enroll on or before the date that is 30 days after the loss of coverage.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment on or before the date that is 30 days after the marriage, birth, adoption, or placement for adoption.

Effective as of April 1, 2009, if you or your eligible dependent children are eligible for, but not enrolled in, the group health plan and you or your eligible dependent children lose coverage under Medicaid or a State child health plan ("CHIP"), or become eligible for a premium assistance subsidy through Medicaid or CHIP, you and your eligible dependent children may enroll in the group health plan, as long as you request enrollment on or before the date that is 60 days after the loss of coverage or the date you or your eligible dependent children became eligible for the premium subsidy. Your enrollment will take effect no later than the first of the month following your loss of coverage and the date the company receives your request for enrollment, as long as your request to enroll on or before the date that is 60 days after the loss of coverage

To request special enrollment or obtain more information, contact Human Resources.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO – Medicaid and CHIP**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org

ARIZONA – CHIP	CHIP Phone: 303-866-3243
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	**FLORIDA – Medicaid**
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid	**MISSOURI – Medicaid**
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	**MONTANA – Medicaid**
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA – Medicaid and CHIP**
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

MAINE – Medicaid	Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	
MASSACHUSETTS – Medicaid and CHIP	**NEW MEXICO** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	
NEW YORK – Medicaid	**TEXAS** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH** – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	**VERMONT**– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA** – Medicaid

Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	**WISCONSIN** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
U.S. Department of Health and Human Services
Employee Benefits Security Administration

www.dol.gov/ebsa
1-866-444-EBSA (3272)

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Important Notice from Jackson-Dawson Communications 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 Jackson-Dawson Communications 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. **Jackson-Dawson Communications has determined that the prescription drug coverage offered by Jackson-Dawson Communications 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 15 to December 7.

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 Jackson-Dawson Communications coverage may be affected.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Jackson-Dawson Communications 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 Jackson-Dawson Communications 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 Jackson-Dawson Communications changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	April 1, 2013
Name of Entity/Sender:	Jacob Elwart
Contact--Position/Office:	Assistant Controller
Address:	One Parklane Boulevard Eleventh Floor East Dearborn, MI 48126
Phone Number:	(313) 593-0690

NOTICE OF PRIVACY PRACTICES
FOR Jackson-Dawson Communications

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.

THIS NOTICE IS EFFECTIVE ON APRIL 1, 2013

The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), and the rules to carry out this law (**Privacy Rules**), require health plans to notify participants and beneficiaries about the policies and practices the plan has adopted to protect the confidentiality of their health information, including health care payment information.

This Notice describes the privacy policies of Jackson-Dawson Communications **Health Plan**, sponsored by **Jackson-Dawson Communications**, which offers health benefits. These policies protect medical information relating to your past, present and future medical conditions, health care treatment and payment for that treatment (**Protected Health Information** or **PHI**).

The law requires the Plan to maintain the privacy of your PHI, to provide you with this Notice of its legal duties, and to abide by the terms of this Notice. In general, the Plan may only use and/or disclose your PHI where required or permitted by law or when you authorize the use or disclosure.

WHEN THE PLAN MUST DISCLOSE YOUR PHI

The Plan must disclose your PHI:

- to you;
- to the Secretary of the United States Department of Health and Human Services (**DHHS**) to determine whether the Plan is in compliance with HIPAA; and
- where required by law. This means the Plan will make the disclosure only when the law requires it do so, but not if the law would just allow it to do so.

WHEN THE PLAN MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

The Plan may use and/or disclose your PHI as follows:

For Treatment. The Plan does not provide medical treatment directly, but it may disclose your PHI to a health care provider who is giving treatment. For example, the Plan may disclose the types of prescription drugs you currently take to an emergency room physician, if you are unable to provide your medical history due to an accident.

For Payment. The Plan may disclose your PHI, as needed, to pay for your medical benefits. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill the Plan might pay. The Plan may also use or disclose your PHI in other ways to administer benefits; for example, to process and review claims, to coordinate benefits with other health plans, to exercise its subrogation rights, and to do utilization review and pre-authorizations.

