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Benefits are effective the first day of the month following 30 days of employment and end the last day of the month in which employment terminates.

Service Directory

Who To Contact

Carrier	Benefit	Phone	Website
Blue Cross Blue Shield of Michigan	Medical	(800) 637-2227	www.bcbsm.com
Blue Care Network	Medical	(800) 662-6667	www.mibcn.com
Guardian/VSP	Vision	(800) 877-7195	www.vsp.com
Guardian / First Commonwealth	Dental (PPO)	(866) 302-4542	www.guardianlife.com www.guardiananytime.com
Guardian / First Commonwealth	Dental (HMO)	(866) 494-4542	www.guardianlife.com www.guardiananytime.com
Guardian	STD	(800) 268-2525	www.guardianlife.com www.guardiananytime.com
Guardian	FSA	(866) 359-4542	www.guardianlife.com www.guardiananytime.com
Lincoln Financial Group	Life/AD&D	(800) 423-2765	www.lfg.com

Claim Information

Blue Cross Blue Shield of Michigan
Attention: B321
600 Lafayette East
Detroit, MI 48226-2998

Blue Care Network
Member Inquiry Department
P.O. Box 68767
Grand Rapids, MI 49516-8767

Guardian / First Commonwealth
Guardian Life Insurance Co.
Group Dental Claims
P.O. Box 2459
Spokane, WA 99210-2459

Healthcare Advisor

Credible and Reliable Healthcare Information

Research medical conditions, treatments, hospitals, doctors and more!

Access through

www.bcbsm.com or www.mibcn.com

Ancillary Plans

Employee Life Insurance / Accidental Death and Dismemberment (Term) (Lincoln Financial Group)

"Core" coverage is provided to you at no cost ($10,000). You may choose to buy an additional $190,000 in coverage on a pre-tax basis. This coverage includes AD&D protection in addition to the basic life insurance. That is, if death occurs from accidental causes, the face amount of coverage is doubled – "double indemnity" (e.g. $300,000 paid on the $150,000 in coverage, due to an accidental death). Similarly, if you become dismembered, all or a portion of the benefit is payable to you. A total amount of coverage over $50,000 will require a small imputed value (of your coverage) be added to your W-2 earnings each January. Any applicable benefits paid out under the plan would be received free of taxation. ADEA Age Reduction schedule is 35% at age 65, 50% of the original amount at age 70.

If you currently elect voluntary life, you can increase your coverage in one-level increments every year to the maximum guarantee issue level without evidence of insurability. If you were offered voluntary life previously and chose not to enroll, and now wish to enroll, you will be required to provide evidence of insurability that is satisfactory to Lincoln before coverage becomes effective. If this is your initial enrollment, you may elect any level of coverage without providing evidence of insurability up to the guarantee issue amount.

Suicide Exclusion . No Supplemental Life benefit will be payable if death results from suicide, whether sane or insane, within 24 months/2 years of the effective date of coverage. Additionally, if death results from suicide, whether sane or insane, within 24 months/2 years of the effective date of an increase in coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 24 month/2 year period mentioned above will include the period of time coverage was in force under a prior plan.

Large Amount Accidental Death & Dismemberment (Lincoln Financial Group)

Large Amount AD&D is voluntary to you. Benefits are payable only from accidental causes, and are paid in addition to your Employee Life Insurance / Accidental Death and Dismemberment. (as referenced above). You may elect no coverage, single coverage, or family coverage including your eligible dependents. Contributions are made pre-tax and any applicable benefits would be received free of taxation. **There is NO medical underwriting and NO pre-existing condition limitations for this coverage.**

Short-Term Disability (Guardian)

You may elect Short-term Disability (STD) coverage. STD is designed to protect your weekly income in the event of a non-work related accident or illness (you have worker's compensation coverage while on-the-job). You may elect "None", or coverage up to 60% of your weekly income (based on a 40-hour work week) to $500 per week. Disability benefits begin on the 8^{h} day following an accident, or the 8th following an illness and are payable for up to 26 weeks if disabled. Employee contributions will be made on a pre-tax basis, and benefits are taxable. **Any pre-existing condition treated in the 3 months prior to or following the effective date of coverage would not be covered for 12 months. If you were offered STD previously and chose not to enroll, and wish to enroll now, you will be considered a late enrollee and be required to provide evidence of insurability that is satisfactory to Guardian before coverage becomes effective.** Late enrollees will be responsible for any costs associated with medical evidence of insurability. If this is your initial enrollment, you may elect coverage without providing evidence of insurability.

Dependent Life Insurance (Lincoln Financial Group)

You may elect to cover eligible dependents for life insurance. This is the only after-tax employee payroll deduction under the flex plan. Any applicable benefits would be received free of taxation. Benefits would be payable to the employee as the beneficiary from any cause of death; however there is no AD&D coverage with this option (no double indemnity feature) – life insurance only. **You can elect any option without evidence of insurability up to the $15,000/$6,000 level without evidence of insurability. Employees with the $15,000/$6,000 option inforce can increase coverage to the $20,000/$8,000 option without evidence of insurability.** If this is your initial enrollment, you can elect any level of coverage without providing evidence of insurability.

Note: If your spouse or dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days.

