

December 19, 2011

Enrollment Deadline: 12/23/2011

Dear Worksite Employee:

Congratulations! On behalf of your worksite employer and ADP TotalSource, we are pleased to provide you with important information on how to take advantage of the comprehensive worksite employee benefits available to you. In addition to health benefits, you are also eligible for a variety of supplemental benefits through Marsh@Work Solutions program. You will soon receive more information on these terrific benefits directly from Marsh@Work Solutions. The enclosed enrollment kit outlines the benefits available to you effective 01/01/2012.

Please note if you are a Self-Employed Individual, there are certain tax rules and regulations which affect the taxable nature of the benefits which you may elect to receive through your worksite employer and ADP TotalSource, Inc. Please refer to the Self-Employed Individual Benefit Participation Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

If you recently participated in an onsite enrollment meeting or already received and completed the enrollment process for this plan at your worksite, no other action is required.

Please note, your eligibility date is fast approaching. To more effectively expedite the enrollment process and receive any carrier ID cards, we encourage you to enroll online today!

Important Information for 2011!

Health Care Reform Legislation

As you may know, Health Care Reform legislation known as the Patient Protection and Affordable Care Act (or PPACA) was passed early in 2010. As such, you may be asking how this will affect your health care benefits through ADP TotalSource. Your employer, through its partnership with ADP TotalSource, already offers comprehensive health care coverage for eligible employees and their eligible family members. We don't expect these measures to significantly affect your access to the valuable programs that support the health and well-being of you and your family. It's important to note that many of the legislations' requirements will be phased in over time, with some of the provisions taking effect in 2014 and later. ADP TotalSource is committed to keeping you informed if there's a provision that will impact your benefits. Please refer to the flyer included in this enrollment kit on specific Health Care Reform disclosures affecting your health care benefits for the plan year beginning June 1, 2011.

Flexible Spending Account (FSA) Enrollment

Have you heard of Flexible Spending Accounts or FSAs? The Health Care FSA and Dependent Care FSA let you pay for certain health care and dependent care expenses tax-free. The maximum contribution limit for the Health Care FSA is \$3,500. The maximum contribution limit for the Dependent Care FSA is \$5,000 (\$2,500, if married filing separately) if you are a non-highly compensated employee and \$2,000 if you are a highly compensated employee. Please refer to the enclosed Dependent Care FSA Summary if you have questions about who is considered a highly compensated employee for this purpose. Please note that participation by a Self-Employed Individual (SEI) in the Dependent Care FSA may be further limited by IRS guidelines. Please refer to the FSA benefit summaries in this kit for Plan details and SEI participation rules. For important Health Care Reform changes affecting the eligibility of Over-the-Counter medications to be reimbursed through the Health Care FSA, please refer to the FSA flyer and FSA benefit summary in this kit.

Health Care FSA - OTC Changes

Please note that in accordance with Health Care Reform legislation, effective January 1, 2011 individuals can no longer use the ADP TotalSource Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription. Refer to the Health Care FSA flyer located in the Benefits Quick Links section at www.mytotalsource.com for more details on the revised rules and for a list of the most commonly used OTC items that are still eligible for reimbursement under the Health Care FSA.

Dependent Eligibility

The Health Care Reform Act requires group health plans and health insurance issuers to extend dependent coverage for adult children until age 26. Further details are provided within this enrollment kit. Additionally, several states have passed legislation allowing parents to extend health coverage for their over age dependent children beyond age 26 that meet certain eligibility criteria. Please refer to the Dependent Eligibility Reference Guide in the Benefits Quick Links section located

on www.mytotalsource.com for further details.

Dependents' Social Security Numbers Required for Enrollment

The Centers for Medicare and Medicaid Studies (CMS) requires Social Security numbers (SSNs) for health plan subscribers and their dependents in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. The Act establishes mandatory insurer reporting requirements, which help the CMS enforce Medicare secondary payer rules. In order to ensure compliance with these mandatory reporting requirements, our health insurance carriers require worksite employees to provide SSNs for all covered dependents. **As such, we will be unable to process the health plan enrollments for your identified dependents without the required SSN information.** ADP TotalSource, as well as each of our health insurance carriers, takes strict precautions to ensure the security of your personal information, including your Social Security number. If you have questions about the security measures your health insurance carrier has in place, please call their Customer Service phone number before completing your enrollment elections.

Your enrollment elections must be made by the enrollment deadline of **12/23/2011** in order to ensure you have coverage on your effective date. **Enrollment elections made after this date will not be processed and you will not be eligible for coverage until the next Open Enrollment period.**

Simply review your Enrollment Kit and make your elections. Please refer to the instruction pages that follow for more details on the process. If you do not have access to enroll online and are electing to make changes by completing the Health and Welfare Benefits Enrollment Form, please return the forms to the address or fax number indicated below.

ADP TotalSource
Attn: Benefits Center
10200 Sunset Drive
Miami, FL 33173
FAX: 1-866-616-8858

Thank you in advance for your cooperation.



ACTION SECTION

If you are making a benefit election for the 2011-2012 Plan Year, please enroll online or complete, sign and return all the forms in this section before your Enrollment Deadline. If you are waiving benefits, you must either enter your waiver online or complete the ADP TotalSource Health & Welfare Enrollment Form in this section.

*Why enroll online?
The online enrollment system
walks you through the process
and helps you enroll quickly
and correctly. There's even a
tutorial available on
My TotalSource!*

Enrollment Instructions: Plan Year 2011-2012

These instructions will help you enroll in your 2011-2012 benefits quickly and easily. Enrolling online is the fastest way to choose your benefits. If you don't have Internet access, see the next page for instructions on completing the paper enrollment form in this kit. Please be sure to enroll before the Enrollment Deadline.

To Enroll Online:

- **Log on to My TotalSource (www.mytotalsource.com).**
 - If you're logging on to My TotalSource for the first time, follow the instructions below:
 1. Open a new browser window.
 2. Copy the following URL, paste it into the address bar of the browser and click **Go** or press the *Enter* key.
<https://totalsource.adp.com/ts/login.do>
 3. Click on the **Register Now** link. *If you've already registered, please skip to step 9.*
 4. Enter your Registration Pass Code – if you don't know your Registration Pass Code, please contact the Employee Service Center at (800) 554-1802.
 5. Click the **Next** button.
 6. Follow the online instructions and complete the registration.
 7. Close the browser window.
 8. Open a new browser window, copy the following URL, paste it into the address bar of your browser and click **Go**.
<https://totalsource.adp.com/ts/login.do>
 9. Click the **Employee Login** button.
 10. Enter your new User ID and Password on the next screen to log on.
- **Follow the step-by-step directions on the Web site to enroll.**
 1. Under Quick Links, select **My Benefits** and click on **Elect Benefits**.
 2. Click on **Enrollment Period**.
 3. Make your selections for each plan you wish to participate in by clicking the radial button next to your desired election category. Click **Continue** after you're finished making your elections. (*Hint* – use your paper enrollment form as a guide.)
 4. Under Add/Edit Dependent & Beneficiary, add your dependent and beneficiary information and attach to appropriate plan type (medical, dental or vision). Click **Continue**.
 5. *For HMO and DMO elections:* Enter your chosen Primary Care Physician (PCP) and/or Primary Care Dentist (PCD) for each dependent on HMO/DMO plans. Click **Continue**.
 6. Enter your beneficiary benefit distribution percentage – remember, percentages must be allocated as whole numbers. Click **Continue**.
 7. Click on **Review Benefits** to review your benefit elections and coverage. If they're correct, click **Accept**. Congratulations – you're done!
- **For your records, print out the Confirmation page and Temporary Insurance Card, if applicable.**

The benefits you elect will be effective through May 31, 2012, and cannot be changed until the next annual Open Enrollment period, unless you experience an IRS-qualified change in status (see the Summary Plan Description for details). After you make your election, you will receive a Confirmation Statement by mail summarizing your benefit elections.

Refer to the *Health Care Reform Disclosure* document in this kit for important information regarding Dependent Coverage and Primary Care Physician (PCP) selection.

To Enroll by Paper Form:

Follow the instructions below to complete the two-page Health and Welfare Benefits Enrollment Form in this kit. If a carrier-specific enrollment form is in this kit, you must complete it, also. Incomplete forms will delay the processing of your benefit elections.

To Waive/Cancel All Coverage(s):

If you are not enrolling in any of the benefits offered:

- Complete the **Personal Information** section, or verify the pre-printed information for accuracy.
- Check (✓) Waive/Cancel All Coverage(s) above the **Medical Options** section.
- Place a check (✓) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- Complete the **Beneficiary Information** section (if Life Insurance is offered to you).
- Sign and date the enrollment form.