For Health Care Operations. The Plan may use and/or disclose your PHI 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 for a claim under a stop-loss or re-insurance policy. Among other things, the Plan may also use your PHI to undertake underwriting, premium rating and other insurance activities relating to changing health insurance contracts or health benefits.

For Special Information. In addition to the Privacy Rule, special protections under state or other federal law may apply to the use and disclosure of your PHI. The Plan will comply with these state or federal laws where they are more protective of your privacy.

To Jackson-Dawson Communications. In certain cases, the Plan may disclose your PHI to Jackson-Dawson Communications.

- Some of the people who administer the Plan work for Jackson-Dawson Communications. Before your PHI can be used by or disclosed to these Jackson-Dawson Communications employees, Jackson-Dawson Communications must certify that it has: (1) amended the Plan documents to explain how your PHI will be protected; (2) identified Jackson-Dawson Communications 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 Jackson-Dawson Communications 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 Jackson-Dawson Communications 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 Jackson-Dawson Communications 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 Jackson-Dawson Communications in connection with the enrollment or disenrollment of individuals into or out of the Plan.

To Business Associates. The Plan may hire third parties that may need your PHI to perform certain services on behalf of the Plan. These third parties are "**Business Associates**" of the Plan. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, the Plan. For example, the Plan may hire a third party administrator to process claims, an auditor to review how an insurer or third party administrator is processing claims, or an insurance agent to assess coverages and help with claim problems.

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 (*e.g.*, sometimes 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 Treatment Alternatives or Health-Related Benefits and Services. The Plan may contact you to provide information about treatment alternatives or other health-related benefits or services that may be of interest to you.

For Public Health Purposes. The Plan may: (1) report specific disease or birth/death information to a public health authority authorized to collect that information; (2) report reactions to medication or problems with medical products to the Food and Drug Administration to help ensure the quality, safety, or effectiveness of those medications or medical products; or (3) if authorized by law, disclose PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or medical condition.

To Report Violence and Abuse. The Plan may report information about victims of abuse, neglect or domestic violence to the proper authorities.

For Health Oversight Activities. The Plan may disclose PHI for civil, administrative or criminal investigations, oversight inspections, licensure or disciplinary actions (*e.g.*, to investigate complaints against medical providers), and other activities for the oversight of the health care system or to monitor government benefit programs.

For Lawsuits and Disputes. The Plan may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. The Plan may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if the Plan has received adequate assurances that the information to be disclosed will be protected. The Plan may also disclose PHI in a lawsuit if necessary for payment or health care operations purposes.

For Law Enforcement. The Plan may disclose PHI to law enforcement officials for law enforcement purposes and to correctional institutions regarding inmates.

To Coroners, Funeral Directors and Medical Examiners. The Plan may disclose PHI to a coroner or medical examiner; for example, to identify a person or determine the cause of death. The Plan may also release PHI to a funeral director that needs it to perform his or her duties.

For Organ Donations. The Plan may disclose PHI to organ procurement organizations to facilitate organ, eye or tissue donations.

For Limited Data Sets. The Plan may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

To Avert Serious Threats to Health or Safety. The Plan may disclose PHI to avert a serious threat to your health or safety or that of members of the public.

For Special Governmental Functions. The Plan may disclose PHI to authorized federal officials in certain circumstances. For example, disclosure may be made for national security purposes or for members of the armed forces if required by military command authorities.

For Workers' Compensation. The Plan may disclose PHI for workers' compensation if necessary to comply with these laws.

For Research. The Plan may disclose PHI for research studies, subject to special procedures intended to protect the privacy of your PHI.

For Emergencies and Disaster Relief. The Plan may disclose PHI to organizations engaged in emergency and disaster relief efforts.

WRITTEN AUTHORIZATION

In all other situations the Plan will not use or disclose your PHI without your written authorization. The authorization must meet the requirements of the Privacy Rules. If you give the Plan a written authorization, you may cancel your authorization, except for uses or disclosures that have already been made based on your authorization. You may not, however, cancel your authorization if it was obtained as a condition for obtaining insurance coverage and if your cancellation will interfere with the insurer's right to contest your claims for benefits under the insurance policy. The Plan may condition your enrollment or eligibility for benefits on your signing an authorization, but only if the authorization is limited to disclosing information necessary for underwriting or risk rating determinations needed for the Plan to obtain insurance coverage.