NOTE: ***This benefit description is not a policy or guarantee of benefits; its use is only to provide information.***

Finding A Provider

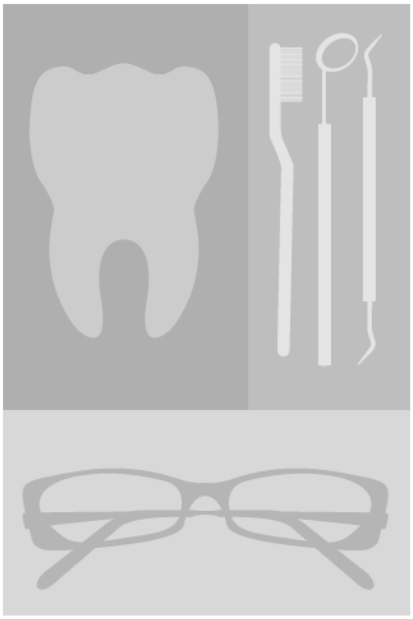
Guardian

GUARDIAN®

Finding a dentist or vision care provider is easy
Go online — it takes just minutes!

It's easy to find dentists or vision care providers you can trust. Whether you're looking for a list of providers that serve your plan (in-network) or trying to locate a specific dentist or vision care provider, it takes just minutes through Guardian's Provider Online Search.

Guardian's Provider Online Search is available to you 24 hours a day, 7 days a week.



Here are just a few things you can do online:

- Customize your search by specialty, languages spoken, gender and more
- Get side-by-side comparisons of provider information (ie. office status, distance)
- Create a short-list of "favorite" providers — for quick reference online
- Get maps and directions to a provider's office location
- View your results online or have them faxed or emailed to you
- Save your search criteria for easy access when you revisit Provider Online Search
- Create a customized provider directory
- Nominate a provider to be included in a network
- And much more!

Just go to **www.GuardianLife.com**.
Under "Resources", click on "Provider Online Search".

Vision

Guardian/VSP

Plan Features:		
Copayment	Exam $10	
	Materials $25	
Benefit Details:	**In-network**	**Out-of-network**
Eye Exams	Covered in Full after Copay	$ 46 Maximum after Copay
	Frequency: Every 12 Months	
Lenses		
Frequency: Every 12 Months		
Single Vision	Covered in Full after Copay	$ 47 Maximum after Copay
Bifocal	Covered in Full after Copay	$ 66 Maximum after Copay
Trifocal	Covered in Full after Copay	$ 85 Maximum after Copay
Lenticular	Covered in Full after Copay	$125 Maximum after Copay
Contact Lenses*	Frequency: Every 12 Months	
Medically Necessary	Covered in Full after Copay	$210 Maximum after Copay
Elective	$120 Maximum (Copay Does Not Apply)	
Frames	$120 Retail Allowance**	$ 47 Maximum after Copay
	Frequency: Every 24 Months	

*If you choose contact lenses, you will not be eligible to receive lenses for 12 months and a frame for 24 months following the date contacts were obtained. For elective and necessary contact lenses, we will pay up to the benefit limits towards, the contact lens evaluation fee, fitting costs and materials. Note, the contact lens evaluation fee and fitting costs are separate from the comprehensive vision care exam.

**Approximately 15,000 frames are covered in full. Frames not fully covered are offered at a discounted cost. If you select a frame that exceeds the retail allowance, the plan will cover 20% of the amount above the allowance. You must pay the rest.

Note: Lens coverage includes polycarbonate lenses for children up to the plan's non-student dependent child age limit of 20.

Dependent Age Limits: Children are covered up to age 20 or 26 if a full time student.

One Year Lock-In/Lock-Out. Your election to enroll in or waive Vision Plan coverage must remain in effect for 12 months (i.e., July 1, 2008 through June 30, 2009). This means: if you enroll in the Plan, you will not be able to drop coverage for yourself or your dependents until the Annual Enrollment in 2009; if you elect not to enroll in the Plan or do not enroll an eligible spouse/child, you may not enroll until Annual Enrollment in 2009.

Dental

Guardian—First Commonwealth Dual Choice Option

Benefits Payable Under This Program

Plan Feature	Dental HMO 3000	PPO Plan VY	
		In Network	Out of Network
Office Visit Copay	$5	$0	$0
Annual Deductible for Basic and Major Services	None	$0	$25 per person $75 per family
Annual Maximum	None	$1,000 with MRA	$1,000 With MRA
Preventive & Diagnostic			
• Cleaning, Exam, X-Rays, Sealants	100%	100%	100%
Basic Services			
Restorative (Fillings, Composites)	80%	75%	75%
Endodontics (Root Canal Therapy (Anterior & Bicuspids))	80%	50%*	50%*
Periodontics (Non Surgical)	80%	75%	75%
Oral Surgery (Simple Extractions)	80%	50%*	50%*
Major Services			
Prosthetics (Crowns, Bridges, Dentures)	50%	50%*	50%*
Specialty Services (Molar Root Canal, Surgical Perios, Complete Extractions and Other Oral Surgery, Inlays, Onlays, Veneers)	50%	50%*	50%*
Cosmetic Services	50%	Not Covered	Not Covered
Child/Adult Orthodontics	$1,000 Savings	Not Covered	Not Covered
Claim Payment Basis	Claimless	Guardian PPO Fee Schedule	UCR 80th Percentile
Waiting Period for Major Services	None	12 Months*	12 Months*
Provider Choice	First Commonwealth DHMO Network	Guardian PPO	Any

NOTE: *This benefit description is not a policy or guarantee of benefits; its use is **only** to provide information.*
*12-month waiting period for these services, with credit given from prior plan.