To Enroll in Benefits Coverage:

- Complete the **Personal Information** section, or verify the pre-printed information for accuracy.
- **Medical Options** – Place a check (✓) beside the plan and coverage level you want. If you don't want to enroll in a Medical Plan, place a check (✓) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- **Dental Options** – Place a check (✓) beside the plan and coverage level you want, or check (✓) Waive Coverage.
- **Vision Options** – Place a check (✓) beside the plan and coverage level you want, or check (✓) Waive Coverage.
- **Basic Life and AD&D / Long Term Disability / Short Term Disability Plans** – If these benefits are offered to you, the level of coverage is indicated. You don't need to do anything.
- **VTL Options** – If these benefits are offered to you, your options are shown. Place a check (✓) beside the plan and coverage level you want, or check (✓) Waive Coverage.
- **FSA Options** – Write in the amount you want to contribute for the 2011-2012 Plan Year, or check (✓) Waive.
- **Health Savings Account (HSA) Option*** – If you're currently contributing to the JPMorgan Chase HSA and if the HSA remains available to you, you can change the amount you contribute on the enrollment form.
- Complete the entire **General Information** section.
- **Dependent Information and PCP Designation**** – All applicable fields in this section must be completed.
 - If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, indicate a primary care physician (PCP) or dentist (PCD), by name and identification number, for yourself and each covered dependent. Refer to the *Health Care Reform Disclosures* document in this kit for important information regarding PCP selection.
 - If you want dependent coverage under any benefit plans, you must provide each dependent's name, relationship to you, Social Security number, date of birth, and gender. Indicate with an "X" if they are to be enrolled in the medical, dental and/or vision plans (and provide PCP/PCD information, if applicable). Refer to the *Health Care Reform Disclosures* document in this kit for important information regarding dependent coverage.
 - ADP TotalSource and our health insurance carriers require worksite employees to provide dependents' SSNs in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.
- **Beneficiary Information** – Complete the table for each person you would like to designate as a beneficiary for Basic Life and AD&PL insurance, if applicable.
- **Authorization** – Sign and date the form at the bottom of page 2. If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, state law requires that your spouse also sign your enrollment form.

* If you are enrolling in the HSA for the first time, you must log on to the JPMorgan Chase Online Enrollment Web site. To access the site, log on to My TotalSource at www.mytotalsource.com and click the 'View My Benefits' link.

** It is very important that you write the DOB, Social Security numbers and the Primary Care Physician/Dentist name and identification number for each dependent to be covered, if applicable.

Information about PCPs: If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, you must identify a primary care physician (PCP) or dentist (PCD) for you and each of your covered dependents by writing the provider's name and identification number (available in the plan's provider directory or on the plan's Web site) in the table. Refer to the *Health Care Reform Disclosures* document in this kit for important information regarding PCP selection. If you do not provide the PCP or PCD's name and identification number, the carrier may assign a provider to you, or your plan identification cards will be delayed.



Health Care Reform Disclosures

Health Care Reform legislation known as the Patient Protection and Affordable Care Act (or PPACA) was passed in early 2010 and requires disclosure of certain changes in coverage that are being made in the ADP TotalSource Health and Welfare Plan as required by PPACA.

EXTENSION OF DEPENDENT COVERAGE TO AGE 26

The Patient Protection and Affordable Care Act (PPACA) includes a provision requiring group health plans and health insurance issuers offering dependent coverage for children to continue providing that coverage for adult children until age 26. This requirement is effective for the ADP TotalSource Health and Welfare Plan on June 1, 2011, therefore, all health plan offerings under the ADP TotalSource Health and Welfare Plan will include coverage for adult children until age 26 effective June 1, 2011. In addition, although not required by PPACA, the TotalSource dental and vision plan offerings will include coverage for adult children until age 26.

PATIENT PROTECTION - PRIMARY CARE PHYSICIAN (PCP) AND OB/GYN SELECTION

Many of the ADP TotalSource health plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the ADP TotalSource health insurance carriers or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health insurance carrier at the phone number indicated on the Benefit Summary provided in your benefits enrollment kit.

In addition to the above disclosures, further health care reform provisions affecting the ADP TotalSource Health and Welfare Plan are detailed in the **Summary of Material Modifications** located in your benefits enrollment kit and in the Benefits Quick Links section of MyTotalSource located at www.mytotalsource.com. Further details can also be found in the applicable health insurance carrier's certificate of coverage booklet. If you have questions regarding the above disclosures or coverage you are eligible for through the ADP TotalSource Health and Welfare Plan, contact the ADP TotalSource Employee Service Center at 1-800-554-1802.

Effective Date: 01/01/2012

Health and Welfare Benefits Enrollment Form (2011-2012 Plan Year)**Personal Information**

Name: _____
 Address: _____
 Phone #:() _____

SSN: _____ - -
 Gender: M / F
 Date of Birth: / /
 Date of Hire: / /

Company: Family Entertainment Group LLC
 Paygroup: 14E / 376909
 Region: Mid-West
 HRG: HRG Midwest-TR
 Ben Rep: Lynn Rowe

Class Code: A / All Employees
 Class State: OH
 Waiting Pd: 30 Days

IMPORTANT: This form has multiple pages. All pages must be completed (including your signature on the last page) and submitted, or your benefit elections may be delayed.

() **Waive/Cancel All Coverage(s).** (Medical option waiver section must be completed)

Medical Options - Elect one (1) Medical plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
UHC-CP 1LW 500/80%-A1-OH	AXKP1	() \$ 82.00	() \$ 484.00	() \$ 432.00	() \$ 821.00
UHC-CP 2LD 1000/100%-A1-OH	AXKS1	() \$ 93.00	() \$ 508.00	() \$ 455.00	() \$ 856.00
UHC-CP 2LF 2000/100%-A1-OH	AXKR1	() \$ 42.00	() \$ 398.00	() \$ 352.00	() \$ 697.00
UHC-CP 2LU 3000/100%-A1-OH	AXLB1	() \$ 16.00	() \$ 343.00	() \$ 301.00	() \$ 618.00

Waive Medical Coverage

() I certify that I am declining medical coverage at this time because I am currently covered under another health plan.

() I certify that I am declining medical coverage at this time and I am NOT currently covered under another health plan

Dental Options - Elect one (1) Dental plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Guardian-Value Midwest	ACOU1	() \$ 29.56	() \$ 59.15	() \$ 61.95	() \$ 94.90

Waive Dental Coverage

() Waive Coverage

Vision Options - Elect or Waive Vision coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
VSP- Choice Vision Plan	ASCX1	() \$ 6.24	() \$ 12.48	() \$ 13.36	() \$ 21.35

Waive Vision Coverage

() Waive Coverage

Life and Disability Plan Options

Plan Type	Plan Offering(s)	Plan Eligibility
Life	Basic \$10,000	Life offered only to those who elect medical benefits
LTD	LTD1 50% \$1,000/mo-180	LTD offered only to those who elect medical benefits

Flexible Spending Account (FSA) Plan Options

	Minimum Contribution	Maximum Contribution	Plan Year Election
() I wish to enroll in the Health Care Flexible Spending Account	\$50	\$3,500.00	\$ _____
() I wish to enroll in the Dependent Care Flexible Spending Account	\$50	\$5,000.00 (\$2,500 if married filing separately)	\$ _____

Waive Flexible Spending Account Coverage

() Waive Health Care FSA Coverage
 () Waive Dependent Care FSA Coverage

Health and Welfare Benefits Enrollment Form (2011-2012 Plan Year)

Effective Date: 01/01/2012

Company: Family Entertainment Group LLC

Enrollment Deadline is 12/23/2011

Paygroup: 14E / 376909 / Mid-West

DEPENDENT INFORMATION AND PCP DESIGNATION

In this section, list yourself and all of your eligible dependents whom you wish to cover under a benefit plan. Provide complete information for each dependent, and identify the benefit plan(s) in which you wish to enroll each dependent by marking "X" under the appropriate benefit plan option(s).