YOUR INDIVIDUAL RIGHTS

You have certain rights under the Privacy Rules relating to your PHI maintained by the Plan. All requests to exercise those rights must be made in writing to the Privacy Official. The Plan's insurers and HMOs keep their own records and you must make your requests relating to your PHI in those records directly to that insurer or HMO. Your rights are:

Right to Request Restrictions on Uses and Disclosures of Your PHI. You may request that the Plan restrict any of the permitted uses and disclosures of your PHI listed above. The Plan, however, does not have to agree to your requested restriction. A restriction cannot prevent uses or disclosures that are required by the Secretary of DHHS to determine or investigate the Plan's compliance with the Privacy Rules, or that are otherwise required by law.

Right to Access or Copy Your PHI. You generally have a right to access your PHI that is kept in the Plan's records, except for: (1) psychotherapy notes (as defined in the Privacy Rules); or (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. 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.

The Plan may charge you a reasonable fee for copying the information you request and the cost of any mailing, but cannot charge you for time-spent finding and assembling the requested information.

Right to an Accounting of Disclosures. At your request, the Plan must provide you with a list of the Plan's disclosures of your PHI made within the six-year period just before the date of your request, except disclosures made:

- for purposes of treatment, payment or health care operations;
- directly to you or close family members involved in your care;
- for purposes of national security;
- incidental to otherwise permitted or required disclosures;
- as part of a limited data set;
- to correctional institutions or law enforcement officials;
- with your express authorization; and
- before April 14, 2004

You may request one accounting, which the Plan must provide at no charge, within a single 12-month period. If you request more than one accounting within the same 12-month period, the Plan may charge you a reasonable fee.

Right to Amend. You may request that the Plan change your PHI that is kept in the Plan's records, but the Plan does not have to agree to your request. The Plan may deny your request if the information in its records: (1) was not created by the Plan; (2) is not part of the Plan's records; (3) would not be information to which you would have a right of access; or (4) is deemed by the Plan to be complete and accurate as it then exists.

Right to Request Restrictions and Confidential Communications. You have the right to request that the Plan communicate with you in a confidential manner, for example, by sending information to an alternative address or by an alternative means. The Plan will accommodate any reasonable request, though it will require that any alternative used must still allow for payment information to be effectively communicated and for payments to be made.

Right to File a Complaint. If you believe your rights have been violated, you have a right to file a written complaint with the Plan's Privacy Official or with the Secretary of the DHHS. The Plan will not retaliate against you for filing a complaint and cannot condition your enrollment or your entitlement to benefits on your waiving these rights. If your complaint is with an insurer or HMO, you may file a complaint with the individual named in their Notice of Privacy Practices to receive complaints. If your complaint is with the Plan, you may submit your complaint to the Privacy Official at the address at the end of this Notice.

To file a complaint with the Secretary of the DHHS, 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 the Privacy Rules. Complaints sent to the Secretary must be addressed to the regional office of the DHHS' Office of Civil Rights (**OCR**) for the state in which the alleged violation occurred. For information on which regional office at which you must file your complaint, and the address of that regional office, go to the OCR web site at *www.hhs.gov/ocr/hipaa/*.

Right to Receive a Paper Copy of This Notice Upon Request. You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of the Notice, contact the Plan's Privacy Official.

HEALTH INFORMATION NOT COVERED BY THIS NOTICE

This Notice does not cover:

- health information that does not identify you and with respect to which there is no reasonable basis to believe that the information could be used to identify you; or
- health information that Jackson-Dawson Communications can have under applicable law (*e.g.*, the Family and Medical Leave Act, the Americans with Disabilities Act, workers' compensation, federal and state occupational health and safety laws, and other state and federal laws), or that Jackson-Dawson Communications properly can get for employment-related purposes through sources other than the Plan and that is kept as part of your employment records (*e.g.*, pre-employment physicals, drug testing, fitness for duty examinations, *etc.*).

CHANGES TO THE NOTICE

The Plan reserves the right to change the terms of this Notice and to make the new revised Notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan before the date of the revised Notice.