Medical

Blue Cross Blue Shield Community Blue PPO 3 Plan

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

	In-Network	Out-of-Network
Preventive Care Services – *Payment for preventive services is limited to a combined maximum of $500 per member per calendar year		
Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological Exam	Covered – 100%*, one per calendar year	Not covered
Pap Smear Screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-Baby and Child Care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Immunizations	Covered – 100%*	Not covered
Fecal Occult Blood Screening	Covered – 100%*, one per calendar year	Not covered
Flexible Sigmoidoscopy Exam	Covered – 100%*, one per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%*, one per calendar year	Not covered
Mammography		
Mammography Screening	Covered – 100%*, one per calendar year	Covered – 60% after deductible
	One per calendar year, no age restrictions	
Physician Office Services		
Office Visits	Covered – $30 copay	Covered – 60% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office Consultations	Covered – $30 copay	Covered – 60% after deductible, must be medically necessary
Urgent Care Visits	Covered – $30 copay	Covered – 60% after deductible, must be medically necessary
Emergency Medical Care		
Hospital Emergency Room	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury
Ambulance Services – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Diagnostic Services		
Laboratory and Pathology Services	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic Tests and X-rays	Covered – 80% after deductible	Covered – 60% after deductible
Therapeutic Radiology	Covered – 80% after deductible	Covered – 60% after deductible
Maternity Services Provided by a Physician		
Prenatal and Postnatal Care	Covered – 100%	Covered – 60% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and Nursery Care	Covered – 80% after deductible	Covered – 60% after deductible
	Includes delivery provided by a certified nurse midwife	

Blue Cross Blue Shield PPO 3 (con't)

	In-Network	Out-of-Network
Hospital Care		
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible	Covered – 60% after deductible
Note: Non-emergency services must be rendered in a **participating** hospital	Unlimited days	
Inpatient Consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to dollar maximum which is adjusted periodically	
Home Health Care	Covered – 80% after deductible	Covered – 80% after deductible
	Unlimited visits	
Surgical Services		
Surgery – includes related surgical services	Covered – 80% after deductible	Covered – 60% after deductible
Voluntary Sterilization	Covered – 80% after deductible	Covered – 60% after deductible
Human Organ Transplants		
Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%	Covered – in designated facilities **only**
	Up to $1 million **lifetime** maximum per transplant type	
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, Cornea and Skin	Covered – 80% after deductible	Covered – 60% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Inpatient Substance Abuse Treatment	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days, up to $15,000 annual, $30,000 lifetime maximum	
Outpatient Mental Health Care		
• Facility and Clinic	Covered – 50% after deductible	Covered – 50% after deductible
• Physician's Office	Covered – 50%	Covered – 50% after deductible
Outpatient Substance Abuse Treatment – in approved facilities	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount which is adjusted annually	

Blue Cross Blue Shield PPO 3 (con't)

Other Services

	In-Network	Out-of-Network
Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible	Covered – 60% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic Spinal Manipulation	Covered – $30 copay	Covered – 60% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy		
• Facility and Clinic	Covered – 80% after deductible	Covered – 80% after deductible
• Physician's Office – **excludes speech and occupational therapy**	Covered – 100%	Covered – 60% after deductible
	A **combined** 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office	
Durable Medical Equipment	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and Orthotic Appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private Duty Nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription Drugs	$15/$50/50% ($70 Min, $100 Max) Rx Card, with contraceptive. Mail order prescription drug (MOPD) 2x copay	

Deductible, Copays and Dollar Maximums

Note: If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Deductible	$250 per member, $500 per family per calendar year **Note**: **Deductible waived if service is performed in a PPO physician's office.**	$500 per member, $1,000 per family per calendar year **Note**: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed Dollar Copays	$30 for office visits and $50 for emergency room visits	$50 for emergency room visits
• Percent Copays	20% for general services, **waived if service is performed in a PPO physician's office**, and 50% for mental health care, substance abuse treatment and private duty nursing	40% for general services and 50% for mental health care, substance abuse treatment and private duty nursing **Note**: Services without a network are covered at the in-network level
Copay Dollar Maximums		
• Fixed Dollar Copays	None	None
• Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays	$1,000 per member, $2,000 family per calendar year	$3,000 per member, $6,000 family per calendar year **Note**: Out-of-network copays also apply toward the in-network maximum.
Dollar Maximums	$1 million lifetime per covered specified organ transplant type and a **separate** $5 million lifetime per member for all other covered services and as noted above for individual services	

Medical

Blue Care Network HMO High Option

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. **Services must be provided or arranged by member's primary care physician or health plan.**

Preventive Services

Health Maintenance Exam	Covered – $20 copay
Annual Gynecological Exam	Covered – $20 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – $0 copay for well child visits through age 6; over age 6, $20 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit

Mammography

Mammography Screening	Covered – Office visit copay may apply per member, per visit

Physician Office Services

Office Visits	Covered – $20 copay
Consulting Specialist Care – when referred	Covered – $20 copay

Emergency Medical Care

Hospital Emergency Room – approved diagnosis (copay waived if admitted)	Covered – $75 copay
Urgent Care Center	Covered – $30 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air services

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – Office visit copay may apply per member, per visit
Radiation Therapy	Covered – Office visit copay may apply per member, per visit

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – $20 copay for first initial visit only; thereafter, no copay
Delivery and Nursery Care	Covered – 100%