Name	Relation	SS#	Date of Birth	Gender	-----Election Information-----			Vision
					Medical PCP	Dental PCD		
	Employee							

BENEFICIARY INFORMATION (List individual(s) you wish to designate as Basic Life Insurance beneficiaries)

Name	Relation	SS#	Date of Birth	Address	Amt. or %	Basic Life	Primary or Contingent

AUTHORIZATION

I have read the explanation of my Health and Welfare benefits options for the current Plan Year. I authorize the elections I have made, as well as any pre-tax payroll deductions required for these elections unless I complete an additional form requesting that benefit deductions be taken on a post-tax basis. I understand that during this or any future open enrollments if I do not make changes to my then-current health plan elections, my elections will default to either the same health plan election or a designated replacement health plan election specified in the personal statement for that enrollment period, and that such a default may result in a higher cost and increased deduction from my pay. By signing this Form, I am also authorizing any pre-tax deductions required to cover the defaulting elections.

I understand that if I am considered a Self-Employed Individual, according to the Internal Revenue Code, I am not eligible to pay for my benefits under the ADP TotalSource, Inc. Health and Welfare Plan ("Plan") on a pre-tax basis, except for the Dependent Care FSA. Additionally, I am not eligible to make contributions to the Health Care FSA.*

I acknowledge that in the event of the termination of my employment, my health, dental, vision and group life insurance coverage will continue through the end of the month in which my termination occurs. Other coverage, such as disability and participation in the FSA plan (if applicable), will end on the date of my employment termination. I agree that upon my termination, the amount needed to cover my contributions to my insurance premium(s) for that month's coverage becomes immediately due and payable and will be deducted from my final paycheck(s). I understand that this final deduction amount may be higher than the amounts deducted in previous pay periods. I understand that I cannot change my elections before the next annual enrollment period, unless a qualified change in status occurs and my requested election change is consistent with the change in status event.* I understand that if I am a newly-eligible employee waiving medical coverage because I am covered under another medical plan, I must indicate this under the medical options section by choosing the first "Waive Coverage" option. Absence of this indication may affect my eligibility for HIPAA special enrollment period should I lose this other coverage at a later date.*

I hereby certify that the above information is complete and accurate.

Worksite Employee Signature _____ Date _____ Spouse's Signature _____ Date _____

Required only for married residents of AZ,CA,IL,LA,NV,NM,TX,WA and WI who are designating a non-spouse beneficiary for the life insurance option.

*Please see the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description for further details.

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 July 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
CALIFORNIA – Medicaid	GEORGIA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

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
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ 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: 603-271-8183
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – 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	Website: http://www.nc.gov Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	VERMONT – Medicaid

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml Phone: 1-888-564-9669	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
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 304-558-1700
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531
UTAH – Medicaid and CHIP	
Website: http://health.utah.gov/upp Phone: 1-866-435-7414	

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

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



Marsh PersonalPlans Voluntary Benefits

ADP TotalSource is constantly looking for ways to enhance your benefits package. We know that we're at our best when you're at your best. That's why we're expanding your voluntary benefits program to keep you and your family safe, healthy and financially secure. In addition to expanding the program, there will be a new dedicated voluntary benefits Web site available starting March 1, 2010. The Web site – www.adptsvoluntarybenefits.com – will have more information and resources to help you learn more about the voluntary benefits.

Here's a brief overview of the benefits that will be coming soon:

Employee Purchase Program

Through the Employee Purchase Program, you may purchase the new, brand-name computers and electronics you want and need through the ease of payroll deductions. With no credit check, no down payment and a 12-month payment plan, buying life-enhancing products is simple and economical. Plus, you can take advantage of easy budgeting via payroll deductions so you no longer have to deal with the hassle of writing checks!

ID TheftSmart™

ID TheftSmart provides comprehensive identity theft safeguards and restoration services. And, if identity theft does strike, Licensed Investigators will do most of the legwork and paperwork to restore your name – saving time, money and aggravation.

Life-Prints®

Life-Prints is a comprehensive identification and records storage software package. With this software, you can create and securely store your loved ones' critical identification information, medical history, health records and other important documents on your personal computer.

The following are benefits that are currently available through ADP TotalSource:

Group Universal Life Insurance (GUL)

Regardless of age, life insurance should be an important part of your financial plan. GUL insurance offers flexible coverage amounts, as well as affordable group rates and payments conveniently deducted from your paychecks.

Pet Insurance

Pet insurance policies cover a multitude of medical programs and conditions related to accidents and illnesses (even cancer) for dogs, cats, birds, ferrets, rabbits, reptiles and other exotic pets. There is also optional routine care coverage, because regular veterinary care is critical to the long-term health of your pets.

Legal Services

With the Legal Services plan, you have the professional legal help you need. As a member, you will always have access to professional attorneys, financial counselors and other valuable resources to help with everyday legal needs such as creating a will, preparing real estate documents, consumer protections issues and much more. Best of all, fees for most covered matters are 100% paid-in-full when you work with a Network Attorney.

You may visit the Voluntary Benefits Web site at www.adptsvoluntarybenefits.com for more information about these programs. Or call (800) 557-1038 to speak with a customer service representative.

PersonalPlans Voluntary Benefits is provided through Marsh Voluntary Benefits, part of Marsh & McLennan, a worldwide leader in risk management. Marsh Voluntary Benefits is the program administrator.

ADP TotalSource Employee Certification of Dependent Tax Status

INSTRUCTIONS: Complete and return this form only if you are enrolling one or more dependents in the following categories for benefits coverage:

- Same-sex spouses and their children,
- Common-law spouses (same-sex) and their children,
- Civil Union partners and their children,
- Adult children that have reached age 26

I understand that the following rules apply to the federal income tax treatment of benefits coverage provided for the above listed dependents:

- If my above-mentioned dependent is a tax dependent as defined by the Internal Revenue Code Section 152, I will not be subject to federal or state income tax on the value of the coverage provided to my dependent.
- If my above-mentioned dependent is not a tax dependent as defined by the Internal Revenue Code Section 152, I will be subject to federal and, if applicable, state income tax on the value of the coverage provided to my dependent. The taxable value of the coverage is considered imputed income, and the amount of imputed income will be determined by ADP TotalSource periodically during the calendar year. Because ADP TotalSource allows me to pay for coverage on a pre-tax basis, any imputed income requires an adjustment to my taxable income. ADP TotalSource will make this adjustment on periodic payrolls during the calendar year and I will be notified prior to any payroll adjustments. I understand that this adjustment may increase my federal and, if applicable, state income tax liability.

Please consult with your tax advisor before certifying below whether your enrolled dependent is a tax dependent as defined by the Internal Revenue Code. List below any dependent(s) you are enrolling from the above listed dependent categories and indicate their tax status.

Last Name	First Name	Dependent Relationship	Dependent Tax Status	
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent

I certify the tax status of my dependent(s) listed above as defined by the Internal Revenue Code. I understand that ADP TotalSource will rely on this certification to determine my federal income and employment taxes. I further understand that I must notify ADP TotalSource if conditions change that would cause my dependent(s) to no longer qualify as my tax dependent.

Employee Name

Employee SSN or Employee ID

Employee Signature

Date

Employee Address

FAX OR MAIL COMPLETED FORM TO:
ADP TOTALSOURCE
Attention: Benefits Center
10200 Sunset Drive
Miami, FL 33173
FAX: 1-866-616-8858



REFERENCE SECTION

The contents of this section are for review only.
Nothing in this section needs to be returned.

SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION FOR THE ADP TOTALSOURCE, INC. HEALTH AND WELFARE PLAN

Note: This document contains important information concerning your benefits. Please review this information carefully and retain with your benefit materials for future reference. Please note that eligibility varies by benefit option and your worksite employer's elections. Those benefit options you are entitled to are described in your benefits enrollment kit.

You previously received enrollment information for the Health and Welfare Plan ("Plan"). This document is a Summary of Material Modifications ("SMM") for the 2010-2011 and 2011-2012 plan years for your review and records, and it contains changes to the Summary Plan Description ("SPD") that you previously received. You may obtain a copy of the SPD by logging on to My TotalSource at www.adptotalsource.com or calling the Employee Service Center at 1-800-554-1802 or by email at esc@adp.com.

This SMM is intended to summarize the Plan amendments. If there is a conflict between this SMM and the actual language of the Plan, the Plan language controls.

Summaries of the Plan Modifications are as follows:

EFFECTIVE JANUARY 1, 2010

Change to the High Deductible Health Plan (HDHP) Deductible and Out-of-Pocket Maximums for 2010

On page 12 of the Summary Plan Description under the section titled **High Deductible Health Plan (HDHP)**, the stated annual deductible and out-of-pocket maximum requirements are changed effective January 1, 2010 for calendar year 2010 as follows:

- For self-only coverage, an HDHP has an annual deductible of at least \$1,200 and an annual out-of-pocket expense (deductibles, co-payments and coinsurance, but not premiums) not exceeding \$5,950.
- For family coverage, an HDHP has an annual deductible of at least \$2,400 and an annual out-of-pocket expenses (deductibles, co-payments and coinsurance, but not premiums) not exceeding \$11,900.