If you agree, the Plan may provide you with a revised Notice electronically. Otherwise, the Plan will provide you with a paper copy of the revised Notice. In addition, the Plan will post the revised Notice on its web site used to provide information about the Plan's benefits.

CONTACT THE PRIVACY OFFICIAL FOR MORE INFORMATION

If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, please contact:

Name of Entity/Sender:	Jacob Elwart
Contact--Position/Office:	Assistant Controller
Address:	One Parklane Boulevard Eleventh Floor East Dearborn, MI 48126
Phone Number:	(313) 593-0690

VALUE ADDED SERVICES

Priority Health

Priority Health on the Web

- Preventative Care
- Calculate BMI
- Know the Risk Factors
- Free Wellness Classes
- Choosing the Right Doctor, Hospital
- Interactive Tools
- Keeping Healthcare Affordable

Priority Health Discounts

- American Cycle and Fitness
- Curves
- Weight Watchers

Staying healthy doesn't mean staying away from the doctor. Priority Health plans encourage you to get regular physicals, mammograms, well-baby exams and other services. Often, Priority Health pays 100 percent of the cost.

If you have Priority Health medical coverage, you have access to many online health resources and tools provided by WebMD.

Once you decide to make healthy choices, then Priority Health's HealthyEncounters™ programs can help you.

Start by visiting the website at: priorityhealth.com and click on a link.

Priority Health on the Web

Use our Preventive Health Care Guidelines
- Find out when to get physicals, screenings, and child immunizations

Calculate your BMI (body mass index)
- Monitor your weight

Know the risk factors
- Get a free private report on your personal health risks

Get regular screenings for colon cancer
- Which type of screening, and how often do you need one?

Check out free wellness classes
- Get inspired to take better care of yourself

Choose the right doctor
- Using our find a Doctor tool

Choose the right hospital
- Select a hospital based on safety and quality ratings

More interactive tools
- Is your weight increasing your health risks?
- How many calories did you burn

How to keep health care affordable
- Get regular preventive care to catch little health problems early
- Ask what your options are before you accept a medical service
- Decide to try more basic services before using high-level care
- Ask to try lower-cost drugs before you the newest (expensive) drug

Priority Health Discounts

American Cycle and Fitness
www.americancycleandfitness.com 15% off the regular MSRP of fitness equipment from Michigan's largest retailer of quality bicycle and fitness equipment. This discount applies at participating locations:

Curves
See website for complete list of locations www.curves.com 66% off joining fee (a savings of $120-$132). Discount offer based on Non CurvesSmart Facility and CurvesSmart Facility. Monthly Premium Membership starting at $34 for a 12-month membership with check draft/EFT. Facility specially designed for women featuring a complete 30-minute workout and weight management program that is fast, fun and safe. This discount applies to any of the 300+ Curves locations in Michigan.

Weight Watchers
866 454-0438 www.weightwatchers.com If you're thinking of losing weight, you'll want to take advantage of the Priority Health 10% discount on the Weight Watchers "local voucher" program. Attend 13 weekly meetings for $107.87. This package includes a free Weight Watchers exercise video valued at $15.00. Attend 18 weekly meetings for $149.36. With this package, you'll get a free walking kit valued at $25.00.

Additional discounts available see: www.priorityhealth.com for more information.

KARMANOS CANCER INSTITUTE

The Barbara Ann Karmanos Cancer Institute, located in Detroit, is Michigan's only hospital completely devoted to fighting cancer. Skilled cancer physicians are among the world's best and are well versed in treating the most common to the most difficult cancers. Patients benefit from having their cases reviewed by an entire team of specialists in a single location, eliminating multiple appointments and ultimately saving precious time.

Karmanos and Cambridge Employee Benefits have partnered together to offer a special "Patient Concierge Service" for our team members and their families. If you or a loved one has been diagnosed with cancer, call Patient Concierge (313) 576-9797 for immediate assistance and to have your cancer questions answered.

At Karmanos, you will receive cancer care second to none. www.karmanos.org

BARBARA ANN
KARMANOS
CANCER INSTITUTE

NOTES

The information in this Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Summary and the actual plan documents the actual plan documents will prevail. The company reserves the right to amend or terminate these benefits at any time. The information in this guide does not constitute a contract of employment. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

CAMBRIDGE
Consulting Group