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%, unlimited days
Outpatient Surgery – see member certificate for specific surgery copays.	Covered – 100%

Blue Care Network HMO High Option (con't)

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 45 days per member per calendar year
Hospice Care	Covered – 100%
Home Health Care	Covered – 100%

Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	Covered – 100%
Voluntary Sterilization	Covered – 100% on all associated costs
Human Organ Transplants	Covered – 100%, subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	**Mental Health Care:** Covered – 100%, up to 30 days per calendar year **Substance Abuse Care:** Covered – 50%, one program per 12-month period
Outpatient Mental Health Care	Covered $15 copay. up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered $15 copay. up to 20 visits per calendar year

Other Services

Allergy Testing and Therapy	Covered – Office visit copay may apply per member per visit
Chiropractic Spinal Manipulation	Covered – $20 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – 100%, limited to 60 consecutive days per episode per year for a combination of therapies; subject to significant improvement within 60 days
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% for consultation, diagnostic testing and treatment when authorized by BCN
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%
Weight Reduction Procedures	Covered - $1,000 copay on all associated costs
Elective First Trimester Termination	Covered – 100%, one procedure every 24 months
Prescription Drugs	Covered - $15 generic, $25 brand. Non-formulary drugs not covered. Mail order covered 2x copay 90 day supply

Deductible, Copays and Dollar Maximums

Deductible	None
Copays • Fixed Dollar Copay	$20 for office visits, $15 for outpatient mental health and outpatient substance abuse; $30 for urgent care visits, $75 for emergency room visits and $1,000 for weight reduction procedures
• Percent Copay	50% for infertility services
Copay Dollar Maximums • Fixed Dollar Copay	None
• Percent Copay	None
Dollar Maximums	None

Medical

Blue Care Network HMO Low Option

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. **Services must be provided or arranged by member's primary care physician or health plan.**The **Deductible** is applicable to all covered services except (1) **preventive services** provided by the member's PCP; (2) **preventive services** obtained as a result of referral from the PCP; (3) routine maternity care; and (4) services paid by a provider or vendor under the delegation of a

Preventive Services

Health Maintenance Exam	Covered – $30 copay
Annual Gynecological Exam	Covered – $30 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – $30 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit

Mammography

Mammography Screening	Covered – Office visit copay may apply per member, per visit

Physician Office Services

Office Visits	Covered – $30 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $30 copay after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – $100 copay after deductible
Urgent Care Center	Covered – $35 copay
Ambulance Services – medically necessary	Covered – 80% after deductible, ground and air service, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year
Radiation Therapy	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – $30 copay
Delivery and Nursery Care	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year; unlimited days
Outpatient Surgery – see member certificate for specific surgical copay	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year

Blue Care Network HMO Low Option (con't)

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible, up to 45 days per calendar year; 20% copay up to $1,500 per member, $3,000 per family per calendar year
Hospice Care	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year
Home Health Care	Covered – $30 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year
Voluntary Sterilization	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered – 80% after deductible, with a 20% copay up to $1,500 per member, $3,000 per family per calendar year; subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	**Mental Health Care**: Covered – 75%, with a 25% copay, up to $1,000 per member, $2,000 per family per calendar year, up to 30 days per calendar year **Substance Abuse Care:** Covered – 50%, one program of treatment per year, up to state mandated dollar limitation which is adjusted annually by the state
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%, one program of treatment per year, up to state mandated dollar limitation which is adjusted annually by the state**. Note**: A program of treatment may include outpatient or intermediate services or both.

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $30 copay after deductible
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – $30 copay after deductible, limited to 60 consecutive days per episode
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Prescription Drug	Covered - 50% ($5 Minimum, $100 Maximum). Non-formulary drugs not covered. Mail order covered 2x copay 90 day supply

Deductible, Copays and Dollar Maximums

Deductible	$1,000 per member / $2,000 per family per calendar year
Copays • Fixed Dollar Copay	$30 for office visits, $35 for urgent care visits, $100 for emergency room visits and $5 for allergy injections
• Percent Copay	20%, 25% and 50% for select services as noted above
Copay Dollar Maximums • Fixed Dollar Copay	None
• Percent Dollar Copay – Medical Services; excludes services with a 50% copay	$1,500 per member, $3,000 per family per calendar year
• Percent Dollar Copay – Inpatient Mental Health Care	$1,000 per member, $2,000 per family per calendar year
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

Flexible Spending Accounts

Guardian

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can actually lower your taxable income.

Essentially, the Internal Revenue Service set up FSAs as a means to provide a tax break to employees and their employers. As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to Social Security (FICA), federal, state, or local income taxes — effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly, depending on your tax bracket. As a result of the personal tax savings you may realize, your spendable income will increase.

The example below illustrates how a flexible spending account can save you money.

Bob and Jane's combined gross income is $30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend $2,000 in adult orthodontia and $3,300 for daycare next plan year, they decide to direct a total of $5,300 into their FSAs.

	Without FSAs	*With FSAs*
Gross income:	*$30,000*	*$30,000*
FSA contributions:	*0*	*-5,300*
Gross income:	*30,000*	*24,700*
Estimated taxes:		
Federal	*-2,550**	*-1,755**
State	*-900***	*-741***
FICA	*-2,295*	*-1,890*
After-tax earnings:	*24,255*	*20,314*
Eligible out-of-pocket		
Medical and dependent care expenses:	*-5,300*	*0*
Remaining spendable income:	*$18,955*	*$20,314*
Spendable income increase:		*$1,359*

Is the FSA Program Right for Me?