These maximums are subject to change by the IRS each January 1st.

Change to Health Savings Account (HSA) Note

On page 28 of the Summary Plan Description under the section titled **Eligibility**, the note following the 3rd bullet is changed to read as follows: "If you choose to enroll in an HDHP and plan on contributing to an HSA any time during the 2010-2011 or 2011-2012 Plan Years, you are not eligible to participate in the Health Care FSA. See page 24 for Limited Health Care FSA details."

Change to Health Savings Account (HSA) Contribution Limits for 2010 and 2011

On page 28 of the Summary Plan Description under the section titled **Contribution Limits**, the stated HSA contribution limits are changed effective January 1, 2010 for calendar year 2010 and 2011 as follows:

- Contribution limit for individual coverage in 2010 and 2011 is \$3,050.
- Contribution limit for family coverage in 2010 and 2011 is \$6,150.

Change to Dependent Care Flexible Spending Account (FSA) Contribution Limits for Highly Compensated Employees

On page 26 of the Summary Plan Description under the section titled, **Contribution Limits for Highly Compensated Employees**, is changed to read as follows: "Highly compensated employees will only be permitted to contribute to the Dependent Care FSA up to the amount of \$2,000 for the 2010-2011 Plan Year and each Plan Year thereafter. In addition, ADP TotalSource may, at any time before or during the Plan Year (June 1 – May 31), notify a highly compensated employee that he or she must discontinue pre-tax contributions to the Dependent Care FSA or that he or she must limit such pre-tax contributions to a particular dollar amount below the \$2,000 maximum if ADP TotalSource determines in its discretion that such action is necessary or advisable in order to satisfy the nondiscrimination requirements applicable to the Dependent Care FSA.

For the 2010-2011 and 2011-2012 Plan Years, a "highly-compensated employee" is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a Client Company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of \$110,000 annually. The definition of a highly-compensated employee may change for future Plan Years."

Change to Cost of COBRA Coverage

On page 45-46 of the Summary Plan Description under the section titled, **Cost of COBRA Coverage**, the second paragraph is changed to read as follows: "The American Recovery and Reinvestment Act of 2009 (ARRA) was enacted on February 17, 2009. On December 19, 2009, the President signed the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010 was signed by the President on March 2, 2010. These laws give assistance eligible individuals the right to pay reduced COBRA premiums that can last up to 15 months.

ARRA, as amended by the Department of Defense Appropriations Act, 2010, and the Temporary Extension Act of 2010 includes a 65% COBRA subsidy for COBRA premiums paid by certain qualified beneficiaries who lose group health plan coverage during the period beginning September 1, 2008 and ending March 31, 2010 (including medical, dental and vision coverage but not Health Care FSA) because of a covered worksite employee's involuntary termination of employment."

The first bullet of the 3rd paragraph is changed to read: "must have lost group health coverage as the result of an employee's involuntary termination of employment during the period beginning September 1, 2008 and ending March 31, 2010, and".

The 4th paragraph, first and second sentences are changed to read: "An assistance-eligible individual may be entitled to receive the COBRA subsidy for a period of up to 15 months. Eligibility for the COBRA subsidy may terminate prior to the end of the 15 month period if the individual has reached the end of the maximum coverage period required under COBRA or the individual becomes eligible for Medicare benefits or coverage under another group health plan."

EFFECTIVE JUNE 1, 2010

Michelle's Law – Continuation of Group Health Coverage for Certain Dependents

On page 8 of the Summary Plan Description a new section titled, **Michelle's Law – Continuation of Group Health Coverage for Certain Dependents**, is added to read as follows: "Michelle's Law allows continuation of group health coverage for up to one year for students who are on medically necessary leaves of absence from a post-secondary educational institution. Refer to the **Coverage While on a Leave of Absence** section located on page 41 for further details regarding this law."

Michelle's Law – Continuation of Group Health Coverage for Certain Dependents

On page 41 of the Summary Plan Description a new section titled, **Michelle's Law – Continuation of Group Health Coverage**, is added to read as follows: "Michelle's Law allows for continuation of group health coverage for a dependent child if the child takes a leave of absence from a post-secondary education institution, or has a change in enrollment status, that: (1) begins while the child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the child to lose student status for purposes of coverage under the plan.

A "dependent child" for purposes of Michelle's Law is a child who (1) is a dependent child of a participant or beneficiary under the terms of the plan, and (2) was enrolled in the plan on the basis of being a student at a post-secondary educational institution immediately before the medical leave of absence began.

The child's coverage will be continued for up to one year after the leave of absence begins or, if earlier, until coverage would have otherwise terminated under the terms of the plan, regardless of student status. The level of coverage and premium provided to the dependent child during Michelle's Law continuation will be the same as the benefits the child would have received if the child had continued as a covered student."

EFFECTIVE DECEMBER 1, 2010

Change to Dependent Eligibility

On page 8 of the Summary Plan Description under the section titled **Dependents**, the following is added: "The Patient Protection and Affordable Care Act (PPACA) includes a provision requiring group health plans and health insurance issuers offering dependent coverage for children to continue providing that coverage for adult children until age 26. This requirement is effective for the ADP TotalSource Health and Welfare Plan on June 1, 2011, however, there are select carriers that have implemented this provision prior to the TotalSource required effective date as follows:

- Effective December 1, 2010 the following carriers allow dependent coverage up to age 26: United Health Care, Neighborhood Health Plans, and Pacificare.
- Effective January 1, 2011 the following carriers allow dependent coverage up to age 26: Blue Cross Blue Shield of Michigan and Blue Care Network."

EFFECTIVE JANUARY 1, 2011

Change to Health Care Flexible Spending Account (FSA) Eligible Expenses List

On page 24 of the Summary Plan Description under the section titled **Eligible Expenses**, the first paragraph is changed to read as follows: "IRS Publication 502 Medical and Dental Expenses provides guidance on what medical expenses are eligible. However, some expenses that are deductible under IRS Publication 502 may not be reimbursable under the Health Care FSA (such as insurance premiums) and some expenses that are not deductible may be reimbursed under the Health Care FSA."

Also, on page 25 of the Summary Plan Description under the section titled **Eligible Expenses**, the following bullet item is **deleted** effective January 1, 2011:

- over-the-counter drugs (excluding cosmetic, dietary supplements or other drugs that are merely beneficial to your general health)

Effective January 1, 2011 In accordance with the Patient Protection and Affordable Care Act (PPACA) individuals will be prohibited from using the ADP TotalSource, Inc. Health Care FSA for the cost of over-the-counter medications that are not otherwise prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

Change to Health Care Flexible Spending Account (FSA) Ineligible Expenses List

On page 25 of the Summary Plan Description under the section titled **Ineligible Expenses**, the following bullet item is **added** effective January 1, 2011:

- over-the-counter drugs (including cosmetic, dietary supplements or other drugs that are merely beneficial to your general health)

Effective January 1, 2011 In accordance with the Patient Protection and Affordable Care Act (PPACA) individuals will be prohibited from using the ADP TotalSource, Inc. Health Care FSA for the cost of over-the-counter medications that are not otherwise prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

Change to Health Savings Account (HSA) Eligible Expenses List

On page 29 of the Summary Plan Description under the section titled **FACTS ABOUT HSAs**, the following is added effective January 1, 2011: "In accordance with the Patient Protection and Affordable Care Act (PPACA) starting on January 1, 2011 you will no longer be able to use HSA funds for over-the-counter ("OTC") medications unless they are prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

Change to Health Savings Account (HSA) Penalty for Non-Qualified Medical Expenses

On page 30 of the Summary Plan Description the response to the question "**What happens if I use my HSA to pay for non-qualified medical expenses?**" is changed to read as follows: "A distribution of funds for reasons other than qualified medical expenses prior to age 65 is taxable and subject to a 20-percent additional penalty. The HSA account holder would need to report this on the tax return for the corresponding tax year."