Flexible Spending Accounts are beneficial for anyone who has out-of-pocket medical, dental, vision, hearing, or dependent care expenses beyond what his or her insurance plan covers.

It's easy to determine if a FSA will save you money. At enrollment time, you will need to determine your annual election amount. Estimate the expenses that you know will occur during the year. These include out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes. If you had $100 or more in recurring or predictable expenses, the accounts can help you stretch your dollars.

How Do the Accounts Work?

If you decide to enroll in one or both of the accounts, your contributions are taken out of each paycheck — before taxes — in equal installments throughout the plan year. These dollars are then placed into your FSA. When you have an eligible health care or dependent care expense, you must submit a claim form along with an itemized receipt to be reimbursed from your account.

Important: Use it or Lose It!

If you decide to contribute to the Health Care Reimbursement FSA or the Dependent Care FSA, you must carefully determine your annual election amount and your spending during the plan year. According to IRS regulations, the money you set aside must be used for expenses incurred during the plan year in which you make the election. Your employer has chosen to offer a 2.5 month extension. Any funds left in the account at the end of the plan year extension will be forfeited.

Benny Card Through Guardian

If you decide to contribute to the Health Care Reimbursement FSA, you will be eligible to receive a Prepaid MasterCard Benny Card through Guardian. For more information, go to www. GuardianAnytime.com, and click on the FlexPlan link.

**Assumes standard deductions and four exemptions.*

*** Varies, assume 3%.*

The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.

Flexible Spending Accounts

Health Care Reimbursement FSA

The Health Care Reimbursement FSA lets you pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. For example, cash that you now spend on deductibles, copayments, or other out-of-pocket medical expenses can instead be placed in the Health Care Reimbursement FSA pre-tax, to pay for these expenses. The annual maximum contribution to the Health Care Reimbursement FSA is determined by your employer.

Eligible Health Care Expenses

Eligible health care expenses for the Health Care Reimbursement FSA include more than just your deductible and copayments. Generally, any medically necessary health care expense that you can deduct on your tax return is considered an eligible expense. Some examples include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

For more information about eligible medical expenses, please refer to the list, in this booklet, of example eligible and ineligible expenses, or refer to IRS Publication 502, Medical and Dental Expenses available at http://www.irs.ustreas.gov.

How do I request payment?

Step 1: Once you have an expense that qualifies for reimbursement, fill out a "Flexible Benefit Claim for Reimbursement" form, which is available from your employer. The FSA plan administrator cannot issue a reimbursement check unless the form is complete and accurate. Your signature on the form will confirm that the expenses you are requesting payment for are valid under the reimbursement account plan.

An eligible expense is any uninsured, out-of-pocket expense that the IRS allows as a deductible medical expense referenced in their publication 502. In addition, you may contact your FSA plan administrator for assistance in clarifying an eligible expense.

Step 2: Attach proof of the expense to the Request for Reimbursement form. Acceptable forms of proof that you have incurred the expense include:

1. Account statements which indicate the name of the provider, date of service, charges, and payment amounts.
2. Handwritten receipts (by Doctor's office on their letterhead only) which indicate; provider's name, date of service, and payment amounts. Otherwise, itemized bill is required.
3. Explanation of Benefits (EOBs) from your insurance carrier. This is the only acceptable proof for items such as deductibles, copayments, or any item that is at least partially covered by your health insurance plan.

How often may I submit a Request for Reimbursement?

You may submit a request at any time, but a check will not be produced until you have accumulated at least $20 worth of expenses. Once a month, however, is the recommended frequency for submitting requests. Since your contributions are per pay period, you can easily determine the amount available for expenses and combine several items on one request.

What if I don't have enough money in my Flexible Spending Account to pay for an expense?

Submit your reimbursement request for the full amount of the expense. The FSA plan administrator will issue a check for the full amount of the expense, up to the total you have designated for the Medical Reimbursement Account for that year. Any portion of the claim amount that has not been deducted from your pay at that time will be advanced by your employer.

Flexible Spending Accounts

Eligible Health Care Reimbursement Expenses

Your Health Care Reimbursement Flexible Spending Account lets you pay for medical care expenses not covered by your insurance plan with pre-tax dollars. The Internal Revenue Service defines medical care expenses as amounts paid for the diagnosis, cure, or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

The products and services listed below are examples of medical expenses eligible for payment under your Health Care Reimbursement FSA, to the extent that such services are not covered by your medical and dental insurance plan. This list is not all-inclusive; additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations. Please refer to *IRS Publication 502 Medical and Dental Expenses* for a complete description of eligible medical and dental expenses.

- Abortion
- Acne treatment
- Acupuncture
- Adoption - *pre-adoption medical expenses*
- Alcoholism treatment
- Allergy medications
- Ambulance
- Antacid
- Antihistamine
- Artificial limbs & teeth
- Aspirin
- Automobile modifications – *if for physically handicapped person*
- Bandages
- Birth control pills
- Blood pressure monitoring devices
- Blood sugar test kit & test strips
- Body scan
- Braille books/magazines
- Breast reconstruction surgery following mastectomy
- Carpal tunnel wrist supports
- Contraceptives
- Condoms
- Chondroitin
- Circumcision
- Co-insurance amounts and deductibles
- Contact lenses – also materials & equipment
- Cough suppressants
- Decongestants
- Dental treatment
- Dentures and denture adhesives
- Diabetic supplies
- Diagnostic items/services
- Disabled dependent care expenses
- Drug addiction treatment
- Drug overdose, treatment of
- Prescription drugs
- Over-the-counter drugs
- Ear plugs – *for medical purposes*
- Egg donor fees
- Fluoridation device or services
- Glucose monitoring equipment
- Guide dog/other animal aid
- Health institute fees – *only if prescribed by a physician*
- Hearing aids
- Hemorrhoid treatments
- Hormone replacement therapy (HRT)
- Hospital services
- Hot/cold packs
- Inclinator
- Insect bite creams and ointments
- Insulin
- Laboratory fees
- Language training
- Laser eye surgery/Lasik
- Learning disability, instructional fees
- Lodging at a hospital or similar institution
- Lodging not at a hospital or similar institution (up to $50/night)
- Lodging of a companion – *yes if accompanying a patient for medical reasons*
- Massage therapy – *only if recommended by a physician to treat a specific trauma or injury*
- Meals at a hospital
- Medic Alert bracelet or necklace
- Medical services
- Menstrual pain relievers
- Motion sickness pills
- Nasal strips or sprays – *only to treat sinus problems; not to prevent snoring*
- Nicotine gum or patches
- Norplant insertion or removal
- Nursing services provided by a nurse or attendant
- Nutritional supplements – *only if they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician*
- Obstetrical expenses
- Occlusal guard to prevent teeth grinding
- Operations
- Optometrist
- Organ donors/transplants
- Orthodontia
- Osteopath fees
- Ovulation monitor
- Oxygen
- Pain relievers
- Patterning exercise
- Physical exams
- Physical therapy
- Pregnancy test kits
- Prescription glasses/sun/reading
- Preventive care screenings
- Prostheses
- Psychiatric care
- Psychoanalysis
- Psychologist
- Radial keratotomy
- Screening tests
- Sinus medications
- Sleep deprivation treatment
- Smoking cessation programs
- Special food required for diet by physician
- Spermicidal foam
- Sterilization procedures
- Prescription sunglasses
- Sunburn cream/ointments
- Surgery
- Taxes on medical services and products
- Toothache/teething pain relievers
- Transplants
- Transportation expenses for person to receive medical care
- Tuition for special needs program
- Vaccines/Immunizations
- Vasectomy
- Veterinary fees – *for the care of seeing- or hearing-impaired animals*
- Viagra – *if prescribed by a physician*
- Weight loss program/drugs – *if prescribed by a physician*
- Wheelchair
- Wig
- X-ray fees

Flexible Spending Accounts

Dependent Care Reimbursement FSA

The Dependent Care FSA lets you use pre-tax dollars towards qualified dependent care. The annual maximum amount you may contribute to the Dependent Care FSA is the lesser of:

- One-half of your taxable income, or
- If you're married, your spouse's taxable income, or the maximum amount shown on your election form (if applicable)

You qualify to use this account if:

- You are a single parent
- You have a working spouse
- Your spouse is a full-time student for at least five months during the year while you are working
- Your spouse is disabled and unable to provide his or her own care

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Eligible Expenses

In order for dependent care services to be eligible, they must be for the care of a tax dependent child under age 13 who lives with you, or a tax dependent parent, spouse, or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours — Saturday night babysitting does not qualify — and cannot be provided by another of your dependents.

Expenses may be reimbursed for services provided:

- Inside or outside your home by anyone other than your spouse, someone who is your dependent for income tax purposes, or one of your children under age 19
- In a dependent care center or a child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations)
- By a housekeeper whose services include, in part, providing care for an eligible dependent
- Day camp expenses (overnight camp is not eligible)

How do I request payment?

Step 1: Once you have an expense that qualifies for reimbursement, fill out a "Flexible Benefit Claim for Reimbursement" form, which is available from your employer. The FSA plan administrator cannot issue a reimbursement check unless the form is complete and accurate. Your signature on the form will confirm that the expenses you are requesting payment for are valid under the reimbursement account plan.

An eligible expense is any uninsured, out-of-pocket expense that the IRS allows as a deductible medical expense referenced in their publication 503. In addition, you may contact your FSA plan administrator for assistance in clarifying an eligible expense.

Step 2: Attach proof of the expense to the Request for Reimbursement form. Acceptable forms of proof that you have incurred the expense include:

1. Cancelled checks or photocopies of the cancelled checks.
2. Account statements which indicate the name of the care provider, date of service, charges, and payment amounts.
3. Handwritten receipts (by care provider on their letter-head only) which indicate; caregiver's name, date of service, and payment amounts. Otherwise, itemized bill is required.

What if I don't have enough money in my Flexible Spending Account to pay for an expense?

Submit your reimbursement request for the full amount of the expense. The FSA plan administrator will issue a check for the amount you currently have available in your account. Each time a payroll deduction is made and deposited to your account, a check will be issued to you for the available account balance until any remaining claims due you have been reimbursed in full, up to the total you have designated for the Dependent Care Reimbursement Account for that year.

Flexible Spending Accounts

Ineligible Health Care & Dependent Care Reimbursement Expenses

The items listed below are examples of products and services that are **NOT** eligible for reimbursement under your **Health Care Reimbursement FSA**, according to the IRS. Typically, expenses for items that promote general health are not eligible expenses. Please note that this list is not all-inclusive, and is subject to change. A complete list of eligible and non-eligible health care expenses is provided in IRS publication 502. You may obtain a copy from the IRS by calling 1-800-829-1040 or can it be found on the World Wide Web at http://www.irs.ustreas.gov.