EFFECTIVE JUNE 1, 2011

Change to Dependent Eligibility

On page 8 of the Summary Plan Description under the section titled **Dependents**, the following is added: "The Patient Protection and Affordable Care Act (PPACA) includes a provision requiring group health plans and health insurance issuers offering dependent coverage for children to continue providing that coverage for adult children until age 26. This requirement is effective for the ADP TotalSource Health and Welfare Plan on June 1, 2011, therefore, all health plan offerings under the ADP TotalSource Health and Welfare Plan will include coverage for adult children until age 26 effective June 1, 2011. In addition, although not required by PPACA, the TotalSource dental and vision plan offerings will include coverage for adult children until age 26.

Important Notice Regarding Annual Dollar Limits

On page 10 of the Summary Plan Description in the section titled **Plan Disclosures** the following language is added: In accordance with applicable law, none of the annual dollar limits (except to the extent they exceed \$750,000 in 2011) that may be included in a health plan offering shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of 2010. The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services. The determination as to whether a benefit constitutes an "essential health benefit" will be made by the applicable insurance carrier.

Important Notice Regarding Lifetime Limits

On page 10 of the Summary Plan Description in the section titled **Plan Disclosures** the following language is added: In accordance with applicable law, none of the lifetime dollar limits that may be included in a health plan offering shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of 2010. The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services. The determination as to whether a benefit constitutes an "essential health benefit" will be made by the applicable insurance carrier.

Patient Protection – Primary Care Physician (PCP) and OB/GYN Selection

On page 11 of the Summary Plan Description a new section titled **Patient Protection – Primary Care Physician (PCP) and OB/GYN Selection**, is added effective June 1, 2011 to read as follows: "The ADP TotalSource health plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the ADP TotalSource health insurance carriers or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health insurance carrier at the phone number indicated on the Benefit Summary provided in your benefits enrollment kit."

Change to Pre-Existing Condition Exclusions

Effective June 1, 2011, no preexisting condition exclusion or limitation under the Plan will apply to any child under age 19. On page 17 of the Summary Plan Description under the section titled **Pre-existing Conditions**, the 3rd paragraph, and 4th bullet is changed to read: "Pre-existing exclusions cannot be applied to any eligible child enrolled in the Plan under age 19."

New Claims and Appeals Procedures

On page 19 of the Summary Plan Description in the section titled **Medical, Dental and Vision Claim Processing** the following language is added: Effective June 1, 2011, there are some enhancements to the claims and appeals process for medical claims. This includes that if your internal appeal of a claim for medical benefits (not related to employee classifications) under the Plan is denied, you will have the right to appeal to an independent reviewer. Additional information about the new internal and external claims and appeals process for medical claims will be furnished in a future communication as well as a future version of the Plan's SPD, and in any written denial you receive.

Change to Flexible Spending Accounts (FSAs) Deadline to File Claims

On page 21 of the Summary Plan Description under the section titled **Requesting Reimbursement**, the 4th paragraph, second sentence is changed to read: "Therefore, the last day to file a claim for the Plan year is **July 30th**."

Rescission of Coverage Rights

On page 27 of the Summary Plan Description in the section titled **When Coverage Under the Plan Ends** the following language is added: ADP TotalSource and its contracted insurance carriers reserve the right to terminate the health care coverage of you/and your dependent(s) prospectively without notice for cause (as determined by ADP TotalSource and/or the applicable insurance carrier), or if you and/or your dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your dependent commits fraud or intentional misrepresentation in an application for health coverage under the Plan, in connection with a benefit claim or appeal, or in response to any request for information by ADP TotalSource or its delegees (including ADP TotalSource or its contracted insurance carriers), ADP TotalSource or the applicable insurance carrier may terminate your coverage retroactively upon 30 days notice. Failure to inform any such persons that you or your dependent is covered under another group health plan or knowingly providing false information in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan.

Change to Taxation of Non-Tax Qualified Dependents

On page 28 of the Summary Plan Description under the section titled **Taxation of Same Sex Spouse/Domestic Partner Benefits & Other Non-Tax Qualified Dependent**, the last sentence is changed to read: "This includes, but is not limited to, same-sex spouses, same-sex common law spouses, civil union dependents, adult children (age 26 and older) and ex-spouse dependents (enrolled only as required in select states)."

EFFECTIVE JANUARY 1, 2012

Change to Health Savings Account (HSA) Contribution Limits for 2012

On page 28 of the Summary Plan Description under the section titled **Contribution Limits**, the stated HSA contribution limits are changed effective January 1, 2012 as follows:

- Contribution limit for individual coverage in 2012 is \$3,100.
- Contribution limit for family coverage in 2012 is \$6,250.

Change to the High Deductible Health Plan (HDHP) Out-of-Pocket Maximums for 2012

On page 12 of the Summary Plan Description under the section titled **High Deductible Health Plan (HDHP)**, the stated annual out-of-pocket maximum requirements are changed effective January 1, 2012 for calendar year 2012 as follows:

- For self-only coverage, an HDHP has an annual out-of-pocket expense (deductibles, co-payments and coinsurance, but not premiums) not exceeding \$6,050.
- For family coverage, an HDHP has an annual out-of-pocket expenses (deductibles, co-payments and coinsurance, but not premiums) not exceeding \$12,100.

These maximums are subject to change by the IRS each January 1st.

IMPORTANT ANNUAL BENEFIT NOTICE(S)

Annual Notice Regarding the Women's Health and Cancer Rights Act

This law requires plans that provide medical and surgical benefits for mastectomies to provide coverage for the following procedures, as requested from the patient in consultation with her physician:

- **Reconstruction of the breast on which the mastectomy has been performed;**
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis (e.g., breast implant); and
- Treatment for physical complications of all stages of the mastectomy, including lymphedemas.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Also, under the Children's Health Insurance Program Reauthorization Act you or your dependent that is eligible, but not enrolled in the Plan, may enroll if either of the following two conditions are met:

- (1) You or your dependent are covered under a Medicaid plan or under a State child health plan and the coverage is terminated due to loss of eligibility and you request coverage under the Plan no later than 60 days after the loss of eligibility; or
- (2) You or your dependent become eligible for assistance for coverage under the Plan, Medicaid plan or State child health plan and you request coverage under the Plan no later than 60 days after you or your dependent are determined to be eligible for assistance.

Plan Description: UHC-CP 1LW 500/80%-OH
Product: POS
Network: Choice Plus

Provider: United Healthcare (UHC)
Member Services Phone #: 1-800-357-0978
Plan Website Address: <http://www.uhc.com/>

Benefit	In-Network	Out-of-Network
General Plan Information		
Lifetime Maximum	• Unlimited	• Unlimited
Calendar Year Deductible - Individual	• \$500	• \$1,000
Calendar Year Deductible - Family	• \$1,500	• \$3,000
Coinsurance	• 80%	• 60%
Calendar Year Out-of-Pocket Max - Individual (incl ded)	• \$3,000	• \$6,000
Calendar Year Out-of-Pocket Max - Family (incl ded)	• \$6,000	• \$12,000
Office Visits		
Primary Care Physician Visit	• \$25 copay per visit	• Covered at 60% after deductible
Specialist Visit	• \$50 copay per visit	• Covered at 60% after deductible
Specialist Referral Required	• No	• No
Hospital Care		
Hospital Care - Inpatient	• Covered at 80% after deductible	• Covered at 60% after deductible
Hospital Care - Outpatient	• Covered at 80% after deductible	• Covered at 60% after deductible
Emergency Care		
Emergency Room (In-Area)	• \$250 copay per visit	• \$250 copay per visit
Urgent Care Facility	• \$75 copay per visit	• Covered at 60% after deductible
Ambulance	• Covered at 80% after deductible	• Covered at 80% after deductible
Prescription		
Tier 1 Retail	• \$15 copay	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 2 Retail	• \$40 copay/\$100 Specialty	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 3 Retail	• \$75 copay/\$300 Specialty (OOP Max: ind \$3,500/fam \$10,500 - combined for all tiers)	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 4 Retail	• Not applicable	• Not applicable
Mail Order	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)
Medicare Part D Compatible	• Yes	• Yes
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	• \$25 copay for initial visit only. Inpatient hospital covered at 80% after deductible	• Covered at 60% after deductible
Preventive Care		
Preventive X-Ray/Lab	• Covered at 100%	• Covered at 60% after deductible
Physical Examinations	• Covered at 100%	• Covered at 60% after deductible
Prostate Screening	• Covered at 100%	• Covered at 60% after deductible
Gynecology Exam	• Covered at 100%	• Covered at 60% after deductible
Mammograms	• Covered at 100%	• Covered at 60% after deductible
Well Baby Care and Immunizations	• Covered at 100%	• Covered at 60% after deductible
Other Services		
Diagnostic X-Ray, Scans & Lab	• Covered at 80% after deductible	• Covered at 60% after deductible
Chiropractic Care	• \$25 copay per visit. Limited to 20 visits.	• Covered at 60% after deductible. Limited to 20 visits per calendar year.
Substance Abuse		
Inpatient Detoxification	• Covered at 80% after deductible	• Covered at 60% after deductible
Substance Abuse - Inpatient	• Covered at 80% after deductible	• Covered at 60% after deductible
Substance Abuse - Outpatient	• \$25 copay.	• Covered at 60% after deductible
Mental Health		
Mental Health - Inpatient	• Covered at 80% after deductible	• Covered at 60% after deductible
Mental Health - Outpatient	• \$25 copay.	• Covered at 60% after deductible

This benefit summary has been prepared by a licensed Insurance carrier or broker based on documents provided by the applicable licensed Insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern. This health insurance plan is part of a large group health plan, as such Medicare is the secondary payer for any insured member that is enrolled in Medicare and this plan. If eligible for Medicare due to ESRD, Medicare becomes primary payer after thirty months of Medicare eligibility. If member is a COBRA participant, Medicare is the primary payer.