Please note the following two exceptions:

1. Premiums are tax deductible on your personal tax return but not reimbursed through your health care flexible spending account.
2. Over the counter drugs are not tax deductible on your personal tax return but are reimbursed through your health care flexible spending account.

- Babysitting and Child Care
- Controlled Substances
- Cosmetic Surgery
- Dancing Lessons
- Diaper Service
- Electrolysis or Hair Removal
- Funeral Expenses
- Future Medical Care
- Hair Transplant
- Health Club Dues
- Health Coverage Tax Credit
- Household Help
- Illegal Operations and Treatments
- Insurance Premiums
- Maternity Clothes
- Medicines and Drugs from Other Countries
- Nutritional Supplements – (unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician)
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees – except for the care of seeing- or hearing-impaired animals
- Weight-Loss Program

The items listed below are examples of products and services that are **NOT** eligible for reimbursement under your **Dependent Care Reimbursement FSA**, according to the IRS. Please note that this list is not all-inclusive, and is subject to change. A complete list of eligible and non-eligible dependent care expenses is provided in IRS publication 503.

- Transportation to and from the dependent care location
- Amounts you pay for child and dependent care while you or your spouse are off work because of illness (including maternity leave, injury, vacation, or leave of absence)
- Summer sleepover camps
- Separate charges for food, diapers, clothing, supplies
- Fees for extracurricular classes, e.g., gymnastics, swimming, dance
- Boarding school
- Nursing homes
- Kindergarten

Flexible Spending Accounts

Health Care & Dependent Care Reimbursement Worksheets

Complete this worksheet to estimate the amount of pre-tax money you wish to contribute to your **Health Care Reimbursement Account**. (Remember, it is important to conservatively estimate what your expenses may be; any amounts remaining at the end of the year are forfeited due to IRS regulations.)

Eligible Health Care Expenses

Medical and dental plan deductibles	$ _____
Medical, dental, vision, and prescription drug co-payments	$ _____
Routine physicals and immunizations	$ _____
Vision exams, eyeglasses, contact lenses, Contact lens saline solution and cleaner	$ _____
Hearing exams and hearing aids	$ _____
Orthodontics	$ _____
Other expenses not covered by medical, dental or vision plans in which enrolled	$ _____
Eligible over the counter drugs* (quantity restrictions apply)	$ _____
Total	**$ _____**

Complete this worksheet to estimate the amount of pre-tax money you wish to contribute to your **Dependent Care Reimbursement Account**. (Remember, it is important to conservatively estimate what your expenses may be; any amounts remaining at the end of the year are forfeited due to IRS regulations.)

Eligible Dependent Care Expenses

Nursery Schools and day care centers for pre-schoolers	$ _____
Individual providing care for your dependent inside your home or outside your home.	$ _____
"Latch-key" programs for elementary students under age 13	$ _____
Centers providing day care (not residential care) for adults	$ _____
Total	**$ _____**

Maximum individual claim submission-90 day drug supply per dependent per claim submission

Federal Mandates

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 normal 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 physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plan providers may not require that a provider obtain authorization for prescribing a hospital length of stay of less than 48 hours (or 96 hours).

Women's Health & Cancer Rights Act

If you receive plan benefits in connection with a mastectomy, you are entitled to coverage for the following under the plan:

- 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 for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

If you would like further information about the Women's Health & Cancer Rights Act, please contact your medical carrier or your employer.

Special Enrollment Events/Changes in Family Status

If you decline coverage for yourself and/or your dependents (including your spouse) now because you are covered by another health insurance plan, you may be able to enroll yourself or your dependents in this plan in the future.

If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the event. These events are referred to as changes in "family status." In addition, if you were to lose coverage, you must request enrollment within 30 days after the coverage ends and if the event qualifies as a "family status" change.

Also, it is your responsibility to notify Human Resources within 30 days if you have a dependent who is no longer eligible under the terms of the plan (for example, a child reaches age 19 and no longer meets the definition of a dependent, you become divorced or due to a death of a dependent).

Those dependents may have continuation rights for medical, dental and vision coverage under the federal law known as COBRA. If you do not notify Human Resources within the required time frame, those dependents will be left with no coverage under the plan.

When you become enrolled as the result of a Special Enrollment Event, coverage will be made effective on the date of the event.

Creditable Coverage Disclosure Notice

Medicare

Important Notice from IPG Services Corp 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 IPG Services Corp and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. **IPG Services Corp has determined that the prescription drug coverage offered by the Blue Cross, Blue Shield of Michigan and Blue Care Network is on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your IPG Services Corp prescription drug coverage, be aware that you and your dependents may not be able get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with IPG Services Corp and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

Creditable Coverage Disclosure Notice (con't)

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through IPG Services Corp changes. You also may request a copy.