Plan Description: UHC-CP 2LD 1000/100%-OH
Product: POS
Network: Choice Plus

Provider: United Healthcare (UHC)
Member Services Phone #: 1-800-357-0978
Plan Website Address: <http://www.uhc.com/>

Benefit	In-Network	Out-of-Network
General Plan Information		
Lifetime Maximum	• Unlimited	• Unlimited
Calendar Year Deductible - Individual	• \$1,000	• \$2,000
Calendar Year Deductible - Family	• \$3,000	• \$6,000
Coinsurance	• 100%	• 80%
Calendar Year Out-of-Pocket Max - Individual (incl ded)	• \$1,000	• \$5,000
Calendar Year Out-of-Pocket Max - Family (incl ded)	• \$3,000	• \$10,000
Office Visits		
Primary Care Physician Visit	• \$25 copay per visit	• Covered at 80% after deductible
Specialist Visit	• \$50 copay per visit	• Covered at 80% after deductible
Specialist Referral Required	• No	• No
Hospital Care		
Hospital Care - Inpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Hospital Care - Outpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Emergency Care		
Emergency Room (In-Area)	• \$250 copay per visit	• \$250 copay per visit
Urgent Care Facility	• \$75 copay per visit	• Covered at 80% after deductible
Ambulance	• Covered at 100% after deductible	• Covered at 100% after deductible
Prescription		
Tier 1 Retail	• \$15 copay	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 2 Retail	• \$40 copay/\$100 Specialty	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 3 Retail	• \$75 copay/\$300 Specialty (OOP Max: ind \$3,500/fam \$10,500 - combined for all tiers)	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 4 Retail	• Not applicable	• Not applicable
Mail Order	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)
Medicare Part D Compatible	• Yes	• Yes
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	• \$25 copay for initial visit only. Inpatient hospital covered at 100% after deductible	• Covered at 80% after deductible
Preventive Care		
Preventive X-Ray/Lab	• Covered at 100%	• Covered at 80% after deductible
Physical Examinations	• Covered at 100%	• Covered at 80% after deductible
Prostate Screening	• Covered at 100%	• Covered at 80% after deductible
Gynecology Exam	• Covered at 100%	• Covered at 80% after deductible
Mammograms	• Covered at 100%	• Covered at 80% after deductible
Well Baby Care and Immunizations	• Covered at 100%	• Covered at 80% after deductible
Other Services		
Diagnostic X-Ray, Scans & Lab	• Covered at 100% after deductible	• Covered at 80% after deductible
Chiropractic Care	• \$25 copay per visit. Limited to 20 visits.	• Covered at 80% after deductible. Limited to 20 visits per calendar year.
Substance Abuse		
Inpatient Detoxification	• Covered at 100% after deductible	• Covered at 80% after deductible
Substance Abuse - Inpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Substance Abuse - Outpatient	• \$25 copay.	• Covered at 80% after deductible
Mental Health		
Mental Health - Inpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Mental Health - Outpatient	• \$25 copay.	• Covered at 80% after deductible

This benefit summary has been prepared by a licensed Insurance carrier or broker based on documents provided by the applicable licensed Insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern. This health insurance plan is part of a large group health plan, as such Medicare is the secondary payer for any insured member that is enrolled in Medicare and this plan. If eligible for Medicare due to ESRD, Medicare becomes primary payer after thirty months of Medicare eligibility. If member is a COBRA participant, Medicare is the primary payer.

Plan Description: UHC-CP 2LF 2000/100%-OH
Product: POS
Network: Choice Plus

Provider: United Healthcare (UHC)
Member Services Phone #: 1-800-357-0978
Plan Website Address: <http://www.uhc.com/>

Benefit	In-Network	Out-of-Network
General Plan Information		
Lifetime Maximum	• Unlimited	• Unlimited
Calendar Year Deductible - Individual	• \$2,000	• \$4,000
Calendar Year Deductible - Family	• \$6,000	• \$12,000
Coinsurance	• 100%	• 80%
Calendar Year Out-of-Pocket Max - Individual (incl ded)	• \$2,000	• \$8,000
Calendar Year Out-of-Pocket Max - Family (incl ded)	• \$6,000	• \$16,000
Office Visits		
Primary Care Physician Visit	• \$25 copay per visit	• Covered at 80% after deductible
Specialist Visit	• \$50 copay per visit	• Covered at 80% after deductible
Specialist Referral Required	• No	• No
Hospital Care		
Hospital Care - Inpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Hospital Care - Outpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Emergency Care		
Emergency Room (In-Area)	• \$250 copay per visit	• \$250 copay per visit
Urgent Care Facility	• \$75 copay per visit	• Covered at 80% after deductible
Ambulance	• Covered at 100% after deductible	• Covered at 100% after deductible
Prescription		
Tier 1 Retail	• \$15 copay	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 2 Retail	• \$40 copay/\$100 Specialty	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 3 Retail	• \$75 copay/\$300 Specialty (OOP Max: ind \$3,500/fam \$10,500 - combined for all tiers)	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 4 Retail	• Not applicable	• Not applicable
Mail Order	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)
Medicare Part D Compatible	• Yes	• Yes
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	• \$25 copay for initial visit only. Inpatient hospital covered at 100% after deductible	• Covered at 80% after deductible
Preventive Care		
Preventive X-Ray/Lab	• Covered at 100%	• Covered at 80% after deductible
Physical Examinations	• Covered at 100%	• Covered at 80% after deductible
Prostate Screening	• Covered at 100%	• Covered at 80% after deductible
Gynecology Exam	• Covered at 100%	• Covered at 80% after deductible
Mammograms	• Covered at 100%	• Covered at 80% after deductible
Well Baby Care and Immunizations	• Covered at 100%	• Covered at 80% after deductible
Other Services		
Diagnostic X-Ray, Scans & Lab	• Covered at 100% after deductible	• Covered at 80% after deductible
Chiropractic Care	• \$25 copay per visit. Limited to 20 visits.	• Covered at 80% after deductible. Limited to 20 visits per calendar year.
Substance Abuse		
Inpatient Detoxification	• Covered at 100% after deductible	• Covered at 80% after deductible
Substance Abuse - Inpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Substance Abuse - Outpatient	• \$25 copay.	• Covered at 80% after deductible
Mental Health		
Mental Health - Inpatient	• Covered at 100% after deductible	• Covered at 80% after deductible
Mental Health - Outpatient	• \$25 copay.	• Covered at 80% after deductible

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Plan Description: UHC-CP 2LU 3000/100%-OH
Product: POS
Network: Choice Plus

Provider: United Healthcare (UHC)
Member Services Phone #: 1-800-357-0978
Plan Website Address: <http://www.uhc.com/>