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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	May 18, 2008
Name of Entity/Sender:	IPG Services Corp
Contact--Position/Office:	Human Resources
Address:	900 Wilshire, Troy, MI
Phone Number:	(248) 362-4233

HIPAA Privacy Rule Policy

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

IPG Services Corp
HIPAA PRIVACY RULE POLICY NOTICE

Effective April 14, 2003 , the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) and the Standards for Privacy of Individually Identifiable Health Information (the **Privacy Rule**) require the ***IPG Services Inc. Health Plan*** (Plan) to protect the confidentiality of your Protected Health Information for purposes of the Medical, Dental, Prescription Drug and Vision Benefit Programs. These Plan Benefit Programs are fully insured and self Insured through insurance carriers ***Blue Cross, Blue Shield of Michigan, Blue Care Network, Guardian***, and ***IPG Services, Inc.*** will not receive any of your Privacy Rule-protected health information (except as set out in the next paragraph) from the insurance carriers, the Plan is not required to provide you with a separate Notice of Privacy Practices from the Plan.

Insurers ***Blue Cross, Blue Shield of Michigan, Blue Care Network, and Guardian*** may not provide the Company with any of your protected health information, except:

- summary health information about your claims history, claims expenses, or type of claims you experienced – with most identifying information remove – to use only for obtaining premium bids or modifying, amending or terminating a particular group health plan; and

- your enrollment and disenrollment information.

The Company will not retaliate against you if you exercise any of your privacy rights under HIPAA nor will the Company require you to waive your privacy rights as a condition of receiving payment, enrolling in a health plan or being eligible for benefits.

The Company adopted this Privacy Policy to protect the confidentiality of your Privacy Rule-protected health information. To maintain the confidentiality of your protected health information, you will need to communicate directly with the insurance carriers ***Blue Cross, Blue Shield of Michigan, Blue Care Network, Guardian*** if you have a claim problem. The Company will only become involved with your claims, if you sign an Authorization, permitting a Company employee to communicate with the insurance carrier on your behalf. If you have any questions, please contact the Human Resources Department.

May, 2008

Additional Benefits

Value Added Programs for Blue Cross Blue Shield Members

Blue Cross Blue Shield of Michigan has many additional benefits to offer members that are enrolled in a BCBSM medical plan. Examples of these benefits are the Weight Watchers Program, Blue Health Line and Naturally Blue. Please read below for further details.

Blue Health Line (for BCBSM)
Blue Health Line is a valuable resource for BCBSM members. Registered nurses are available to offer health information 24 hours a day, seven days a week, by calling (800) 811-1764. By calling this number, members can obtain advice to help them to make informed decisions regarding their health care. Members can also listen to one of the many tapes that are available in an audio library. Topics range from generic self care to understanding specific illnesses.

Blue Health Connection
Blue Health Connection Health Education is a valuable resource for Blue Cross Blue Shield and BCN members.

- Blue Cross members can call (800) 775-BLUE (2583), 24 hours a day, any day. Or visit us the website at www.bcbsm.com

- Blue Care Network members can call (800) 637-2972 to request materials on specific health topics. Visit the new BCN Web site at www.MiBCN.com.

***BlueSafe**
BlueSafe is an injury prevention program for Blue Cross Blue Shield and Blue Care Network of Michigan members. Show your Blues identification card to save 20 percent at Michigan Dunham's Sports for safety items such as helmets and padding for bicycles, in-line skates and scooters, athletic braces and supports, and life jackets.
Our members also save 20 percent at Michigan Wright & Filippis stores on all home medical equipment not covered by their health coverage, including bathroom safety seats, grab bars and first aid kits.

Weight Watchers
We have formed a partnership with Weight Watchers to help you lose pounds. Even a moderate weight loss can help reduce your risk of chronic health conditions, including diabetes, high blood pressure, heart disease and certain types of cancer. Show your Blues identification card at your first Weight Watchers meeting to receive your special discount. Call Weight Watchers at (800) 651-6000 or visit www.weightwatchers.com to find the Weight Watchers location nearest you.

Naturally Blue
Through the Naturally Blue program, members are able to receive a discount on such items as massage therapy and acupuncture. For a list of providers please log on to: http://bcbsm.wholehealthmd.com

Quit the Nic!
Smoking Cessation Program
We have developed tools to help our members quit smoking. In addition to the option of using Zyban and nicotine replacement therapy such as patches, gum or nasal sprays, we encourage our smoking members to enroll in Quit the Nic! Participants receive telephone support, educational materials, and opportunities to speak with a health coach about how to kick the habit. Our health coaches help develop a plan of action and establish a quit date. They also serve as a support system by offering encouragement, answering questions and evaluating progress.

The Healthcare Advisor ™
This online decision-making support resource provides information that empowers you to manage your health and make better health care decisions. Included in the Healthcare Advisor is:

- **PharmaAdvisor™** — allows you to research and compare drug treatment options
- **Physician Selection Advisor™** — allows you to select a physician using the criteria most important to you
- **Hospital Advisor™** — allows you to find and compare hospitals using the factors most important to you
- **Treatment Cost Advisor™** — allows you to research the cost of common health care service.

Coverage Advisor ™
Coverage Advisor helps you consider the health care services you and your family are likely to need, allows you to estimate the costs for those services and allows you to forecast out-of-pocket costs under various scenarios. Coverage Advisor also helps you determine whether a consumer-directed plan is right for you.

Online. Explanation of Benefits
Get a complete explanation of benefits statements on our secure Web site to confirm your claim payments and help you manage your health care spending

Publications
BCBS publications help you lead a healthier lifestyle with relevant health information for you and your family. The following publications will be available to you based on your coverage; Living Healthy, Good Health, and Your Health Advantage.

*Please note that certain programs apply only to Michigan residents.