Benefit	In-Network	Out-of-Network
General Plan Information		
Lifetime Maximum	• Unlimited	• Unlimited
Calendar Year Deductible - Individual	• \$3,000	• \$6,000
Calendar Year Deductible - Family	• 2X Individual	• 2X Individual
Coinsurance	• 100%	• 80%
Calendar Year Out-of-Pocket Max - Individual (incl ded)	• \$4,000	• \$12,000
Calendar Year Out-of-Pocket Max - Family (incl ded)	• 2X Individual	• 2X Individual
Office Visits		
Primary Care Physician Visit	• \$30 copay per visit	• Covered at 80% after deductible
Specialist Visit	• \$60 copay per visit	• Covered at 80% after deductible
Specialist Referral Required	• No	• No
Hospital Care		
Hospital Care - Inpatient	• 100% after \$500 per occurrence deductible and annual deductible	• 80% after \$500 per occurrence deductible and annual deductible
Hospital Care - Outpatient	• 100% after \$250 per occurrence deductible and annual deductible	• 80% after \$250 per occurrence deductible and annual deductible
Emergency Care		
Emergency Room (In-Area)	• \$250 copay per visit	• \$250 copay per visit
Urgent Care Facility	• \$100 copay per visit	• Covered at 80% after deductible
Ambulance	• Covered at 100% after deductible	• Covered at 100% after deductible
Prescription		
Tier 1 Retail	• \$15 copay	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 2 Retail	• \$40 copay/\$100 Specialty	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 3 Retail	• \$75 copay/\$300 Specialty (OOP Max: ind \$3,500/fam \$10,500 - combined for all tiers)	• Reimbursed at the in-network pharmacy contracted rate less the in-network copay
Tier 4 Retail	• Not applicable	• Not applicable
Mail Order	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)	• \$37.50/\$100/\$187.50 copay (Specialty Rx not covered through mail order)
Medicare Part D Compatible	• Yes	• Yes
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	• \$30 copay for initial visit only. Inpatient hospital covered at 100% after \$500 per occurrence deductible and annual deductible	• Covered at 80% after deductible
Preventive Care		
Preventive X-Ray/Lab	• Covered at 100%	• Covered at 80% after deductible
Physical Examinations	• Covered at 100%	• Covered at 80% after deductible
Prostate Screening	• Covered at 100%	• Covered at 80% after deductible
Gynecology Exam	• Covered at 100%	• Covered at 80% after deductible
Mammograms	• Covered at 100%	• Covered at 80% after deductible
Well Baby Care and Immunizations	• Covered at 100%	• Covered at 80% after deductible
Other Services		
Diagnostic X-Ray, Scans & Lab	• Covered at 100% after deductible	• Covered at 80% after deductible
Chiropractic Care	• \$30 copay per visit. Limited to 20 visits.	• Covered at 80% after deductible. Limited to 20 visits per calendar year.
Substance Abuse		
Inpatient Detoxification	• 100% after \$500 per occurrence deductible and annual deductible	• 80% after \$500 per occurrence deductible and annual deductible
Substance Abuse - Inpatient	• 100% after \$500 per occurrence deductible and annual deductible	• 80% after \$500 per occurrence deductible and annual deductible
Substance Abuse - Outpatient	• Covered at 100%	• Covered at 80% after deductible
Mental Health		
Mental Health - Inpatient	• 100% after \$500 per occurrence deductible and annual deductible	• 80% after \$500 per occurrence deductible and annual deductible
Mental Health - Outpatient	• Covered at 100%	• Covered at 80% after deductible

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2011/2012

Plan Description: Guardian Value Midwest
Product: Dental - PPO
Network: DentalGuard Preferred

Provider: Guardian Dental
Member Services Phone #: 1-800-627-4200
Plan Website Address: <http://www.guardianlife.com>

Benefit	In-Network	Out-of-Network
Deductibles & Maximum Amounts		
Calendar Year Benefit Maximum	• \$1,000	• \$1,000
Calendar Year Deductible - Individual	• \$50	• \$50
Calendar Year Deductible - Family	• \$150	• \$150
Preventive & Diagnostic Services		
Preventive & Diagnostic Services	• 100%	• 100% of In-Network Established Fee
Basic / Restorative Services		
Basic / Restorative Services	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Major Services		
Major Services	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Orthodontic Services		
Orthodontic Lifetime Maximum	• \$1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered	• \$1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered
Orthodontic Deductible	• None	• None
Orthodontic Coinsurance	• 50%	• 50% of In-Network Established Fee
Diagnosis	• 50%	• 50% of In-Network Established Fee
Initial Placement of Orthodontic Appliance	• Covered as part of Active and Retention Treatments	• Covered as part of Active and Retention Treatments
Active and Retention Treatments	• 50%	• 50% of In-Network Established Fee
Services		
Oral Examination Copay / Coinsurance	• 100%	• 100% of In-Network Established Fee
Dental X-Rays	• 100%	• 100% of In-Network Established Fee
Prophylaxis - Adult	• 100%	• 100% of In-Network Established Fee
Prophylaxis - Child	• 100%	• 100% of In-Network Established Fee
Topical Application of Fluoride	• 100%	• 100% of In-Network Established Fee
Topical Application of Sealants	• 100%	• 100% of In-Network Established Fee
Fillings	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Periodontic Services	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Extractions	• Simple and Surgical Extractions covered at 80%	• Deductible then 80% of In-Network Established Fee
Endodontics	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Oral Surgery	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Inlays	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Crowns	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Dentures	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Bridges	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee

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2011/2012

Plan Description: Choice Vision Plan

Product: Vision

Network: VSP Choice

Provider: VSP

Member Services Phone #: 1-800-877-7195

Plan Website Address: <http://www.vsp.com>

		In-Network	Out-of-Network **
General Plan Information			
Well Vision Exam		• \$5 copay	• Up to \$45
Prescription Glasses (material)		• \$10 copay	• Not applicable
Prescription Glasses (Lenses)			
Single Vision		• Covered at 100%	• Up to \$45
Lined Bifocal		• Covered at 100%	• Up to \$65
Lined Trifocal		• Covered at 100%	• Up to \$85
Polycarbonate lenses for children		• Covered at 100%	• Not applicable
Lens Options		• Average 20% savings on all non-covered lens options	• Not applicable
Prescription Glasses (Frames)			
Allowance for any frame		• \$180 allowance	• Up to \$70 allowance
Discount off the amount exceeding the allowance		• 20%	• Not applicable
Contacts (instead of glasses)			
Allowance for contacts and fitting evaluations (You may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses)		• \$150 allowance	• \$150 allowance for Elective Contact Lens/ \$210 allowance for Necessary Contact Lens
Laser Vision Correction (instead of glasses or contacts)			
Allowance for both eyes		• \$150 allowance	• \$150 allowance
Discount off regular price or		• 15%	• Not applicable
Discount on promotional price from VSP contracted facilities		• 5%	• Not applicable
Low Vision		• Up to \$1,000 every two years	• Not applicable
If you have had laser surgery, you can use your frame allowance (if eligible) for non-prescription sunglasses from a VSP doctor.			
Extra Savings and Discounts			
Prescription Glasses		• 20% off additional glasses and sunglasses, including lens options from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam*	
Contacts		• 15% off cost of contact lens exam (fitting and evaluation)*	• Not applicable

* Available from any VSP doctor within twelve months of your last eye exam.

Frequency: Every year beginning in June

**In Network copays apply to billed amounts for out of network services and materials

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Plan Description: Basic Life \$10K
Product: Life Plan

Provider: AETNA
Member Services Phone #: 1-800-554-1802
Plan Website Address: <http://www.aetna.com/group/giweb>

Eligibility	Covers a regular full-time or part-time employee eligible for the Basic plan who is residing or working in the United States; is scheduled to work a minimum of 30 hours per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
Date Coverage Starts	Coverage starts on the first day of the month coinciding with or following completion of the worksite employer's waiting period; or the day the worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
Benefit Options	An amount equal to \$10,000 for Life; \$10,000 for Accidental Death & Personal Loss (AD&PL)
Age Reduction	Total amount of Term automatically reduces as follows: 65% at age 65 to 69, 50% at age 70 to 74, and 35% at age 75 and over. Employee Reduction Rule will be based on age as of the June 1st that coincides with or follows the member's birth date.
Benefit Features	
Conversion	Employee will have the opportunity to convert their term life insurance to an individual policy at termination, if no longer eligible for coverage, or if coverage reduces due to age. There is a 60-day conversion application period. Should the employee die during the conversion period, benefits will be payable equal to the maximum amount the employee had a Right to Convert, whether or not he or she applied for an individual policy.
Portability	Employees can port their Life coverage and the Accidental Death rider in the same amount at termination. There is a 60-day conversion application period. Associates may NOT port coverage for themselves if they are sick or injured and away from active work when their life insurance coverage ends. Coverage ported will reduce starting at age 65 and reduced amounts may be converted.
Accelerated Death Benefit (ADB)	If the employee has a terminal illness with a life expectancy of no longer than 24 months, the policy will pay, while employee is still alive - 75% of the life insurance benefit to a maximum of \$500,000.00. This benefit can help with expenses not covered by the employee's medical plan, pay other bills, enable the employee to visit relatives and help the employee get his or her affairs in order. It pays an advance benefit and ensures that the employee's beneficiary will receive the rest of the life insurance benefit upon the employee's death. Repayment is not required should the employee recover within 24 months. The advance benefit may be requested once for the employee and it is not subject to income tax.
Passenger Restraint and Airbag	In the event that a covered person is properly using a passengers restraining device and an airbag is activated and neither contributes to saving the person's life, this benefit will supplement the accidental death benefit.
Repatriation of Remains	In the unfortunate event that a covered person dies while 200 or more miles from home, this benefit offers financial assistance for preparation and return of the deceased's body to a mortuary. For additional benefit features, please refer to the Certificate of Coverage.
Premium Waiver	If the employee is less than age 60 and has been permanently and totally disabled for at least 6 months (as approved by Aetna), premium payments are waived until the employee recovers or reaches age 65.

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

Plan Description: LTD 50% \$1,000/mo-180
Product: Long Term Disability

Provider: AETNA

Claim Service Number #: 1-800-554-1802

Plan Website Address: <http://www.aetna.com/group/giweb>

Eligibility	Covers an active member of an employer that elected to provide LTD benefits to its employees under the Policyholder's Flexible Benefits Plan and is regularly working a minimum of 30 hours per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
Date Coverage Starts	Coverage starts on the first day of the month coinciding with or next following completion of the worksite employer's waiting period; or day worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
Elimination Period	To be eligible for benefits, the employee must be out of work for 180 continuous days due to an occupational or non-occupational injury or illness.
Monthly Benefit	The plan provides income protection to replace up to 50% of the employee's pre-disability monthly earnings.
Minimum Monthly Benefit	\$100 or 10% of gross monthly benefit level, whichever is greater.
Maximum Monthly Benefit	\$1,000 (combined with other income benefits, as specified, in the Certificate Booklet/Summary).
Benefit Duration	As long as the employee remains totally disabled, LTD benefit payments will continue according to the certificate booklet. <i>*Normal retirement age means the Social Security normal retirement age as stated in the 1983 according revision of the United States Social Security Act.</i> <i>* Mental Health & Substance Abuse are limited to 24 months. See the Certificate Booklet/Summary for more details.</i>
Disability Provision	Own Occupation Period is the first 24 months for which LTD Benefits are paid. Any Occupation Period is from the end of the Own Occupation period to the end of the Maximum Benefit Period.
Feature and Limitations Rehabilitation	Our ultimate goal is to help the employee return to gainful employment. Our consultants review each Disability claim and determine if Aetna rehabilitation services would be appropriate and effective. After reviewing the employee's claim, if Aetna feels the employee would benefit from our services, we will contact the employee.
Pre-existing Conditions	A disease or injury if, during the 3 months prior to the employee's effective date of coverage: -it was diagnosed or treated; or -services were received for the diagnosis or treatment of the illness or injury; or the employee took drugs or -the employee took drugs or medicines prescribed or recommended by a physician for that condition and the employee has been covered under The Plan for 12 consecutive months.
Benefit Coordination & Deductible Income	LTD benefits are coordinated with Social Security, Workers Compensation, State or Federal government disability or retirement benefits. For details regarding coordination of benefits please refer to the Certificate Booklet/Summary
Conversion Option	None
	This benefit option may not be available to all industries

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

Plan Description: Health Care Flexible Spending
Account Summary
Product: Health Care FSA

Member Services Phone #: 1-800-554-1802
Website Address: www.mytotalsource.com

Health Care Flexible Spending Accounts

General Plan Information	
Plan Year	June 1 – May 31
Maximum Plan Year Contribution	\$3,500
Who is covered?	Worksite employee plus eligible dependents
How are contributions processed?	Payroll deduction from pre-tax income
Health Care FSA	
Eligibility	You are not eligible to participate in the Health Care FSA if you choose to enroll in a High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2011-2012 Plan Year. See below for Limited Health Care FSA details.
What expenses are eligible?	The following expenses are eligible for reimbursement if they are not otherwise covered by insurance or any other source: <ul style="list-style-type: none"> • Medical or dental co-payments, deductibles and/or co-insurance payments • Medical expenses¹ • Prescription drug expenses • Over-the-counter medications (if prescribed by a physician)² • Dental and orthodontic treatment • Vision care, including eyeglasses and contact lenses • Routine physicals, vaccinations and screening tests • Medical monitoring/testing devices and supplies, including for diabetes
Limited Health Care FSA	
Eligibility	You may participate in the Limited Health Care FSA if you enroll in a qualified High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2011-2012 Plan Year. You may use this account to pay for eligible dental and vision expenses and certain preventive care expenses with tax-free dollars. The Limited Health Care FSA <u>will not</u> reimburse medical expenses. Federal Regulations do not allow individuals to receive reimbursement for medical expenses tax-free through a Health Care FSA and contribute to a HSA during the same Plan Year.
What expenses are eligible?	The following expenses are eligible for reimbursement under the Limited Health Care FSA: <ul style="list-style-type: none"> • Dental and vision co-payments, deductibles and/or co-insurance payments • Dental and orthodontic treatment • Vision care, including eyeglasses and contact lenses • Certain preventive care expenses, such as immunizations and routine examinations and procedures

NOTE: Outlined above are examples of eligible expenses. For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description on My TotalSource at www.mytotalsource.com.

¹ If you plan on contributing to a Health Savings Account at any time during the 2011-2012 Plan Year, you may only elect to enroll in the Limited Health Care FSA. Only eligible dental and vision expenses and certain preventive care expenses may be submitted for reimbursement under the Limited Health Care FSA. The Limited Health Care FSA will not reimburse medical expenses.

² In accordance with Health Care Reform legislation, effective January 1, 2011, individuals can no longer use the ADP TotalSource Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription. Refer to the Health Care FSA flyer located in the Benefits Quick Links section at www.mytotalsource.com for more details on the revised rules and for a list of the most commonly used OTC items that are still eligible for reimbursement under the Health Care FSA.

Plan Description: Dependent Care Flexible Spending Member Services Phone #: 1-800-554-1802
Account Summary Website Address: www.mytotalsource.com
Product: Dependent Care FSA

Dependent Care Flexible Spending Accounts

General Plan Information	
Plan Year	June 1 – May 31
Maximum Plan Year Contribution	
General	\$5,000
If married, filing separately ¹	\$2,500
If a Highly Compensated Employee (HCE) ²	\$2,000
Who is eligible?	<ul style="list-style-type: none"> • Worksite employees and spouse (if applicable) who need dependent care in order to work or look for work • Note: Self-Employed Individuals (SEIs) may only participate on a post-tax basis and only if they are receiving W-2 wages
How are contributions processed?	Payroll deduction from pre-tax income
What expenses are eligible?	<ul style="list-style-type: none"> • Care of a dependent³ under 13 years of age, including fees charged by: <ul style="list-style-type: none"> • qualified child care centers or nursery schools • in-home babysitters or nannies • after-school programs that enable worksite employee and spouse to hold gainful employment • Non-nursing care of a dependent 13 or older who is physically or mentally incapable of self-care • Non-medical care of an elderly dependent whose caregiver spends at least 8 hours a day at the taxpayer's home

NOTE: Outlined above are examples of eligible expenses. Qualified expenses under the Dependent Care FSA include eligible dependent care costs that you must pay to enable you to work or look for work. **The Dependent Care FSA does NOT cover medical expenses for you or your dependents.** For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description and the Summary of Material Modifications on My TotalSource at www.mytotalsource.com.

¹ Note that if more than \$5,000 (\$2,500 if married filing separately) is contributed to the Plan during a single calendar year, the excess amount will be included in your taxable income.

² Highly compensated employees are only permitted to contribute up to \$2,000 per Plan Year to the ADP TotalSource Dependent Care FSA. In addition, ADP TotalSource may, at any time before or during the Plan Year (June 1-May 31), notify a highly compensated employee that he or she must discontinue pre-tax contributions to the Dependent Care FSA or that he or she must limit such pre-tax contributions to a particular dollar amount below the \$2,000 maximum if ADP TotalSource determines in its discretion that such action is necessary or advisable in order to satisfy the nondiscrimination requirements applicable to the Dependent Care FSA.

For the 2011-2012 Plan Year, a "highly compensated employee" is defined by the IRS as an individual who (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a Client Company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of \$110,000 annually. Please note that the definition of a highly compensated employee may change for future Plan Years.

³ Certain IRS rules apply with respect to caregiver/provider eligibility.